Selecting and Implementing Evidence-Based Practices

DASA Treatment Institute

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AGENDA

- What is an Evidence-Based Practice?
- How do you go about Selecting and EBP?
- Implementing EBPs – The Ins and Outs!!
- What about Fidelity?

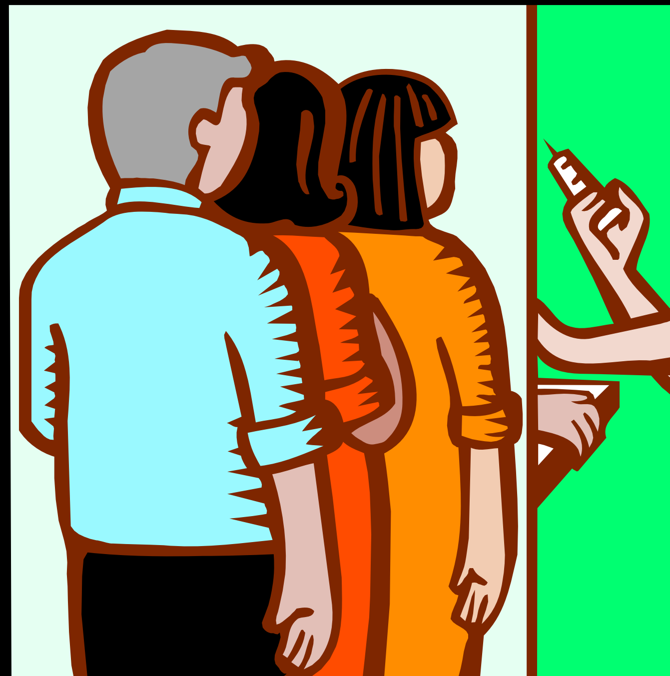
What Makes A Practice Evidence-Based?

Why Should You Care?

- Research directly or indirectly affects the practice of prevention and treatment on a daily basis.
- Research is ongoing and evolving…what "works" today may be replaced by more effective treatments later

Trepanation once was a "scientific cure" for mental illness.

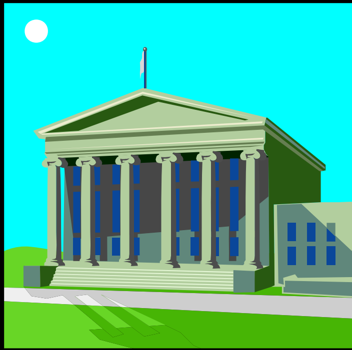
You treat opiate addicts and they are not meeting expected treatment outcomes, so your clinical director provides you with information on some new treatments and asks you to pick a different approach.....



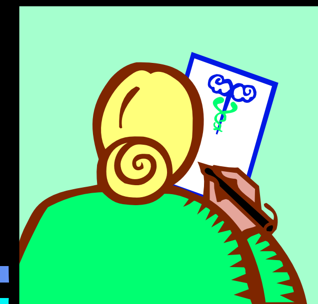
Which treatment would you choose?

A. "this treatment produced a 17% reduction in illicit opioid-positive urine screens"
B. "compared with the other treatment, illicit opioid use was reduced by 31%"
C. "for every 6 clients given this treatment one additional client achieved an illicit opioidfree outcome"

increasingly important skill: understand the nature of clinical research and be able to interpret and apply it



The Process of Research



Hierarchy of Evidence

Systematic Reviews / Meta-Analyses of RCTs (what the heck are all these studies saying?)

Randomized Controlled Trials (can you spell A-N-A-L?)

Cohort Studies (you got treated and I didn't)

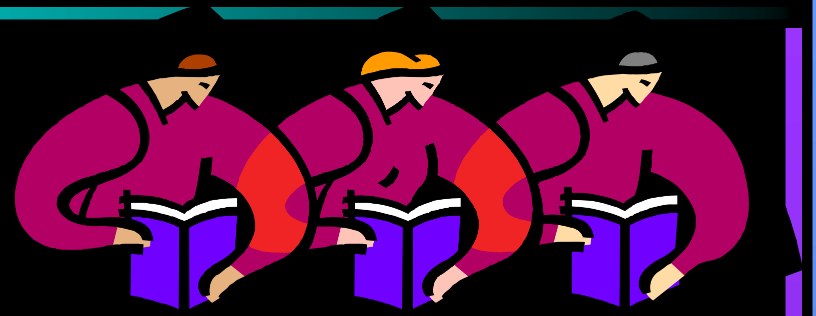
Case-Control Studies (what happened to the haves versus the have nots?)

Cross-Sectional Surveys (this way to media hype "X is associated with Y")

Case Reports (guess what happened to this guy?)

"Perspectives" Articles (everyone's entitled to my opinion)

Essential Understandings



- Research is an ***imperfect*** science, yet yields important information
- Scientific research does not “prove” anything to be true *or* not true
- Research/reporting is often ***biased***
- Research must be critically examined and interpreted for particular clinical needs and patient benefits

Positive results 3-12 times more likely to be published

Positive findings reported within 4.8 yrs

Negative findings take 8 yrs

Case in point:

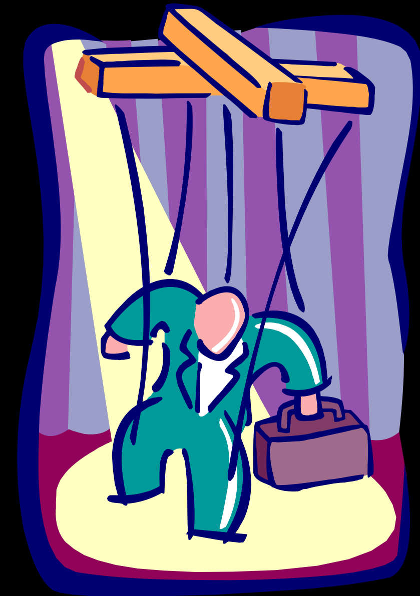
NIDA Clinical Trials Network (CTN)

Treatment tested in real agencies with real clients and real counselors

Even the best studies have limitations.....

Discussion:

- Who gets studied?
- Who gets left out?
- Are those who are studied similar to your clients?



National Drug Abuse Treatment

Clinical Trials Network

Motivational Enhancement Therapy for Pregnant Substance Users

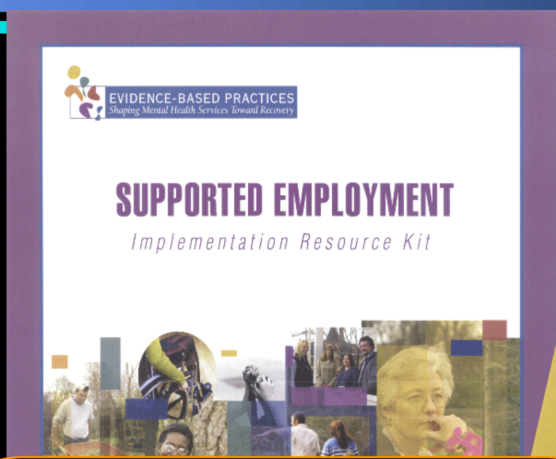
http://clinicaltrials.gov/show/NCT00078143

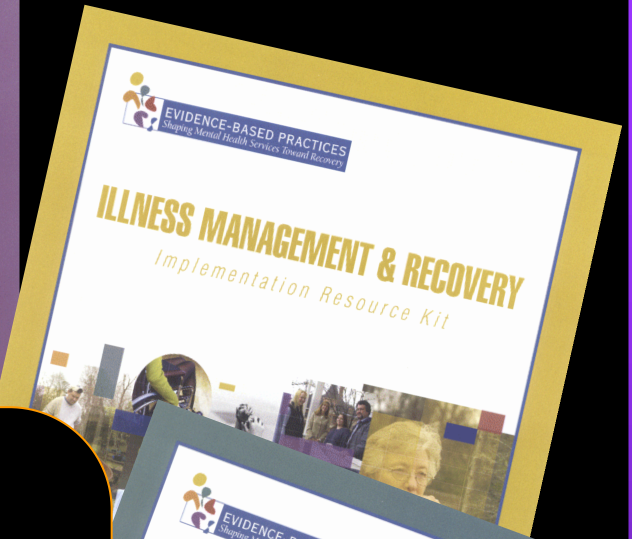
In theory, there is no difference between theory and practice.

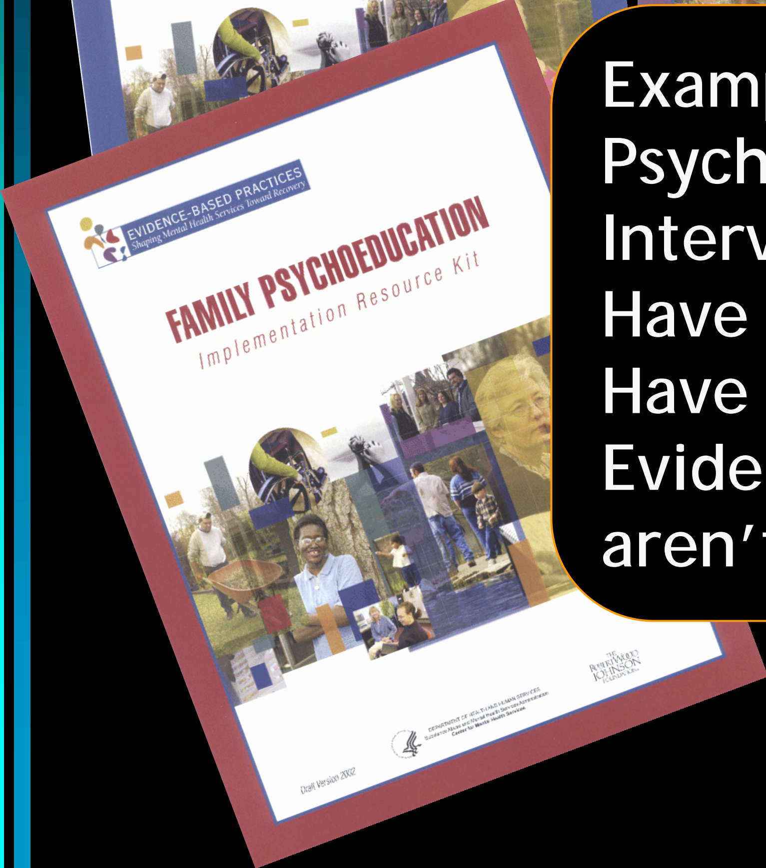
But in practice there is.

Bottom line:

the final “laboratory” is the program/person/practitioner







Examples of Psychosocial Interventions that Have Been Shown To Have Substantial Evidence…there aren't that many!

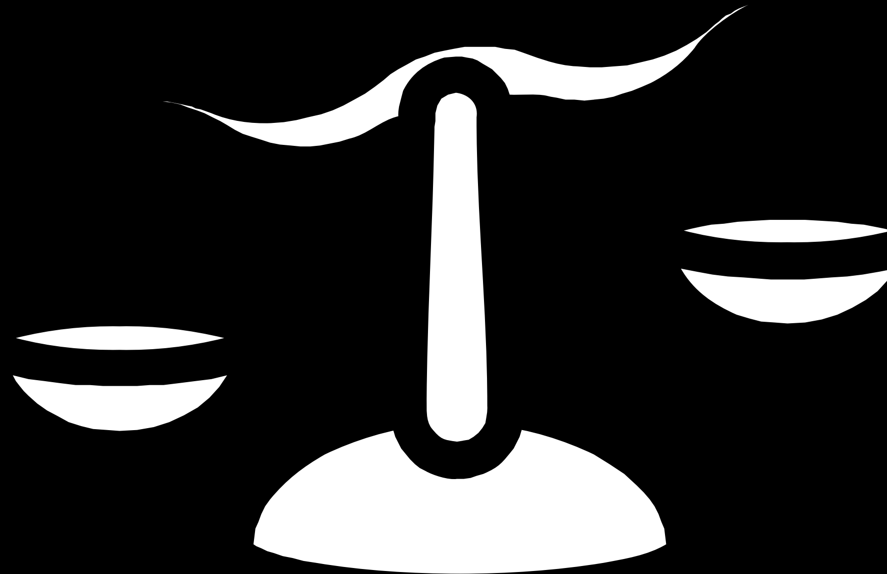
On the other hand.... “local innovations”

- knowledge that is developed from the field that has shown some positive outcomes.
- Sometimes called “practice-based evidence”
- Alcoholics Anonymous is a good example

Your Opinion: which is most important on the treatment effectiveness scale???

Use of EBP with fidelity

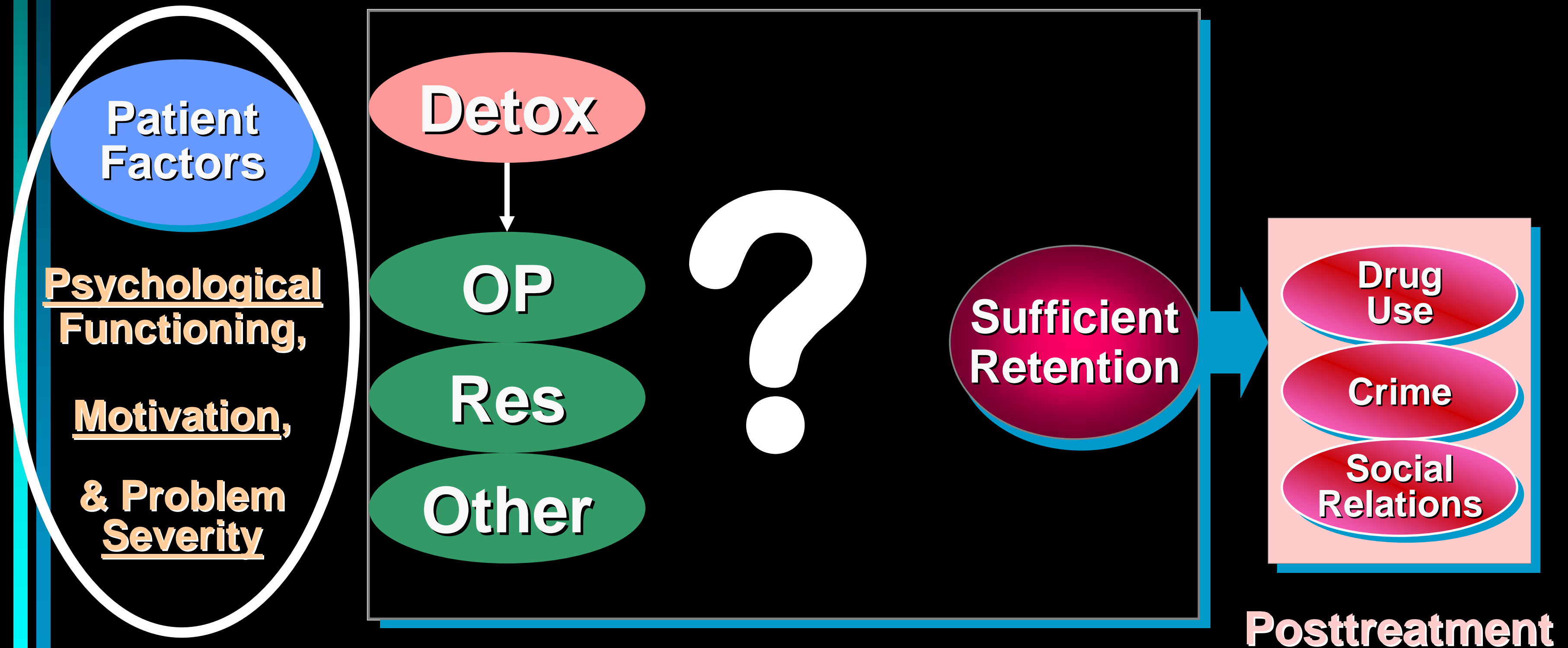
Therapeutic Alliance



How Do you Decide?

- Take a moment and read the case study on page 10 of The Change Book
- Think for a moment about how your agency decided on the EBP(s) you have implemented or plan to implement in your program?

Elements of a Model for the Treatment Process



Simpson, 2004

Consider treatment a process

Patient Readiness for Tx

Program Participation

Behavioral Change

Therapeuti Relationshi

Cognitive Change

Adequate Stay in Trt

rug se

Cri

Social Relations

Pos treat ent

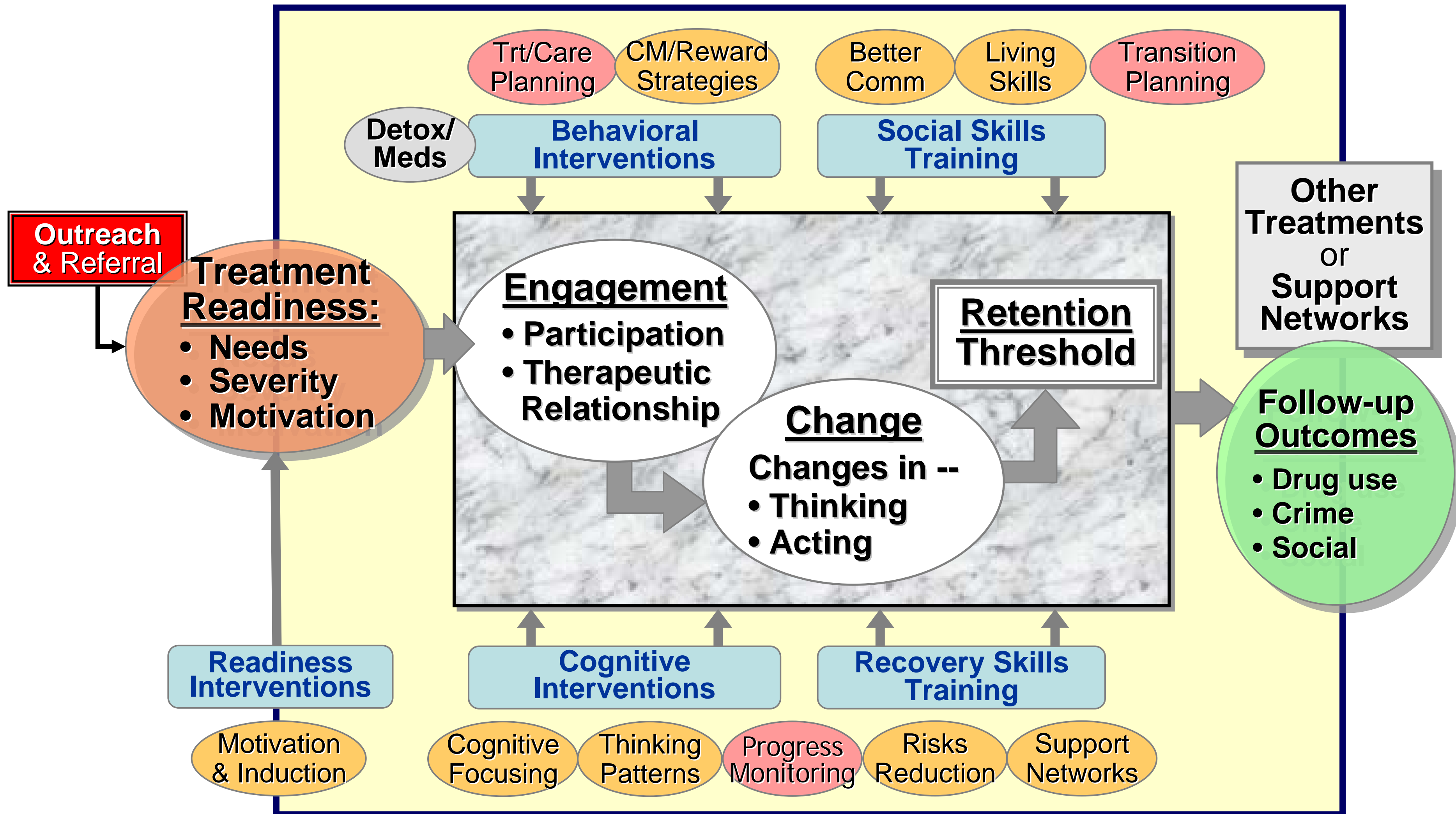
Targeted Interventions

Adapted from Simpson, 2004

Small Group Activity

- Discuss with your group the EBPs you are using or EBPs you are familiar with and decide what parts of the "TCU" treatment process each of these practices "might" improve (e.g., motivation, engagement in treatment, improving early recovery, & retention and reentry).
- Identify a recorder for your group and a spokesperson to report your findings

Treatment Process Model



Simpson, 2004 (JSAT)

TCU © 2007

Assessing Agency Needs

How do you decide what part of the treatment process to focus on?

EBPs & Fidelity Basics

"We are faced with the paradox of non-evidenced based implementation of evidence-based programs."

-Drake, Gorman, & Torrey (2002)

Choosing is just the Beginning!

Effective intervention practices

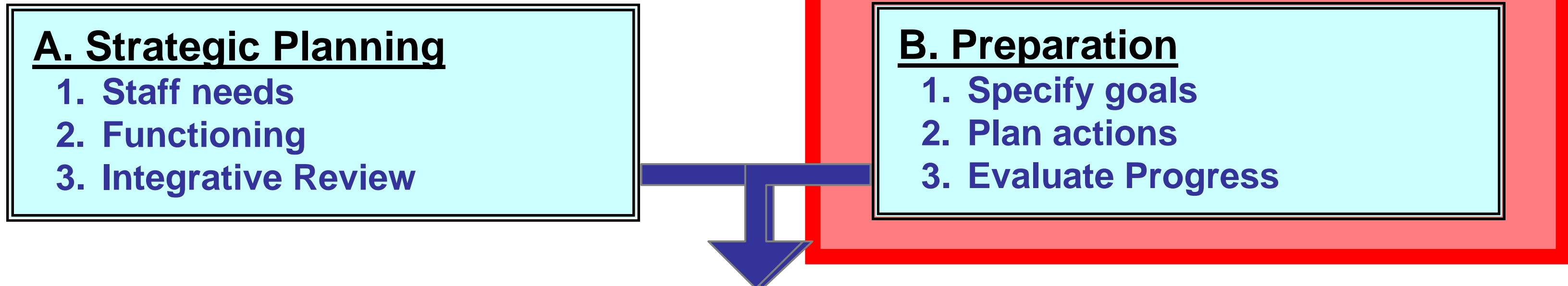
+

Effective implementation practices =

POSITIVE CLIENT OUTCOMES

Fixsen, et al 2005

Innovation Planning & Implementation



Innovation Implementation Process

1. Training
- Relevance
- Accessible
- Accredited

2. Adoption

A. Decision
- Leadership
- Quality/Utility
- Adaptability

B. Action
- Capacity
- Satisfaction
- Resistance

3. Implementation
- Effectiveness
- Feasibility
- Sustainability

4. Practice Improvement
- Outcomes
- Services
- Budget

Motivation

Resources

Staff Attributes

Program Climate

Organizational Readiness & Functioning

Simpson & Flynn, 2007 (*Special Issue* of JSAT)

TCU
© 2007

Fidelity case study: OREOs

What are the key characteristics of this "model" cookie?

Which of these represents "fidelity" to the original "model"?

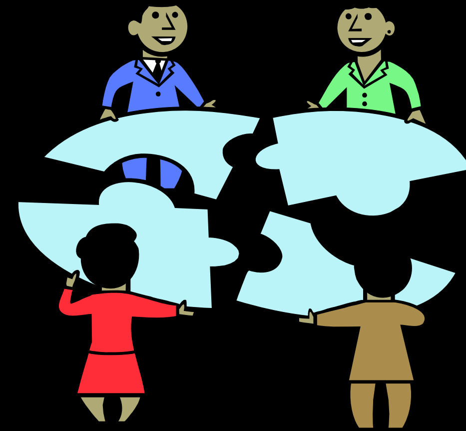
What about OREO "matching"? Which is best for the dieter? The person allergic to chocolate? The endorphin-seeker?

You can take the basic elements of the model and come up with your own applications…does it produce the desired outcome? How would you know?

Fidelity Helps Ensure Positive Outcomes

What A Difference Fidelity Makes!

McHugo (1999) Study

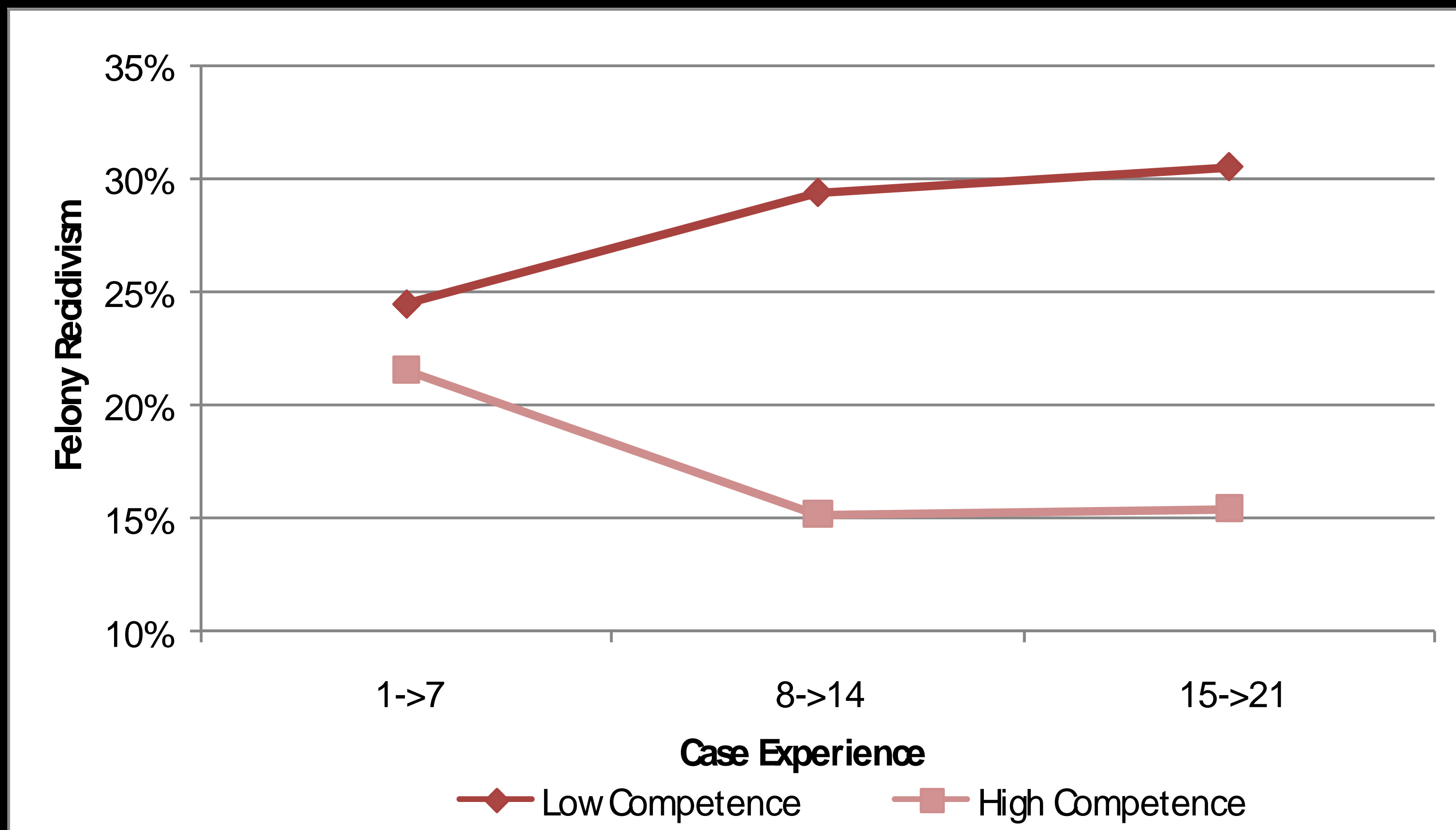


- Clients with MH and SUD received ACT in 7 mainly rural mental health centers
- 4 sites had high-fidelity ACT (n = 61)
- 3 centers had low-fidelity ACT (n = 26)
- Rigorous 3-year follow-up study

	High ACT Fidelity	Low ACT Fidelity
Treatment Dropouts	15%	30%
Substance Use in Remission	58%	13%
Hospital Admissions	2.87	4.69

…another example…..

Felony Recidivism Rates of Families Served by High and Low Competent FFT Therapist



Source: Washington State Juvenile Justice Program. Total number of Therapist equal 38; total number of families = 502.

and another…

meta-analysis of 72 MI studies found

“robust and enduring effects when MI is added at the beginning of treatment.”

- **increases engagement and retention**
- **improves treatment outcomes**

Hettema, J, Steele, J. & Miller, W. R. (2005). A meta-analysis of research on MI treatment effectiveness (MARMITE), *Annual Review of Clinical Psychology,* Vol 1.

Fidelity to MI involved:

- Introduce MI into **one** assessment interview
- Train counselors and supervisors in MI
- Provide ongoing supervision of MI
- Tape counseling sessions
- Train supervisors in a simple tape rating system
- Rate counseling sessions on a regular basis
- Use information from recordings and ratings to guide supervision to increase adherence and competency in MI
- If possible, use a MI style in supervision

Good News/Bad News

Good News:

A substantial number of counselors in the US are being training in MI and report that they are “doing MI” in their sessions.

Bad News:

- Research demonstrates that most counselors who say they are doing MI really are **not**.
- Unless counselors record sessions that can later be rated, it is not possible to know if they are really doing MI (or adhering to any type of practice).

clinicians' self reports on MI proficiency were unrelated to proficiency levels in observed practice

4 mos after quality training, increase in skill level was gone

Evaluating Methods for Motivational Enhancement Education study (Miller, 2004)

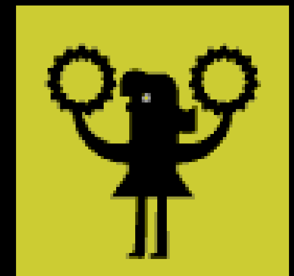
Monitoring Fidelity

Typical methods

- Practitioner completed checklists
- Consumer ratings
- Independent observations (audiotapes, videotapes, in-person)

And now for the best news of the day:

Monitoring fidelity in itself promotes fidelity



Fidelity Is About Outcomes

Definition: degree to which program program model, similar to a recipe

if you're making cookies and you leave out ONE ingredient what is the outcome? It depends:

If it's the raisins you leave out...they're still cookies
If it's the sugar you leave out....they're not

Need to know which "ingredient" creates which effect to know if it's ok to omit it...same with modifying EBP

fidelity is like…..

characteristics of organizations that implement with fidelity

- Early and ongoing collaboration with program developer
- Inclusion of all key stakeholders in the planning and evaluation of the program
- Site based, rather than centralized implementation planning and adoption
- Internal marketing for organizational and community support
- Identification of a staff coordinator

characteristics of organizations that implement with fidelity

- driving and restraining forces for program success identified and clear action steps for both
- Three to five year commitment to funding and program institutionalization
- Training and ongoing technical support for providers
- Both process and outcome evaluation

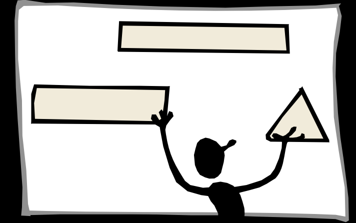
Modifications and Adaptations

common modifications include:

- eliminating
- abbreviating
- reorganizing or
- supplementing

the program structure or content

When is it ok to adapt?



The more narrowly drawn the program is, the less acceptable are adaptations, except for essentials like cultural appropriateness or language comprehension.

"Good" adaptations: increase the power of the materials to communicate with cultural appropriateness, language comprehension, and illustrative examples……these generally don't hurt outcomes

"Bad" adaptations: insertions of old or extraneous material, reduction in number, purpose, or intensity of sessions…these have a negative impact on outcomes.

core components: what are they?

“active ingredients”

- program structure (e.g. the sequence of sessions or context of delivery),
- program content (e.g. specific concepts or skill sets), or
- method of delivery (e.g. assignments, group activities).

In theory, core components must be implemented precisely as intended in order to achieve demonstrated outcomes.

where are they??

specified in the program description, itemized within the implementation manual, or referred to as “required” elements.

If not identified, contact the program developer for information.

"OK" adaptations

- Adapt program content to the culture and language of participants.

Example: Adjust language, or activities to account for culture

- Modify program content to account for developmental influences.

Example: Opt not to use designated puppets if inappropriate for participants' maturity level

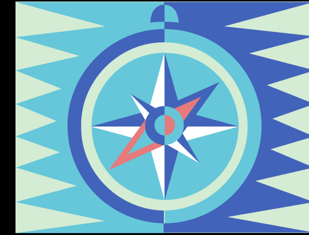
Hallmarks of "watered down" programs

- Agency issues/agendas take priority over program mission
- Implementers pick and choose from model/curriculum components at will
- Program staff can't give a clear & detailed description of the program model
- Modifications aren't identified within the implementation process

Successful adaptations have the following characteristics:

- They are made in consultation with the program developer
- Adaptations are consistent with theoretical foundations of the program
- All adaptations are documented and referenced when conducting or reporting evaluation data
- Evaluation of adaptations is conducted after they have been implemented.

Getting (Back) on Track



- Don’t sweep concerns under the rug. Identify areas that pose challenges, lack clarity, or need attention.
- Take stock of strengths *and* weaknesses related to program fidelity and adaptation. It’s all part of the big picture.
- Start documenting what you’ve done. Or take the “no looking back” approach and start documenting what you’re doing as of today.

Getting (Back) on Track

- Make the new or renewed approach to fidelity and adaptation a team effort.
- Access support and resources from program partners, program developers.

Don't forget!!

Monitoring fidelity in itself promotes fidelity