Evidence-Based Practice:
What is it? Why Should We Care?

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What is Evidence-Based Practice?

Some definitions

“The conscientious, explicit, and judicious use of the current best evidence in making decisions about the care of individual patients”

-Sackett et al., (2000)
Some definitions

“Integration of best research evidence with clinical expertise and patient values”

-Institute of Medicine (2001)

Some definitions

“Integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences”

-APA (2005)

National Association of Social Workers, SSW Standards (2012)

Standard 4. Intervention

School social workers shall understand and use evidence-informed practices in their interventions

School social workers shall remain current with school-based intervention research and use evidence-informed practices in service delivery.
Clinical Decision-Making

Best available research evidence

Patient’s values, characteristics, and circumstances

Clinical Expertise

What are the relevant research findings?
What is the quality of the research?
- Use systematic reviews
- Learn how to evaluate research quality

Is the research relevant to your patient?

What are your existing skills and resources?
Do you have the skills to use best-evidence model?
Is training and/or supervision available?
Is the best-evidence model(s):
- Applicable to the characteristics of this patient?
- Acceptable to this patient?
- Likely to succeed with this patient?

What are your patient’s values and preferences?

Best available research evidence

Patient’s values, characteristics, and circumstances

Clinical Expertise

Clinical Decision-Making

But it works? So who cares?

"Interesting. But what makes you so sure I'm your patient? Rather than the other way around?"
Consumer Reports Study

2,900 subscribers
- 37% psychologists
- 22% psychiatrists
- 14% social workers
- 9% marriage counselors
- 18% other MH professionals

Results:
- Most reported getting better
- 87-92% reported improvement
- Long-term better than short-term therapy

CR results

Results continued...
- Psychologists, psychiatrists, and social workers did better than marriage counselors
- Family doctors fine in the short-term, not long-term
- AA better than anyone
- "No specific modality of psychotherapy did any better than any other for any problem"
  - Dodo bird hypothesis
- Those with insurance limitations did worse

“Everyone has won, so all must have prizes!"

Problems with the CR study

Non-random
- Likely biased sample
Cognitive dissonance ≠ positive bias
Regression to the mean
- No control group
The Role of Evidence…

Evidence-Based Medicine Movement
Evolution:
- Does psychotherapy work?
- Empirically-Validated Treatment
- Empirically-Support Treatments
- Evidence-Based Practice

The First Evidence-Based Medicine

History of EBM
Because resources are limited, they should be used to provide equitably those forms of health care which had been shown in properly designed evaluations to be effective.

1910 - Flexner report
1972 - Archie Cochrane: Effectiveness and Efficiency: Random Reflections on Health Services
1973 - John Wennberg: widespread unwarranted practice variation
1985 - IOM: 15% medical practices evidence-based
1992 - Cochrane Collaboration
1997 - How to Read a Paper: The Basics of Evidence-Based Medicine
2000 - Sackett - How to Practice and Teach EBM
EBP in Mental Health

1995: First EBP Psychiatry article in Canadian Journal of Psychiatry
1998: Evidence-Based Mental Health Journal
2001: Volume in Psychiatric Services devoted to EBP
2005: Adoption of EBP policy by American Psychological Association
2012: NASW, Standards for School Social Work Services

The Research Practice Gap

10-15 year gap between research & practice

"Despite substantial evidence documenting the efficacy of numerous treatments for mental and substance-use problems and illnesses, mental and/ or substance-use health care (like all health care) often fails to provide care consistent with this evidence" IOM (2006)

False beliefs about EBP

- Manualized or “cookbook” approach to treatment
- All about cutting costs
- Must rigidly follow treatment guidelines and pathways
- Dictates my practice from the “top-down”
Connie Sensus

Connie sought treatment for anxiety. Her counselor, recently trained in an EBP for anxiety, began to apply the treatment to Connie’s anxiety. Connie participated in the sessions, but did not find them helpful; indeed, the enthusiastic counselor was so excited about implementing the new therapy, she never got the background to Connie’s anxiety (i.e., sexual assault). Rather than disappoint her counselor, she reported that she was better and left treatment.

Koocher et al., 2008

Non-EBP Approaches

• Eminence-based medicine
• Eloquence-based medicine
• Vehemence-based medicine
• Nervousness-based medicine

Typical Non-EBP Approaches

• Training from graduate school
• Clinical experience
• Uncritical acceptance of the results of one study
• Over-reliance on expert opinion
• Approaches that are nicely packaged
• Approaches that are easiest to do
• Cure-alls
• Propaganda from Pharmaceutical companies
• Unfounded beliefs
Sammy Soggy

Sammy Soggy has had nighttime bedwetting accidents for 4 years since he was trained at age 2. Accidents have increased since the birth of a sibling. Dr. Seymour Toodoo, an analyst, advises Sammy’s parents that his enuresis represents displaced aggression tied to sibling rivalry, and recommends psychodynamic therapy 3Xs per week.

Kocher et al., 2008

5 steps of EBP

Ask a Question

Ask client-oriented, relevant, answerable questions
Distinguish between background (general) and foreground (specific) questions
Formulate foreground questions using a structured framework: PICO
• Patient/Population characteristics
• Intervention
• Comparison condition
• Outcome
Ask a Question: PICO

What is the patient and/or problem you want an answer to?
- "In patients with depression..."

What is the intervention you are interested in
- does adding psychotherapy to pharmacotherapy,

Control or alternative treatment
- when compared to pharmacotherapy alone,

Outcome of interest
- prevent relapse?"

Ask a Question

Prioritize questions by the importance/significance of the problem
Distinguish between different types of questions
- Assessment
- Intervention
- Prevention, Response, Remission, Recovery, Relapse Prevention
- Prognosis
- Harm
- Cost-effectiveness

Know the best type(s) of evidence to answer each kind of question

Acquire the Evidence

Find the best available evidence to answer your question
- Primary research
- Secondary (synthesized) research evidence
  - Critical registry and listings
  - Critical synthesis of secondary research
- Guidelines & practice parameters
Acquire the Evidence: Primary

PubMed (free)

PsychInfo ($)

Individual Journal Subscriptions:
- Archives of General Psychiatry
- American Journal of Psychiatry
- Journal of Consulting and Clinical Psychology
- Clinical Psychology Review
- Psychological Medicine
- Journal of Clinical Psychiatry
- Clinical Psychology Review
- Evidence-Based Mental Health

Acquire the Evidence: Secondary

SAMHSA's National Registry of Evidence-based Programs and Practice
- http://nrepp.samhsa.gov/

AHRQ's National Guideline Clearninghouse
- http://www.guideline.gov/

Hawaii’s Department of Health:

Society of Clinical Child & Adolescent Psychology
- http://effectivechildtherapy.com/

Acquire the Evidence: Secondary

- Cochrane Summaries
  - http://summaries.cochrane.org/
- DARE
  - http://agatha.york.ac.uk/darehp.htm

BMJ Evidence Centre
- http://group.bmj.com/products/evidence-centre

TRIP database
- http://www.tripdatabase.com/

SUMSearch
- http://sumsearch.org/
Acquire the Evidence:
Guidelines & Practice Parameters

American Psychiatric Association
- http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm

American Academy of Child & Adolescent Psychiatry

American Psychological Association

Example:
Postnatal Depression at BMJ’s Clinical Evidence

SSRIs may improve symptoms of postnatal depression, but we found few studies evaluating their effect specifically in postpartum women.

- We don’t know whether other types of antidepressant are effective compared with placebo or psychological treatments.
- We don’t know whether oestrogen treatment or St John’s Wort improve symptoms compared with placebo.

Example
Postnatal Depression at BMJ’s Clinical Evidence

Psychological treatments such as individual CBT, non-directive counselling, interpersonal psychotherapy, and psychodynamic therapy are likely to improve symptoms compared with routine care, but long-term benefits are unclear.

We don’t know whether light therapy, group CBT, psychoeducation with the partner, mother-infant interaction coaching, telephone-based peer support, infant massage, or physical exercise improve symptoms of postnatal depression as we found few studies.
Appraise the Evidence

Is the study valid?
- Was it a randomized controlled trial?
- Was the randomization list concealed?
- Were subjects and clinicians blinded?
- Were all subjects accounted for?
- Was intention-to-treat analysis used?
- Despite randomization, were the groups dissimilar?
- Aside from the experimental treatment, were the groups treated equally?

AHRQ: Levels of Evidence
1++: High quality meta-analyses, systematic reviews of randomized clinical trials, or high-quality clinical trials with a very low risk of bias.
1+: Well conducted meta-analyses, systematic reviews, or randomized clinical trials with a low risk of bias.
1-: Meta-analyses, systematic reviews of clinical trials, or clinical trials with a high risk of bias.
2++: High quality systematic reviews of cohort studies or case-control studies or high-quality diagnostic test studies, high-quality cohort studies or case-control studies of diagnostic tests with a very low risk of bias and a high probability that the relationship is causal.
2+: Well conducted cohort studies or case-control studies or diagnostic test studies with a low risk of bias and a moderate probability that the relationship is causal.
2-: Cohort studies or case-control studies with a high risk of bias.
3: Non-analytical studies, such as case reports and case series.
4: Expert opinion.
AHRQ: Strength of Recommendation

A: At least one meta-analysis, systematic review of randomized controlled trials (RCTs), rated as 1++, and directly applicable to the target population, or sufficient evidence derived from level 1+ studies that are directly applicable to the target population and that demonstrate overall consistency of results.

B: A body of evidence derived from level 2++ studies that are directly applicable to the target population and that demonstrate overall consistency of results. Extrapolated evidence from level 1++ or 1+ studies.

C: A body of evidence derived from level 2+ studies that are directly applicable to the target population and that demonstrate overall consistency of results. Extrapolated evidence from level 2++ studies.

D: Evidence level 3 or 4. Extrapolated evidence from level 2+ studies.

Good Clinical Practice: Recommended best practice based on the clinical experience and the consensus of the guideline development group.

Appraise the Evidence

Are the results important?
- How large is the treatment effect?
- How precise are the results?

Types of effect:
- Effect Size
- Number Needed to Treat
- Odds Ratio
- Hazard Ratio

General term for the amount of change produced by a treatment

# of people needed to receive a treatment before one person would experience a beneficial or harmful outcome

The ratio of the odds of an event in one group to the odds of an event in another group

The increased risk that one group is likely to experience an outcome

Appraise the Evidence

Can I apply the results to my patient?
- Is my patient too different from those in the study?
- Is the treatment consistent with my patient’s values and preferences?
- Is the treatment feasible in my setting?
Apply the Evidence

Integrate appraisal of the evidence with:
- Available expertise and resources
- Patient’s characteristics, values, preferences, and context

Engage in collaborative decision making
Decide on an approach
Self-assess skills
If needed:
- Locate training and supervisory resources
- Learn new interventions
- Update skills

Analyze and Adjust

Practice-based continuous quality improvement
Assess process & outcomes
- Compare change to published findings
Evaluate process & outcomes measurements
- Compare change to benchmarks, published findings
Adjust treatment if needed
- Adjust for specific patients
- Adjust overall approach
- Adjust programming

Analyze and Adjust

What do you measure?
- Outcomes
  - Symptoms, Functioning, Quality of life
- Process
  - Common Factors
    - e.g., Therapeutic relationship/alliance, Motivation, positive expectancies (hope), social support
  - Specific Factors
    - E.g., Cognitive distortions, behavioral activation, interpersonal relationships, insight,
Outcome Systems

Outcome Questionnaire-45/30 ($)  
- Symptoms  
- Interpersonal problems  
- Social role functioning  

Assessment for Signal Cases  
- Therapeutic relationship  
- Social support network  
- Patient motivation  

Youth-Outcome Questionnaire-64  
- Interpersonal Distress, Somatic, Intrapersonal Relations, Critical Items, Social Problems, Behavioral Dysfunction

Outcome Systems

Clinical Outcomes in Routine Evaluation-34 (free)  
- Subjective well-being  
- Problems/symptoms  
- Life functioning  
- Risk/harm  

Treatment Outcome Package (free -> $)  
- Multidimensional  
  - Depression, anxiety, bipolar, SUD, ADHD, psychosis, eating disorders, elimination, insomnia, suicide, violence,  
  - Quality of Life, work/social/sexual functioning  
  - Assertiveness, strengths
Outcome Systems
Partners for Change Outcome Management System ($)
- Outcome Rating Scale
- Session Rating Scale

https://www.myoutcomes.com/

Outcome Systems - Child
Peabody Treatment Progress Battery (free)
- Treatment Progress:
  - Symptoms & Functioning
  - Life Satisfaction
  - Hope
- Treatment Process:
  - Therapeutic Alliance
  - Treatment Motivation
  - Treatment Expectancies
  - Service Satisfaction
  - Perceived Session Impact
  - Caregiver Strain
  - Life Satisfaction

peabody.vanderbilt.edu/ptpb
http://cfsystemsonline.com/

General Outcome Measures
Behavior and Symptom Identification Scale ($)
  - http://www.basissurvey.org/
Symptom Checklist-90-Revised ($)
  - http://www.pearsonassessments.com/tests/scl90r.htm
Brief Symptom Inventory ($)
  - www.pearsonassessments.com/tests/bsi.htm
Short Form Health Survey ($)
  - http://www.sf-36.org/
Sheehan Disability Scale (Free)
Outcome Measures - Child

Pediatric Symptom Checklist (free)
  - http://www2.massgeneral.org/allpsych/psc/psc_home.htm
Strengths & Difficulties Questionnaire (free)
  - http://www.sdqinfo.com/
Child Behavior Checklist ($)  
  - http://www.aseba.org/
Behavior Assessment System for Children ($)  
  - http://ags.pearsonassessments.com/

Specific Symptom Measures

Depression & Anxiety
  - Patient Health Questionnaire – 9 (free)  
    - http://www.phqscreeners.com
  - Inventory of Depressive Symptomatology (free)
    - http://www.ids-qids.org/
  - Hamilton Rating Scale for Depression (free)
    - http://healthnet.umassmed.edu/mhealth/HAMD.pdf
  - Generalized Anxiety Disorder Assessment – 7 (free)
    - http://www.phqscreeners.com
  - Beck Depression & Anxiety Inventories ($)
    - http://www.pearsonassessments.com

OCD
  - Yale—Brown Obsessive Compulsive Scale (free)
    - http://healthnet.umassmed.edu/mhealth/YBOCSymptomChecklist.pdf
  - Dimensional Obsessive-Compulsive Scale (free)
    - http://www.unc.edu/~jonabram/DOCS.html

Substance Abuse
  - Alcohol Use Disorders Identification Test (free)
  - CAGE-AID (free)
Specific Symptom Measures

Eating disorders
- Eating Disorder Examination (free)
  - http://www.psychiatry.ox.ac.uk/research/researchunits/credo
- Eating Attitudes Test – 26 (free?)
ADHD: Adult AD HD Self-Report Scale (free)

Specific Symptom Measures

Psychosis: Brief Psychiatric Rating Scale (free)

Specific Symptom Measures

Bipolar Disorder
- Altman Self-Rating Mania Scale (free)
- Mood Disorder Questionnaire (free)
- Young Mania Rating Scale (free)
Specific Symptom Measures

Suicide
- Suicide Behaviors Questionnaire-Revised
- Suicidal Ideation and Risk Level Assessment:

5 steps of EBP

- Ask a question
- Acquire evidence for answers
- Appraise evidence for quality and relevance
- Apply the evidence
- Evaluate, dissemination & follow-up

EXAMPLES
Simple Example: Depression

34 year-old woman with Major Depressive Disorder
  - IDS-SR = 33 (Moderate)
  - HAM-D = 19 (Moderate, close to Severe)

First onset
No co-occurring disorders
  - Some marital problems
  - Some interpersonal problems at work and with extended family

Ask the Question:
  - For an adult woman with Major Depressive Disorder, what psychotherapy is the most effective in reducing symptoms?
    - P = Adult Woman, MDD
    - I = Psychotherapy
    - C = Vs. other psychotherapies
    - O = Reducing symptoms

Acquire the Evidence:
  - Primary: PubMed:
    - Search Terms: depression therapy meta-analysis
Cognitive therapy might be an effective treatment for depression measured on Hamilton Rating Scale for Depression and Beck Depression Inventory, but these outcomes may be overestimated due to risks of systematic errors (bias) and random errors (play of chance). Furthermore, the effects of cognitive therapy on no remission, suicidality, adverse events, and quality of life are unclear. There is a need for randomized trials with low risk of bias, low risk of random errors, and longer follow-up assessing both benefits and harms with clinically relevant outcome measures.

Simple Example: Depression

Acquire the Evidence:

- Secondary: AHRQ Website:
  - Search Term: “depression”
In mild and moderate depression, specific and brief psychological treatment (such as problem-solving therapy, cognitive behavioural therapy, or counselling) in 6 to 8 sessions during 10 to 12 weeks should be considered (Strength of Recommendation B). The preferred psychological treatment for moderate, severe, or resistant depression is cognitive behavioural therapy. Interpersonal therapy can be considered as a reasonable alternative (Strength of Recommendation B).

For moderate and severe depression, suitable psychological treatment should include 16 to 20 sessions during at least 5 months (Strength of Recommendation B). For moderate depression, either antidepressant drug treatment or suitable psychological intervention can be recommended (Strength of Recommendation B).

Cognitive behavioural therapy should be offered to patients with moderate or severe depression who reject drug treatment or for whom avoiding the secondary effects of antidepressants is a clinical priority or who express that personal preference (Strength of Recommendation B). Couples therapy should be considered, if applicable, in the event that a suitable response is not obtained with previous individual intervention (Strength of Recommendation B).
AHRQ: Major Recommendations

Cognitive behavioural therapy should be considered for patients who have:

- not had a suitable response to other interventions or who may have a prior history of relapses or residual symptoms, despite treatment (Strength of Recommendation B).
- recurrent depression and who have relapsed despite antidepressant treatment or who express a preference for psychological treatment (Strength of Recommendation B).

AHRQ: Major Recommendations

For patients whose depression is resistant to pharmacological treatment and/or who have multiple episodes of recurrence, a combination of antidepressants and cognitive behavioural therapy should be offered (Strength of Recommendation A).

A combination of cognitive behavioural therapy and antidepressant medication should be offered to patients with chronic depression (Strength of Recommendation A).

AHRQ: Major Recommendations

Whenever cognitive behavioural therapy is applied to more severe patients, the techniques based on behavioural activation should be given priority (Strength of Recommendation C).

Psychological interventions other than the aforementioned could be useful for dealing with comorbidity or the complexity of the family relationships frequently associated with the depressive disorder (Strength of Recommendation C).
Appraise the Evidence

A: At least one meta-analysis, systematic review of randomized controlled trials (RCTs), rated as 1++, and directly applicable to the target population, or sufficient evidence derived from level 1+ studies that are directly applicable to the target population and that demonstrate overall consistency of results.

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D: Evidence level 3 or 4. Extrapolated evidence from level 2+ studies.

Good Clinical Practice: Recommended best practice based on the clinical experience and the consensus of the guideline development group.

Apply: Match Evidence to Patient

Moderate-to-Severe:

- CBT or IPT, 16 to 20 sessions for at least 5 months
- Consider starting with behavioral activation

First episode:

- Hold off on antidepressant medication

Marital problems:

- Consider couples therapy if individual is not effective

Interpersonal Problems:

- Interpersonal effectiveness skills training (DBT), Consider interpersonal approaches (IPT), brief psychodynamic transference-based therapies

Apply: Resources

Prior Training
Books & Manuals
Training

- ABBHH Certificate program with Art Freeman: Cognitive-Behavioral Therapy (CBT) Treatment for Different Disorders, Populations, Modalities, & Settings

Supervision & Consultation
Analyze & Adjust

Concerns with Therapeutic Alliance?

Yes ➔ Alliance Interventions

No ➔

Problems with Motivation?

Yes ➔ Motivation Interventions

No ➔

Inadequate Social Support?

Yes ➔ Social Support Interventions

No ➔

Inaccurate Formulation?

Yes ➔ Modify Treatment Plan

No ➔ Whipple & Lambert, 2011
More Complex Example

28 year-old male with PTSD and Substance Abuse

- PTSD Checklist - Civilian = 74 (cutoff = 50)
- AUDIT Screener = 22 (cutoff = 20)

Recurrent; onset at age 19
Numerous functional impairments

- Unemployed
- Divorced
- Minimal sober social support

Ask the Question

For an adult man with recurrent Alcohol Dependence and PTSD, what psychotherapy is the most effective in improving functioning and preventing relapse?

- P = Adult Male, Alcohol Dependence with co-occurring PTSD
- I = Psychotherapy
- C = Vs. other psychotherapies
- O = Improving functioning and preventing relapse

Acquire the Evidence

Primary: PubMed:

- Search Terms: alcohol PTSD psychotherapy meta-analysis
  - NOTHING
- Search Terms: alcohol dependence PTSD treatment
Paroxetine did not show statistical superiority to desipramine for the treatment of PTSD symptoms. However, desipramine was superior to paroxetine with respect to study retention and alcohol use outcomes. Naltrexone reduced alcohol craving relative to placebo, but it conferred no advantage on drinking use outcomes. Although the serotonin uptake inhibitors are the only FDA-approved medications for the treatment of PTSD, the current study suggests that norepinephrine uptake inhibitors may present clinical advantages when treating male veterans with PTSD and AD. However, naltrexone did not show evidence of efficacy in this population.

Acquire the Evidence

Primary: PubMed:
- Search Terms: alcohol dependence PTSD psychotherapy
PTSD severity reductions were more likely to be associated with substance use improvement, with minimal evidence of substance use symptom reduction improving PTSD symptoms. Results support the self-medication model of coping with PTSD symptoms and an empirical basis for integrated interventions for improved substance use outcomes in patients with severe symptoms.

Acquire the Evidence

Secondary: SAMHSA’s NREPP Website:
- Search Term: “PTSD substance abuse”

<table>
<thead>
<tr>
<th>Intervention(s) Found</th>
<th>Search criteria: PTSD, substance abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Intervention Title</td>
</tr>
<tr>
<td>Stress Management and Relational Therapy (SMRT) is a culturally sensitive psychological tool designed to reduce trauma-related stress symptoms and depression symptoms associated with post-traumatic stress disorder (PTSD) and to improve overall mental health functioning.</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Smoking Cessation</td>
</tr>
<tr>
<td>Trauma Recovery and Empowerment Model (TREM)</td>
<td>Trauma Recovery and Empowerment Model (TREM) is a fully manualized group-based intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse.</td>
</tr>
</tbody>
</table>
Seeking Safety

Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on coping skills and psychoeducation and has five key principles: (1) safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); (2) integrated treatment (working on both posttraumatic stress disorder [PTSD] and substance abuse at the same time); (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5) attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

Appraise the Evidence


<table>
<thead>
<tr>
<th>Identifier</th>
<th>Methodology</th>
<th>Validity</th>
<th>Feasibility</th>
<th>Clinical utility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PTSD</td>
<td>2.5</td>
<td>2.5</td>
<td>2.0</td>
<td>2.5</td>
</tr>
<tr>
<td>2. Substance Abuse</td>
<td>2.7</td>
<td>2.7</td>
<td>2.9</td>
<td>2.0</td>
</tr>
<tr>
<td>3. VA</td>
<td>2.4</td>
<td>2.6</td>
<td>2.5</td>
<td>3.0</td>
</tr>
<tr>
<td>4. DoD</td>
<td>2.4</td>
<td>2.6</td>
<td>2.5</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Reviewers use a scale of 0.0 to 4.0, with 4.0 being the highest rating given.

Acquire the Evidence

Secondary: AHRQ’s Clearinghouse
- Search Term: “PTSD substance abuse”
AHRQ’s Recommendation

- Co-occurring mild to moderate disorders, such as substance use, pain disorders, and sleep problems, can frequently be effectively treated in the context of PTSD treatment and do not require a referral to specialty care.
- Co-occurring severe psychiatric disorders, while not precluding concurrent PTSD treatment, typically justify referral to specialty care for evaluation and treatment. These disorders may include: severe major depression or major depression with suicidality, unstable bipolar disorder, severe personality disorders, psychotic disorders, significant TBI, and severe substance use disorder (SUD) or substance abuse of such intensity that PTSD treatment components are likely to be difficult to implement.

AHRQ’s Recommendation

- Patients with SUD and PTSD should be educated about the relationships between PTSD and substance abuse. The patient’s prior treatment experience and preference should be considered since no single intervention approach for the co-morbidity has yet emerged as the treatment of choice.
- There is insufficient evidence to recommend for or against any specific psychosocial approach to addressing PTSD that is co-morbid with SUD.
- Treat other concurrent substance use disorders, including concurrent pharmacotherapy.

Acquire the Evidence

Cochrane Review

- Search Terms “PTSD and Substance Abuse”
- Psychosocial interventions for people with both severe mental illness and substance misuse (2010)
They used different psychosocial interventions, with four trials using integrated models of care, four using non-integrated, three combining Motivational Interviewing (MI) and CBT, four using CBT, five using MI and two using skills training... No trial showed any definitive difference between the psychosocial intervention and the usual treatment... There are also problems caused by high dropout rates, differences in the outcome measures and dependability in the way psychological interventions were used. To allow more thorough assessment of whether psychosocial interventions work for people with substance abuse problems and severe mental illnesses, more quality trials are needed which address these problems.

Other Treatments*

Transcend
- 12 week PHP: skill development & trauma processing
- Substance Abuse Rehabilitation within 6 months of starting
- Evidence: 1 uncontrolled cohort study (Level 2; D)

Concurrent Treatment of Posttraumatic Stress Disorder and Cocaine Dependence
- 16-session individual CBT for SA & exposure for PTSD
- Evidence: 1 uncontrolled cohort study (Level 2; D)

Other Treatments

Substance Dependence Posttraumatic Stress Disorder Therapy (Assisted Recovery from Trauma and Substances)
- 40-session individual therapy; CBT for SA and stress-inoculation for PTSD
- Evidence: 1 pilot RCT, but no difference from 12-step control
Appraise the Evidence: Summary

No strong evidence-based treatment for co-occurring
- Substance Abuse = CBT, MI, 12-step
- PTSD = exposure-based therapies
- SA & PTSD??

Sequential vs. Concurrent vs. Integrative treatment?
- Some evidence supporting integrative
  - E.g., Seeking Safety
  - PubMed study
- Some evidence supports self-medication hypothesis
  - PTSD drives SUD

Apply: Match Evidence to Patient

Recurrent PTSD & SA
- Integrative treatment
- Use MI pre-treatment
- Attempt Seeking Safety
- If not enough, consider integrating:
  - Additional motivational enhancement
  - CBT and Relapse Prevention for SA
  - ERP for PTSD

Not a brief treatment
- Between 16-40 sessions
Consider specialty PHP level of care if non-responsive
Consider relapse prevention medication

Apply: Resources

Prior Training
- Book & articles
- Training
  - http://www.seekingsafety.org/
- Supervision & Consultation
Why Should I adopt EBP?

EBP should result in:

- Improve quality and accountability
- More effective and efficient treatment
- Less costly care
- Less use of restrictive settings

Why Should I adopt EBP?

The EBP process helps to differentiate:

- Evidence from propaganda (advertisement)
- Probability from certainty
- Data from assertions
- Rational belief from superstitions
- Science from folklore
Why should I adopt EBP?

EBP provides a RoadMap for:
- Staying current
- Using the best available treatments
- Maintaining effective in a clinical reality

EBP is orientation agnostic!
- Sidesteps the religious fervor of theoretical orientations
- Requires a pluralistic, evidence-based but reality-grounded approach to treatment

What gets in the way

Belief that it is “all about the relationship”
- Specific treatments/strategies are unimportant

Belief that evidence-based practices will conflict with a specific theoretical orientation

Graduate training that did not emphasize psychotherapy research

Having many years of therapy experience!

Downsides of EBP

Takes extra time
- Requires information resources

Available evidence is often limited
- But can only improve!

May need to pay for training & supervision
What do you think? Ready to use it?

Questions? Comments?

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