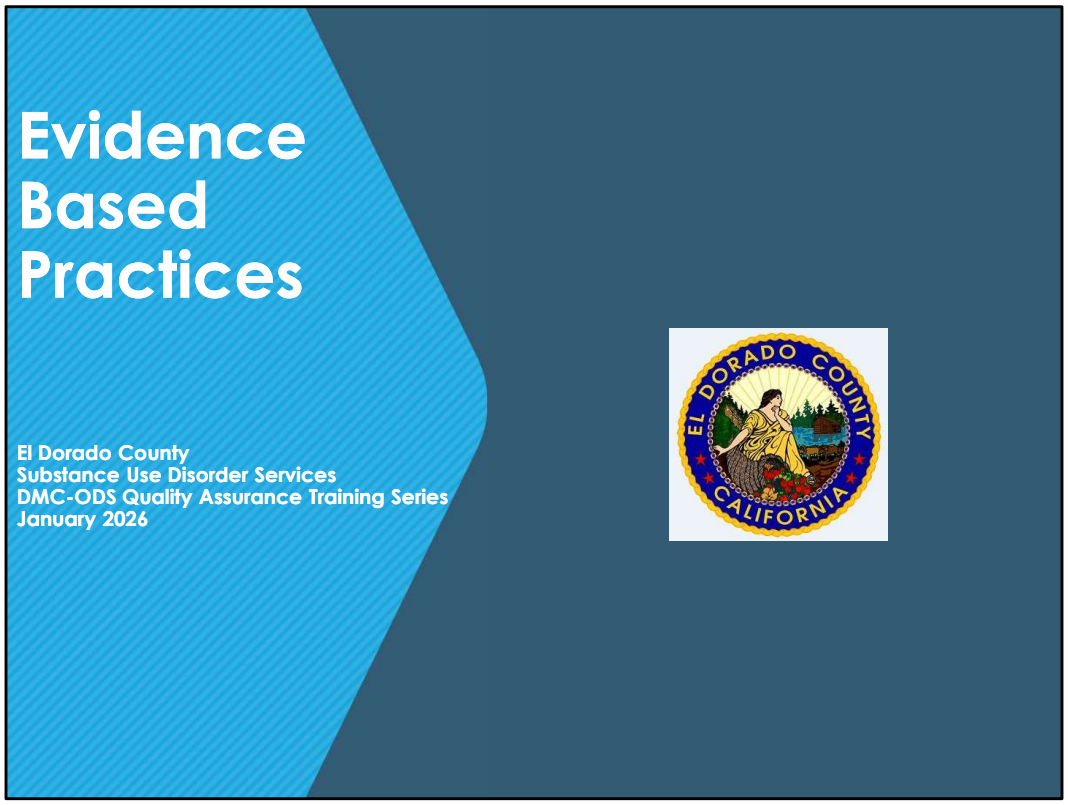
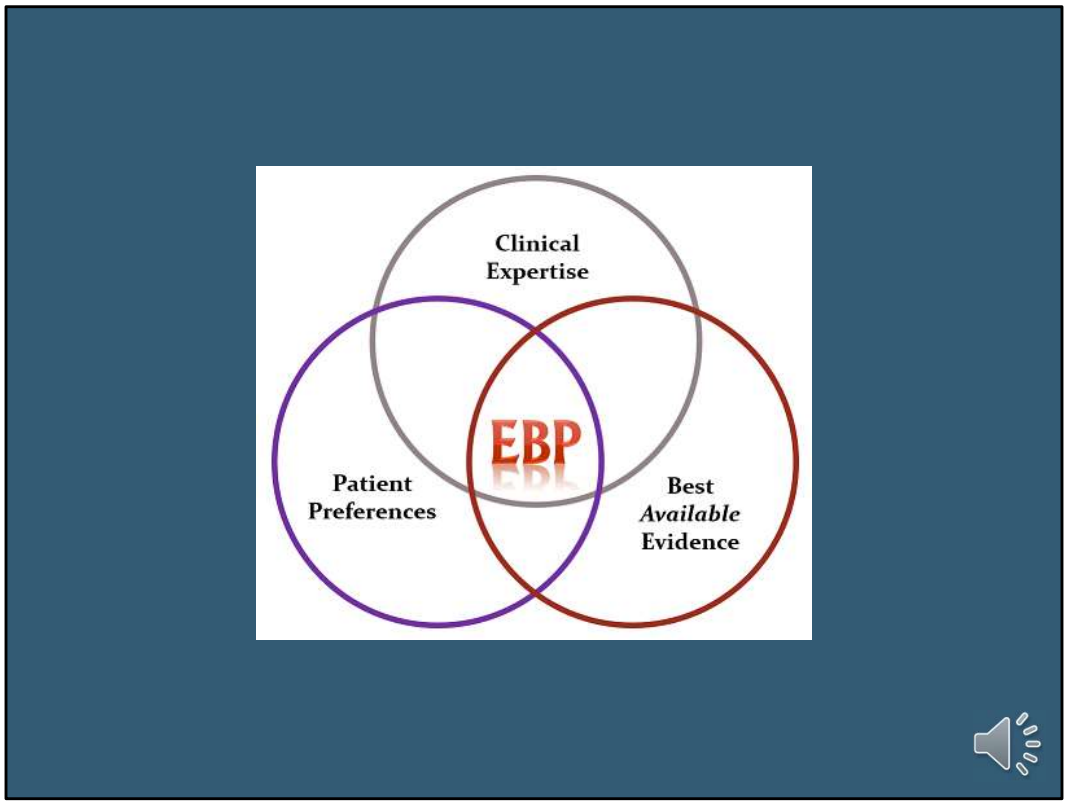


Hello everyone and thanks for coming. This training will be taped and a copy will be on the EDC SUDS webpage later this week. Please remember to MUTE your computer.

CEUs and Certificates of Attendance will be sent out to all attendees who are signed in. You will need to complete the Course exam to receive CEUs. You will need to be on the sign in sheet to receive a CoA.

Start Code for the training is 2301. Write this down and use it on the Exam you will all be sent after this training.

Welcome to the Evidence Based Practices training.



Evidence based practices can best be summed up by looking at the intersectionality of three concepts:

Clinical expertise
Best available evidence
Patient preferences

All three overlap into evidence-based practice.

And right about now you might be asking yourself, “Self, what does this have to do with my work?”

At the end of this 1.5 hour Continuing Education Training, participants will have the knowledge necessary to understand the following:

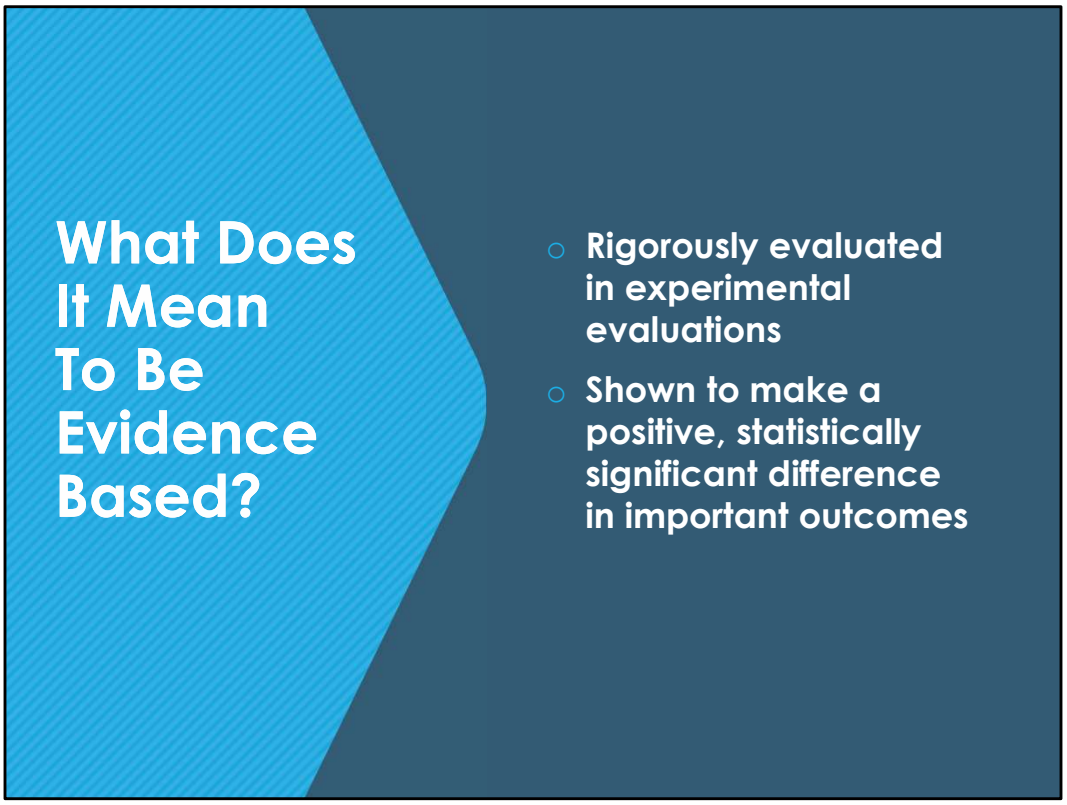
What are EBPs
Description of EBPs
Ensuring integrity of EBP
Tips for Ensuring EBP integrity

Please make note that this training is not meant to be an in depth exploration of each EBP. This is more of an overview. Each EBP has extensive information available on line. Feel free to reach out to me if you would like assistance in further research.

There are many definitions of Evidence-Based Practice (EBP). It is the integration of the best research evidence, clinical expertise and patient needs that will result in the best patient outcomes. EBP is an umbrella term that covers evidence-based medicine, evidence-based nursing, evidence-based public health, evidence-based dentistry, etc. Each specialty, however, may have their own approach to implementation.

Evidence-based practice (EBP) is **the objective, balanced, and responsible use of current research and the best available data to guide policy and practice decisions**, such that outcomes for consumers are improved.

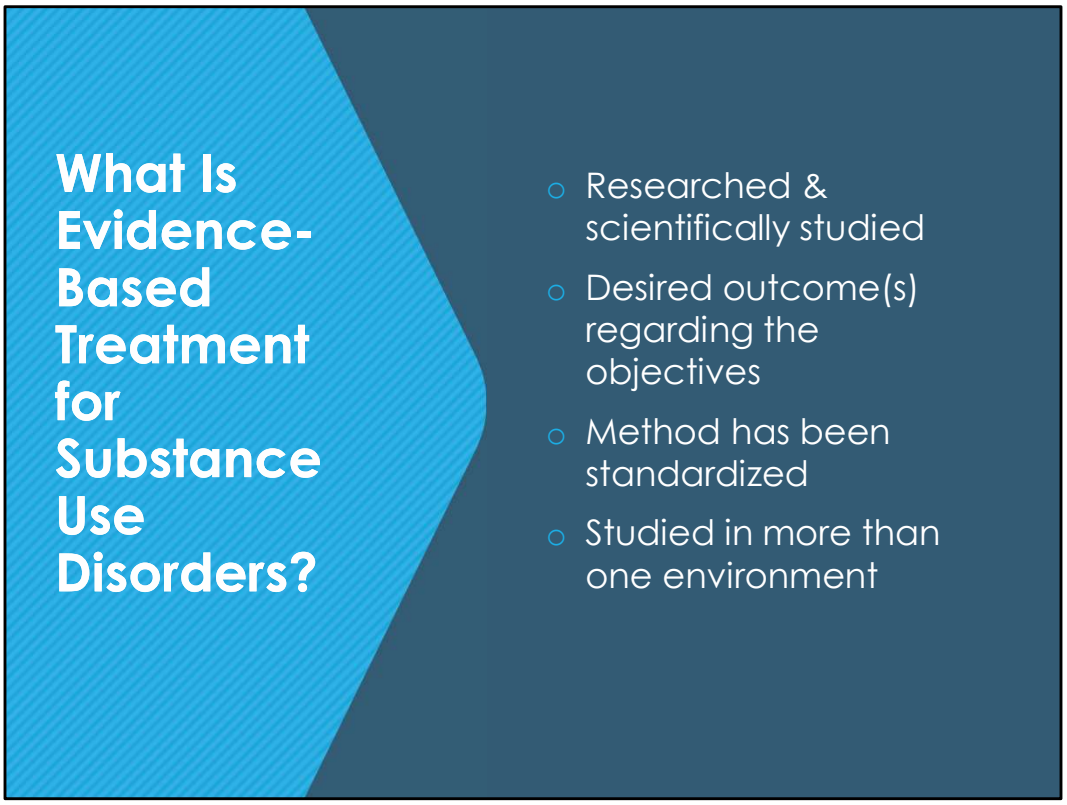
The integration of clinical expertise, client values, and the best research evidence into the decision making process for client care



Knowing what it means for a program to be "evidence-based" helps practitioners choose interventions with the greatest potential to treat substance use disorders.

An evidence-based practice is a practice that has been rigorously evaluated in experimental evaluations – like randomized controlled trials – and shown to make a positive, statistically significant difference in important outcomes.

A practice that has stood the test of rigorous experimental evaluations, has shown that it is supported by data, not just based on theory,
has been repeatedly tested and is more effective than standard care or an alternative practice, & can be reproduced in other settings.



Although many SUD treatment programs emphasize the fact that they utilize evidence-based treatment methods, what does this actually mean? According to the SAMHSA Evidence-Based Practices Resource Center, for a treatment method to be "evidence-based", it must have published research citing it as such or be recognized by reputable organizations as evidence-based.

Evidence-based practices or treatment methods should also have the following qualities:
The method has been researched, scientifically studied, and the research has been published in a peer-reviewed journal.

The method has provided the desired outcome(s) regarding the objectives of the addiction treatment.

The method has been standardized so it can be repeated. Usually, this means instructions have been printed, detailing how the addiction treatment method should be used, with whom it should be used, the overall goals of the method, and any other materials needed to complete the method successfully.

The treatment method has been studied in more than one environment and has provided consistent and effective results.

A measure could be (or has already been developed) to determine how well the implementation of the treatment method is adhering to the protocol that was originally researched.

SAMHSA defines evidence-based interventions as those that fall into one or more of three categories:

The intervention is included in a federal registry of evidence-based interventions **OR**

The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer-reviewed journal **OR**

The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which must be followed.

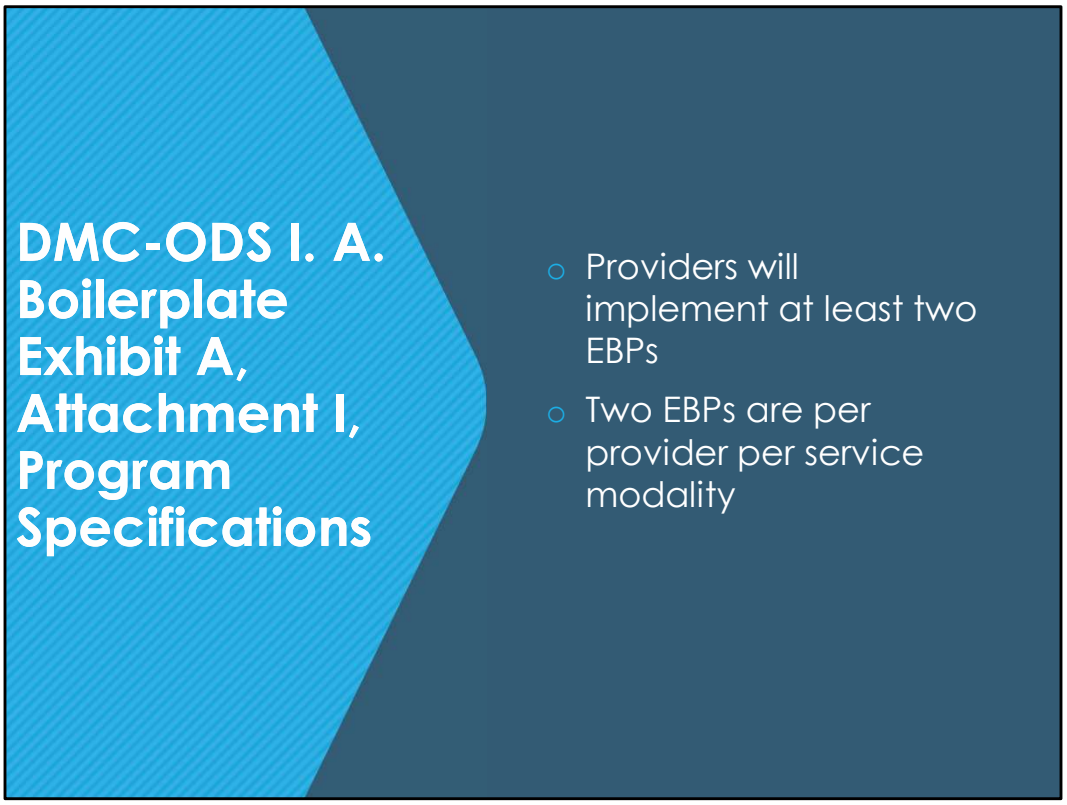
These guidelines require interventions to be:

Based on a theory of change that is documented in a clear logic or conceptual mode **AND**

Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals **AND**

Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects. **AND**

Reviewed and deemed appropriate by a panel of informed experts that includes qualified researchers experienced in evaluating interventions similar to those under review.



Evidence Based Practices (EBPs):

Providers will implement at least two of the following EBPs based on the timeline established in the county implementation plan.

MI,
CBT,
Relapse Prevention,
Trauma-Informed Treatment
Psycho-Education.

The two EBPs are per provider per service modality. Counties will ensure the providers have implemented EBPs.

As a requirement of El Dorado DMC-ODS, each provider must implement—and assess integrity to—at least two of the following Evidenced Based Practices per modality:

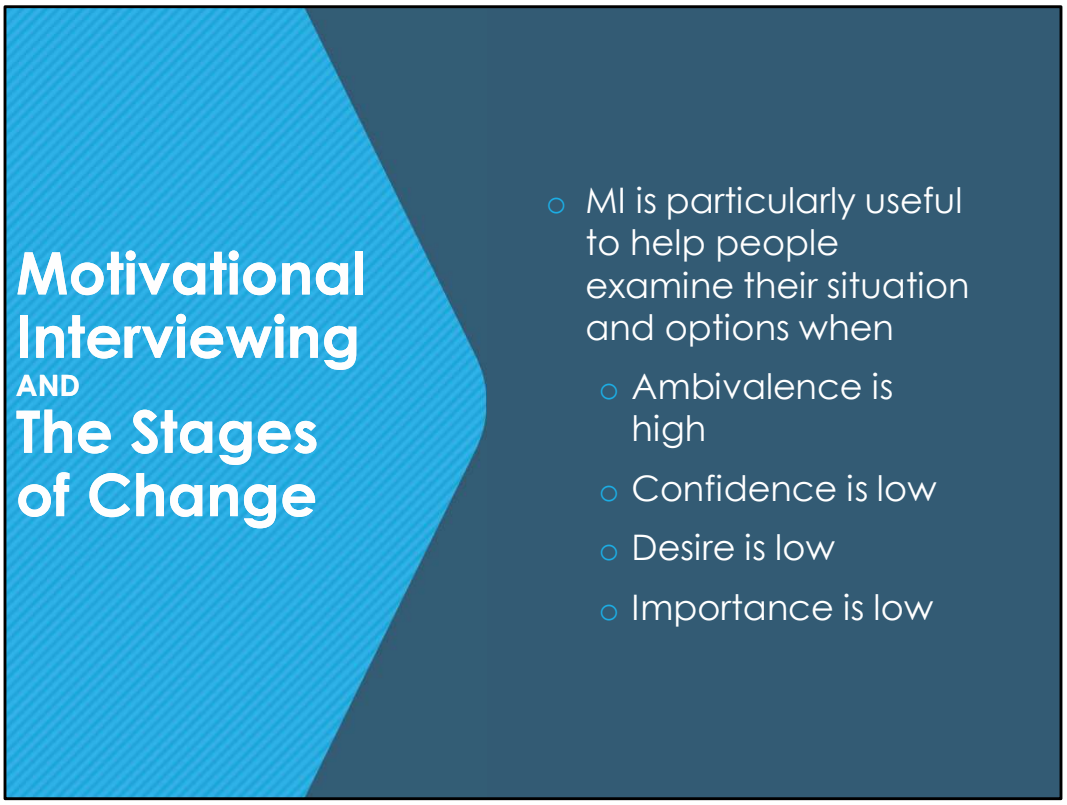
MI,
CBT,
Relapse Prevention,
Trauma-Informed Treatment
Psycho-Education.

The most current version of MI is described in detail in Miller and Rollnick (2013) *Motivational Interviewing: Helping people to change* (3rd edition).

What is MI?

"MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion." (Miller & Rollnick, 2013, p. 29)

Key qualities include:
MI is a **guiding** style of communication, that sits between **following** (good listening) and **directing** (giving information and advice).
MI is designed to **empower** people to change by drawing out their own meaning, importance and capacity for change.
MI is based on a **respectful** and **curious** way of being with people that facilitates the natural process of change and honors client autonomy.



A practitioner using MI views a client's readiness to change as dynamic. Clients can move along these stages by increasing their motivation to change.

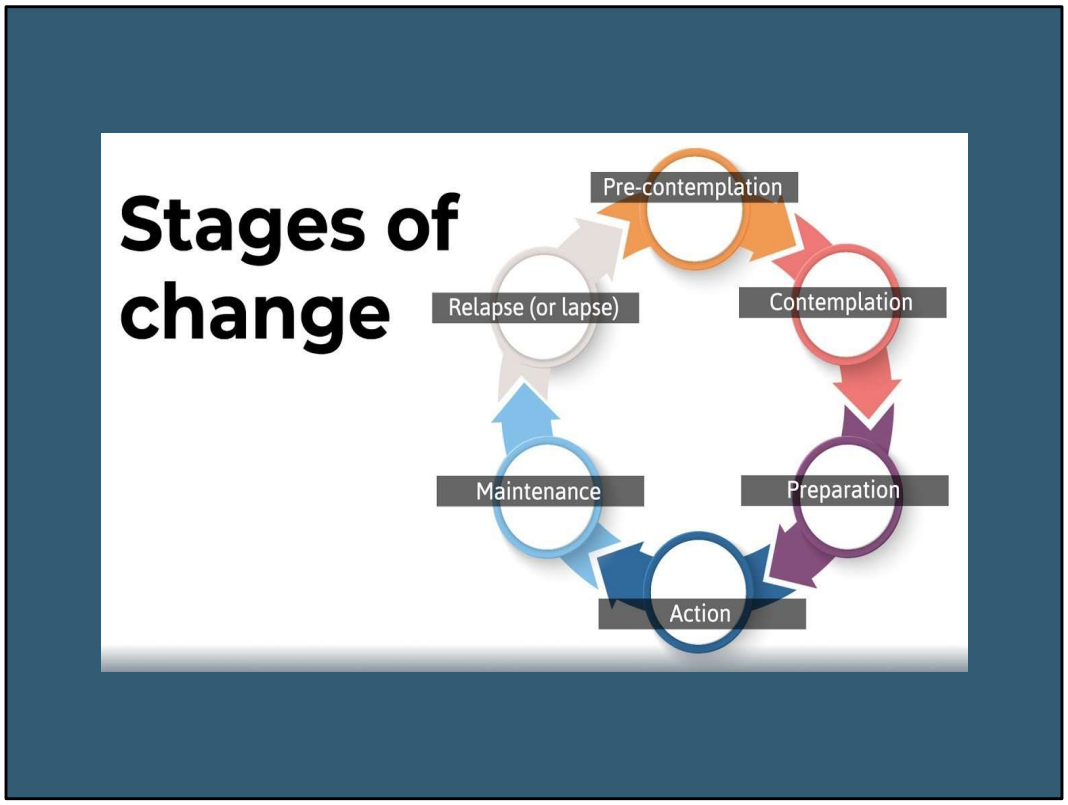
MI is particularly useful to help people examine their situation and options when any of the following are present:

Ambivalence is high and people are stuck in mixed feelings about change

Confidence is low and people doubt their abilities to change

Desire is low and people are uncertain about whether they want to make a change

Importance is low and the benefits of change and disadvantages of the current situation are unclear.



Pre-contemplation Clients in this stage are not even thinking about making a change.

Contemplation Clients are beginning to consider making a change, but are not yet ready to make a commitment.

Preparation Clients in this stage are preparing for action to change in the foreseeable future

Action Clients in this stage are actively implementing a plan for change

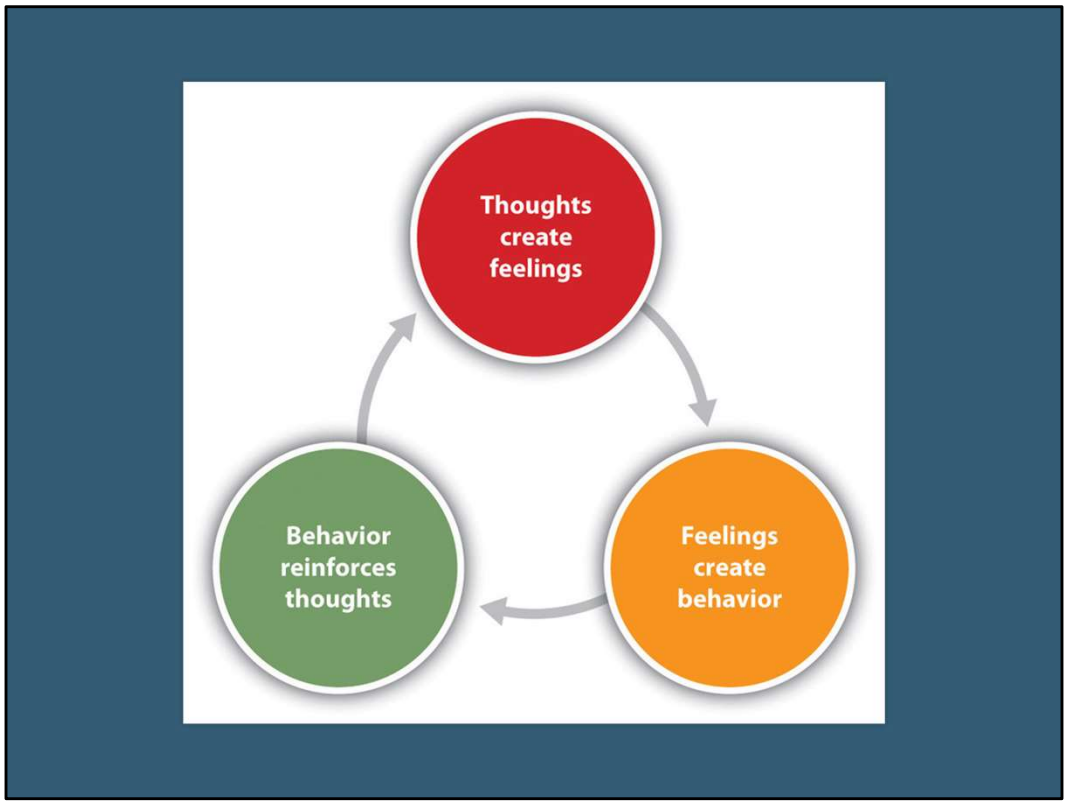
Maintenance Clients in this stage are maintaining healthy lifestyle changes they have made.

Relapse or lapse Clients in this stage may fall back into any of the other stages-Not every client will enter this stage

It is also important to note that clients can travel along the Stages of Change like a continuum. The SoC are not always linear.

What is CBT?

Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.



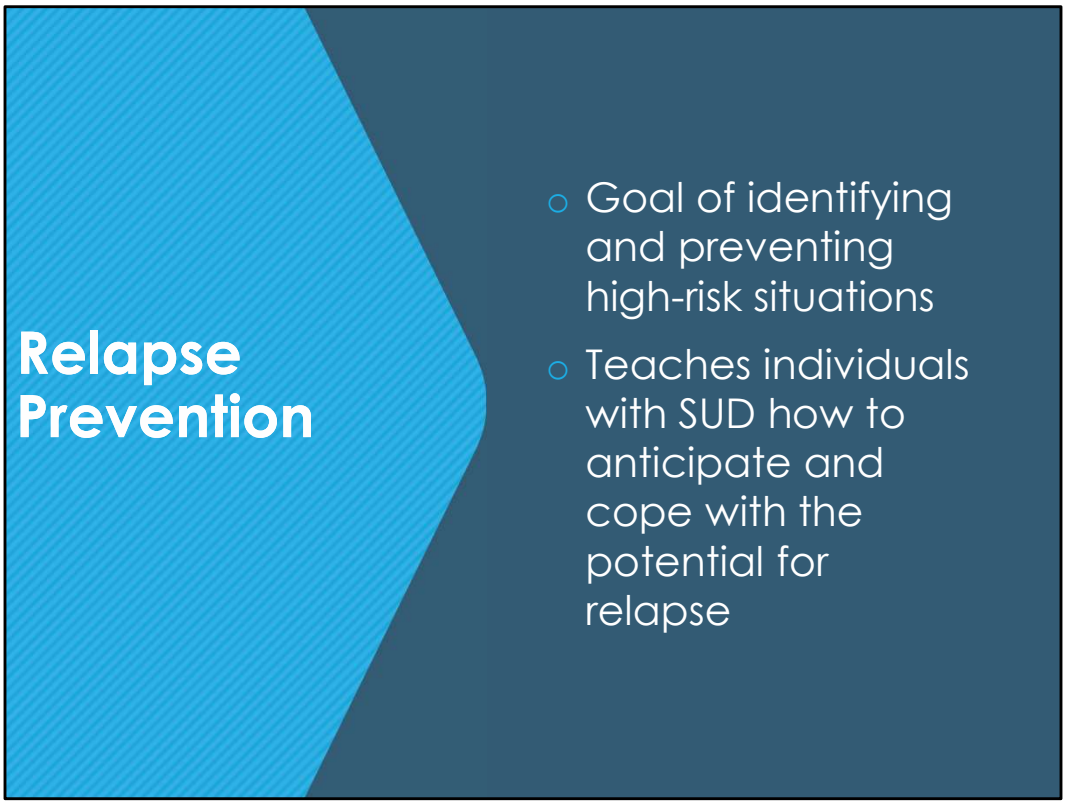
Studies have shown CBT to be an effective treatment for substance use disorders.

For individuals with substance use disorders, CBT aims to reframe maladaptive thoughts, such as denial, minimizing and catastrophizing thought patterns, with healthier narratives

Specific techniques include identifying potential triggers and developing coping mechanisms to manage high-risk situations.

Research has shown CBT to be particularly effective when combined with other therapy-based treatments including MAT

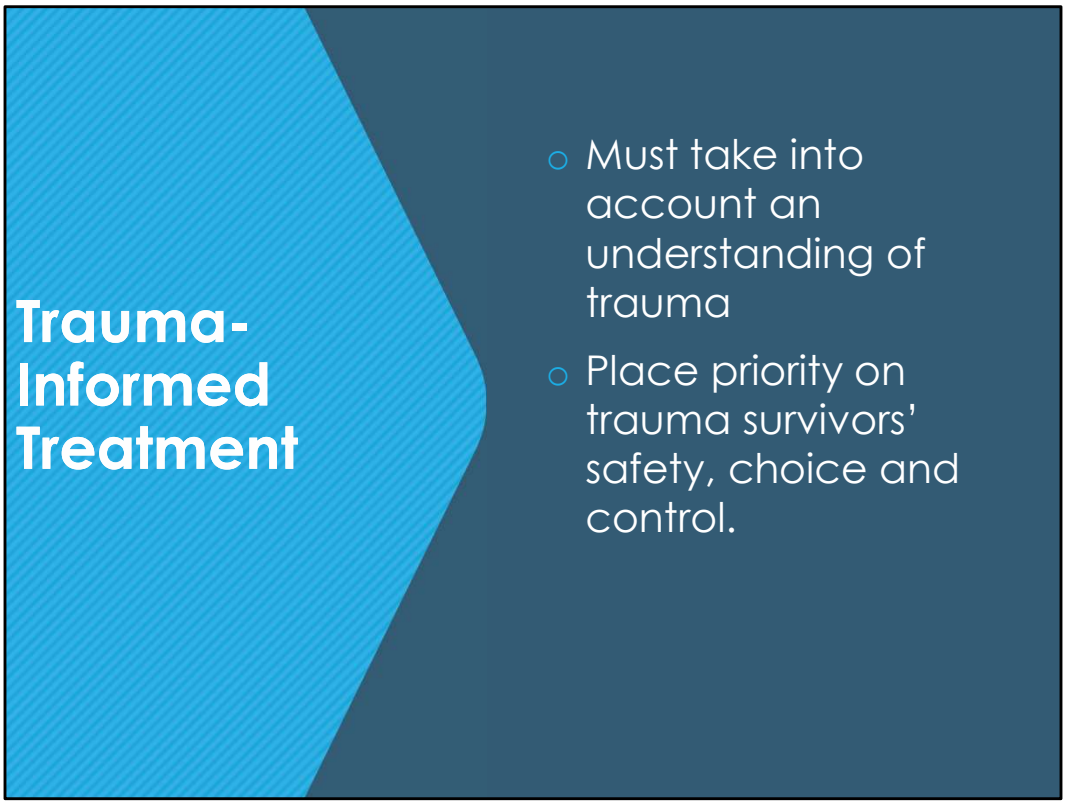
It is also important to note that clients can travel along the Stages of Change like a continuum. The SoC are not always linear.



Relapse is seen as both an outcome and a transgression in the process of behavior change. An initial setback or lapse may translate into either a return to the previous problematic behavior, known as relapse or the individual turning again towards positive change. A relapse often occurs in the following stages:
emotional relapse, mental relapse, and finally, physical relapse.

Each stage is characterized by feelings, thoughts, and actions that ultimately lead to the individual's returning to their old behavior.

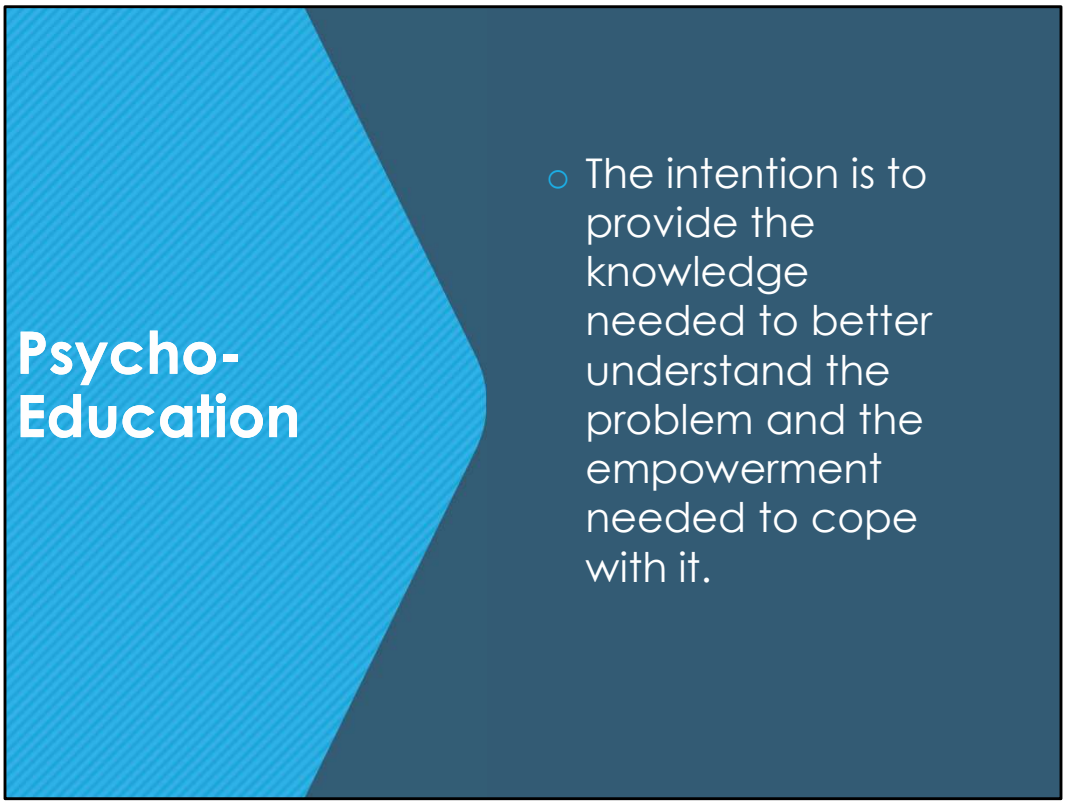
Relapse prevention (RP) is a cognitive-behavioral approach to relapse with the goal of identifying and preventing high-risk situations that teaches individuals with SUD how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone SUD treatment program or as an aftercare program to sustain gains achieved during initial SUD treatment.



Trauma-Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Trauma-Informed Treatment Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.

> Trauma-informed treatments takes into account knowledge about trauma—its impact, interpersonal dynamics, and paths to recovery—and incorporate this knowledge thoroughly in all aspects of service delivery



Psycho-educational groups are designed to educate clients about substance abuse, and related behaviors and consequences.

It is typically used in conjunction with other approaches of group-based therapies and cognitive-behavioral treatments. The intention of this effort is to provide individuals struggling with SUD the knowledge needed to better understand their problem and the empowerment needed to cope with it.

Typically psychoeducation elements involve evidence-based research and cover a broad spectrum of topics. It provides a more thorough understanding of the nature of addiction and the disease model.

Psycho-educational groups provide information designed to have a direct application to clients' lives; to instill self- awareness, suggest options for growth and change identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

Pharmacological treatments are considered **evidence-based practices** when their effectiveness and safety are supported by strong scientific research and they are applied using clinical expertise in a way that aligns with patient needs.

Key Points

- **Grounded in rigorous research**: Medications must be validated through high-quality studies such as randomized controlled trials and systematic reviews.
- **Recommended by clinical guidelines**: Professional organizations incorporate research findings into treatment guidelines, which helps define which medications qualify as EBPs.
- **Delivered with clinical expertise**: Clinicians interpret evidence, monitor patient response, and adjust treatment appropriately.
- **Aligned with patient preferences and circumstances**: Evidence-based practice requires shared decision-making, not just prescribing based on research alone.
- **Replicable and effective in real-world settings**: Medications must demonstrate consistent benefits outside controlled research environments.

Pharmacotherapies for alcohol use disorders

- Disulfiram.
- Naltrexone
- Acamprosate

Pharmacotherapies for opioid use disorders

- Methadone
- Levo-alpha acetylmethadol
- Buprenorphine
- Naltrexone

Behavioral and psychological therapies are considered **evidence-based practices** when they are supported by strong scientific research, delivered with professional clinical expertise, and tailored to the client's individual characteristics, culture, and preferences.

Key Points

Research-supported: The therapy has demonstrated effectiveness in high-quality studies such as randomized controlled trials, systematic reviews, or meta-analyses.

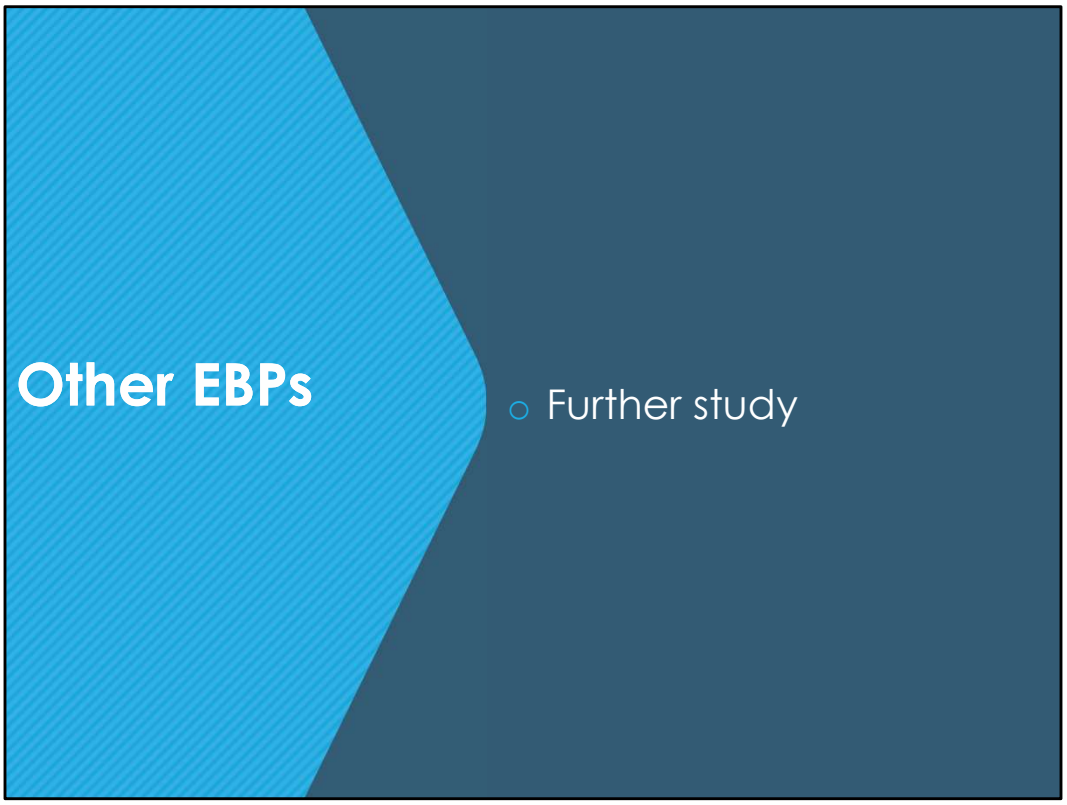
Clinically guided: Therapists use their training and judgment to apply the treatment appropriately, monitor progress, and make adjustments.

Client-centered: Treatment is adapted to the client's goals, cultural background, values, and readiness for change.

Replicable and structured: Evidence-based therapies typically have clear procedures or manuals that allow consistent delivery across settings.

Behavioral or psychological therapies

- Behavioral couples therapy
- Brief interventions
- Brief strategic family therapy
- Cognitive–behavioral therapy
- Contingency management
- Motivational enhancement therapy/motivational interviewing
- Multi-dimensional family therapy
- Psychodynamic (supportive–expressive)
- Twelve-step facilitation therapy



Information on each of the EBPs just discussed can be found at the SAMHSA EBP webpage.

Evidence-Based Practices Resource Center | SAMHSA

Think of what we are about to discuss next as continuing education, monitoring prep and enlightenment.

As most of you may know under DMC-ODS, programs are not only expected to implement EBPs according to standards, but must also assess and ensure the **fidelity** of EBPs.

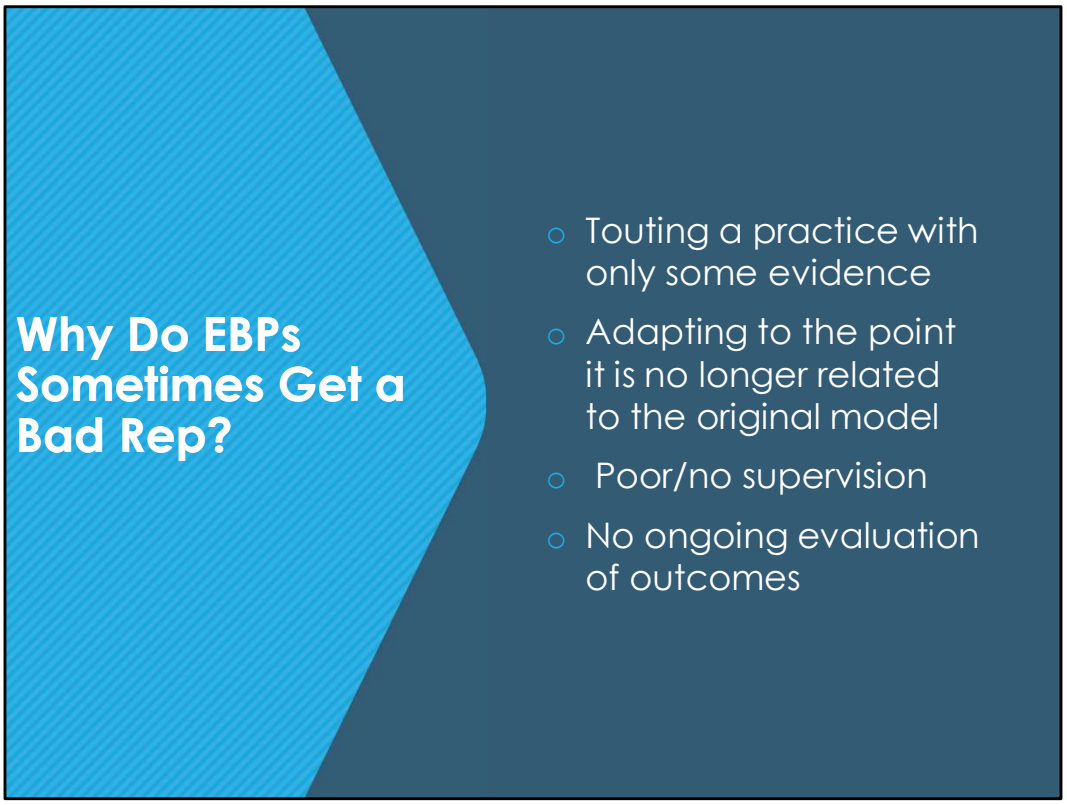
So, what is fidelity?

Faithfulness to a person, cause, or belief, demonstrated by continuing loyalty and support. **The degree of exactness with which something is copied or reproduced.**

So, what is fidelity in EBP?

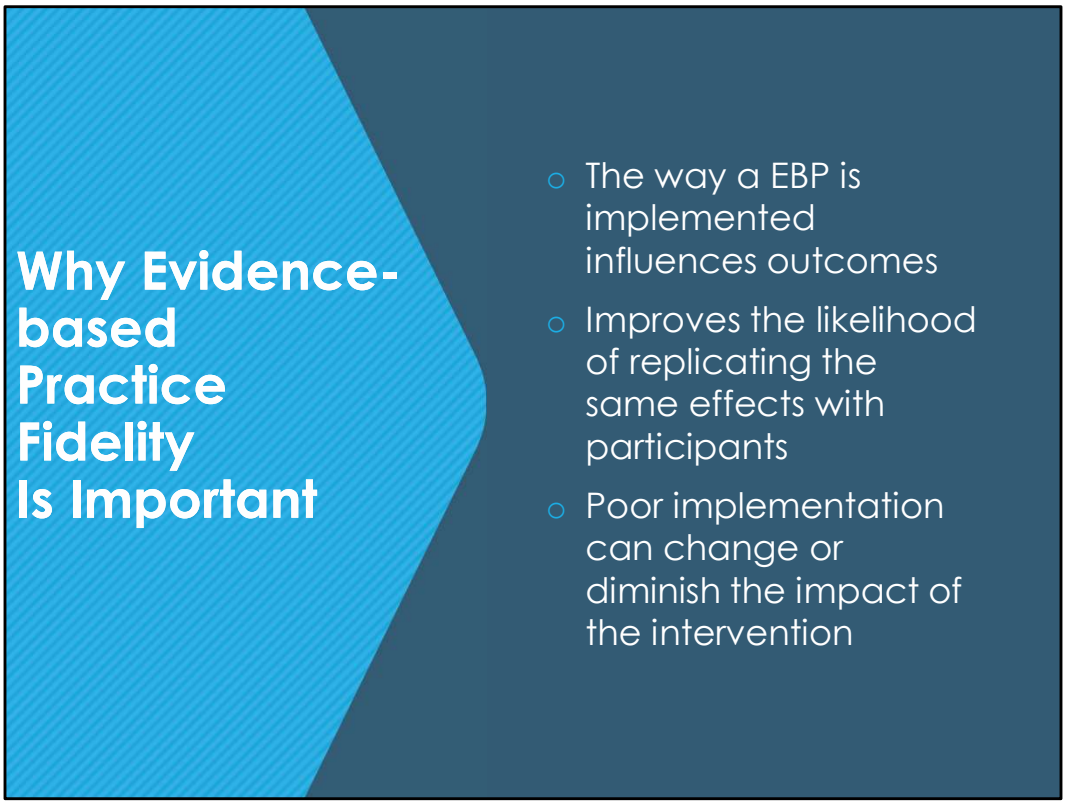
When thinking about fidelity and EBP it is important to consider this:

Fidelity is a term used in the EBP field to represent a practice, specific procedure, or construct. ... Evidence-based practice reflects an approach that attempts to ensure that treatment works.



Several reasons exist as to why EBPs sometimes get a bad rep. They include:
Touting a practice with some evidence as "Evidence Based Practice"
Adapting the EBP to the point it is no longer related to the original model
Poor/no supervision, **and**

Doing EBP without ongoing evaluation of outcomes and/or fidelity to the model

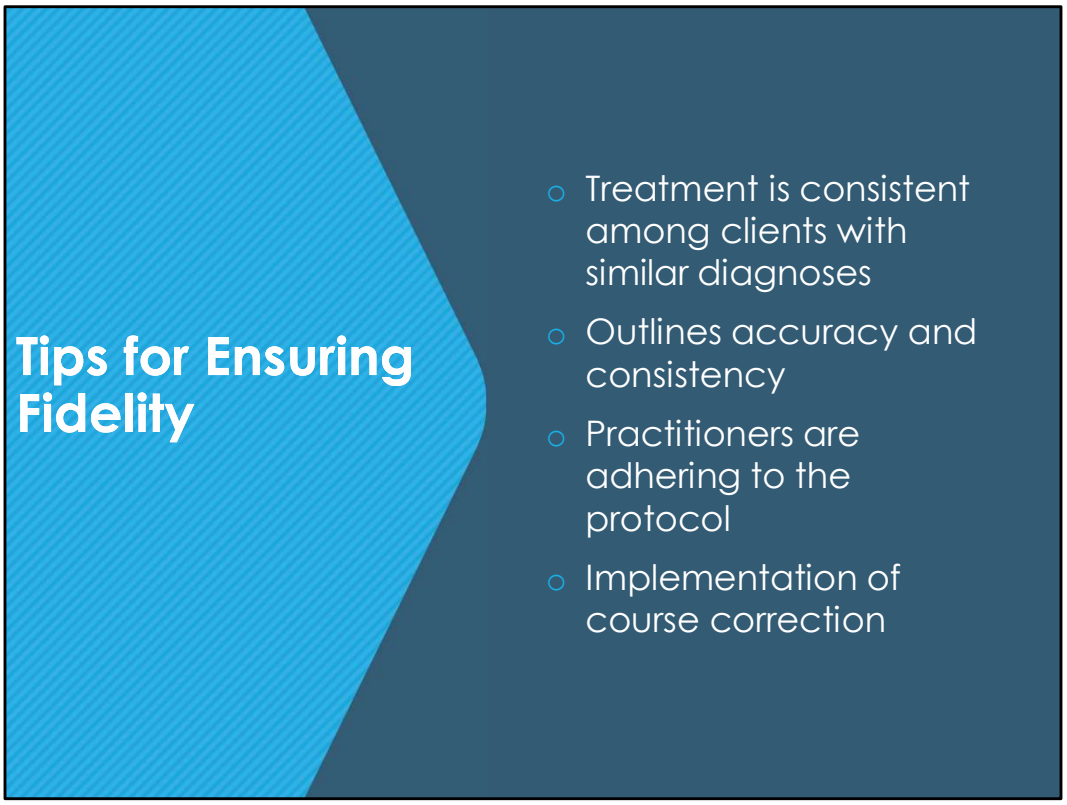


One of the most **important** considerations when implementing an **evidence-based practice** is **fidelity** (sometimes called adherence or integrity) to the original approach. Preserving the components that made the original practice effective can directly impact the success of desired outcomes.

Effectiveness research tells us that the way a EBP is implemented influences outcomes

Implementing an EBP with fidelity improves the likelihood of replicating the same effects with participants as the original study.

Poor implementation or lack of implementation fidelity can, and often does, change or diminish the impact of the intervention.



Fidelity measuring must include:

A method for ensuring the treatment "dose" (intensity, frequency, length of contact) is consistent among clients with similar diagnoses.

A protocol for the delivery of EBP that outlines accuracy and consistency.

A method for determining that the practitioners are adhering to the protocol.

A method for identifying areas for course correction (drift) and provide an outline for implementation of course correction.

Regular monitoring of EBP

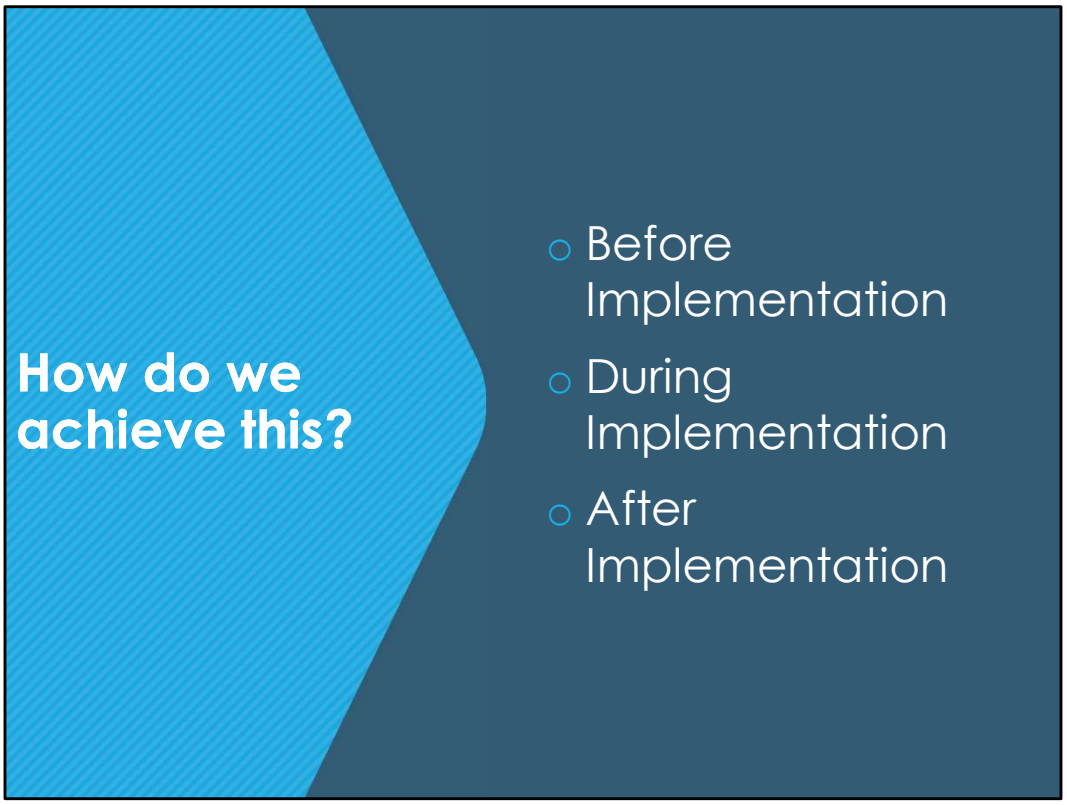
Fidelity monitoring enables documentation of EBP successes and challenges. It allows for feedback and improvement, as well as opportunities for quality assurance and continuous quality improvement.

Fidelity monitoring also assists EBP implementation by regularly identifying planned and unplanned adaptations.

Thinking about EBP Fidelity should include some variation of the following:

Dosage, or the amount of time providers spend implementing the core components of the program, compared with the time recommended in the program model
Adherence, or the percentage of program model components implemented as intended (the extent to which the model is implemented)
Quality, or the extent to which the program model components are implemented using strong practices (the extent to which the model is implemented well)

This way of thinking allows for a monitoring framework that will show if one is staying true to the aims and outcomes of an EBP.



Over the next few slides we will look at what should be accomplished

- Before Implementation
- During Implementation
- After Implementation

Each area must have a strong fidelity component to it so as to make that the EBP is valid and faithfully adhered to. One wrong step at any point can invalidate the entire process and then you no longer have an evidence based practice, just a practice.

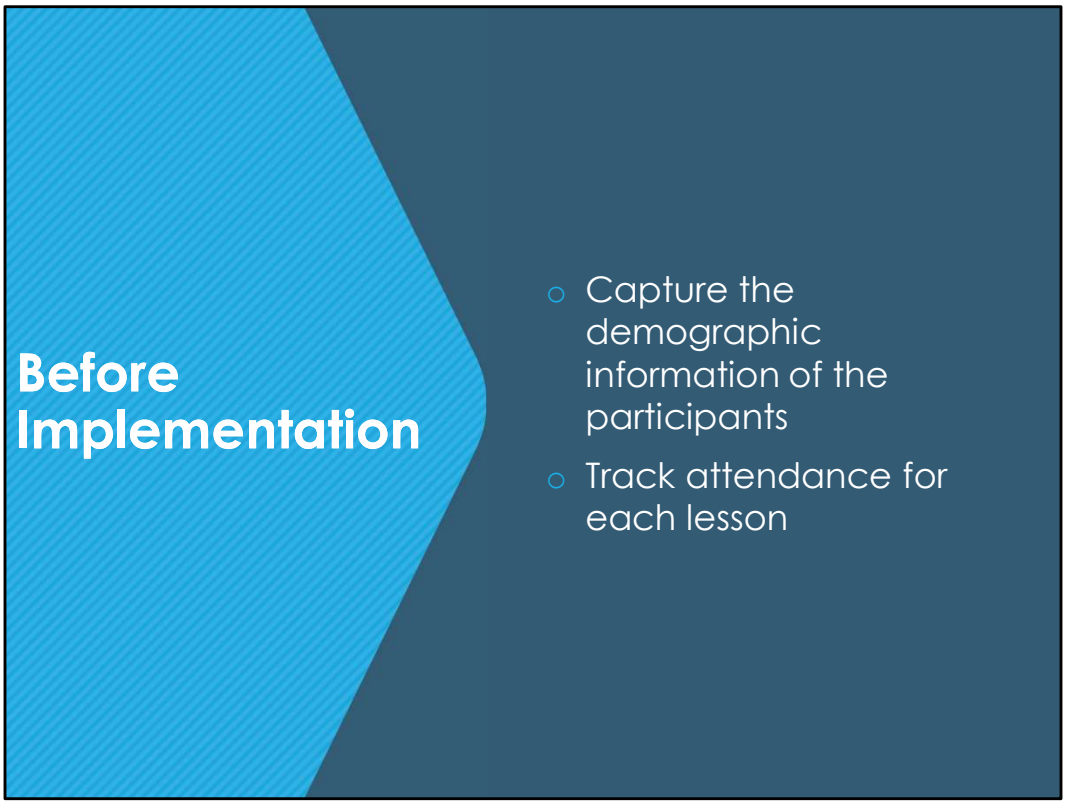
Identify and fully understand the EBPs core components.

Thoroughly read the printed curriculum and be familiar with handouts, activities, worksheets, game materials, videos, music and all related program materials.

When reading through the curriculum, gain an understanding of how the program progresses in terms of knowledge and skill building.

Note how activities progress from the first few lessons to later lessons. Note the importance of the first lesson in setting up a positive and safe learning environment.

It's helpful to gain a good understanding of the EBPs theory of behavioral change or theoretical underpinning (i.e. how and why the program works).
Activities and lessons are thus directly tied to achieving outcomes.
This understanding helps program facilitators and educators to comprehend the importance of program fidelity and helps them to conduct program lessons as intended by program developers.



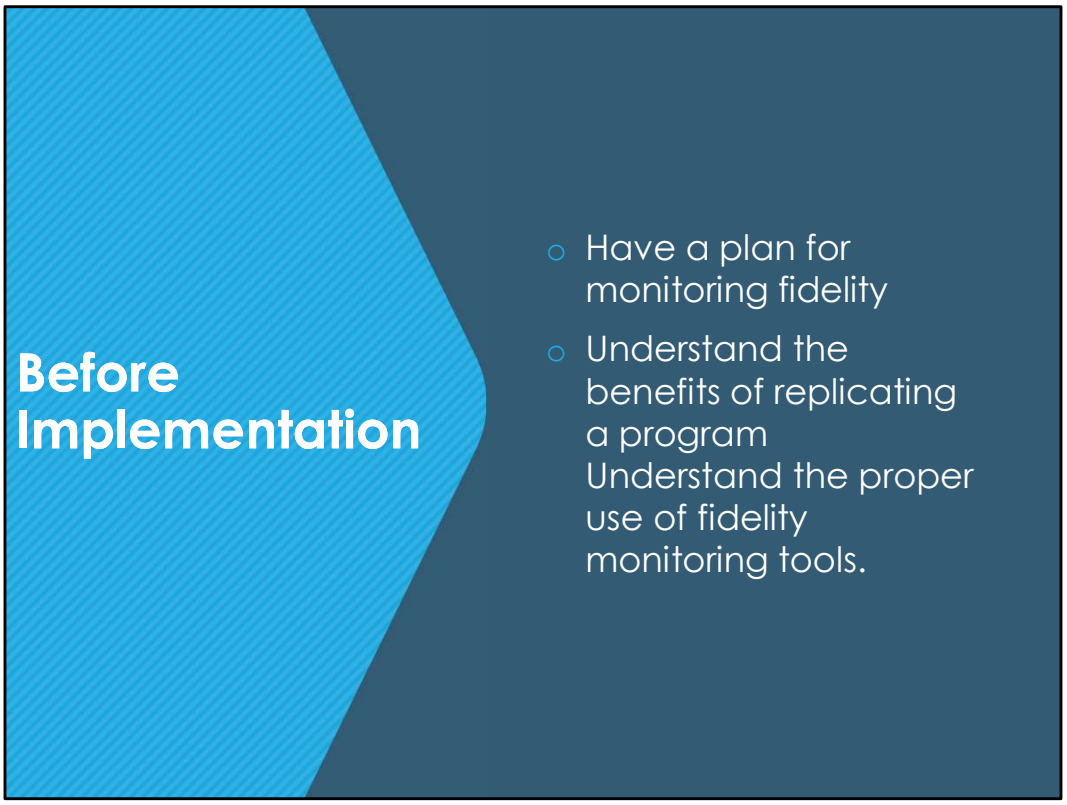
Identify or create a fidelity monitoring process form.

The fidelity monitoring process form must capture the demographic information of the participants and track attendance for each lesson.

Provide proper fidelity monitoring training for program facilitators.

- Understand the importance of fidelity and adaptation.
- Understand the proper use of fidelity monitoring tools.

Identify lessons or activities that will be adapted.



Have a plan for monitoring fidelity before implementation.

Understand the benefits of replicating a program with fidelity.

This will help all program facilitators and educators adhere to the program design and use program fidelity monitoring tools consistently and effectively.

Conduct the lessons.

- If feasible, have an observer take notes as the lessons progress.
- Track what is implemented during each session.

Complete the fidelity monitoring progress form at the conclusion of each lesson.

- Note planned and unplanned adaptations.
- Record unplanned adaptations (how and why) for each lesson.

Identify problems with implementation as they unfold.

Note what worked and what did not.

Provide on-going training, technical assistance and supervision.

Program facilitators must receive ongoing support from administrators, coordinators, and other key players.

As a result, participants will be more likely to demonstrate positive behavioral outcomes resulting from quality program implementation.

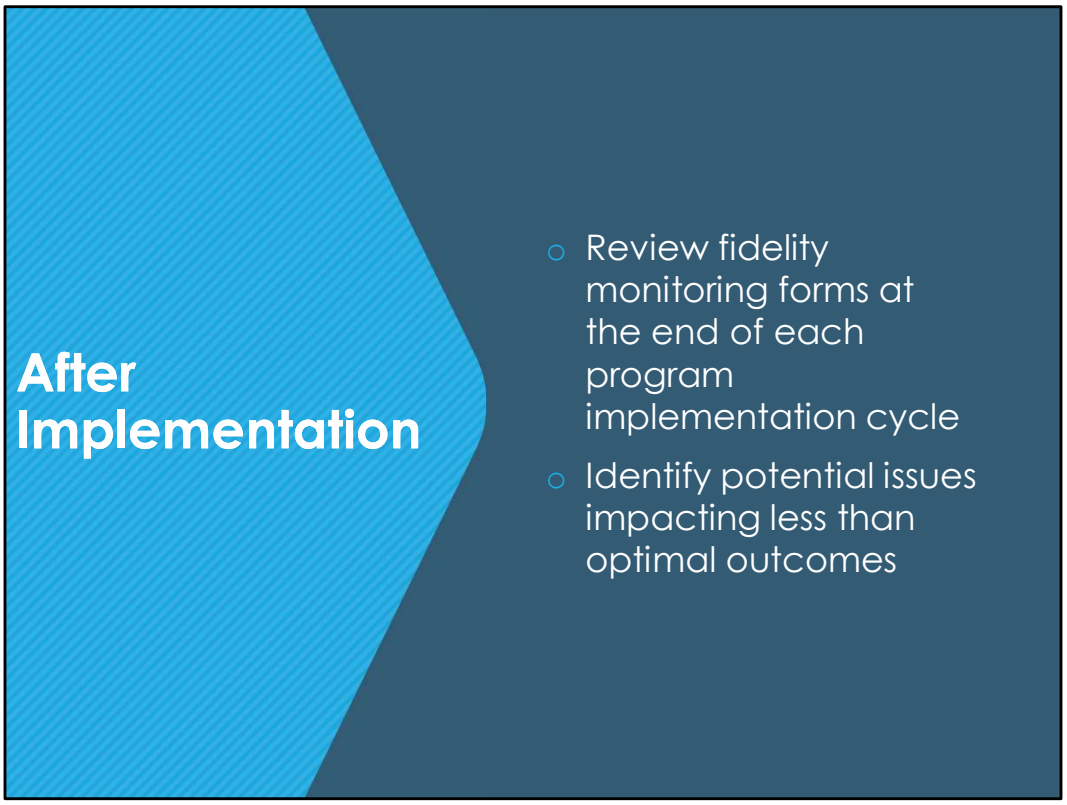
This will increase likelihood of larger scale impact.

Warm Fuzzy Story ask if people have examples

Ensure that all fidelity monitoring forms have been completed.

Collect the forms from the facilitators on an on-going basis.

Do not allow too much time to lapse between the session and collection of forms from the facilitators.



Schedule an appointment with the evaluator and a team of vested individuals to review fidelity monitoring forms at the end of each program implementation cycle.

In this way, many people are involved in the process of continuous quality improvement, and each program cycle results in increased implementation quality.

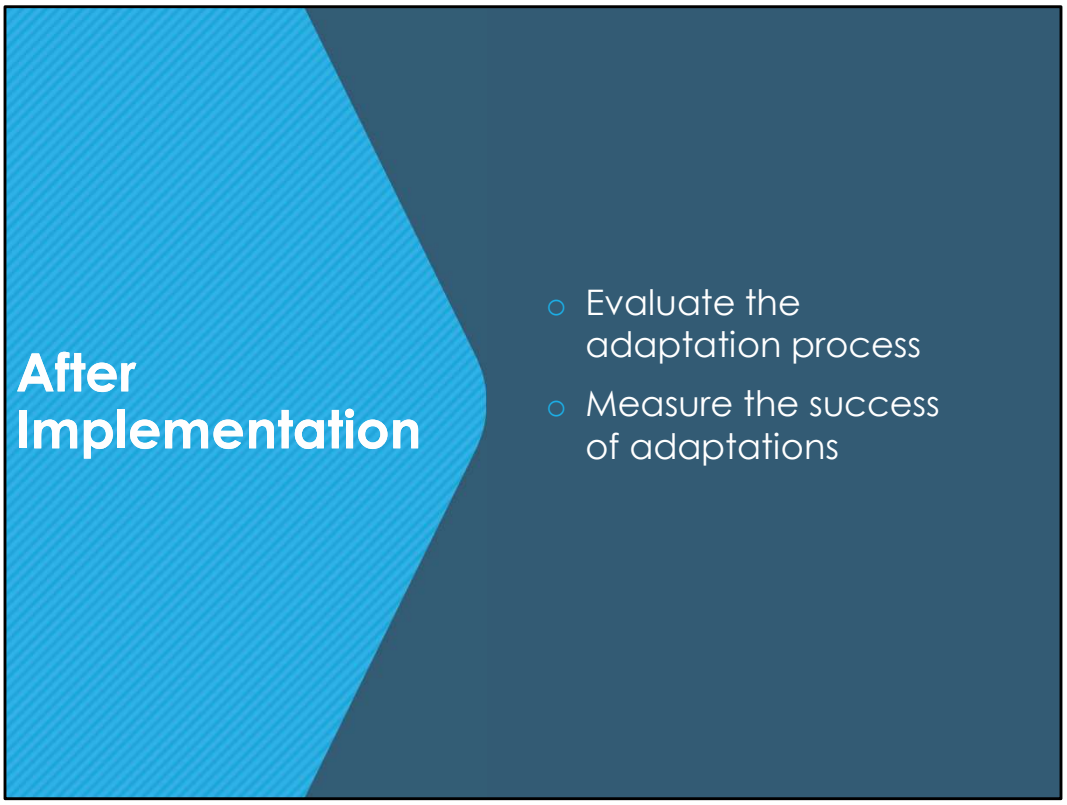
Identify potential issues impacting less than optimal outcomes.

How much is attributed to not selecting/using the most effective/appropriate evidence-based program?

How much is attributed to an effective EBP not being implemented well?

•Continually improve quality.

•Plan for future program implementation by revising lesson plans based on fidelity monitoring outcomes and evaluation findings.



Evaluate the adaptation process and measure the success of adaptations.

Identify if adaptations may have improved the delivery of the sessions.

Work with evaluators to develop an easy evaluation tool for future adaptation if the changes improved outcomes.

Remember:

Adaptations should not be made only for the convenience or comfort level of a program facilitator.

Successful adaptions can result in an intervention that is a better fit for the program participants.

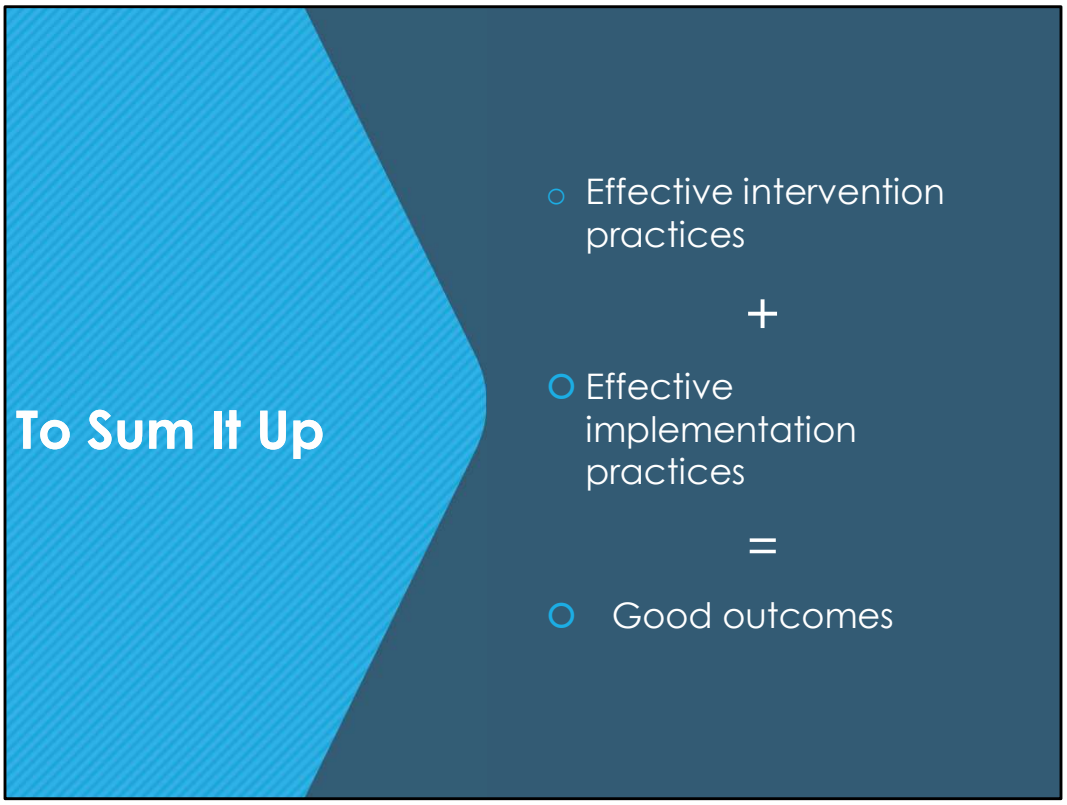
Create a training schedule and description of the training for practitioners (through documentation).
Required elements to ensure they have been satisfactorily trained to deliver the intervention are

Standardization of training upon hire: ensuring all clinicians are trained in the same manner.
Skill acquisition: should include didactic sessions, modeling, use of video materials, training manuals, role plays.
Measurement of practitioner skill: determining performance criteria that include a rating for a “demonstrated understanding of key concepts” and documentation of review.
Maintenance of skill over time: continued training and EBP documented with performance reviews.

Regularly and randomly performed, documented, assessments should be kept by the program and made available to monitors.

The assessment should include

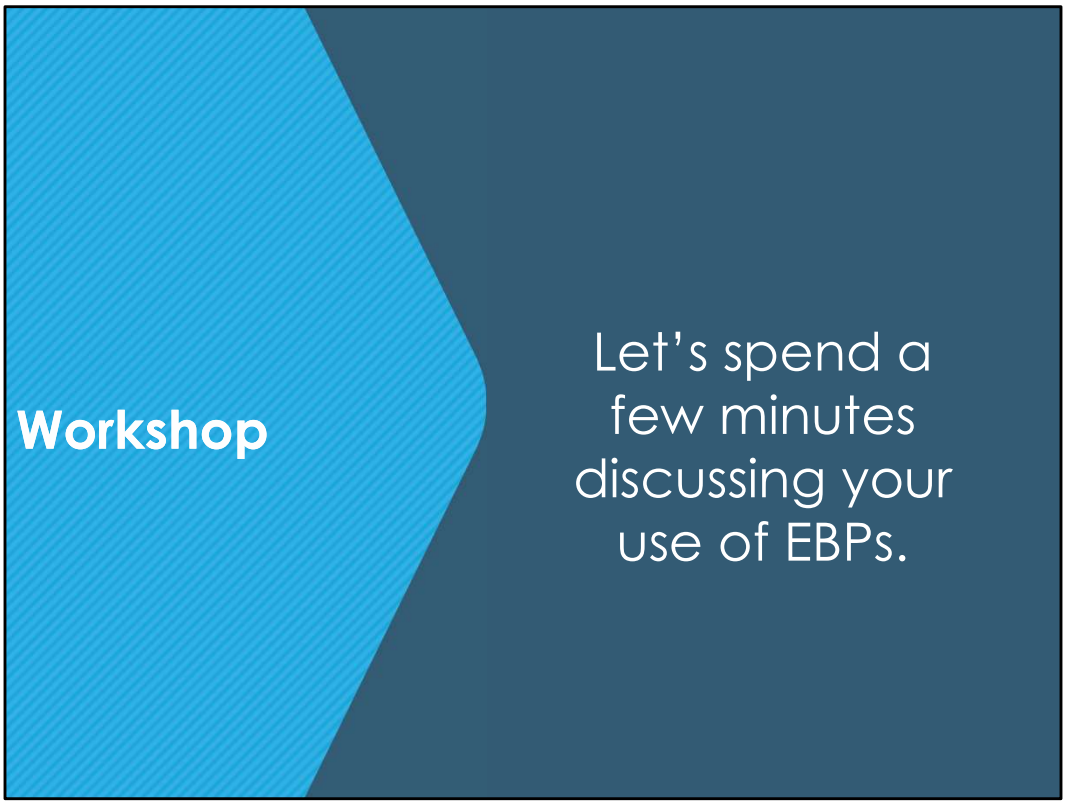
- A list of current scripted intervention protocols.
- A list of current treatment manuals that are utilized.
- A list of current staff training for each EBP implemented.
- A Performance review rating(s) for each clinician understands of EBP (self-assessment tool).
- A Self-report anonymous questionnaire from client's (a way to measure a client's comprehension: understand and perform treatment related behavioral skills and cognitive strategies) also referred to as "Treatment Receipt."
- Qualitative interviews with clinician and clients alike.
- Direct observation of a clinician from a performance reviewer.



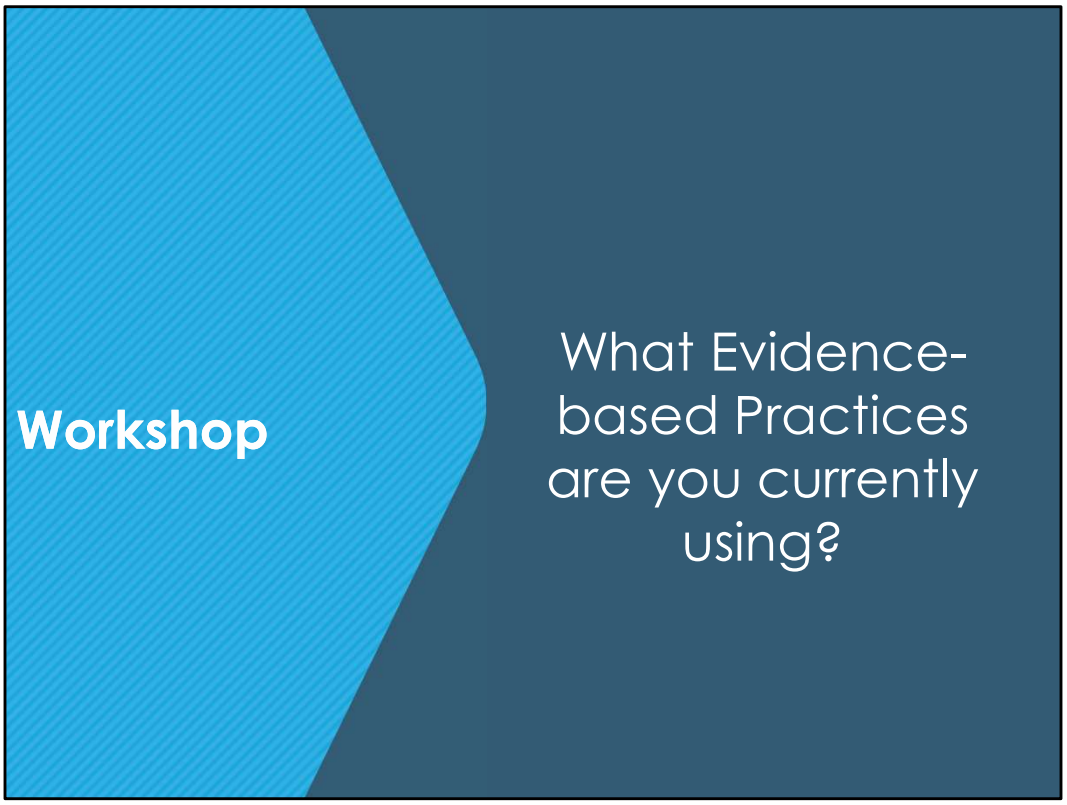
The research on EBPs tells us:

Effective intervention practices +Effective implementation practices = Good outcomes for patients

No other combination of factors reliably produces desired outcomes for patients.

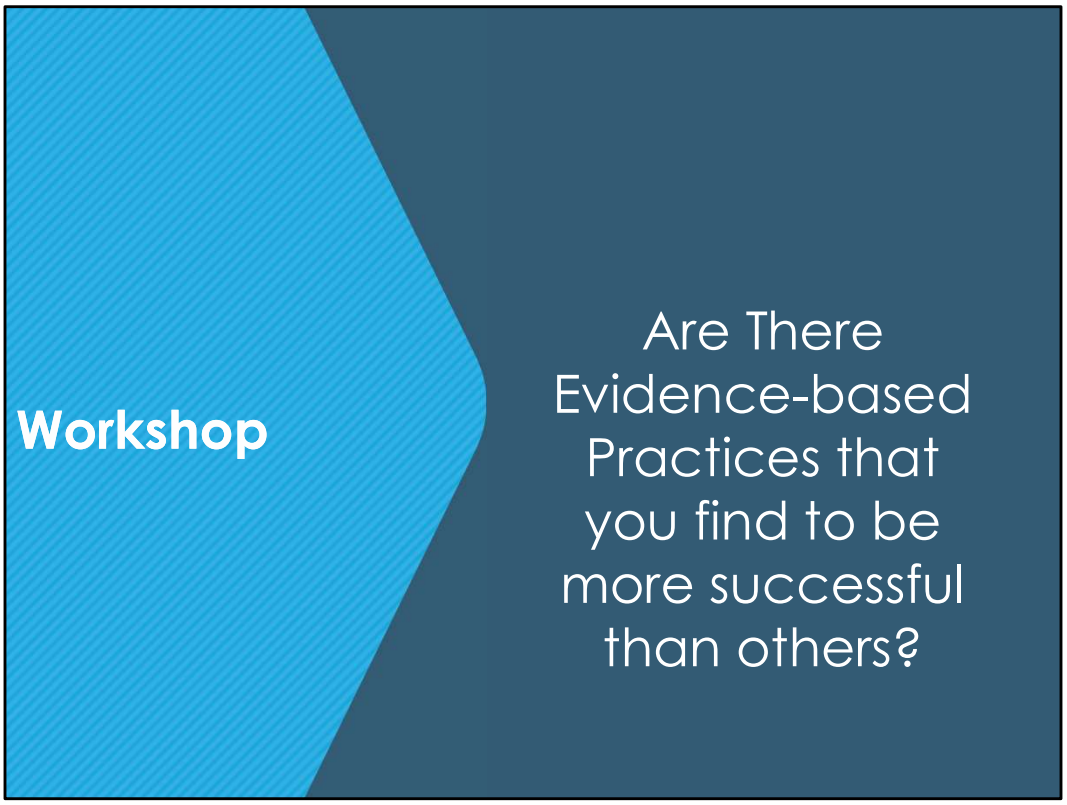


Let's spend a few minutes discussing your use of EBPs.



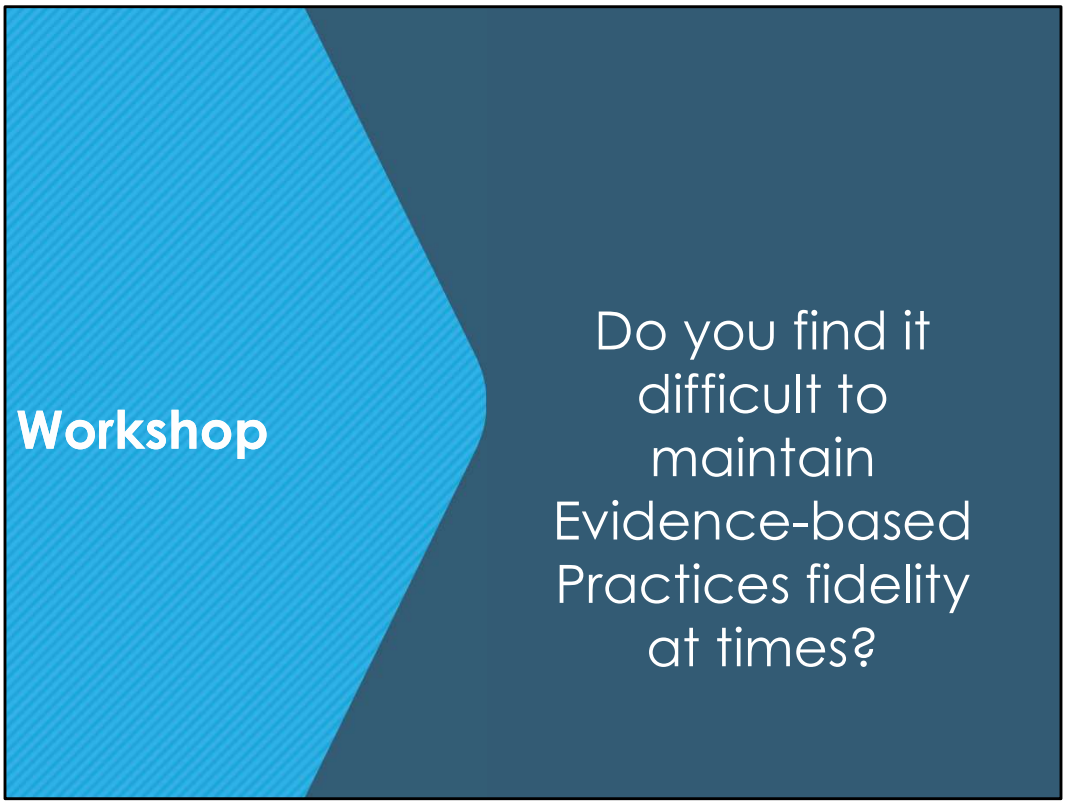
What Evidence-based Practices are you currently using?

Are there barriers to implementing Evidence-based Practices?



Are There Evidence-based Practices that you find to be more successful than others?

Do you currently assess fidelity of implemented Evidence-based Practices?



Do you find it difficult to maintain Evidence-based Practices fidelity at times?

Are there concerns around maintaining Evidence-based Practices fidelity?


ANY
QUESTIONS
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I want to thank everyone for attending today.

Our next training will take place in February 2026 for CLAS Standards and SUD

Please feel free to contact Chase or myself for any questions you may have.

The End Code is 4987

CUEs will be sent out later this week once the exam has been completed. Make sure you are signed in or you will receive no credit for attending. Same goes for Certificates of Attendance. You must be signed in to receive credit.