CHAPTER 11

Making Treatment Count: Client-Directed, Outcome-Informed Clinical Work with Problem Drinkers

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"The proof of the pudding is in the eating."

—Cervantes, *Don Quixote*

The misuse of alcohol is a serious and widespread problem. Whether clinicians are interested, available evidence indicates they will encounter it on a regular basis throughout their careers. Indeed, the prevalence of abuse and its impact on the drinker, significant others, and society makes avoiding the problem impossible in any clinical, health, or medical setting. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services (HHS), the latest research indicates that an estimated 22 million Americans suffered from substance dependence or abuse due to drugs, alcohol, or both (National Survey on Drug Use and Health [SAMHSA], 2002). Data from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) further shows that problem drinking is associated with more than 100,000 deaths per year—the statistical equivalent of a plane crash killing 274 people every single days—and costs society an estimated $185 billion (Tenth Special Report to Congress on Alcohol and Health, 2000).

The consequences of problem drinking on the family are well established. In the January 2000 issue of the *American Journal of Public Health,* for example, researchers found that 25 percent of all U.S. children are exposed to alcohol abuse and/or dependence in the family (Grant, 2000). This dry recitation of statistics takes on a sense of urgency when the problematic use of alcohol in the home is linked with poorer school performance, increased risk of delinquency, child neglect, divorce, homelessness, and violence. With regard to the latter, available evidence indicates that as many as 80 percent of incidents of familial violence are associated with alcohol abuse (Collins & Messerschmidt, 1993; Eighth Special Report to the U.S. Congress on Alcohol and Health, 1993).

Sadly, many people who want or could benefit from professional intervention do not get the services they need or desire. For example, of the 362,000 people who rec-

ognized and sought help for a drug abuse problem in the year 2002, nearly a quarter (88,000) were unable to obtain treatment. That same year, 266,000 problem drinkers were turned away (National Survey on Drug Use and Health [SAMSHA], 2002). As is true of any large social issue, the reasons for the failure to provide services to those in need are likely many, including poor funding of treatment programs, lingering social stigma associated with problem drinking, lack of professional knowledge and skills, and confusing and often contradictory information about the components of effective care.

Whatever the cause of the disconnect, research leaves little doubt about the overall effectiveness of therapy once it is obtained. Regardless of the type of treatment, the measures of success included, the duration of the study or follow-up period, study after study, and study of studies, document improvements in physical, mental, family, and social functioning, as well as decreased problematic use of alcohol or drugs following intervention (Hubbard, Craddock, Flynn, Anderson, & Etheridge, 1997), Institute of Medicine, 1990; Project MATCH, 1997; Stanton & Shadish, 1997). The same research documents the impact of services on stability of housing and employment in addition to decreased involvement with the criminal justice system.

Taken together, the extent of the problem and the general efficacy of treatment provide astute clinicians with a tremendous opportunity—the chance to partner with problem drinkers, their families, and significant others to both arrest the damage and chart a course toward a more rewarding and productive life. In the sections that follow, the elements of a client-directed, outcome-informed approach are presented. Along the way, emphasis will be placed on documenting how this way of thinking about and working with problem drinkers facilitates better client engagement and improved treatment outcomes. We begin with history and development.

ROOTS OF THE APPROACH

> *"Do not become the slave of your model."*
>
> —Vincent van Gogh

As is true of the field of therapy, the history of drug and alcohol treatment has been marked by contention and debate. In 1956, for example, the American Medical Association declared the misuse of alcohol a "disease" requiring careful examination and detoxification by a physician. Controversy soon followed. Supporters of the disease model of alcoholism cited research showing a progressive loss of control characteristic of an underlying pathophysiological process (see Jellinek, 1960) or pointed to studies indicating that the problem ran in families (see Goodwin, Schulsinger, Hermansen, Guze, & Winokur, 1973). Dissenters, in turn, were quick to cite numerous, and what are now widely acknowledged, flaws in the early studies. These latter researchers noted that the majority of people with alcoholic parentage do *not* go on to abuse alcohol, thus calling any simple view of genetic transmission into serious question (Murray, Clifford, & Gurling, 1983).

Efforts to identify the elements of effective care have been similarly divisive. Historically, the most popular view among clinicians and the public has been that

people can recover from alcoholism, but never be cured. For many years, the right treatment involved a hospital-based detoxification, followed by a stay in a 28-day residential facility, lifelong commitment to total abstinence from alcohol, and ongoing participation in some form of mutual help group (e.g., Alcoholic's Anonymous, Rational Recovery). Meanwhile, a smaller group of researchers, academics, and clinicians published data critical of virtually every aspect of the dominant perspective. As just one example, research consistently failed to provide any evidence of superior outcomes for traditional, long-term (and, therefore, expensive) treatment over brief, targeted intervention, or even a single session of advice-giving with a family physician (Bein, Miller, & Tonigan, 1993; Miller, & Hester, 1986; Orford & Edwards, 1977). Where detox was once thought an essential first step toward sobriety, subsequent research has found that the practice actually increased the likelihood of future episodes of medically supervised withdrawal that, in turn, enhanced the risk of impaired neurocognitive functioning (Duka, Townshend, Collier, & Stephens, 2003; Miller & Hester, 1986).

Over the last 15 years, professional discourse and practice has continued to evolve, gradually but steadily moving away from the diagnosis and program-driven treatment discussed above and toward what Mee-Lee (2001) terms "individualized, assessment-driven treatment." Rather than trying to fit people into treatments based on their diagnosis, this perspective, as the term implies, attempts to fit services to the individual, based on an ongoing assessment of that person's needs and level of functioning.

The idea of matching treatments to clients has a considerable amount of commonsense appeal and, at first blush, research support. Virtually all of the literature, for instance, shows that clients vary significantly in their response to different approaches (Duncan, Miller, & Sparks, 2004). The question, of course, is whether the variables assessed by clinicians lead to treatment matches that reliably improve outcome.

Enter Project MATCH, the largest and most statistically powerful clinical trial in the history of the field of alcohol and drug treatment (Project MATCH Research Group, 1997). Briefly, this NIAAA-organized study assessed the impact of matching people to one of three possible treatment approaches based on 21 carefully chosen variables, including severity of alcohol involvement, cognitive impairment, psychiatric severity, conceptual level, gender, meaning-seeking, motivational readiness to change, social support for drinking versus abstinence, sociopathy, and typology of alcoholism. The results were less than encouraging. *Out of 64 possible interactions tested, only one match proved significant.* Moreover, while participants in the study showed considerable and sustained improvement overall, no differences in outcome were found between the three competing approaches. The same results were observed in a follow-up study conducted 10 years after the formal initiation of Project MATCH. As researchers Tonigan, Miller, Chavez, Porter, Worth, & Westfall et al., (2003) conclude, "No support for differential treatment response was found using percent days abstinent (PDA), drinks per drinking day (DDD), and total standard drink measures in comparing cognitive behavioral (CBT), motivational enhancement (MET), and twelve step facilitation (TSF) therapies 10 years after treatment" (p. 1).

As unexpected as the results were to researchers and clinicians, they are entirely consistent with findings from the field of psychotherapy. As Wampold (2001) concludes in his review of the data, "decades of research" conducted by different researchers, using different methods on a variety of treatment populations, provides clear evidence that "the type of treatment is irrelevant, and adherence to a protocol is misguided" (p. 202). Simply put, the method does not matter. Indeed, available evidence indicates that the particular approach employed accounts for 1 percent or less of the variance in treatment outcome (Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997).

The same body of evidence showing the broad equivalence of treatment approaches provides important clues about the predictors of successful intervention (Hubble, Duncan, & Miller, 1999). To begin, research makes clear that, regardless of type or intensity of approach, *client engagement* is the single best predictor of outcome. Forgoing the customary equivocation typical of researchers, Orlinsky, Grawe, & Parks (1994) conclude:

> The quality of the patient's (*sic*) participation stands out as the most important determinant of outcome . . . these consistent process-process outcome relations, based on literally hundreds of empirical findings, can be considered *facts* established by 40-plus years of research. (p. 361)

High on the list of factors mediating the link between participation and outcome is the quality of the therapeutic relationship—in particular, the *consumer*'s experience *early* in treatment (Bachelor & Horvath, 1999; Orlinsky, Grawe, & Parks, 1994). In fact, meta-analytic studies indicate "a little over half of the beneficial effects of psychotherapy . . . are linked to the quality of the alliance" (Horvath, 2001, p. 366). Similar findings have been reported in the alcohol treatment literature, where between 50 to 66 percent of the variance in outcome is attributable to qualities of the alliance between client and therapist (Miller, Wilbourne, & Hettema, 2003). Said another way, the therapeutic relationship contributes 5 to 10 times more to outcome than the particular model or approach employed (Bachelor & Horvath, 1999; Duncan, Miller, & Sparks, 2004; Wampold, 2001). Given such findings, it should come as little surprise that a post-hoc analysis of the Project MATCH data found that the therapeutic relationship was, unlike the particular treatment approach employed, a significant predictor of treatment participation, drinking behavior during treatment, and drinking at 12-month follow-up (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997).

Another factor known to be a significant predictor of outcome is the client's subjective experience of improvement early in the treatment process (Duncan, Miller, & Sparks, 2004). In one study of more than 2,000 therapists and thousands of clients, for example, Brown, Dreis, & Nace (1999) found that treatments in which no improvement occurred by the third visit did not, on average, result in improvement over the entire course of therapy. This study further showed that clients who worsened by the third visit were twice as likely to drop out as those reporting progress. More telling, variables such as diagnosis, severity, family support, and type of therapy were "not . . . as important [in predicting eventual outcome] as knowing whether or not the treatment being provided [was] actually

working" (p. 404). Similar results were found in Project Match, where all of the change in the outpatient arm of the study occurred within the first 4 weeks (Stout, Del Boca, Carbonari, Rychtarik, Litt, & Cooney, 2003).

In recent years, researchers have been using data generated *during* treatment regarding the alliance and improvement to enhance the quality and outcome of care (Howard, Moras, Brill, Martinovich, & Lutz, 1996; Johnson, 1995). In one representative study, clients whose therapists had access to outcome *and* alliance information were less likely to deteriorate, more likely to stay longer (i.e., remain engaged), and *twice as likely* to achieve a clinically significant change (Whipple, Lambert, Vermeersch, Smart, Nielsen, & Hawkins, 2003). Notably, these findings were obtained without any attempt to organize, systematize, or otherwise control the treatment process. Neither were the therapists in this study trained in any new therapeutic modalities, treatment techniques, or diagnostic procedures. Rather, the individual clinicians were completely free to engage their individual clients in the manner they saw fit. The only constant in an otherwise diverse treatment environment was the availability of formal client feedback.

Such findings, when taken in combination with the field's continuing failure to discover and systematize therapeutic process in a manner that reliably improves success, have led us to conclude that conventional approaches to assessment, diagnosis, and treatment selection are no longer viable. Moreover, a simpler path to effective, efficient, and accountable intervention exists. Instead of assuming that a therapist's a priori assessment of the client's needs, level of functioning, and severity of illness will lead to a match with the type and level of treatment most likely to lead to favorable results, ongoing feedback from consumers regarding both the process and outcome of care can be used to construct and guide service delivery as well as to inspire innovation. Rather than attempting to fit clients into fixed programming or manualized treatment approaches via "evidence-based practice," we recommend that therapists and systems of care tailor their work to individual clients through "practice-based evidence." On the basis of measurable improvements in outcome alone, practice-based evidence may be the most effective evidence-based practice identified to date. Indeed, as Lambert, Whipple, Hawkins, Vermeersch, Nielsen, & Smart (2003) point out, "those advocating the use of empirically supported psychotherapies do so on the basis of much smaller treatment effects." (p. 296)

SPECIFIC INTERVENTION STRATEGIES

> *"Absolutely anything you want to say about alcoholics is true about some of them and not true about all of them."*
>
> —Thomas McLellan

The client-directed, outcome-informed approach described in this chapter contains no fixed techniques, no invariant patterns in therapeutic process, no definitive prescriptions to produce good treatment outcome, and no causal theory regarding the concerns that bring people into treatment. Because the particular method employed or type of problem being treated is not a robust predictor of outcome across clients (~1 percent of variance), almost any type (e.g., dynamic,

cognitive-behavioral, family-of-origin treatment, 12-step), mode (e.g., individual, group, family sessions), or intensity (e.g., medically supervised detoxification, residential, inpatient or outpatient setting, self-help, or any combination thereof) of service delivery has the potential to be helpful. As a result, therapists may, in principle, work in whatever manner they wish, limited only by practical and ethical considerations and their creativity.

Of course, in practice, both individual practitioners and the larger healthcare systems in which most work require structure and direction in order to operate. In this regard, operationalizing client-directed, outcome-informed work in real-world clinical settings involves the following three key procedures:

1. A highly individualized service delivery plan for each client in care.
2. Formal, ongoing feedback from clients regarding the plan, process, and outcome of treatment.
3. The integration of both the plan and feedback into an innovative and flexible continuum of care, that is, because of points 1 and 2, maximally responsive to the individual client.

As is clear, the underlying theme is making sure that the client is an integral partner, rather than a passive or compliant recipient, of a treatment program. While the procedures are, in and of themselves, not imbued with the power to ensure a positive outcome, they do serve to provide therapists and systems of care with enough structure to begin treatment and avoid organizational chaos. As will be shown, the three activities also enable therapists to meet their ethical obligations to do no harm and be good stewards of the limited treatment resources available. A detailed discussion of each of these three steps now follows.

Developing an Individualized Service Delivery Plan

The individualized service delivery plan is basically a written summary—a snapshot, so to speak—of the alliance between a particular client and therapist (or treatment system) at a given point in time. While definitions vary from researcher to researcher, most agree that an effective alliance contains three essential ingredients: (1) shared goals; (2) consensus on means, methods, or tasks of treatment; and (3) an emotional bond (Bachelor & Horvath, 1999; Bordin, 1979; Horvath & Bedi, 2002). To these three, we have added a fourth; namely, the client's frame of reference regarding the presenting problem, its causes, and potential remedies—what has been termed the client's theory of change (Duncan, Hubble, & Miller, 1997).

With regard to the client's theory, a significant amount of data indicates that congruence between a person's beliefs about the causes of his or her problems and the treatment approach results in stronger therapeutic relationships, increased duration in treatment, and improved rates of success (Duncan, Miller, & Sparks, 2004; Hubble, Duncan, & Miller, 1999). Consider a study conducted by Hester, Miller, Delaney, & Meyers (1990) comparing the effectiveness of a traditional alcohol treatment with a learning-based approach. Consistent with previous studies, no differences in outcome were found at the conclusion of treatment. At

follow-up, however, participants who prior to the formal initiation of treatment believed that problems with alcohol were caused by a disease were much more likely to be sober had they received traditional (e.g., abstinence-based) treatment. In contrast, people who believed that their problematic use of alcohol was a "bad habit" did better in the learning-based (e.g., moderation management) treatment (Wolfe & Meyers, 1999).

The four parts of the alliance can be thought of as a three-legged stool (see Figure 11.1). In this analogy, each leg of the stool stands for one of the core ingredients of the therapeutic alliance. Holding everything together is the client's theory of change. Consistent with the metaphor, goals, methods, and a bond that are congruent with the client's theory are likely to keep people comfortably seated (i.e., engaged) in treatment. Similarly, any disagreement between various components works to destabilize the relationship, either making the stool uncomfortable or toppling it completely.

When the individualized service plan is considered to be *a* written reflection of the alliance between a client and therapist and not *the* game plan for expert intervention, both the document and the process leading to its creation are entirely different from traditional care. Instead of being a fixed statement of how treatment will proceed, given the client's diagnosis, severity of illness, level of functioning, and available programming, the plan becomes a living, dynamic document—a collaboratively developed synopsis of the goals, type, and level of interaction the client wants from the counselor or system of care.

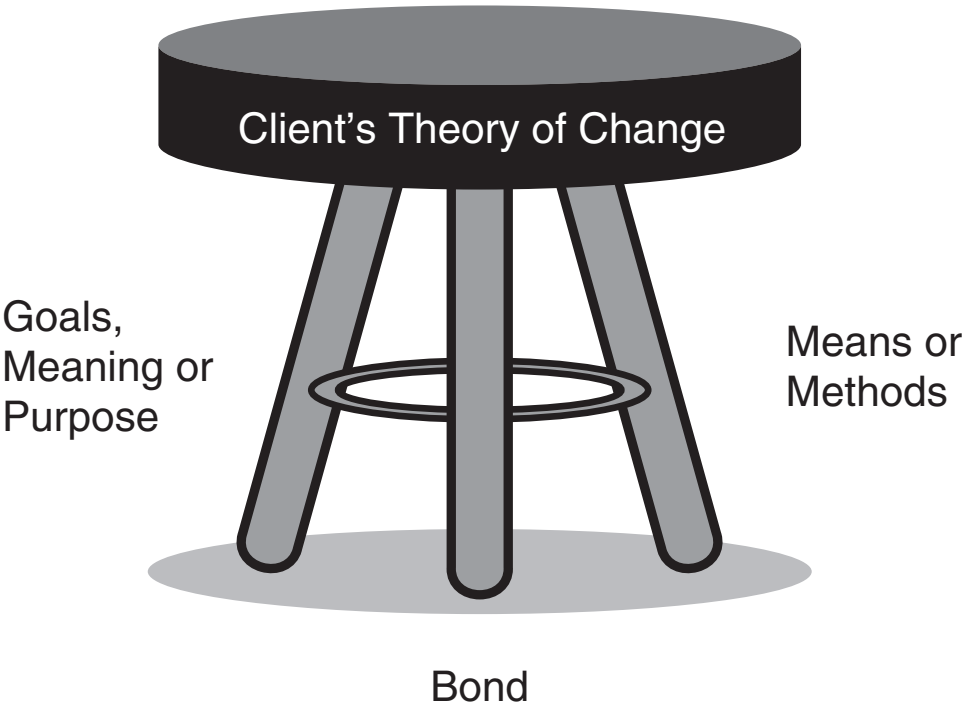

Figure 11.1 The Therapeutic Alliance

In the case of family therapy, the notion of developing an individualized service plan may, at first pass, seem incongruous. Not infrequently, for example, the person believed to have an alcohol problem is not sure or even actively denies there is a problem. Even more challenging, perhaps, are those occasions where concerned family members attend the session and the identified client is absent. An individualized service plan is, however, not the same as a service plan for a client seen individually. The question is, "Who is the client?" In the latter instance, the family is presenting for services. As such, the service plan is the written summary of the alliance between the counselor and the family members present at that visit. As is the case in individual treatment, services are aimed at fulfilling the hopes or resolving the concerns that led the family to seek assistance in the first place (e.g., fix our loved one, get our [child, parent, or others] to stop drinking). Conversely, when a person presents for services *because* of the family (e.g., my spouse or kids are nagging me, my parents don't trust me or are on my back all the time), the alliance is organized around solving the specific problems that motivated that client to seek help (e.g., help me get my spouse to stop nagging, help me get my parents to give me more freedom and independence). Developing a plan when the various family members have different views, concerns, and objectives is the focus of the case example at the conclusion of this chapter.

One structured format for developing an individualized service plan was developed by the American Society of Addiction Medicine (ASAM; Hoffmann, Halikas, Mee-Lee, & Weedman, 1991; Mee-Lee, Shulman, Fishman, Gastfriend, & Griffith, 2001). Briefly, this tool uses six dimensions for organizing client information and tracking services received, including: (1) acute intoxication and/or withdrawal potential; (2) medical conditions and complications; (3) emotional, behavioral, or cognitive conditions and complications; (4) readiness or interest in change; (5) potential for relapse or continued use; and (6) living/recovery environment. When done correctly, the multidimensional assessment criteria (MDA) not only help practitioners identify, organize, and stay focused on what clients want, but also provide suggestions for the type and level of care most likely to be congruent with their goals.

Several controlled studies have found that treatment congruent with service plans based on the MDA are associated with less morbidity, better client functioning, and more efficient service utilization than mismatched treatment (Gastfriend & Mee-Lee, 2003). Moreover, a recent survey of 450 private substance abuse treatment agencies conducted by the National Treatment Center (NTC) found that adoption of the ASAM Patient Placement Criteria was associated with program survival. Specifically, programs that had not survived 24 months after the initial survey were less likely to be ASAM adopters, and those that closed within 6 months of the initial survey had even lower adoption rates. The association between the criteria and program survival is intriguing, and the NTC study group will propose more detailed, longitudinal follow-up, including a study of the impact on treatment quality and outcomes (Clinical Trials Network Bulletin, 2004).

As an example of using the MDA to develop an individualized service plan likely to engage a client at the outset of care, consider the following two cases. The first, Tracey, is a 16-year-old female brought to the emergency room of an acute

care hospital by the police. The teenager was taken into custody following an altercation with her parents that culminated in her throwing a chair. Both the police who responded and Tracey's parents, who called 911, believe that she was under the influence at the time of the incident.

When interviewed by an ER physician and a nurse from the hospital's psychiatric unit, Tracey reports that this latest episode was one of many recent clashes at home, typically starting whenever her parents—especially her father—complain about her drinking, late hours, or poor choice of friends. She freely admits to being angry with her parents, noting, in particular, that they treat her "like a toddler rather than a teenager." When asked, she says she had been drinking "some" earlier that evening, but denied using alcohol or drugs on anything more than an occasional basis. "The problem," she maintains, is her parents—"They are always on my back." Until that is resolved, she continues, "Sending me home is a bad idea."

Where intake and assessment traditionally focus on finding a placement for Tracey that fits her psychiatric diagnosis, the emphasis of the MDA is on developing a partnership with clients around the goals, type, and level of interaction desired from the counselor or system of care. To that end, using the six dimensions, the clinical information presented by Tracey, the police, and her parents were organized as follows:

1. *Acute intoxication and/or withdrawal potential:* Tracey is no longer intoxicated and denies using alcohol or other drugs in large enough quantities over a long enough period to worry about any problems with withdrawal.
2. *Biomedical conditions and complications:* During the interview in the ER, Tracey indicates that she is not taking any medications and has no complaints of a medical nature. On observation, she appears physically healthy.
3. *Emotional, behavioral, or cognitive conditions and complications:* Tracey is admittedly frustrated and angry. She confirms throwing the chair but denies being tempted to act on her feelings if separated from the parents.
4. *Interest in change (readiness):* Tracey talks openly with the physician and nurse. She views her parents as being overbearing and mistrustful and expresses interest in anything (e.g., therapy) that will "get her parents off [her] back." At the same time, however, she is clear about not wanting to go home with her parents.
5. *Relapse, continued use, or continued problem potential:* Given Tracey's statements, a reoccurrence of the fighting appears likely if she is returned home this evening.
6. *Recovery environment:* Tracey reports considerable discord at home. Her parents, who are in the waiting room at the ER, report being frustrated and angry, and ask that Tracey be admitted to the hospital.

While both the ER physician and the psychiatric nurse are initially tempted to admit Tracey to the psychiatric unit—at least for the night—a review of the MDA suggests otherwise. Yes, Tracey threw the chair when she was intoxicated. She is

no longer under the influence, however, and the incident appears to be directly related to problems at home. In addition, no evidence of severe or imminently dangerous biomedical, emotional, behavioral, or cognitive problems requiring the resources of a medically managed intensive inpatient setting exists. Finally, and most important, Tracey views her parents as the problem. As such, hospitalization is more likely to evoke opposition and defiance than engagement and cooperation.

Instead, the physician and nurse use the MDA to provide a structure for conducting an open and collaborative conversation with Tracey and her parents. Everyone present agrees that a physical separation would decrease the chances of another fight. When various options are considered, the family decides to have Tracey stay overnight with a trusted relative. Sessions with the family are scheduled for the next day, in order to address the difficulties at home. As far as the Individualized Service Plan is concerned, the various agreements and MDA are written down and signed by Tracey, her parents, the nurse, and the physician. While significant challenges remain, all are engaged and anticipating the services to come by the end of the process.

In the second case, a 45-year-old man named Bob presents for services at an outpatient alcohol and drug treatment center. It does not take long to determine his goal for treatment either. Within minutes, he says, "The only reason I'm here is because of the wife. She says she's going to divorce me if I don't get the treatment." Bob then continues, "and don't give me any of that 'one day at a time,' or '90 meetings in 90 days' crap. Been there, done that. I don't have no allergy to alcohol. No sir. I got an allergy to my wife. Her nagging."

As the interview proceeds, the therapist is careful to avoid any conversation about alcohol dependence or hints that Bob needs to be in a recovery-oriented treatment program. Instead, the majority of time is spent working with Bob to determine the best way to keep his marriage, and even, if he wishes, gathering the evidence needed to show his wife that he does not have a drinking problem. In both instances, the MDA provide a structure for exploring how best to reach his goal and a written service plan. For example, Bob quickly agrees that his wife's threats about ending the marriage escalated when a recent physical turned up evidence of alcohol-related liver damage (Dimension 2): a visit to the physician that was prompted, by the way, following her complaints about his moodiness (Dimension 3) and recent absenteeism from work (Dimension 6). At the conclusion of the interview, changes in physical and emotional health (e.g., liver enzymes, general energy, decreased depression) in addition to improved work attendance were simply written into the initial individualized service plan as formal treatment objectives. His active participation in the services that followed indicates that the plan, as constructed, fit with his view of the problem and goals for therapy.

Naturally, as is true of any relationship, treatment or otherwise, plans change. Time, experience—even chance events—impact what people want, are interested in, or are willing to try or do. Given that any fracturing of consensus between the plan and the client risks disengagement, some way for monitoring the status of the alliance and progress in treatment is required. In the section that follows, we take a detailed look at methods for obtaining and incorporating client feedback in therapy.

Formal Client Feedback

As any experienced clinician knows, therapy is a complex affair, full of nuance and uncertainty. In contrast to the examples found in manuals and textbooks—where the treatment, if done in the manner described, seems to flow logically and inexorably toward the predetermined outcome—finding what works for a given client most often proceeds by trial and error. Traditionally, the frenzy of real-world clinical practice has been managed by programming—standardized packages, or treatment "tracks," to which clients are assigned and their progress assessed by their degree of compliance and movement from one level to the next. In contrast, the client-directed, outcome-informed approach to problem drinking described in this chapter begins with the experience and outcome the *client* desires, then works backwards to create the means by which they will be achieved. All along, the client is in charge, helping to fine tune or alter, continue, or end treatment via ongoing feedback.

While most therapists strive to listen and be responsive to clients, available data suggests that they are not, despite their best efforts, alert to treatment failure (Lambert et al. 2003). Moreover, a virtual mountain of evidence shows that clinical judgments regarding the alliance and progress in treatment are inferior to formal client feedback (Duncan, Miller, & Sparks, 2004).

Gathering feedback begins with finding measures of process and outcome that are valid, reliable, and feasible for the context in which the tools will be employed (Duncan & Miller, 2000). In reality, no perfect measure exists. Simple, brief, and therefore user-friendly measures, for example, are likely to be less reliable. At the same time, any gains in reliability and validity associated with a longer and more complicated measure are likely to be offset by decreases in feasibility.

In our own work and research, an effective balance for obtaining feedback regarding the client's experience of treatment process was achieved with the *Session Rating Scale* 3.0 (SRS; Miller, Duncan, & Johnson, 2000).[1] Briefly, the *SRS* is a four-item measure of the therapeutic alliance. It takes less than a minute to complete and score and is available in both written and oral forms in several different languages. In addition to being practical, the scale possesses sound psychometric qualities and has been applied in a variety of clinical settings with positive effect (e.g., outpatient, inpatient, residential, group, individual, and family therapy). Most important, studies have found the *SRS* to be a valid measure of those qualities of the therapeutic relationship noted earlier to be associated with retention in and outcome from treatment (Duncan, Miller, Reynolds, Sparks, Claud, Brown, & Johnson, 2004).

As for obtaining feedback regarding the client's experience of change, we use the Outcome Rating Scale (ORS; Miller & Duncan, 2000). Similar in structure to the SRS, the ORS is a four-item visual analog scale. Clients simply place a hash mark on a line nearest the pole that best describes their experience. The measure takes less than a minute to administer and score and is available in both written and oral forms in several languages. Research to date indicates that the scale pos-

[1] Individual practitioners can download copies of the SRS and ORS for free at www.talkingcure.com

sesses good psychometric qualities, with estimates of internal consistency and test-retest reliability at .74 and .66, respectively (Miller, Duncan, Brown, Sparks, & Claud, 2003). The same research shows that the ORS is a valid measure of the outcomes most likely to result from the treatment offered at the settings in which we work (i.e., change in individual, relational, and social functioning). Finally, and of critical importance when selecting an outcome tool, the ORS has been shown to be sensitive to change in those undergoing treatment while being stable in a non-treated population (Miller et al., 2003). As Vermeersch, Lambert, & Burlingame (2000) point out, many scales presently in use were not specifically designed to be sensitive to change, but rather to assess stable personality traits or a specific problematic behavior (e.g., *DSM* diagnostic categories, MAST [Michigan Alcoholism Screening Test], AUDIT [Alcohol Use Disorders Identification Test], ASI [Addiction Severity Index]).

Incorporating the outcome and process tools into treatment can be as simple as scoring and discussing results together with clients at each session, or as complex as an automated, computer-based data entry, scoring, and interpretation software program. The approach chosen will depend on the needs, aims, and resources of the user. Regardless of the method, the purpose of the scales is always explained to clients, and their active participation is solicited prior to the formal initiation of treatment.

As for the actual interpretation of the results, a single-subject case design, in which measures are hand scored and results tracked and discussed from session to session, will suffice for most practitioners. The SRS, for example, is administered at the end of each session. Scores of 36 or below are ordinarily considered cause for concern, as they fall at the 25th percentile of those who complete the measure. Because research indicates that clients frequently drop out of treatment *before* discussing problems in the alliance, a therapist would want to use the opportunity provided by the scale to open discussion about the relationship, review the individualized service plan, and remedy whatever discrepancies exist between what the client wants and is receiving (Bachelor & Horvath, 1999).

On the other hand, the ORS is typically given at or near the start of each visit. 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 (Duncan, Miller, & Sparks, 2004). In such instances, the MDA can provide a structure for reviewing the type and level of treatment being offered, as well as suggesting alternatives. As the MDA make abundantly clear, failure at one type or level of care does not automatically warrant an intensification of services but rather a review of the individualized service plan (Mee-Lee, Shulman, Fishman, Gastfriend, & Griffith, 2001). Nor should a client have to experience a poor outcome at a lower level of service before being admitted to a more intensive treatment option. In all instances where a client worsens in the initial stages of treatment, or is responding poorly to care by the eighth session (or measure of outcome), however, a change of therapists or treatment settings is almost always warranted, because the available research shows the client to be at significant risk for dropping out or ending treatment unsuccessfully (Duncan, Miller, & Sparks, 2004).

A special index on the ORS, known as the "clinical cutoff," can provide a check on any decisions made via the MDA about the intensity of treatment (e.g., outpatient versus inpatient, treatment versus education or supportive care). Brown et al. (1999) and Miller, Duncan, Brown, Sorrell, & Chalk (2004) found, for example, that as many as one third of clients entering treatment started with a score on the outcome tool that exceeded the clinical cutoff (a score of 25 or higher on the ORS). Such clients, it turns out, are at significant risk for worsening rather than improving over the course of treatment. Encouraging therapists to adopt a strengths-based or problem-solving approach in lieu of depth-oriented, confrontational, or other intensive treatment strategies can serve to maximize engagement while minimizing the risk of client deterioration.

In situations that include multiple participants or stakeholders (e.g., family or group therapy, court-referred clients) the same general guidelines for interpreting the scales apply. At the same time, both the kind of information sought by the measure and the manner in which it is used during treatment varies, depending on specific circumstances involved. As an example, consider the case of mandated clients. In our experience, it is common for such people to score above the clinical cutoff on the ORS (> 25). Rather than trying to convince the client that matters are actually worse than he or she might think, the client's view of the referral source's rating of him or her is plotted and used to assess change over the course of treatment (Duncan, Miller, & Sparks, 2004). In such cases, the client and therapist are technically working together to resolve the problem that the referent (e.g., court, employer, family) has with the client.

A similar procedure can be followed in family therapy when the focus of concern is on a particular person—the so-called "identified patient" (Duncan, Miller, & Sparks, 2004). Moreover, where differences of opinion exist, a graph on which each family members outcome score is plotted in a different color provides a simple yet effective structure for stimulating a manageable and inclusive discussion about who is most interested in change, what the problem is, and what needs to happen for improvement. A graph containing each member's response on the SRS can, in turn, be used to monitor engagement, providing both the family and therapist with an opportunity to reach out to anyone feeling excluded from the process. The process is virtually the same when treatment is delivered via groups—the underlying principle being utilization of the scales in a manner that increases the engagement of everyone involved.

Consider the case of Ted, a 47-year-old who presented for outpatient services after being confronted about his drinking by his wife Sharon and their three adult children. Given that Ted wanted to do anything to save his marriage, couples therapy became a part of the individualized service plan developed at the first visit. Not surprisingly, the couple's scores on the ORS and SRS differed significantly. As a result, the therapist began asking Ted and Sharon at each visit to guess how the other would rate the session and progress. Any differences were then discussed.

At one session, for example, Ted rated the alliance high while Sharon scored quite low. On inspecting the measure, it was clear to both the therapist and couple that the difference centered on a disagreement over the goals of the therapy. The content of the hour had focused almost exclusively on Ted's problematic use of

alcohol. However, when asked, Sharon indicated that she was actually less concerned about the drinking than she was about the affairs her husband had when he drank. As one can imagine, discussion of this important difference changed the focus of the work in the couple's therapy significantly.

While the single-subject design previously described profits from ease and simplicity of use, it suffers in terms of precision and reliability. The broad guidelines for evaluating progress, for example, are based on data pooled over a large number of clients. Because the amount and speed of change in treatment varies depending on how an individual client scores at the first session, such suggestions are likely to underestimate the amount of change necessary for some cases (i.e., those starting treatment with a lower score on the outcome measure) while overestimating it in others (i.e., those with a higher initial score). A simple linear regression model offers a more precise method for predicting the score at the end of treatment (or at any intermediate point in treatment), based on the score at intake. Using the slope and an intercept, a regression formula can be calculated for all clients in a given sample. Once completed, the formula is used to calculate the expected outcome for any new client based on his or her intake score.

Miller et al. (2004) employed linear regression as part of a computerized feedback system employed in a large healthcare organization. Figure 11.2 depicts the outcome of treatment derived from an ORS administered at the beginning of each session of therapy with a sample client. The dotted line represents the expected

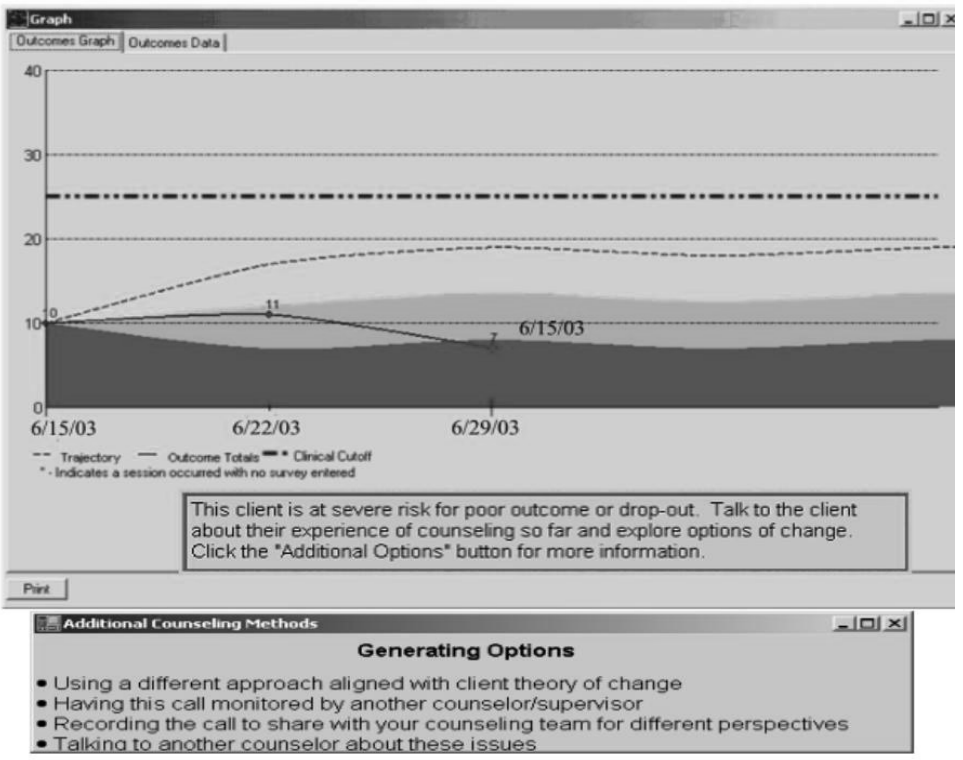

Figure 11.2 Signal Outcome Feedback Screen

trajectory of change for the clients at this clinic, whose total score is four at the initial visit. In contrast, the solid line plots the client's actual score from session to session. As can be seen, the two lines are divergent, with this client reporting significantly less progress than average. In fact, scores falling in the solid dark area represent the 10th percentile of responders. As a result, the therapist receives a "red" signal, warning of the potential for premature dropout or negative outcome should therapy continue unchanged. An option button provides suggestions, including everything from simply reviewing the matter with the client to, depending on amount of time in treatment, referring the client elsewhere. Client responses on the SRS were plotted in a similar fashion at the end of each visit. Scores falling below the 25th and 10th percentiles triggered a yellow and red signal, respectively. The program further encouraged therapists to check in with their client and to express concern about their work together. Exploring options for changing the interaction *before* ending the session is critical, as available research indicates that clients rarely report problems with the relationship until they have already decided to terminate (Bachelor & Horvath, 1999).

Prior to moving on to the next section, mention should be made of two related advantages of automated data entry and feedback. The first is the ability to compare the customer service (e.g., alliance) and effectiveness levels of different clinicians and treatment sites. Research indicates, for example, that *who* the therapist is accounts for six to nine times as much variance in outcome as *what* treatment approach is employed (Lambert, 1989; Luborsky, Crits-Christoph, McLellan, Woody, Piper, Liberman, Imber, & Pilkonis, 1986; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Wampold, 2001). Being able to compare therapists not only allows for the identification of therapists in need of training or supervision, but also identifies those with reliably superior results—an obvious benefit to both payers and consumers (Lambert, Whipple, Bishop, Vermeersch, Gray, & Finch, 2002).

To illustrate, consider data on 22 therapists reported by Miller et al. (2004) in Figure 11.3. In this sample, a therapist is statistically above average at a 70 percent confidence interval when the bottom end of his or her range falls above the average effect size for the agency as a whole. A number of research projects currently underway are attempting to identify any differences in practice between the effective and ineffective providers that might serve to inform therapy in the future (Johnson & Miller, manuscript in preparation). Of perhaps greater importance, while having documented tremendous improvements in cases at risk for a negative or null outcome, Lambert (personal communication, 2003)[2] has not found that the overall effectiveness of individual therapists improves with time and feedback. If confirmed, such findings, when taken in combination with the weak historical link between training and outcome in therapy (Lambert & Ogles, 2004),

[2] In an-email to the first author, dated July 3, 2003, Lambert said: "The question is—have therapists learned anything from having gotten feedback? Or, do the gains disappear when feedback disappears? About the same question. We found that there is little improvement from year to year even though therapists have gotten feedback on half their cases for over 3 years. It appears to us that therapists do not learn how to detect failing cases. Remember that in our studies the feedback has no effect on cases who are progressing as expected—only the signal alarm cases profit from feedback."

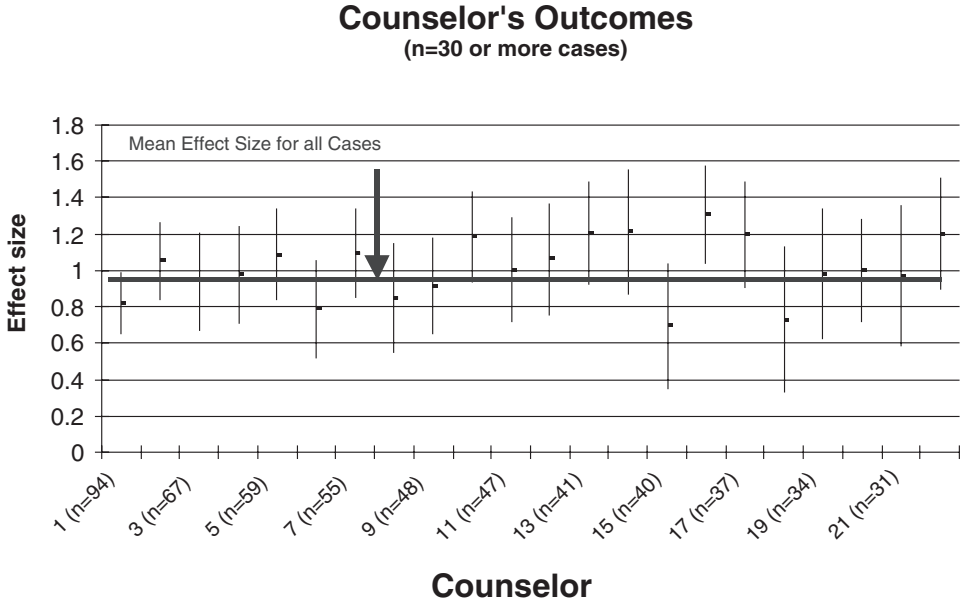

Figure 11.3 Comparison of effect sizes of 22 therapists in a single agency

further underscores the need to spend less time and resources training clinicians in new treatment approaches and more in helping them solicit and use formal client feedback to guide services.

In a similar way, automatic data entry and feedback can be used to provide real-time quality and outcome assurance for traditionally underrepresented and underserved client groups (e.g., diagnostic, low-income, ethnocultural). Much has been written of late, for example, regarding the importance of cultural competence in clinical work with clients from different ethnic groups. As Clarkin & Levy (2004) point out, however, "Unfortunately, the clinical wisdom offered for maximizing treatment benefits is seldom studied and remains largely untested" (p. 204). In fact, the mix of culturally sensitive stereotypes swirling inside the therapist's interpretive head may actually diminish connecting with a particular client. In contrast, Duncan & Miller (2000) describe a step-by-step process, starting with the selection of the measures used, through data gathering and norm derivation, to insure that feedback is representative of and generalizable to the particular client being treated. As was the case with therapists and settings, such data can be used to identify effective practices, settings, and clinicians, as well as quality improvement opportunities for different client groups.

Integrating the Plan and Feedback into a Flexible Continuum of Care

Historically, treatment was synonymous with completing a program of predetermined length and fixed number of steps or modules. Problem drinkers were sent to rehab for whatever length of time third party payers would cover. While its origins are now long forgotten, the once popular 28-day stay in residential treatment was not a product of science but rather a result of limits on reimbursement im-

posed by insurers (Institute of Medicine, 1990). Unfortunately, the evidence indicates that programming often took precedence over client preference in such settings and, in turn, had a negative impact on client engagement and retention.

If a key to effective services exists, it is, in a word, flexibility. As a result, when client-directed and outcome-informed, treatment contains no fixed program content, length of stay, or levels of care. Instead, a continuum of possibilities is made available to the client that includes everything from community resources, natural alliances with the family and significant others, to formal treatment and care within healthcare institutions. Literally everything is on the table. Along the way, the MDA and formal client feedback provide a structure for collaborating with the client in the development, continuation, modification, or termination of contact. As the old saying from Alcoholics Anonymous goes, "The question is not *if* we should help but instead *when* and *how.*"

Borrowing an example from business, a truly flexible continuum of care offers all the benefits associated with large discount chains such as Target and Wal-Mart—where a wide number of products are available in one place and at a good price—with the individual attention and customer service typically reserved for fashionable boutiques. When the setting and resources are, by definition, limited in scope (e.g., private practice, rural settings), practitioners serve their clients best by following another standard business practice: outsourcing. Even under the most optimal conditions, no provider or system of care can be all things to all people. When formal client feedback indicates that the partnership with a particular therapist or treatment center is not working, a network of informal yet organized contacts in the local community ensures continuity of care across a virtually limitless continuum of possibilities (e.g., church, service and support groups, volunteer organizations, community leaders, local healers, contacts via e-mail or the Internet).

RESEARCH EVIDENCE SUPPORTING CLIENT-DIRECTED, OUTCOME-INFORMED CLINICAL WORK

> *"Frothy eloquence neither convinces or satisfies me . . . you've got to show me."*
>
> —William Duncan Vandiver

A number of empirical studies, including one meta-analysis, now exist that document significant improvement in retention rates and outcome from therapies that incorporate formal, ongoing client feedback regarding both the process and outcome of treatment (Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins, 2001; Lambert et al., 2002; Whipple et al., 2003; Lambert et al., 2003). In one study of several thousand cases conducted by the first author of this chapter (Miller et al., 2004), use of process and outcome feedback effectively doubled the average effect size of clinical services (from .4 to .86) and significantly lowered dropout rates (see Figure 11.4). With regard to the latter, clients of therapists who failed to obtain feedback regarding the alliance were twice as likely to drop out of treatment and three to four times more likely to have a negative or null outcome. Notably, retention and success rates in this study improved the moment that formal feedback

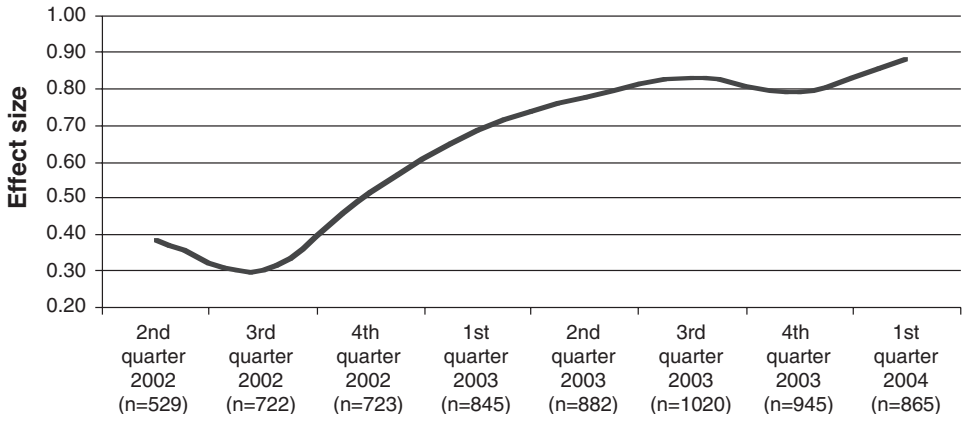

Figure 11.4 Improvement in effect size following feedback

became available to clinicians, without any attempt to organize, systematize, or otherwise control treatment process or training in any new diagnostic or treatment procedures. Similar to the study by Whipple et al. (2003), formal client feedback was the only constant in an otherwise diverse treatment environment.

Because this particular chapter is focused on the treatment of problem drinking, it is also important to note that improved outcomes were observed whether the clients were seeking help for a mental health concern, alcohol or substance problem, or a combination of the two. Indeed, if anything, those being treated exclusively for problems related to their use of alcohol fared better. Specifically, the average client in the study was better off than approximately 70 percent of people without the benefit of formal treatment (ES = .80), while those treated for drug and alcohol problems were better off than 86% (ES = 1.13).

In summary, the results of Miller et al. (2004) and other studies previously cited are compelling enough for Lambert et al. (2004) to argue that clinicians begin "routinely and formally to monitor patient response" (p. 288). Clearly, the treatment effects associated with so-called empirically supported psychotherapies are much smaller (Feedback ES = .39 versus Average ES difference = .20, p. 296). And yet, more research remains to be done. Most studies to date have focused on services delivered to adults in outpatient settings or via the telephone. Projects aimed at determining the degree to which the approach applies across modes of service delivery (e.g., inpatient, residential, group), consumer groups (e.g., children, adolescents, elderly, mandated versus voluntary), and on specific treatment issues (e.g., substance abuse, psychosis) are currently underway.

Case Study

". . . personal perspective . . . is the only kind of history that exists."

—Joyce Carol Oates

Heather is a 21-year-old female who agreed to meet with a counselor for an assessment after being confronted by her parents about using alcohol and cocaine.

Over the preceding year, this once outgoing young adult had dropped out of college, become pregnant following unprotected sex with a stranger while she was intoxicated, began dealing drugs, and spent $20,000 feeding her growing habit. In addition to losing many of her close friends, Heather had recently come under surveillance of the local police. When word spread that a bust was imminent, a former college friend who had a contact within the police department tipped Heather's parents.

Although Heather readily acknowledged using alcohol and drugs, she initially refused to obtain help, insisting instead that she could quit on her own. Exasperated and concerned, her parents eventually issued Heather an ultimatum. She could either come home at once and get substance abuse counseling, or continue living with her two drug-dealing roommates, and face whatever personal and legal consequences followed alone. They further informed her that choosing the latter alternative would result in their contacting the police to share what they knew about their daughter. Thankfully, Heather chose to enter treatment, showing up for her first appointment with her parents.

Briefly, the agency where Heather sought treatment is the second largest provider of substance abuse services in her home state, encompassing a broad continuum of care that includes medical detoxification, residential, intensive outpatient, and individual and family outpatient services. In any given year, this center serves approximately 6000 culturally and economically diverse clients, ranging in age from 15 to 80. From 1997 to 2004, the agency underwent a radical transformation, shifting from a fixed-length, diagnosis-driven, and one-size-fits-all treatment program to a state-of-the-art, client-directed, outcome-informed service delivery system. Once suffering from poor staff morale, high client attrition rates, and nearing economic collapse, the agency now enjoys a large economic surplus, high rates of client retention and satisfaction, and a highly engaged and motivated staff. Outcome and alliance data gathered at the treatment center using the ORS and SRS since summer 2002 compare favorably with data reported by Miller et al. (2004).

Typically, the initial contact with clients at the agency where Heather sought care is limited to the person with the identified drug or alcohol problem. The reason for this policy is that clients are often guarded about sharing information when the family is present—particularly in cases involving abuse or neglect. In this instance, however, Heather's parents asked to be present during the first part of the initial session. Heather agreed, and the meeting began with the administration of the ORS.

Next, the therapist scored the instrument. Importantly, everyone fell below the clinical cutoff of 25, with Heather at a total score of 16 and her parents rating somewhat lower (Mother = 12; Father = 10). As such, each family member scored more like people who are in treatment and looking for a change. These results, as well as the philosophy of client-directed, outcome-informed work, were then explained to the family.

Therapist: Thank you for taking the time to fill out the forms.

Heather: That's okay.

Parents: We're just glad you're here.

Therapist: Well, thank you, and, let me just start by repeating a bit of what I told you on the phone. At the center, we are really dedicated to helping people get what they want from treatment. And this is one of the forms that will help with that.

Father: Uh huh, okay.

Therapist: Here's how it works. Basically, the research says that if we're going to be helpful, we should see signs of that sooner rather than later.

Heather: (*nodding*).

Therapist: Now, that doesn't mean that the minute things start improving, we're going to say, "Get out!"

Heather: (*laughing*).

Mother: Good.

Therapist: No, it just means that everyone's feedback is essential. It will tell us if our work together is on the right track, or whether we need to change something about it, or, if we're not helping—that happens sometimes—when we need to consider making a referral to some one or some place else in order to help you get what you want.

Heather and Parents: (*nod*).

Therapist: Does that make sense to you?

Heather and Parents: (*nodding*). Yes.

Therapist: And so, let me show you what these scores look like. Um, basically this just kind of gives us a snapshot of how things are overall in your lives and family.

Heather and Parents: (*leaning forward to view graph*).

Therapist: . . . this graph tells us how things are overall in your life. And, uh, if a score falls below this dotted line.

Heather: Uh huh.

Therapist: Then it means that the scores are more like people who are in therapy and who are saying that there are some things they'd like to change or feel better about.

Mother: Looks like we're all feeling that way . . . that something needs to change.

Therapist: Yes . . . it does . . . and we'll be working to get the scores above that line.

Father: That could take a long while. This is a pretty serious situ—

Heather: (*interrupting*). Dad!

Therapist: Well . . . as long as there is measurable change, and you want to continue, we can continue to work together as long as you like . . . but this will just help us stay on track. And you can see, you're pretty much in agreement

here . . . with each of you saying that you're feeling like there are things that need to change in your lives.

Everyone expressed agreement with the therapist's last statement, and a lively discussion followed. About midway through the visit, a natural break in the conversation occurred and the therapist asked to speak with Heather alone. Heather's parents agreed, and left the interviewing room. It was during this time that Heather disclosed her pregnancy, indicating further that she wanted this information to be kept confidential for the present.

As the end of the interview neared, Heather's parents were invited back into the room. The therapist then used the six dimensions of the MDA to both organize the information presented and initiate a dialogue about the type and level of service desired.

Therapist: We have a lot of choices when it comes to services. And so, uh, we've found it helpful, when trying to figure out where to go and what to do, to look at everything you've talked about in terms of six different areas.

Heather: Uh huh.

Parents: (*nodding*).

Therapist: Here are the six areas, and I'll just read them just like they are written. The first is "acute intoxication or withdrawal potential." That means, you know, are you high now or have you been using enough that we need to be concerned. And, Heather, you said earlier that you haven't used for over a week. Is that right?

Heather: Yeah.

Therapist: And so, that means that we don't need to send you like to detox so that you could be monitored by a doctor and such.

Heather: Uh huh.

Therapist: The second is, "biomedical conditions." Heather indicates that she is in good health.

Parents: (*nodding*).

Heather: Mmm huh.

Dimension 2 of the MDA is actually the appropriate area for recording important biological and health-related data, such as pregnancy. While documented in the medical record, this information, given Heather's wishes, was not shared with her parents. The discussion continued uninterrupted:

Therapist: Okay. Emotional, behavioral, cognitive disorders or conditions. We talked about this, and the main reason you're here is because of the alcohol and drugs, right?

Heather: Yes.

Therapist: And all of you said that no one has ever been in counseling before for any other kind of problem?

Heather and Parents: (*nodding*).

Therapist: Again . . . that basically tells us that we can focus on the alcohol and drugs . . . because before all this, you were doing really well . . . you've been a good student, you've always had a lot of friends.

Father: Right.

Therapist: The next area is "interest in or readiness for change." And if I've understood this correctly, you're saying, Heather, that you're ready.

Heather: Yeah.

Therapist: And mostly, you're concerned about your relationship with your, how this all has affected your relationship with your parents?

Heather: Yeah . . . 'cause I think I can quit on my own . . . but they don't think so . . . and so, I don't want to lose them . . . and I know how concerned they . . . we've got to get back to where we were before . . . able to talk. Like I said, my Mom and Dad have always been my best friends . . . and this has really screwed it all up.

Father: We want that, too.

Therapist: Okay. Getting close here. . . . "Dimension 5: Continued use, relapse, continued Problem Potential." You said you're still having cravings.

Heather: (*nodding*).

Therapist: So . . . this is an issue . . . and this is also where your Mom and Dad fit in because you said, that you don't think . . . that. . . . You know you need their help to deal with that . . . so, at a minimum, in terms of services, we do want to have everyone involved in some way.

Heather and Parents: (*nodding*).

Father: Like family sessions or something.

Therapist: Exactly, right . . . and that fits really well with the next area, "recovery environment." You're planning to stay at home. Everyone agrees that there won't be any contact with your old roommates . . . and that as long as there is no drug or alcohol use, your parents will help pay your bills . . . and so it makes sense that we work together in some family sessions . . . to get things back on track. Does that sound right?

Heather and her parents agreed, and the interview concluded with a plan for intensive outpatient services and weekly family sessions. As discussed, the focus of the individual work would be on her use of alcohol and drugs—initially, dealing with her cravings for cocaine. At the same time, meetings with the family would center on restoring relationships via improved communication. Just prior to ending the visit, the therapist asked everyone to complete the SRS. From the scores, all appeared to be satisfied with the therapist, the interview, and the plan for services.

In the weeks that followed, Heather and her parents followed through with the service plan that was developed in the first meeting. Each person's scores on the ORS improved gradually and steadily, indicating that the combination of intensive outpatient services and family sessions were working. Scores on the SRS remained high throughout. And, while one might wonder what the therapist actually did in the sessions that led to such scores, it is important to remember that from a client-directed, outcome-informed point of view, the particular therapeutic approach employed is irrelevant. Rather, a plan for services that fits with the client's subjective experience of the alliance and improvement early in the treatment process is critical to success.

By the fourth week, communication had improved enough for Heather to feel comfortable telling her parents about the pregnancy. She did so at home. According to the family, this was a major milestone. Indeed, the discussion had gone so well that the family had been able to come to an agreement about what to do prior to their session that week. The pregnancy would be ended. In fact, an appointment for an abortion had already been made.

Scores on the ORS confirmed the family's view of progress. Everyone had passed the clinical cutoff (> 25) and the scores even appeared to be leveling off. While historically seen as problematic, such plateauing is actually quite common, and can be used to guide decisions regarding treatment intensity. Research suggests, on the one hand, that the probability of change is maximized by meeting clients on a more regular basis in the beginning of treatment, when the slope of change is steep. On the other hand, change is best maintained by spacing visits as the rate of change decreases (see Howard et al., 1996). In any event, when this research and the family's results on the ORS were discussed, all agreed to less intensive services. Heather would leave the intensive outpatient program but continue her work in weekly sessions with an individual counselor. At the same time, the family would continue to meet as a group on a monthly basis.

In a family session 6 months later, Heather reported that she had used alcohol on a couple of occasions in the company of friends. At this point, she was working full time and still living at home. There had been no contact with her drug-dealing roommates, and no further use of cocaine. What's more, Heather's parents were aware she had been drinking. Everyone agreed, however, that communication continued to be good. In fact, Heather had approached her parents prior to drinking, to discuss having a beer with friends after seeing a movie. According to her parents, Heather had continued to keep reasonable hours and had not returned home intoxicated.

When the therapist expressed concern, fearing this would lead to a relapse to cocaine abuse, or simply increased drinking, Heather's father responded, "It's not like we think she has to be a 'teetotaler' or something," and then added, "we just don't want her to get hurt, and to be responsible." And, in truth, abstinence from alcohol had never been one of Heather's or her parent's goals for treatment. All felt that the services they had received had been helpful. "The key is that we're talking again," Heather's mother concluded, "We're all confident that will continue." The session concluded with a brief review of the six dimensions of the MDA and the SRS. Within weeks, the family discussed ending ongoing treat-

ment, opting for sessions in the future on an "as needed" basis. At last report, Heather had rented an apartment near her parents' home. She was working full time, planning on returning to school, and had no further problems with alcohol or cocaine.

CONCLUSION

"Data talks, bullshit walks."

—Geraldo Rivera

More than any previous time in the history of the field, policymakers and payers are stridently insisting that to be paid, therapists and the systems of care in which they operate must deliver the goods. Consumers are also demanding results. Indeed, while stigma, lack of knowledge, and concerns about the length of treatment are frequently offered as explanations, a significantly larger number of potential consumers identify low confidence in the outcome of services as *the* major deterrent to seeking care (76 percent versus 53 percent, 47 percent, and 59 percent respectively [APA, 1998]).

In an attempt to provide effective and efficient services, the field of alcohol and drug treatment has embraced the notion of evidence-based practice. Briefly, the idea behind this perspective is that specific techniques or approaches, once identified and delivered in reliable and consistent fashion, will work to enhance success. Of course, we believe the data indicate otherwise. What's more, in this chapter, we have presented a much simpler method for insuring effective, efficient, and accountable treatment services. Instead of attempting to match clients to treatments via evidence-based practice, the client-directed, outcome-informed perspective uses practice-based evidence to tailor services to the individual client.

In closing, imagine a treatment system in which clients are full and complete partners in their care, where their voice is used to structure and direct treatment. Gone and gladly forgotten will be the countless hours devoted to the generation of histories, interview protocols, and treatment programming. Notes and documentation will report events in the treatment that bear directly on outcome. Gone, too, will be the attitude that therapists know what is best for their clients. When it is more important to know whether change is occurring in any given circumstance, theories of therapy and the many diagnostic labels they have sponsored become distractions. Therapists will no longer be evaluated on how well they "talk the talk," at best a dubious standard for competence, but by how well they "walk the walk." For those reared on the belief that change, should it occur at all, is an internal and arcane experience, long in coming and perhaps unmeasurable, the client's input from one session to the next may feel disconcerting, even suspect. And yet, failing to respond to the demands of payers, policymakers, and consumers is sure to court exclusion. As the American psychotherapist, Carl Rogers, once said, "the facts are always friendly." Better to know what is working or not, in the here and now, than mere failure down the road.

REFERENCES

American Psychological Association. (1998). *Communicating the value of psychology to the public.* Washington, D.C.: Author.

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 113–178). Washington, DC: American Psychological Association Press.

Bein, T. H., Miller, W. R., & Tonigan, J. S. (1993). Brief interventions for alcohol problems: A review. *Addiction, 88,* 315–336.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy, 16,* 252–260.

Brown, J., Dreis, S., & Nace, D. K. (1999). What really makes a difference in psychotherapy outcome? Why does managed care want to know? In M. A. Hubble, B. L. Duncan, and S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 389–406). Washington, DC: American Psychological Association Press.

Clarkin, J. F., & Levy, K. N. (2004). The influence of client variables on psychotherapy. In M. J. Lambert (Ed.), *The handbook of psychotherapy and behavior change* (pp. 194–226). (5th ed.). New York: Wiley.

Clinical Trials Network Bulletin. (March 10, 2004). Treatment matching interest group. Volume 04–05, 4.

Collins, J. J., & Messerschmidt, M. A. (1993). Epidemiology of alcohol-related violence. *Alcohol Health and Research World, 17,* 93–100. Washington, DC: United States Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism.

Connors, G. J., Carroll, K. M., DiClemente, C. C., Longabaugh, R., & Donovan, D. M. (1997). The therapeutic alliance and its relationship to alcoholism treatment participation and outcome. *Journal of Consulting and Clinical Psychology, 65,* 588–598.

Duka, T., Townshend, J. M., Collier, K., & Stephens, D. N. (2003). Impairment in cognitive functions after multiple detoxifications in alcoholic inpatients. *Alcoholism: Clinical and Experimental Research, 27,* 1563–1573.

Duncan, B. L., Hubble, M. A., & Miller, S. D. (1997). *Psychotherapy with impossible cases.* New York: Norton.

Duncan, B. L., & Miller, S. D. (2000). *The heroic client: Principles of client-directed, outcome-informed therapy.* San Francisco: Jossey-Bass.

Duncan, B. L., Miller, S. D., Reynolds, L., Sparks, J., Claud, D., Brown, J., & Johnson, L. D. (2004). The session rating scale: Psychometric properties of a "working" alliance scale. *Journal of Brief Therapy, 3,* 3–11.

Duncan, B. L., Miller, S. D., & Sparks, J. (2004). *The heroic client: Principles of client-directed, outcome-informed therapy* (revised). San Francisco: Jossey-Bass.

Eighth Special Report to U.S. Congress on Alcohol and Health From the Secretary of Health and Human Services (1993). Rockville, MD: U.S. Department of Health and Human Services.

Gastfriend, D. R., & Mee-Lee, D. (2003). The ASAM Patient Placement Criteria: Context, Concepts and Continuing Development in Addiction Treatment Matching—Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria. *Journal of Addictive Diseases, 22,* Supplement no. 1, 2, 1–8.

Goodwin, D. W., Schulsinger, F., Hermansen, L., Guze, S. B., & Winokur, G. (1973). Alcohol problems in adoptees raised apart from alcoholic biological parents. *Archives of General Psychiatry, 28,* 238–243.

Grant, B. F. (2000). Estimates of U.S. children exposed to alcohol abuse and dependence in the family. *American Journal of Public Health, 90,* 112–115.

Hester, R., Miller, W., Delaney, H., & Meyers, R. (1990, November). *Effectiveness of the community reinforcement approach.* Paper presented at the 24th annual meeting of the Association for the Advancement of Behavior Therapy. San Francisco, CA.

Hoffmann, N. G., Halikas, J. A., Mee-Lee, D., & Weedman, R. D. (1991). *Patient placement criteria for the treatment of psychoactive substance use disorders.* Washington, DC: American Society of Addiction Medicine.

Horvath, A. O. (2001). The alliance. *Psychotherapy, 38,* 365–372.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 37–69). New York: Oxford University Press.

Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist, 51,* 1059–1065.

Hubbard, R. L., Craddock, S. G., Flynn, P. M., Anderson, J., & Etheridge, R. M. (1997). Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11,* 261–278.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). Directing attention to what works. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 407–448). Washington, DC: American Psychological Association Press.

Institute of Medicine. (1990). *Broadening the base of treatment for alcohol problems.* Washington, DC: National Academies Press.

Jellinek, E. M. (1960). *The disease concept of alcoholism.* New Haven, CT: Hillhouse Press.

Johnson, L. D. (1995). *Psychotherapy in the age of accountability.* New York: Norton.

Johnson, L. D., & Miller, S. D. *Qualities of effective mental health clinics.* Manuscript in preparation.

Lambert, M. J. (1989). The individual therapist's contribution to psychotherapy process and outcome. *Clinical Psychology Review, 9,* 469–485.

Lambert, M., & Ogles, B. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139–193). New York: Wiley.

Lambert, M. J., Whipple, J. L., Bishop, M. J., Vermeersch, D. A., Gray, G. V., & Finch, E. (2002). Comparison of empirically derived and rationally derived methods for identifying clients at risk for treatment failure. *Clinical Psychology and Psychotherapy, 9,* l49–164.

Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it time for clinicians routinely to track patient outcome? A meta-analysis. *Clinical Psychology, 10,* 288–301.

Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D. A., Nielsen, S. L., & Hawkins, E. J. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research, 11,* 49–68.

Luborsky, L., Crits-Cristoph, P., McLellan, T., Woody, G., Piper, W., Liberman, B., Imber, S., & Pilkonis, P. (1986). Do therapists vary much in their success? Findings from four outcome studies. *American Journal of Orthopsychiatry, 56,* 501–512.

Luborsky, L., McLellan, A. T., Diguer, L., Woody, G., & Seligman, D. A. (1997). The psychotherapist matters: Comparison of outcome scores across twenty-two therapists and seven patient samples. *Clinical Psychology, 4,* 53–65.

Mee-Lee, D. (2001). Persons with addictive disorders, system failures, and managed care. In E. Clarke

Ross (Ed.), *Managed behavioral health care handbook* (pp. 225–266). Gaithersburg, MD: Aspen Publishers.

Mee-Lee, D., Shulman, G. D., Fishman, M., Gastfriend, D. R., & Griffith, J. H. (Eds.). (2001). *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders* (2nd ed. revised) Chevy Chase, MD: American Society of Addiction Medicine.

Miller, S. D., & Duncan, B. L. (2000). *The Outcome Rating Scale.* Chicago: Authors.

Miller, S. D., Duncan, B. L., Brown, J., Sorrell, R., & Chalk, M. B. (2004). Using outcome to inform and improve treatment outcomes. *Journal of Brief Therapy.*

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J., & Claud, D. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2,* 91–100.

Miller, S. D., Duncan, B. L., & Johnson, L. D. (2000). *The Session Rating Scale 3.0.* Chicago: Authors.

Miller, W., & Hester, R. (1986). Inpatient alcoholism treatment: Who benefits? *American Psychologist, 41,* 794–805.

Miller, W. R., Wilbourne, P. L., & Hettema, J. E. (2002). What works? A summary of alcohol treatment outcome research. In R. K. Hester & W. R. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives* (pp. 13–63). New York: Allyn & Bacon.

Murray, R. M., Clifford, C. A., & Gurling, H. M. D. (1983). Twin and adoption studies: How good is the evidence for a genetic role? In M. Galanter (Ed.), *Recent developments in alcoholism* (pp. 25–48). New York: Plenum.

National Survey on Drug Use and Health. (2002). Substance Abuse and Mental Health Services Administration (SAMHSA). Retrieved at www.DrugAbuseStatistics.samhsa.gov

Orford, J., & Edwards, G. (1977). *Alcoholism: A comparison of treatment and advice, with a study of the influence of marriage.* Oxford: Oxford University Press.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy–noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270–378). New York: Wiley.

Project MATCH Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol, 58,* 7–29.

Stanton, M. D., & Shadish, W. R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin, 122,* 170–191.

Stout, R., Del Boca, F., Carbonari, J., Rychtarik, R., Litt, M. D., & Cooney, N. L. (2003). Primary treatment outcomes and matching effects: Outpatient arm. In T. F. Babor & F. K. Del Boca (Eds.), *Treatment matching in alcoholism* (pp. 105–134). Cambridge, England: Cambridge University Press.

Tenth Special Report to U.S. Congress on Alcohol and Health From the Secretary of Health and Human Services. (2000). Rockville, MD: U.S. Department of Health and Human Services.

Tonigan, Miller, Chavez, Porter, Worth, & Westfall, et al., (2003). Project Match 10-year treatment outcome: Preliminary findings based on the Albuquerque Clinical Research Unit. Accessed at http://casaa-0031.unm.edu/crbposters/project%20match%2010-year%20treatment%20outcome.pdf

Vermeersch, D. A., Lambert, M. J., & Burlingame, G. M. (2000). Outcome questionnaire: Item sensitivity to change. *Journal of Personality Assessment, 74,* 242–261.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Hillsdale, NJ: Lawrence Erlbaum.

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes." *Psychological Bulletin, 122,* 203–215.

Whipple, J. L., Lambert, M. J., Vermeersch, D. A., Smart, D. W., Nielsen, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment and problem-solving strategies in routine practice. *Journal of Counseling Psychology, 50,* 59–68.

Wolfe, B. L., & Meyers, R. J. (1999). Cost-effective alcohol treatment: The community reinforcement approach. *Cognitive and Behavioral Practice, 6,* 105–109.