NOTE TO WEBINAR PARTICIPANTS

This webinar is a "primer." The applied research on evidence-based care is massive. Many of the EBP Model Builders have employed marketing strategies to promote their EBP, much like other products that are available to the consuming public. It is important to recognize that the research and scholarship on EBPs is scientifically complex, which includes methodological flaws, mixed results, and serious limitations. In other words, with ongoing research, EBPs will change and it is the responsibility of EBP users to maintain a current understanding of the applied literature and act according to the ethical standards of your discipline.
QUESTIONS ADDRESSED IN THIS PRESENTATION

• What is the meaning of the term “Promising Practice?”
• What is the difference between a “Promising Practice” and an “Evidence Based Treatment?”
• Why do we want to use Evidence Based Treatments and promising practices?
• How do you determine if a practice or treatment is effective?
• How do you choose an evidence based practice or promising practice?
• Are there known harmful practices and treatments that are currently being used?
For more than 20 years, the field of behavioral health has faced a national crisis surrounding its workforce.

Critical issues include recruitment and retention and a serious lack of relevant preparation for work in behavioral health.

Current practices (usual care) is not based upon either evidence or promising practices; university curricula and post graduate training programs are not current with the science nor are continuing education programs designed to improve core competencies aimed at meeting these needs.
BUILDING A BETTER BEHAVIORAL HEALTH WORKFORCE

• Both the Institute of Medicine (2001) and the New Freedom Commission on Mental Health (2003), identified the critical need to redesign academic and continuing education curricula to better prepare the behavioral health workforce.

• Both reports concluded that system redesign needs to be targeted to both licensed and non-licensed professionals staff to bring the current workforce up to par.
THE VISION: NEW FREEDOM COMMISSION ON MENTAL HEALTH

• First, services and treatments must be consumer and family centered, geared to give consumers real and meaningful choices about treatment options and providers not oriented to the requirements of bureaucracies.

• Second, care must focus on increasing consumers’ ability to successfully cope with life’s challenges, on facilitating recovery, and on building resilience, not just managing symptoms.
CORE ATTITUDES, KNOWLEDGE, SKILLS, AND COMPETENCIES REQUIRED FOR THE BEHAVIORAL HEALTH WORKFORCE

• Public behavioral health has not identified, standardized, or implemented a core set of portable constructs or competencies for direct care staff in any cohesive manner.

• Five core competencies that all clinicians should possess regardless of discipline include: person-centered care; working in interdisciplinary teams, using evidence-based practices, applying quality improvement principles, and using informatics.
WHAT CONSTITUTES AN EVIDENCE-BASED TREATMENT?

• Since the 1960s, professional evaluation has aimed to apply scientific research methods to develop evidence-based practice and programs (EBPs).

• Over the past 40 years, the term “evidence-based” has gained traction in many disciplines including behavioral health.

• However, the policy of the United States Office of Management and Budget (OMB) directs federal agencies to use the concept of “credible” evidence in the formulation of budget proposals and performance plans. The OMB further encourages funding of programs that are backed by strong evidence of effectiveness.
What precisely constitutes credible evidence continues to be debated. The difference between credible evidence and evidence based is also hotly debated by researchers and political bodies.

However, Evidence-Based Treatments have become the central mechanism for the application of scientific findings to practice delivered in service settings.

The number of EBTs has grown, and a number of catalogues have attempted to organize what is known about them.
EBP & EIP

Shared Components:
Commitment to CQI & Ongoing Evaluation
Logic Model
Manual/Protocol
Not Harmful
Accepted Practice
Evidence-Informed
Emerging

- Ongoing collection of pre/post Data
- Peer Review
- Document all implementation activities

Evidence-Promising

- All elements of emerging plus:
  - 1 study, quasi-experimental design with control or comparison group
  - model fidelity
  - one year sustained effect

Evidence-Supported

- All elements of promising plus:
  - 2 randomized trials or 2 between group studies (or comparable methodology)
  - Multiple site replication

Evidence-Well Supported

- All elements of supported, plus:
  - Multiple site replication

Evidence-Based
CATALOGUING OF EBPS & KNOWLEDGE SYNTHESIS

• It is the application of explicit and reproducible methods to the identification, appraisal, and synthesis of studies or information relevant to specific question.

• In behavioral health, these reviews, meta-analyses, and registries serve as lists from which one can select a single EBT that is well suited to a single client, e.g., depressed teenager.

• Increased understanding of the specific challenges to implementing EBTs is part of the strategic mission of the National Institute of Mental Health (2008) as well as the U.S. Department of Health and Human Services (2007).
• Despite considerable investments and initiatives over a 20-year period, the connection between evidence and practice in health care has been inefficient and fragmented, with approximately one third of all health practice being inconsistent with scientific findings and more than 20% either unnecessary or harmful.

• The gulf between evidence and practice is more severe in behavioral health, with the majority of services delivered in usual settings having little or no relation to practice supported by research.
Evaluations of behavioral health interventions have identified many that are potentially effective. Qualified clinicians and other decision makers typically lack the time and ability to effectively search and synthesize the relevant research literature. A number of “what works” websites have emerged to assist decision makers in selecting interventions with the highest probability of benefit. These websites are not well understood.
In 2009, a simple Google search of the term “evidence-based practice” yielded more than one million entries, in contrast to 74,000 entries in Google Scholar.

In 2014, the same search yielded more than 2.5 million entries in Google, and over 60,000 in Google Scholar. A search for the term “evidence-based programs in 2014 yielded approximately 200,000 and 8,000 respectfully.

How can this information become useful for clinicians and decision makers?
The following are agreed upon registries for EBTs:

Blueprints for healthy youth development; California evidence-based clearing house for child welfare; CDC diffusion of evidence based interventions; CDC prevention research synthesis project; Child Trends.org; CrimeSolutions.gov; Effective child therapy; Evidence-based practices for substance use disorders; Home visiting evidence of effectiveness; National registry of evidence-based programs and practices; OAHS teen pregnancy prevention; PracticeWise; Promising practices network on children, families, and communities; Resource center for adolescent pregnancy prevention; Social programs that work/top tier evidence; The Campbell collaboration; The centers for reviews and dissemination-York; The Cochrane collaboration; The guide to community preventive services-the community guide: what works to promote health; The what works clearinghouse.
PRACTICEWISE: AN EXAMPLE

- PracticeWise uses an approach to managing and adapting practice (map). The system is designed to improve the quality, efficiency, and outcomes of children’s behavioral health services by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols.

- Using an online database, the system can suggest formal evidence-based programs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth’s characteristics.
PRACTICEWISE: MAP APPROACH

• The MAP system is grounded in an ongoing review of the behavioral health services literature that is summarized in the PracticeWise Evidence-Based Services Database and procedures with the Practitioner Guides.

• The MAP system encompasses a broad set of targets and practices across the following areas: Anxiety & Avoidance; Inattention & Hyperactivity; Autism Spectrum; Depression & Withdrawal; Disruptive Behavior; Eating; Elimination; Mania; Substance Use; Suicidality; Traumatic Stress.
SELECTING THE EVIDENCE-BASED TREATMENT: FOUR PHASES

• **Exploration Phase** - Which EBP might best solve a clinical or service problem?

• **Preparation Phase** - Plan for integrating the EBP into the existing system or organization.

• **Implementation Phase** - The adopted practice must be implemented. It is not as easy as it appears.

• **Evaluation Phase** - Is the practice being implemented as required? What are the problems encountered?

• **Sustainment Phase** - EBP is institutionalized within the culture of the organization.
SO WHAT NOW?

• Many EBPs have detectable positive effects. Each system of care needs to have a procedure by which to differentiate the best from the others, whether best, good, marginally effective or ineffective.

• Although greater consistency in the standards of evidence used by the registers would reduce uncertainty in program or treatment selection, one can’t assume that evidence can be judged from a single framework.

• Systems of Care need to clarify their consistent standards of evidence and incorporate that process in the system-wide approach across interests (Child Welfare, Behavioral Health, Probation, Public Health).
WHAT IS THE EVIDENCE OF POTENTIALLY HARMFUL TREATMENTS?

• The principle of “nonmaleficence” has been part of every code of ethics for many years.

• Concerns and alarms about potential harms done to children by certain behavioral health interventions have been stated periodically over the last 40 years.

• In 1973, the Transactional Analysis therapeutic approach was tied to a scalding death of a teenager.

• In 1976, there was a report of the harmful effects of aversive conditioning practices

• In 1992 a study by Lipsey (1992), noted that 29% of a large number of trials of treatments of problem adolescents showed some harmful effects.

• In 1994, “holding therapy” was linked to serious injury, including death.

• In 1999, McCord and Poulin (1999), reported that a group of interventions for delinquent behavior were associated with worsened outcomes.

• Norross, Koocher, and Garofalo (2006), through a panel of psychologists considered psychological treatments that were “discredited” included holding therapy, conversion/reparative therapy, re-parenting therapies, Scared Straight, and the DARE drug abuse programs to be on the list of discredited.
DEFINITION OF POTENTIALLY OR KNOWN TO BE HARMFUL TREATMENTS OR SERVICES

• Potentially Harmful Treatments (PHTs) are psychological treatments and psychotherapeutic interventions that are known to have caused harm or been associated with adverse events, or treatments that might logically be expected to cause adverse events in some cases:
  • Demonstrated psychological or physical harm to clients or others;
  • Enduring harmful effects; and
  • Replicated evidence of harmful effects by independent research groups.
Potentially Harmful Policies and Public Practices: The Case of Collateral Consequences

Contrary to the proposed benefits of “getting tough on crime,” research in criminology documents devastating consequences for offenders, families, and communities.

“A Culture of Control” is one reflection of a deeper modern emphasis on surveillance, judgment, and punitive exclusion.

Banishment is used by government bodies and organizations to remove people deemed deviant, such as youth or homeless, from public view. The rationale is one of protecting the “order” and organization.

Current school discipline practices are far more invasive and punitive than in past decades, reflecting the sense of needing to control student misbehavior.

Research strongly suggests that a “culture of control” in schools jeopardizes student success.

An overreaching culture of control actually destabilizes school communities and fosters anxiety and distrust.
An informed and skilled workforce is critical to make a helpful System of Care a reality.

Leadership within the System of Care must develop processes to identify the best practices and avoid harmful policies and practices.

Members, at all levels, must understand and be able to use known and emerging applied research findings within each component of the system.

Leadership must adopt principles to create alliances with providers and service recipients.

It is imperative to have a workforce completely indoctrinated in the value and power of full inclusion and aggressively repel exclusionary policies, practices, and known harmful approaches.

Leaders must formalize and concretize “ethical” conduct, practice, and roles within the system of care.