Evidence-Based Practice: What It Is & Why It’s Important to Family Advocates

A Web Cast of the University of Illinois at Chicago National Research & Training Center on Psychiatric Disability
Presenters

- Sita Diehl, M.S.S.W.
- Judith A. Cook, Ph.D.
- Sue Pickett, Ph.D.
Topics Covered in Today’s Webinar

• Why evidence-based practice (EBP) is important to families
• What is EBP?
• NAMI family-led education as an EBP
• The need for Intervention Science
• What NAMI members can do to support and encourage EBP & promising practices
Why Evidence-Based Practice is Important to Families

Presented by Sita Diehl
Why Is Evidence-Based Practice So Important?
Why is Evidence Based Practice (EBP) Important to Families?

- **We want treatment that works**
  - EBPs have been put to the test
  - Specify diagnoses, special populations

- **Effective treatment increases adherence**
  - Fewer “false starts”
  - Promotes recovery
Why is Evidence Based Practice (EBP) Important to Families?

• Advocate for best use of public dollar
  – Government and insurers should cover what works
  – Clinicians change to doing what works
  – Promote evidence for “promising practices”
What Is Evidence-Based Practice?

Presented by Judith Cook
Evidence-Based Practice

An intervention that has been shown to be effective by causing pre-defined outcomes in people’s lives when tested in a randomized controlled trial.
Central Research Question

How confident are we that a particular intervention produces positive changes in the lives of participants?
What’s a Randomized Controlled Trial (RCT)?

- People randomly assigned to experimental (E) or control (C) group
- E group receives intervention, C doesn’t
- Creates 2 equal groups to compare before & after receiving an intervention
- Any changes (outcomes) are due to the intervention
Some other research designs

- **Pre-test/Post-test** – Study a group of people before & after an intervention to see if they change

- **Comparison group** – Compare people who receive an intervention to a similar (non-randomized) group

- **Case study** – Conduct an in-depth descriptive analysis of intervention participants, services they receive, & outcomes they achieve

- **Correlational study** – Examine statistical relationships (between participants & outcomes, between services & outcomes, etc.)
Typical Steps in RCTs

• Create a manualized version of the intervention (a detailed, “how-to” manual) to be tested
• Develop a fidelity assessment measuring extent to which intervention is delivered as intended
• Train experienced providers of the intervention to deliver the manualized version
• Recruit a large # of people into the study, interview, & randomly assign them
• Deliver the intervention with fidelity
• Collect data from participants at multiple time-points, analyze it, & disseminate results
Grading the Evidence for Mental Health Interventions
The Level of Evidence Supporting an Intervention Determines Whether it is an Evidence-Based Practice

Guide to Research Methods - The Evidence Pyramid: http://library.downstate.edu/EBM2/2100.htm

Level Ia  evidence from a meta-analysis of multiple RCTs
Level Ib  evidence from at least 1 RCT
Level IIa evidence from at least 1 well-designed controlled study without randomization
Level IIb evidence from at least 1 other well-designed, non-controlled, quasi-experimental study
Level III evidence from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies, & case studies
Level IV expert committee reports or opinions &/or clinical experiences of respected authorities

* Now called the Agency for Healthcare Research & Quality
What Is the Level of Evidence for NAMI Family Education?

Presented by Sue Pickett
Family Consultation and Brief Family Education: Evidence Base

- Brief individual family consultation
  - 6-10 hours of one-on-one assessment and consultation

- Brief family education
  - 10-session educational workshop taught by a family/professional team

- Research Design-RCT led by Phyllis Solomon and colleagues
  - 225 family members randomly assigned to family consultation or educational workshop (experimental or E groups) or wait-list control group (C group)

- Results
  - E groups showed significantly increased confidence in ability to manage their relative’s illness and reducing their own stress and burden, C group did not

- Evidence “Grade” - Level Ib (Evidence from at least one randomized controlled trial, U.S. Agency for Healthcare Research & Quality 1992 Evidence Rating Guidelines)
Journey of Hope (JOH): Evidence Base

- 8-week family-led education course similar to NAMI’s Family-to-Family program
- Research Design: RCT led by Sue Pickett and colleagues
  - 462 family members randomly assigned to JOH (experimental or E group) or a wait-list control group (C group)
- Results
  - E group showed significant gains in knowledge of mental illness and its treatment; decreased depressive symptoms; improved relationships with ill relatives; and greater caregiving satisfaction compared to C group
- Evidence “Grade” - Level Ib
Family to Family (F2F): Evidence Base

- 12-week family-led education course
- Research Design: Two pilot studies conducted by Lisa Dixon and colleagues
  - 37 family members assessed pre-post F2F and 6 months later
  - 95 family members on a 3 month wait-list for F2F assessed at wait-list, pre-post F2F and 6 months later
- Results
  - Families in both studies had increased empowerment and decreased subjective burden. Families in the second study had significant improvements in problem-solving, self-care, and understanding of mental illness and the mental health service system.
- RCT of F2F currently underway
- Evidence “Grade” - Level IIa (Evidence from at least one controlled trial without randomization, U.S. Agency for Healthcare Research & Quality 1992 Evidence Rating Guidelines)
6 SAMHSA Evidence-Based Practices

How Available are they in Your Area?

Supported employment
• Family psychoeducation
• Assertive community treatment
• Integrated treatment for co-occurring disorders (substance use and mental illness)
• Medication management
• Illness management and recovery

6 SAMHSA Evidence-Based Practices Implementation Resource Toolkits

- Resource kits developed by clinicians, consumers and family members to help promote use of EBPs
- Kits include information sheets, videos, manuals
- Printed versions are FREE!

http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/
The Need for Intervention
Science

Presented by Judith Cook
Important Question: How Can Scientists & Advocates Work Together?

“Basically, we’re all trying to say the same thing.”
Questions to address…

• Why do so many states continue to fund non-EBP services?

• Whose participation is essential (both necessary & sufficient) for system-wide EBP implementation?

• How can states incentivize changes in clinical practice & service organizations needed for EBP?

• What can advocacy organizations like NAMI do to promote EBP?

• What type of science can help us to answer these questions?
We need a different kind of science

- Shift the emphasis from primarily funding clinical trials science to including intervention science.
Intervention Science (IS) Plays an Important Role In EBP Service System Development

• IS is an interdisciplinary effort to develop & research ways that enable communities to use EBP interventions effectively & efficiently (Wandersman, 2003)

• IS is a phased process of evidence-gathering & model testing

• Stakeholders including consumers, families, state MH authorities, etc. participate in every phase

• Stakeholders steer, scientists row (Leff et al., 2003)
Creating EBP Systems Takes Time & Resources: The Ladder of Evidence According to Intervention Science

1. Discovery
2. Development
3. Effectiveness
4. Generalizability
5. Disseminability
6. Monitoring

Increasing evidence supporting large-scale use

Evidence-Based Practice
Promising Practice
Currently, We Don’t Have Good Knowledge…

- About the nature of EBPs beyond rung 3
- Costs to fund services that have made it to rung 3
- Best ways to move an EBP to rungs 4-6

(Leff et al., 2003)
How NAMI Can Support Evidence-Based & Promising Practices

Presented by Sita Diehl
NAMI Members Can Influence Science
What can we do to Support EBP?

Shift Funding from Ineffective Services to Effective Community-Based Services

- Look at what the state funds and how much it spends on different models
- Advocate for de-funding ineffective services & implementing EBPs in their place
- Urge the state to use a “braided” or “blended” funding approach since different funding streams are often needed to fund EBP
What is Braided Funding?

Funds from different sources are combined in order to pay for a service or program.

Typical sources in mental health include state general revenue (tax dollars), Medicaid, state vocational rehabilitation (VR), & other sources.

EBP often requires braided funding because services are comprehensive.
One Example: Braided Funding for Supported Employment in Maryland

1) Pre-job placement (MH state general funds)
2) Job development (VR funding)
3) Placement (MH state general funds)
4) Job coaching (VR funding)
5) Psychiatric rehabilitation (Medicaid)
6) Clinical coordination (MH state general funds)

http://www.dors.state.md.us/NR/rdonlyres/2FC3C649-5D3D-4239-A498-B298DDB88A2E/0/DDA_Agreement.pdf
Change Training and Clinical Practice

Currently:

- Minimal outcome accountability
- “Train and hope” approach to transferring EBP into mainstream service delivery
- Degrees can act as licenses to practice based on out-dated knowledge

In the (Near) Future:

- Create accountability for EBP services
- Measurement & report outcomes to the community
- Use mix of EBPs & promising practices
For further information

Visit the UIC website at…
http://www.cmhsgrp.uic.edu/nrtc/

Visit the NAMI-TN website at…
http://www.namitn.org/
Thank You!