IF THE WATER IS DRINKABLE, THE HORSE WILL DRINK:

ADAPTING EVIDENCE-BASED PRACTICES FOR COMMUNITY TREATMENT

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Presenters

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La Frontera Center, Inc.

- One of the original CMHCs, 1968
- Largest community behavioral health organization in Arizona; top 5% in US
- Over $50 million annual budget
- 21 sites and 17,000+ clients served, FY 09/10
- Capitated funding predominant

Agenda - Implementing EBPs at LFA

- General considerations
- Our experience with implementation
  - Selection
  - Challenges and solutions
  - Adaptations
  - Evaluation – methods and results
  - Lessons learned

EBP Implementation Examples

- SMART Recovery®
- Motivational Interviewing
- Motivational Incentives
- Seeking Safety
- ADMIRE Plus: EBPs; SRS/ORS
Viewpoints considered:

- System
- Clinicians
- Program evaluators
- Participants

COMMUNITY TREATMENT CONSIDERATIONS

Community Treatment-System Challenges

- Clients - most with co-occurring conditions:
  - multiple challenges, in early recovery

- Limited resources:
  - funds, time for services, training & supervision

- Treatment:
  - group, open-enrollment needed
Community Treatment - EBP Challenges

- EBPs- adapting and implementing them:
  - Developed for clients with 1 diagnosis
  - Highly structured, manual driven
  - Extensive training and supervision needed
  - Clinicians with MA, PhD
  - Timeline specified and limited

Complex Conditions: Now What?

What Clients Want*

- Listen to, affirm, support client
- Positive, upbeat environment
- Non-judgmental, non-confrontational
- Work with clients’ strengths, goals
- Teach a variety of recovery tools
- Good access and follow-through

*Penn & Brooks, 2002; Brooks & Penn, 2003; Brooks et al., 2007
SOME THINGS TO REMEMBER ABOUT IMPLEMENTATION

**What Doesn’t Work**
- Information dissemination alone
  - research literature, mailings, promulgation of practice guidelines
- Training alone
  - no matter how well done

  Fixsen, et al, 2005

**What Works**
- Strong evidence for skills-based training + performance or fidelity measurement
- Good evidence for coaching and careful practitioner selection
- Having a champion

  Fixsen, et al, 2005
Implementing with higher fidelity produces better outcomes for participants

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**WHY IS EVALUATION IMPORTANT?**

- Allows you to know what works/what does not work
- Lets you test adjustments you make
- Qualitative data reveals hidden topics important to participants
- Contributes to the national data base
- Lends credibility
- Can be a helpful treatment tool
**Useful Qualitative Questions**

- What worked?
- What didn’t work?
- What would you like to see added or changed?

**OUR EXPERIENCES WITH IMPLEMENTATION & ADAPTATIONS**

**First, We got SMART!**

SMART Recovery®
Self Management & Recovery Training
SMART Recovery®

- Non-profit self-help program, 1994
- Derived from Albert Ellis’ REBT
- Originally RR, then divided
- Alternative/addition to 12-Step

SMART Recovery® at LFA

- Selection:
  - We got a grant!
  - In popular use: CBT, self-help
- Training:
  - Manuals, website
  - National training
  - Consultant
- EBP – uses common methods of CBT
- Evaluation: part of the NIDA grant

Implementing SMART

- Challenges
  - Split with Rational Recovery
  - Quick implementation required
  - Use methods/philosophy in entire IOP
- Solutions
  - Consultants
  - SMART resources
  - Designed a SMART fidelity tool
Results: Our NIDA 
& CSAT Studies

- NIDA
  - Compared SMART® and 12-Step based IOPs
  - ASI, Lehman QOL & other measures
  - 112 participants over 4 years
- CSAT - Two focus groups
  - Clients (n=12), Counselors (n=8)
  - All experienced with both 12-Step & SMART Recovery® self-help

NIDA - Outcomes for Both, 
12 Month Follow-up

- Alcohol use reduced
- Drug use remained low
- Increased life satisfaction
- Equally effective for women, minorities, variety of diagnoses

Additional Results for SMART®:

- Increased employment
- Improved health status
- Psych status better during the program
- SMART® applied to more issues
SMART® Outcomes:
Clients Liked It

- Fewer client complaints
- 25% higher completion rate
- Higher client satisfaction:
  - Courtesy and respect from staff
  - Program structure met needs
  - Total scores higher

Focus Group Results

Positive to negative comment ratio:

12-Step: 0.3 to 1

SMART®: 16 to 1

Focus Group Themes:
Clients re. SMART®

- Tools are taught and practiced
- Wide applicability of tools
- Treats the whole person
- Harm reduction approach
- Respectful method – no labeling
- Builds self confidence
- Feels safe with facilitators
Client Comments

- “SMART gave me pride. It showed me how to get self-worth. It was basically building me up in order to be receptive to everything else.”
- “Cognitive therapy has been good... More of a positive outlook, the way I talk and the things I do.”
- “I will never again say that I’m an alcoholic or addict... that’s a very small portion of what I am. So that’s what I love about SMART. We don’t have to self-deprecate.”

Bianca’s Experience with SMART®

Focus Group: Counselors

- Agreed with clients re: strengths
- Useful for persons with CC
- Works for early stages of recovery
- Helps some clients be able to use 12-Step programs
Counselor Comments

- “…I was introduced to people with [CC] who were not real open to 12-Step [but] benefiting from SMART.”
- “[SMART] is not just sitting around saying my experience is this [and] that. It is tools.
- “SMART does not come from a place of expecting abstinence…it is just more doable.”
- “It is simple to grasp.”

Conclusions: Why we liked SMART and what we learned

- Uses best practices for co-occurring conditions:
  - Is an integrated approach
  - Builds motivation, confidence & skills
  - Can be used with many readiness stages
  - Is person-centered
  - Teaches new skills
  - Can be used in treatment and self-help aftercare

Why SMART? (cont.)

- Feasible for community treatment:
  - Designed for open enrollment groups
  - Useful for many problems
  - Is easy, inexpensive to learn and use
  - Makes typical CBT methods, which have much evidence support, feasible to use
  - Participants like it
SMART Recovery® at LFA Now

- IOP - ADMIRE Plus
- Residential treatment
- Outpatient groups
- Community self-help groups
- Train staff at other agencies, corrections

No refinement to SMART needed!

CBT Method that didn’t work 😞

Mind Over Mood:

- Plusses
  - EBP
  - User friendly manual

- Why it didn’t work for us
  - Designed for individual therapy
  - Training - longer, $$
  - Staff turnover

MOTIVATIONAL INTERVIEWING

Referred to as MI hereafter
Motivational Interviewing

- Miller and Rollnick, 2002
- A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence
- An EBP – numerous studies, applications
- Many resources: books, articles, web

MI at LFA

- Selection: originally heard about it at a meeting
- Training:
  - Book, presentations
  - Brought Dr. Yahne from CASAA to LFA
  - Sent 2 staff to CASAA – train the trainer
  - Later: Funder designed and required
- Adaptations: applied to intakes, first in A+, then the agency
- Evaluation: none

MI – challenges and solutions

- Challenges – using it fully and correctly
  - Many think they know it, but don’t
  - Getting everyone to use it
  - Implementing required training
- Solutions:
  - Training, training – in house trainers
  - Supervision groups
- What didn’t work
  - Assigning staff to learn it
  - Externally imposed process
MOTIVATIONAL INCENTIVES

CONTINGENT REINFORCEMENT, CONTINGENCY MANAGEMENT

Referred to as CM hereafter

Contingency Management

- Using low-cost reinforcement
  - prizes, vouchers, privileges, etc.
- Delivered in conjunction with goals
  - negative UAs, individual goals, etc.
- Promotes higher rates of target behaviors
  - abstinence, attendance, completion
- EBP – Many studies, very effective
- Underutilized in treatment, often used in business

CM at LFA

- Selection:
  - Residential facility: a form of CM commonly used
  - Meth IOP: required element
  - A+: presentations, literature, colleagues
- Training:
  - Tradition
  - ATTC - PAMI
  - Literature
- Evaluation: Qualitative
CM at LFA - Adaptations

- Residential: privileges (e.g., phone use, community passes) based on good behavior (e.g., attending groups, doing chores). Is changing.
- A+: Bi-weekly prize selections and monthly fishbowl drawing for attending outside meetings and achieving recovery goals
- Meth IOP: fishbowl drawings for clean UAs

CM Implementation

- Challenges
  - Funding for prizes
  - Attitudes – reward/pay clients?
  - Based on punishment rather than reward

- Solutions
  - Non-monetary rewards
  - Use petty cash
  - Educate, train staff

CM – Qualitative Results

- Meth IOP staff: CM is the most effective part of the program
- Many A+ participants:
  - “I have never won anything before in my life”....
  - “It feels great to be recognized for our efforts.”
  - “I like the reward system, even if I don’t get anything.... Client of month-very important! Announcing attendance—important! Size does not matter...accountability matters!”
- Residential: mixed feedback
SEEKING SAFETY

Seeking Safety
Integrated PTSD and Substance Abuse Tx

- Developed by Dr. Lisa Najavits
- First designed for: women, groups
- Accessible manual, website
- An EBP: studies with diverse populations

Features:
- Emphasizes: optimism, self-efficacy
- Makes the treatment engaging: quotations, everyday language
- Trauma details not part of group therapy
- Harm reduction model
- Prepares participants to use other treatments
- Gives participants control wherever possible - empowerment
Why We Initially Chose Seeking Safety

- Participant need – many with this CC
- Demonstrated efficacy
- Useful for a wide range of participants
- Treatment is relatively brief
- Focus on strengths and building positive coping
- Appeared to be user friendly
- Some flexibility seemed possible

Implementing SS at LFA

- Selection: heard about it via NIDA CTN
- Training: manual, website, supervision
- Chose a likely site (residential)
- Decided on staff (psychology interns)
- Evaluation: designed our own
  - LASC
  - client satisfaction
  - Qualitative
- Challenge: adapting it to site

LFA Adaptations:

- Mixed gender groups
- Open enrollment
- Topics
  - Let participants choose some
  - Vary order of topics
  - Extend/repeat some topics
Repeated Measures Analysis
PTSD Scores – Combined Data 2007-09

PTSD Scores - Female Facilitators
Combined Data 2007 - 09

PTSD Scores - Male Facilitators
Combined Data 2007 - 09
Satisfaction Data
Combined Facilitators 2009

1  2  3  4

How would you rate the quality of services you received?
Did you get the kind of services you wanted?
How satisfied are you with the methods used for your service?
To what extent have the services met your needs?
How satisfied are you with the amount of help you received?
Have the services you received helped you to deal more effectively with your problems?
Overall, how satisfied are you with the service you received?

Observations from Facilitators

- Many participants seem to feel relaxed in the emotionally “managed” atmosphere
- Most participants leave group in a positive, upbeat mood
- Participants refer to the tools they are learning when outside of group

What Participants Have Said

- Noted improvements in overall self-esteem
- Greater confidence coping with PTSD and SA triggers
- Said they felt “safe” in group
- Topics and handouts were very useful
Participant Quotes Include

- “If I learn to manage my symptoms, I am able to manage my life.”
- “A safe refuge where you can freely bare your soul.”
- “A new way of survival for me... a new way of life.”
- “Boundaries! Boundaries! How to set them and stick with them; being assertive and no longer being a victim, which feels so good!”
- “The tools are realistic and practical. They are easy to learn and implement in my daily life.”

BIANCA’S EXPERIENCE WITH SEEKING SAFETY

Our Data Suggest

- The method can be successfully used with mixed gender groups
- Open enrollment is possible
- Topic order adaptations are feasible (and may increase participant engagement)
- Participants and facilitators like it
- Closer supervision may be needed, esp. regarding gender considerations
- Look at the data frequently
Why We like Seeking Safety

**Uses best practices for co-occurring conditions**

**Very Flexible:**
- Necessary in community treatment
- Open enrollment possible
- Topic order can be varied
- Participants can choose topics
- Topics can be repeated

Adaptable to many treatment settings

ADMIRE Plus

Hereafter also referred to as A+

ADMIRE Plus

Multifaceted IOP for CC, mostly groups

- Challenges:
  - Design an IOP (groups) that uses best practices for co-occurring conditions
  - Design program evaluation
- Solutions:
  - Chose EBPs carefully – must be feasible, client-centered, teach tools
  - Eval: got external funding; designed our own
A+ at LFA

- Selection of treatments: literature, meetings, colleagues
- Training: manuals, websites, supervision
- Evaluation:
  - grant (CSAT)
  - SRS/ORS adaptation

A+: EBPs include

- SMART Recovery
- Motivational Interviewing
- Seeking Safety – new
- Other CBT methods
- 12-Step Facilitation
- Journaling
- Goal Setting

SRS/ORS – our adaptation

- Developed by Miller and Duncan (2000)
- A brief but systematic way of determining client progress and satisfaction
- Used primarily with individual therapy
- ORS - assesses life functioning
- SRS - assesses the therapeutic relationship
- Four-item visual analog scales
A+: SRS/ORS

- Selection: previous pilot at LFA
- Training: website, colleagues
- EBP – growing
- Challenge: SRS/ORS for groups
- Solution: try it - involve whole team and research department

Method

Our adaptation of the SRS/ORS for groups:

- Each participant completes SRS/ORS for the day
- Added a comment section
- Scores are entered into an Excel file
- Results are reviewed with participants monthly
- Data is also analyzed at the program level:
  - e.g., by day, month, Dx, gender, ethnicity, willingness, primary/secondary drug of choice

ORS Scores
Oct 2009 – April 2010

<table>
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<th>Month</th>
<th>Individual</th>
<th>Interpersonal</th>
<th>Social</th>
<th>Overall</th>
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(N=N value for each month)
Overall ORS Scores By Day of the Week

Monday: 7.7
Wednesday: 8
Friday: 8.3

Overall ORS Scores By Gender

Males (N=5): 8.2
Females (N=14): 7.8

Overall ORS Scores By Level of Program Willingness

Level 8 (N=4): 7
Level 9 (N=2): 7.5
Level 10 (N=11): 8.4
SRS Scores
October 2009 – April 2010

Overall SRS Scores By Gender

Implementation of EBTs:
Our Lessons Learned

Choose wisely – feasible for the setting?
- Groups
- Open enrollment
- Some flexibility in implementation possible
- Has tools that can be generalized
- Useful for diverse participants
- Client-centered, strengths based
- Low cost, used friendly training
- Variety of support materials
Implementation of EBPs: 
Our Lessons Learned

- Start small
- Start with a friendly, willing site & staff
- Experiment with necessary adaptations
- Stay as close to the model as you can
- Collect and use data over time
- Regular supervision/consultation/monitoring
- Communicate with author
- Think about grant funding
- Give presentations

You Can Do This!

*Whatever you can do or dream you can, begin it. Boldness has genius, power, and magic in it.*

Johann Wolfgang von Goethe

DISCUSSION:

WHAT IS ONE STEP YOU COULD TAKE TO START IMPLEMENTING AN EBP?
RESOURCES for this talk:

- SMART: www.smartrecovery.org
- MI: www.motivationalinterview.org
- MI: casaa.unm.edu/mi.html
- Seeking Safety: www.seekingsafety.org
- SRS/ORS: www.talkingcure.com
- CR: www.drugabuse.gov/blending/PAMI.html
- CR: www.nattc.org/pami

General EBP Resources

- Evidence-Based Mental Health Journal: http://ebmh.bmjournals.com
- Evidence-Based Practice Centers: http://www.ahcpr.gov/clinic/epc
- NRI Center for Mental Health Quality and Accountability: http://www.nri-inc.org/cmhqa/cmhqa.cfm
- For specific conditions: http://www.therapyadvisor.org

Thank you!