Objectives

- Participants will gain understanding of the strengths and struggles of implementing multiple Evidence-Based Programs
- Participants will learn strategies from the EBPs that will increase the effectiveness of supervision
- Participants will identify ways to improve multi-system collaboration to increase successful outcomes with clients.
- Participants will discuss outcome data and how to use data to improve services
Research of effectiveness is shown through carefully controlled scientific studies, including random clinical trials.
Research to Usual Care

Replication Issues:

- Efficacy vs. Effectiveness
- Diffusion vs. Dissemination
- Imitate vs. Replicate
- Technical vs. Cultural
Research to Practice

- Development and Manualizing of Protocol
- Efficacy Trial
- Single Case Application
- Initial Effectiveness Trial
- Full Effectiveness Trial
- Effectiveness of Moderators and Mediators
- Goodness-of-Fit Within the Organizational or Practice Context
- Dissemination and Quality in a Variety of Organizational or Practice Contexts

Hoagwood, Burns & Weisz
“Community Treatment for Youth”, 2002
Research Issues:

• Evidence
• Ecology
• Transportability
• Fidelity
Why Did Touchstone Choose EBPs?
Evidence of effectiveness: In multiple clinical trials, FFT achieved significant reductions in the proportion of youths who reoffended (60 percent of treated youths were arrested after the program versus 93 percent of controls in one study and 11 percent versus 67 percent in another) and the frequency of offending up to 2.5 years after participation in the intervention. Diffusion effects on the siblings of target youths have also been observed, with significantly fewer siblings of FFT youths than control youths having juvenile court records 2.5 to 3.5 years after the program.
Multisystemic Therapy

Evidence of effectiveness: This program has been evaluated in multiple, well-designed clinical trials. Studies conducted in Memphis, Tennessee, and South Carolina (among seriously delinquent youths) show that participation in MST can have significant positive effects on behavior problems (including conduct problems, anxiety-withdrawal, immaturity, and socialized aggression), family relations, and self-reported offenses immediately after treatment. Fifty-nine weeks after referral, seriously delinquent youth who participated in MST had slightly more than half as many arrests as controls (mean = 0.87 versus 1.52), spent an average of 73 fewer days incarcerated in justice system facilities, and showed reductions in aggression with peers. After 2.4 years, MST youths were half as likely as control youths to have been rearrested. In Columbia, Missouri, MST improved family relations and arrest rates, including arrests for violent and substance-related crimes, and demonstrated a dose-response effect, with program completers demonstrating significantly more benefits than dropouts.
Brief Strategic Family Therapy

Relative to comparisons, participating children/adolescents and their families showed:

75% reduction in drug use
75% of families remained in the program for the full dosage
58% reduction in association with antisocial peers
42% improvement in conduct disorder

In addition, Families showed statistically significant:

Increase in family participation in therapy (92% of referred/non mandated families)
Improvements in maladaptive patterns of family interactions (family functioning)
Improvements in family communication, conflict-resolution, and problem-solving skills
Improvements in family cohesiveness, collaboration, and child/family bonding
Youth who were charged with a sexual offense and referred by the county State's attorney were randomly assigned to receive MST-PSB or typical offender-specific treatment, which consisted of group treatment and referrals. Based on youth and parent/caregiver reports on the two ASBI subscales, MST-PSB youth had a significantly greater reduction in problem sexual behavior from pretreatment to 12 months posttreatment than their counterparts in the comparison group (p < .05 for youth and parent/caregiver reports on the deviant sexual interests subscale and the youth report on the sexual risk subscale; p < .01 for the parent/caregiver report on the sexual risk subscale).
Myths About Evidenced-Based Treatment

Substitutes for the Arizona Model

Too Prescriptive

Stifles Creativity

Effective for Everyone

Too Expensive

Outsiders
Realities About Evidenced-Based Treatment

Licensing Issues

Contract Issues

Matrix Issues

Referral Issues
Cost Effectiveness

Washington Institute for Public Policy

Greenwood & Associates, Inc.
EBP

Practices vs. Programs
- Refers to both Evidence-Based Practices & Evidence-Based Programs

How to distinguish if there is a difference
- Fidelity-how measured
  self report/monitoring vs. national adherence monitoring

Coaching/Supervision
- initial training
- duration of external oversight (frequency and for how long)
- on-going monitoring/boosters

Model Training
- training in one model vs. multiple models
- practice of one approach vs. modifying for clients

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SAMHSA

(Substance Abuse and Mental Health Services Administration)

National Registry of Evidence-Based Programs & Practices (NREPP)
* Not exhaustive list
  194 EBPs listed

- Purchasing manual on-line (as low as $50) self monitored
- Training costs per therapist/agency fees/on-going boosters (can exceed $100k/ year)
  - national adherence and data collection
    * multiple fees and on-going reports to one minimal fee with no external reports

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Hypothesis

- Strong, engaging clinician more likely to achieve positive therapeutic results
- Fully trained EBP clinician with on-going supervision most likely to achieve best results
Challenges

- Maintaining a strong enough referral base to keep all clinicians with a full case load
- Triaging of referrals - our desire is for a centralized referral process
- Due to the national adherence standards, an increase in client and staff evaluation which leads to non-billable hours
- High expense of operating model

Touchstone’s experience:

- FFT - initially trained in model but allowed to practice with general population as well
- MST - trained solely to work with MST population
- BSFT - trained existing Touchstone clinicians to work primarily with BSFT population
  (if census low allowed to work with other clients)
Clinical Supervision & Outcomes

There are significant challenges in researching the effects of clinical supervision on youth outcomes outside of a manualized treatment protocol.

MST research indicates a positive relationship between supervisor adherence to the quality assurance protocol (including supervision, monitoring of therapists, etc.) and successful client outcomes.
Multiple Perspectives

- Why?
- Therapy notes
- Audiotapes/videotapes of sessions
- Session observation
- Role plays (with supervisor and with peers)
- Peers all trained in the same model; able to shadow each other and provide feedback
Effective Group Supervision

What makes a difference to you?

Knowing what we know, what might make group supervision more effective?
Strategies to Increase Effectiveness in Group Supervision

- Supervisor & Therapist comes prepared for supervision (reviewing case notes, prioritizing cases most likely to close unsuccessfully or not meeting treatment goals)
- Limit story-telling, develop guidelines around “how to present a case”
- Focus on increasing therapist skills; use individual supervision to target particular skill sets the therapist wants to focus on. Role play in supervision with peers who have the skill a therapist wants to focus on.
- Structure the time; limit “administrative” tasks to specific time frames, plan for getting through a specific number of cases each week.

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Outcomes

- What’s meaningful? Vs. What’s NOT!
- Who are we asking?
- How are we asking it?
- Are there objective answers vs. subjective answers?
Outcomes

What do you do with outcome data to make a difference in services delivered?
Multisystem Collaboration

Research indicates that the more all parties involved with a client’s treatment (including medical issues) collaborate successfully, the more successful the client is in meeting treatment goals.

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...AND THAT IS WHY WE LIFT ON THREE...

COMMUNICATION
Collaboration

Low collaboration results in:

- Overlap in services
- Different messages from different providers
- Negativity about family members or team members

High collaboration results in:

- Everyone understanding the goals and their part in working towards those goals
- Clients completing services successfully!
Strategies to Consistently Collaborate

- Develop an understanding of each person’s roles & responsibilities
- Agree that each party can be responsible for different pieces of treatment.
- Agree to disagree at times
- Weekly update phone calls—with a purpose
- Supervisor oversight, checking in on collaboration on difficult cases
Annual Summer Institute
12th Annual Arizona Summer Institute

Thank You

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