It’s Not All About Evidenced-Based Practice

Michael S. Levy, Ph.D.
Director of Clinical Treatment Services
CAB Health & Recovery Services, Inc.

American Psychological Association
August 11, 2006
Evidence-Based Practice is One Aspect of Delivering Quality Care

Evidence-Based Practice is One Aspect of Delivering Quality Care

- On the basis of the Horvath and Symonds (1991) meta-analysis, Wampold (2001) portioned 7% of the overall variance of outcome to the alliance. Putting this into perspective, the amount of change attributable to the alliance is about seven times that of specific model or techniques.

- Conservative estimates indicate that between 6% (Crits-Christoph et al. 1991) and 9% (Project MATCH research Group, 1998) of the variance in outcomes is attributable to therapist effects, whereas treatment context accounts for up to 3% to 4% (Wampold, 2001).

Evidence-Based Practice is One Aspect of Delivering Quality Care

In looking at individual drug counseling (IDC) in NIDA’s Collaborative Cocaine Treatment Study, it was found that in cases when the alliance was strong, counselor adherence did not much matter; those patients typically improved. However, for cases in which the alliance was weak, adherence did matter. Those patients improved more when their counselors adhered moderately to IDC principles than when the counselors were either minimally or highly adherent.

From Barber, et al. (2006). The role of therapist adherence, therapist competence, and alliance in predicting outcome of individual drug counseling: Results from the National Institute Drug Abuse Collaborative Cocaine Treatment Study. Psychotherapy Research, 16, 229-240.
Evidence-Based Practice is One Aspect of Delivering Quality Care

NIDA’s Principles of Drug Addiction Treatment:

- No single treatment is appropriate for all individuals.
- Treatment needs to be readily available.
- Effective treatment attends to multiple needs of the individual, not just his or her drug use.
- An individual’s treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person’s changing needs.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
Evidence-Based Practice is One Aspect of Delivering Quality Care

- Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
- Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
- Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
Evidence-Based Practice is One Aspect of Delivering Quality Care

- Treatment does not need to be voluntary to be effective.
- Possible drug use during treatment must be monitored continuously.
- Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.
- Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.
Evidence-Based Practice is One Aspect of Delivering Quality Care

- The point, though, is not convincing you or anyone else of the merits of using EBPs.

- Rather, the point is that when trying to deliver quality care in a substance abuse treatment organization, there are so many other things to think about and to focus on in order to ensure quality treatment. *And it isn’t all about evidenced based practices.*
Frustrations and Realities of Implementing EBPs

- Most EBPs focus on the outpatient realm, which is a much more circumscribed treatment intervention.

- The energy it takes to focus on fidelity monitoring is enormous and what has been found to be effective with careful monitoring may not be a reality in a community setting.

- Staff turnover issues

- The costs may be immense
The Bottom Line: Where Should I Place My Energies?

- Client Satisfaction:
  - You can have the greatest EBPs in the world in your program. Yet with poor client satisfaction, the client’s entire treatment experience will be destroyed.
  - In a residential program for about 85 homeless men with SUDs, on a scale of 1-4, overall satisfaction was 2.6. When asked if they would refer someone to the program, only 60-65% stated that they would. Finally, treatment completion rates were about 30%. There were many complaints of disrespectful and unprofessional staff. And this can be maintenance, secretarial, direct care, or kitchen staff.
The Bottom Line: Where Should I Place My Energies?

- Created trainings on power and powerlessness using the Stanford Prison Experiment Video.
- Conducted other trainings on customer satisfaction (quality care).
- We consistently bring both positive and negative feedback to staff and address identified issues.
- Overall satisfaction is now about 3.2 and consistently over 90% of clients would refer someone to the program. Treatment completion rates are now 56%. And very few complaints of disrespectful and unprofessional staff.
Getting people to even come to treatment: if they don’t come, they won’t get help.

- We found in our outpatient office that in general, of 100 intake appointments, only 53 came (47% no show rate), and of those, only 32 returned for another appointment (40% no return rate).

- Developed quality improvement projects to decrease no show rates and to increase the number of people who returned for follow up.
Getting people to even come to treatment: if they don’t come, they won’t get help.

- Spoke with clients about transportation concerns.
- Spoke with clients directly who were referred from hospitals and detoxification programs.
- Scheduled clients more quickly.
- Created an orientation brochure and reviewed it with clients.
- Called back clients when they did not show for treatment.
Getting people to even come to treatment: if they don’t come, they won’t get help.

- Over five months, we decreased our intake no show rate to 22% and decreased our no return rate for a follow up appointment to 27%. So now, of 100 intake appointments, 78 come and of those, 57 return.

- Next plan is to begin a patient feedback system in which clinicians get real time feedback about the quality of their alliances with their clients.
Increasing treatment retention – if clients don’t stay in treatment, they won’t get better.

- In our detoxification programs, treatment completion was about 53%.

- Developed many projects to see if we can increase the rates of treatment completion. These included:
  - Having counselors touch with clients the day of admission, even if they couldn’t meet with them for the psychosocial assessment
  - Introducing new clients to the charge nurse
  - Creating a drop off box
  - Contingency Management
  - Adding more recreational time
Increasing treatment retention - if clients don’t stay in treatment, they won’t get better.

- Were able to increase treatment completion to 65%.

- Of those who complete treatment, 25-30% go on for further residential treatment.

- Among those that do not complete treatment, the percentage is ZERO.
Getting People in the Door in a Timely Way

Within our Methadone Treatment Program, we found that the time from first phone call to time of first dose of methadone was 18 days.

- Increased lab time
- Increased nurse practitioner and physician time
- Made getting clients in the door more quickly an important focus
- Increase intake slot appointments
- Developed a tracking system

We decreased this time to an average of 8 days.
Ensuring Clients Get the Treatment They Need

- On a weekly basis, we review all new admissions in our outpatient office and review the ASI, treatment plans, and progress notes to ensure that treatment needs and services needed are, in fact, provided and received.

- Feedback is given back to clinicians.
Summary

- Concern is that providers’ focus is and will be primarily concerned with implementing evidence-based practices. While important, this can result in less focus on other aspects of quality care.
- These other aspects of care are every bit, if not more important.
- These other elements of care must not be forgotten in the ethos of demanding the implementation of EBPs.