**PHILLIPS Community Conversation**

**Evidence-based Programs: What’s Next and Why?**

**SUMMARY REPORT**

**October 21, Friday, 1:00PM-4:00PM.**

**Community Conversation[[1]](#footnote-1)that will:**

* Stimulate debate about a topic (evidence-based programs in this case) among interested people;
* Meet and build relationships with new people and groups;
* Take part in interesting conversation about topical issues.

**Not a discussion, rather a conversation/dialogue that matters and creates inspiration to do something about the topic.**

*Creating a positive future begins in human conversation. The simplest and most powerful investment any member of a community or an organization may make in renewal is to begin talking with other people as though the answers mattered. – William Grieder, Who Will Tell the People?*

**Desired Results:** A conversation that matters, shifting small talk to bigger talk, making sense of evidence-based programs for the future in our region.

**Topic:** To what extent is our community able and interested in supporting evidence-based models of youth service and how should we? What relevance does EBP have for our community?

**Subtopics:**

* What are the advantages and disadvantages of EBP?
* What are the costs of operating EBP and is it worth it?
* What are the pressures on providers, funders, others to provide services that are EBP?
* Are there credible alternatives to EBP’s based on the highest levels of evidence?

Moderator described the problems with the varied definitions particularly the concern with the narrowing of the definition to include only programs that have been validated using one particular experimental design: randomized clinical trials.

**Evidence-Based Practice Defined:** *Approaches to prevention or treatment that are based in theory and have undergone scientific evaluation. "Evidence-based" stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.* [Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices]

**LOGISTICS:**

**Participant Agreements** (on table tent cards):

* **Open-mindedness:** Listen to and respect all points of view;
* **Acceptance:** Suspendjudgment as best you can;
* **Curiosity:** Seek to understand rather than persuade;
* **Discovery:** Question assumptions; look for new insights.
* **Sincerity:** Speak from your heart and personal experience;
* **Brevity:** Go for honesty and depth but don’t go on and on.

**Materials available** for participants: Going Green: copies of materials from the panelists, notes from the meeting, and evaluation results will be posted on PHILLIPS website.

**FORMAT:**

**Host :** Nancy Mercer, PHILLIPS CEO, welcomed people and explained why PHLLIPS decided to do this.

**Panelists and Moderator:** Pamela Meadowcroft, Ph.D. (Meadowcroft and Associates, University of Pittsburgh faculty associate) reviewed what the Community Conversation format is, where it comes from (based on Café Conversations to some extent), what is to be achieved (deeper conversation about EBP than otherwise), the ground rules, logistics, agenda. Expert panelists included Pamela Meadowcroft,Ph.D., Janet L. Bessemer, PhD, LCP **(**Comprehensive Services Act Utilization Review Manager, Fairfax-Falls Church), Ira Lourie, MD (Child psychiatrist and system of care reformer of children's mental health services), and Doug Muetzel, CEO (Wesley Spectrum Services, Pittsburgh, PA).

**Participants:** About 50 participants, including government staff, private providers, and PHILLIPS staff.

**Three discussion questions:** There were three rounds of questions, each round lasting about 50 minutes. Each round had a question (or set of questions) that was first addressed by the members of the expert panel. Then participants at each table had the chance to have a conversation among those at their able on the same questions. Between round one and round two questions, participants moved to new tables to be with a new group.

**ROUND 1:**

**“What is your personal experience with EBP, what do you think about it, what do you feel about it; from your experience what are its advantages and disadvantages?”**

Expert panelists: The point of the conversation is to make it as personal as possible. So the experts aren’t supposed to simply lecture – they need to have a little skin in the discussion (heart/heat), including what they feel about it and what is inspiring them to do something about it.

Pam:

Two decades experience developing EBP models; therefore originally a very strong supporter. Saw first-hand the difficulties in replicating even within the same agency (and community)! Additionally, saw that among many of the emerging, effective models in children’s services many were actually doing very similar things!

Supporter of evidence-based movement UNTIL it became synonymous with set programs proven via RCTs (randomized clinical trails) and subsequently packaged name-brand programs.

* Advantages:
  + Training in what really works, materials and supervision to support
  + Greater likelihood investment could yield positive results
* Disadvantages:
  + Initial and ongoing costs
  + Limited external validity
  + Difficulty maintaining fidelity to the model
  + Scalability
  + Can decrease staff commitment (it’s someone else’s model or it doesn’t fit us right)

Ira:

Strong opposition to EBP since it asks the wrong questions (very narrow set of questions) with equally narrow data. “EBPs only work for those who it works for. And for people it doesn’t work for it doesn’t.” Access is limited. And thirdly, those who do it aren’t well trained. Personal history of changing children’s MH services nationwide via CASSP at NIMH showing that “demonstration projects work!” Also learned that the “models” do not necessarily work as they should. Did not ascribe to EBP models that constrain individualization and innovation. Issue with outcome movement: what are outcomes, are there acceptable outcome measures? The tools we have now are not particularly sensitive. Instead: as practitioner, notice what works and when it isn’t working, try something else. EBP doesn’t allow for modification which is a hazard for responsive interventions. Self-knowledge of what works for me as practitioner more important than compliance with the criteria of an EBP model.

Doug:

EBP – fills a service accountability void in much needed area. In implementing one of the EBP models, we learned a lot but we had to (with the County) close the program because it was impossible to scale it up. We lost over $200,000 because we were never able to get the appropriate referrals in sufficient qualities to make the business model work. Adaptation was limited, who could be served had to be approved by the purveyor of the model; altogether, it had limited generalization. Statewide in PA, providers had similar experiences with two very prominent EBP models.

Janet:

* Trained in Parent-child Interaction Therapy (PCIT) an empirically-supported treatment
* Personal and professional commitment to seeing that we are enhancing our service delivery system to achieve the best outcomes for children and their families
* VA, unlike some neighboring states like District of Columbia, MD and PA, has not had a state-wide initiative focused on implementation of EBTs. Although we are spending millions on behavioral health care, VA has not done enough to demonstrate the effectiveness of services on outcomes for youth
* General Assembly has sponsored the Commission on Youth’s collection of EBTs but does not promote any particular treatments; VA’s late entry into this work allows us to benefit from the experience of those jurisdictions who’ve gone before us
* Locally, as part of our System of Care reform initiative we have formed a workgroup to review EBTs and make recommendations about the appropriate plan for enhancing our services
* Our current system is very much about “let the buyer beware”
* And clearly the cost of the investment in EBTs has resulted in us carefully considering our options –
  + with the Name brand EBT you aren’t reinventing the wheel
  + Locally-developed or evidence-informed requires a provider or some entity to develop a program and implement program evaluation, does every provider have the capacity to hire their own consultant and develop a program?
  + Practice-based evidence – against what benchmark shall these be measured? Might not the individual outcomes have been better with an EBT.

Participants at each table discussed the same question.

FIVE-TEN MINUTE BREAK WHILE PARTICIPANTS SWITCHED TABLES. Recorder/reporters stayed with their assigned table.

**ROUND 2:**

**“If not Evidence-based Practice or Evidence-based Programs, then what? What happened that made you think that way and how does this affect you personally?”**

Pam:

Common elements exist across all successful programs. Mark Lipsey and Bruce Chorpita’s recent research (meta-analyses) is relevant for this point. Lipsey’s meta-analyses show clearly that some programs using “generic” family counseling in fact outperform brand-name family-counseling programs. Common elements from the “bottom up” (practitioner to model rather than model to practitioner or research to practitioner): Fidelity Management requires focus on MONITORING. Steps include

* Identifying the key elements in any program
* Finding existing research support for these key elements
* Developing tracking tools to ensure staff use the research-supported key elements (and providing a metric for how much they do this – i.e., model fidelity “scores”)
* Measuring key outcomes
* Correlating model fidelity with key outcomes
* Embedding in CQI process

Advantages

* Builds on existing community values
* Uses existing researched practices for community identified populations
* Allows for scalability (referral sources, staff relationships, etc.)
* Gives program low-cost, program-owned tools and metrics for continuously monitoring their effectiveness – builds program capacity to continual improve using appropriate tools.
* Gives program, system means by which new evidence-based practices can be integrated into an existing “model”
* Increased access to services that are effective
* Increased return on investment

Ira:

*Practice based evidence* as a more responsive alternative to EBP*.* Less in “model” and more in quality improvement kinds of paradigms to make sure whatever you’re doing is meeting goals and having positive outcomes. Whatever you’re using you’re doing it the way it’s supposed to be done. I’m good and I do what works for me; I continually adjust my practice based on what is working, building in continuous improvement. The evolution of effective services requires that more than brand-name EBP models.

Janet:

* There’s a place for all three approaches within a continuum of care.
* Run the risk of negating the positives that have developed from the movement towards EBPs and by discrediting EBTs, allow for more of the same - providers providing what they provide “take it or leave it” at whatever quality they deem
* Must at least agree on the core component necessary no matter what approach you take:
  + Conditions for change – relationship based, trauma-informed, culturally competent
  + Assessment
  + Quality assurance/CQI
  + Measurement of outcomes
  + Client satisfaction/choice
* I anticipate that state and local governments in VA will be moving towards performance-based contracting with the expectation that providers will have those core components in their infrastructure
* Proponents of the name brand of EBTs have focused on implementation and have developed methods for improving the training, practitioner credentialing, scalability and fidelity monitoring (e.g., High fidelity wraparound has been shown to be effective, not just services called wraparound)
* One particular approach is to follow the Learning Collaborative model. In this model, multiple providers and providers who offer services at different levels of care would be trained and supported in the implementation of a particular intervention. This approach has shown greater fidelity to the model and greater retention of staff.
* We have considered that the cost of the training/Learning collaboration, that initial and ongoing investment could be funded by a public-private partnership that results in cost and risk sharing.
* If each of our providers decided to develop their own model with their own assessments, outcome tools, etc. Local government will be placed in the situation we find ourselves in now of Be a very wary Buyer; once again a fragmented and competitive service delivery system.
* When an agency develops their own program, they bear the costs of the program solo and the burden of proving its efficacy rests with them
* Perhaps the model we practice of CSA, with a public-private partnership affords us a unique opportunity that differs significantly from the funding structure of PA and their cautionary tale of EBP experiences.

Doug:

Fidelity Management as an alternative. It’s working for us. We’re trying it out with several of our programs now (school-based MH, individualized-residential treatment, in-home family therapy). Not interested in throwing the baby out with the bathwater – need for higher degree of accountability for the very complex funding environments we find ourselves in (multiple accountabilities). This requires knowing what results we can/should shoot for and what to expect…. These are essential business practices.CEOs need to be able to stay mission-focused and be able negotiate with confidence; that requires having more confidence that their services (their practices) are in fact producing positive outcomes for kids and families.

Participants at each table discussed the same question.

FIVE-TEN MINUTE BREAK WHILE PARTICIPANTS SWITCH TABLES. Recorder/reporters stayed with their assigned tables.

**ROUND THREE (FINAL):**

**“What challenged, inspired, or changed you in your conversation today?**

**Are there questions you have of any of the panelists?”**

**Participants’ comments:**

1. **Emerged from today: A path forward**
   * Good government-provider/private collaborations are possible.
   * Use of intuition is still important…how to use it within a framework of EBP.
   * An alternative to EBP could be replication of what works; replications of a program with positive outcomes should be considered.
   * Ongoing MONITORING is important; training will never be sufficient.Cultural differences require ongoing monitoring and supervision, not just training.
   * Outcomes, individualization, staff buy-in, fidelity… all ingredients important to any service, model or not.
   * Don’t relay only on set models.
   * Core elements – a good path forward.
   * Inspiration and optimism.
   * Good service systems have to have flexibility, individualization, continuous innovation, focus on meeting needs of diverse clients with diverse staff, responsive interventions AND accountability.
   * Need to consider fitting EBP into what we know and do; not the reverse.
   * Individual interpretation if no “model.”
   * Performance-based contracting: value systems with fidelity but can/should focus on various process measures (quality improvement cycles – the very core of what started evidence-based practices!)
   * Collaboration, coordination, expectation for improved outcomes, holding selves accountable, stewards of the public trust.
2. **Concerns:**
   * Hard to measure success – tools often don’t match services. Need more discussion on this.
   * Application/implementation of EBP is hard to do in regions like VA where there are many different cultures.
   * Prevention/intervention: EBP may be an ideal but given implementation issues, it is not likely.
   * Be prepared for model drift regardless!
   * EBP “fit” not likely; too much diversity (clients, communities, staff at all levels, etc.).
   * Evidence-based practice but not evidence-based clients!
   * Measurement needs to be ongoing, not point in time evaluation; capacity issue among providers and how can government help.
   * Disconnect between researchers and practitioners (e.g., building-in intuitional changes in treatment).
   * Interesting that the “empirical nature of therapy” is still being discussed!
   * Shouldn’t be “stuck in a box” when providing services in very complex systems.

**EVALUATION and WRAP-UP:**

**As a result of today’s “conversation,” what will you do over the next month?**

**Themes (and comments)**

1. **Use within current services:**

* I want to go through my cases using the model Phillips has developed so far and try to measure process and success
* I will continue to look at own work within the system, expectations from within and without, and monitor to ensure clients/families reach positive outcomes (that are hopefully also evidence-based).
* Will definitely look into the topic more deeply to find out more of what I can do within my own work. Share/discuss with other members of my team to increase their interest.
* Continue the movement “our “social work services department has started: data collection of our interventions, meeting our collaborative teams to continue to look at social services “best practices” at FCPS; look at outcome measurement tools for specifics interventions used at FCPS.
* I will find out more about what Phillips is experiencing from their data collection regarding evidence based guidelines for practice within home services; Look at our training and sustaining of high level values within program; join a work group within community; participate in private provider discussions on this topic.
* Talk with supervisor about agencies thoughts in development of “core elements”.
* Return to my program and revise outcome measurements to be more specific to services provided.
* Look at our program and try to implement some ideas that I have learned (look at what other similar programs use)
* Track my outcomes more thoughtfully both for outcome and for process; get feedback more frequently.
* Talk to staff about our own core values (what they think is an important practice at Phillips)
* Continue to monitor and change practices according to outcomes.
* Increase applying introspection and self-assessment for my own effectiveness in providing services to my patients. I believe in the notion of parallel process and things working top to bottom and bottom to top.
* Talk to team members and supervisors about our model and its implementation.

1. **Consider systems implications:**

* I would continue to discuss how Fairfax County agencies can support and factor evidence-based practices throughout the County. Also I would like to see CSA adopt evidence-based criteria that encourages CSPs vendors to identify/utilize approaches that are evidence based as well.
* Re-evaluate which home/youth MH ad ADS services are meeting needs of the County Y&F and which take away from just what services we provide
* Look at info on website; keep it in mind as County Human Services System looks at result-based accountability; determine how it all fits in with performance based contracting expectation – that is also being pushed.
* As a result of this conversation, I will immediately listen to other providers and administrators about their concerns and ideas regarding how services can improve systematically.
* Request approval to have conversation with our LACM and providers on supervision and find a way to standardize how they can “report on” for even demonstration program status: Challenge – the detailed supervision will be complex for ½ staff.

1. **Expand learning and communicating about this topic:**

* Learn about the efficacy of evidence-based models that have been adapted to certain populations. Contribute to the solution by having this discussion with other professionals.
* Talk to my colleagues who attended to share our take-aways. Consider hosting another conversation; review relevant literature.
* Will definitely take opinions and ideas back to my supervisor who is an evidence-based advocate.
* Keep an Open Mind! Share information provided with the EBT Group I participate in.
* Talk to agency colleague and university colleagues about state of EBP and difficulty measuring success or outcomes.
* Review article provided/ cited regarding return on investment (75 cents vs. $7); Convent a similar discussion within my agency, especially with service directors and clinicians.
* I am more able to discuss pros/cons of EBP and feel more able to describe it to others. This can help my work with families by examining the process that PHILLIPS goes through to try to meet their needs and offer support. It may help in describing services to others.

**What would you suggest to improve today’s conversation?**

**Themes (and comments):**

1. **More conversation:**

* Continue with more dialogue among providers in different capacities.
* Could use more time such as 10AM-4PM
* More service providers from other counties and different services providers involved with the court.
* Communication with community contacts about EBP.

1. **Format: useful but some tweaking**

* I found this forum very thought provoking and validating. Thank you!
* Longer period of time for panel presentations
* A little less panel discussion and more information on the subject (less opinion and more lecture).
* More open discussion that includes panelists AND participants.
* Ideas for improving – None
* This is my first time here. I really enjoyed the conversation and learned lots of new, interesting and thought-provoking ideas. I would love to come again.
* I can’t think of a thing. Very well organized.
* Great presentation; enjoyed the interactions with others.
* Larger forum possibly.

1. **More information/conversation on measurement systems, tools.**

* In particular what measurement and assessment tools exist that can indicate client progress
* I would have enjoyed hearing about the process Phillips has been going through in identifying their practice elements, how you will measure your outcomes, etc.
* Continue to work with larger government system to establish clean and simple outcome measures of service.

1. The format of our Community Conversation is based on Café Conversations http://www.conversationcafe.org/ [↑](#footnote-ref-1)