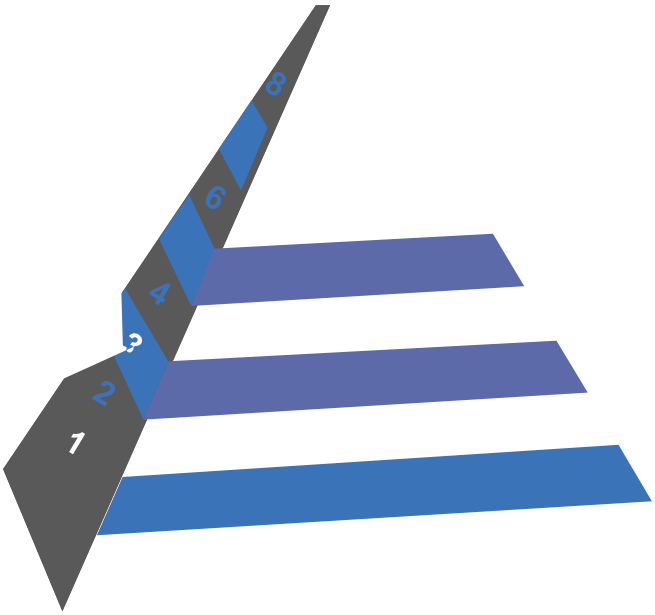
VIEW PAPER 6

Acknowledgments

question in determining whether a practice is
e based is: What is the strength of evidence indicat-
the practice leads to a specific clinical outcome?
no gold standard for assessing strength of evidence,
ly evidence derived from clinical experience. How-
CE has developed a pyramid to represent the level or
of evidence derived from various research activities.
e seen in Figure 2, evidence may be obtained from a
studies including preliminary pilot investigations
ase studies through rigorous clinical trials that
experimental designs. Higher levels of research
derive from literature reviews that analyze studies
for their scientific merit in a particular treatment
ical trial replications often with different popula-
d meta-analytic studies of a body of research
. Finally, at the highest level of the pyramid, are
nel reviews of the research literature.

: Pyramid of Evidence-Based Practices



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There is no s rd, the designation of a p ces from a review of research and possibly other evidence by experts in the field (see Question 1). Different organizations use different processes and standards to determine whether practices are evidence based.

In evaluating evidence, it is important to understand the distinction between efficacy and evidence. Efficacy means that a treatment or intervention produces positive results in a controlled experimental research trial. Effectiveness means that treatment or intervention produces positive results in a usual or routine care setting (i.e., in the real world). Efficacy established in controlled research does not necessarily equate with effectiveness in real world settings. For example, it may be impractical to provide real world clinicians with the level of training and supervision provided to clinicians in research studies, or real world target populations and community contexts may differ from those used in the research, and so on.

3. Why should EBPs be used?

There are several reasons to use EBPs. Foremost, when services are informed by the best available evidence, the quality of care is improved. Using EBPs increases the likelihood that desired outcomes will be obtained. EBPs that are based upon research typically have carefully described service components, and many have manuals to guide their implementation. This allows for consistent delivery of the practice and high fidelity to the model. Lastly, by employing these practices, providers will often more efficiently use available resources.

4. What are the differences between EBPs, "consensus-based practices," "science-based practices," "best practices," "promising practices," "emerging practices," "effective programs," and "model programs"?

A number of terms have been used at different times, and by different groups, to describe practices that are expected to produce a specific clinical outcome. These terms are somewhat interchangeable. The terms "promising" and "emerging" are consistent with the notion that the strength of evidence varies among practices deemed likely to produce specific clinical outcomes. COCE avoids descriptors like "best" and "model" because they may imply that there is a single best approach to treating all persons with COD. COCE also avoids the term "effective" because no hard criterion exists for the level of evidence by which "effectiveness" is established.

The term "consensus based" refers to a process by which evidence is commonly evaluated and synthesized to determine if a given practice is an EBP. Other common processes include evaluation of evidence using standardized criteria and numerical scores, meta-analysis, and synthesis by a single scholar. COCE views the consensus process as the best way to identify and evaluate EBPs.

5. Is all manualized treatment evidence-based treatment? Have all EBPs been manualized?

Just because a practice is in manual form does not mean it has risen to the level of an EBP. Manual development can be an early step in outcome research, and that research may show the manualized treatment to be ineffective. Moreover, manuals are sometimes developed as marketing tools for treatments that have undergone little research.

However, once an EBP is established, the development of treatment manuals and practice guidelines help make the EBP accessible to providers. Manuals can minimize the need for costly trainings and often contain fidelity measures and outcome assessment strategies. They can also improve clinical decisionmaking by laying out guidelines for critical circumstances. Practice manuals vary in their level of detail and may not be useful as stand-alone products. Not all EBPs have manuals, but many do.

6. What is EBP fidelity and why does it matter?

Fidelity is the extent to which a treatment approach as actually implemented corresponds to the treatment strategy as designed. Following the initial design with high fidelity is expected to result in greater success in achieving desired client outcomes than deviating from the design (i.e., having low fidelity).

7. What are some evidence-based practices for co-occurring disorders?

Because the treatment of COD is a relatively new field, there has not been time for the development and testing of a large number of EBPs specifically for clients with COD. Clearly EBPs developed solely for MH or SA should be considered in the treatment of people with COD.

EBPs for COD should combine both treatment elements (e.g., the use of motivational strategies) and programmatic elements (e.g., composition of multidisciplinary teams). COCE has outlined the critical components of COD practices (see Overview Paper 3, Overarching Principles) that should guide the selection of these elements.

At the *treatment level*, interventions that have their own evidence to support them as EBPs are frequently a part of a comprehensive and integrated response to persons with COD. These include:

- Psychopharmacological Interventions (e.g., desipramine and bupropion for people with cocaine use disorders and depression [Rounsaville, 2004])
- Motivational Interventions (e.g., motivational enhancement therapy [Miller, 1996; Miller & Rollnick, 2002])
- Cognitive-Behavioral Interventions (e.g., contingency management [Roth et al., 2005; Shaner et al., 1997])

At the *program level*, the following models have an evidence base for producing positive clinical outcomes for persons with COD:

- Modified Therapeutic Communities (De Leon, 1993; De Leon et al., 2000; Sacks et al., 1998, 1999)
- Integrated Dual Disorders Treatment (CMHS, 2002; Drake et al., 1998b, 2004)

- Assertive Community Treatment (Drake et al., 1998a; Morse et al., 1997; Wingerson & Ries, 1999)

The current state of the science highlights the need for evidence-based thinking in making both programmatic and clinical decisions in the treatment of people with COD.

8. How can I learn about new developments in EBPs?

At SAMHSA, the National Registry of Effective Programs and Practices (NREPP) is a decision-support tool that assesses the strength of evidence and readiness for dissemination of a variety of mental health and substance abuse prevention and treatment interventions. The NREPP system is currently in transition and will be available through a new Web site (www.nationalregistry.samhsa.gov) in Spring 2006. A highly respected organization in Great Britain, the Cochrane Collaborative, maintains the Cochrane Library, which contains regularly updated evidence-based healthcare databases (see www.cochrane.org) on a comprehensive array of health practices. Relevant specialty organizations (e.g., American Psychological Association) also publish lists of evidence-based practices. These compilations of programs and interventions may or may not be generalizable to persons with COD, and the reader should look for specific reference to COD populations.

9. What issues should be considered in the use of EBPs?

Most EBPs are not universally applicable to all communities, treatment settings, and clients. If communities, treatment settings, and/or clients vary from those for which the EPB is designed, or if the human and facilities resources needed for the EBP are not available, effectiveness may be reduced. The various issues that must be considered in the use of an evidence-based practice include:

- Client population characteristics including culture, socioeconomic status, and the existence of other health and social issues that may complicate service delivery (e.g., pregnancy, incarceration, disabilities)
- Staff attitudes and skills required by the EBP
- Facilities and resources required by the EBP
- Agency policies and administrative procedures needed to support the EBP

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