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Increasing the Uptake of Effective Youth Addiction Treatment via Dissemination and Implementation Science

Sara Becker, PhD

NIDA Special Interest Group

November 2022

Acknowledgments

Related Article

Meissner HI, Glasgow RE, Vinson CA, et al. The U.S. training institute for dissemination and implementation research in health. *Implement Sci*. 2013;8:12. doi:10.1186/1748-5908-8-12.

Studies Discussed Today:

P50DA054072-5710 (Becker)
U2CDA057717 (Becker/ Becker/Brown/McGovern)
P01AA019072 (Becker/Kuo)
R37DA052918 (Becker)
R34DA039289 (Becker)
K23DA031743 (Becker)

Two of my favorite background implementation science slides are from TIDIRH 2011 faculty – Drs. Enola Proctor and Larry Green. Highly recommend NIH implementation science training!

Goals of Presentation

1. Provide an overview of
   - ❖ WHAT
   - ❖ WHY
   - ❖ HOW
2. Take a deep dive into case examples
3. Share NIDA-funded resources

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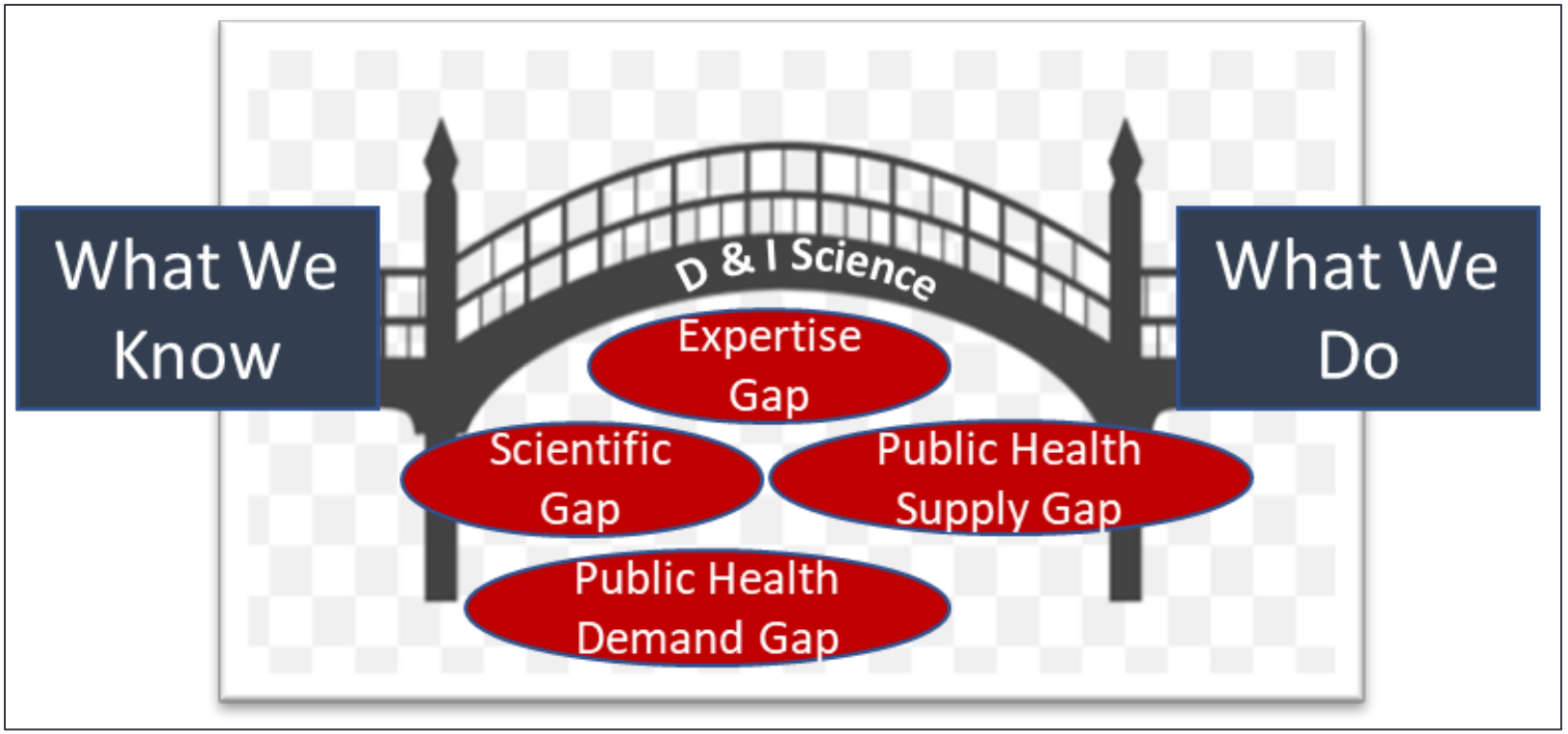
Dissemination & Implementation Science: WHAT, WHY, and HOW

*with a focus on youth addiction health services

WHAT is Dissemination and Implementation (D&I) Science?



Bridging the gap between what we **know** and what we **do**

D&I Science: NIH Definitions

Dissemination Research (Demand)

"The scientific study of targeted distribution of information and intervention materials to a specific public health or clinical practice audience."

Implementation Research (Supply)

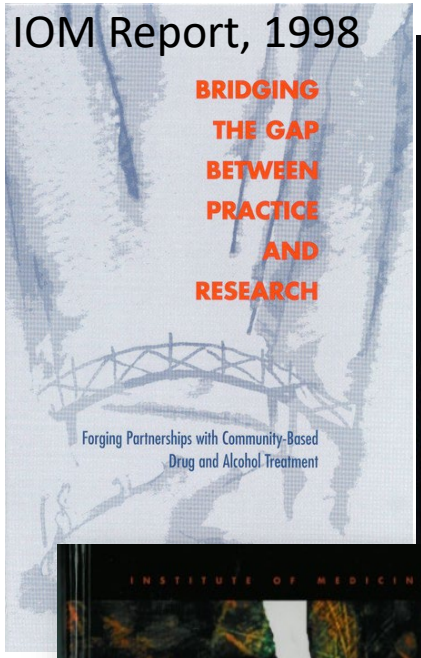
"The scientific study of the use of strategies to adopt and integrate evidence-based health interventions into clinical and community settings in order to improve patient outcomes and benefit population health."

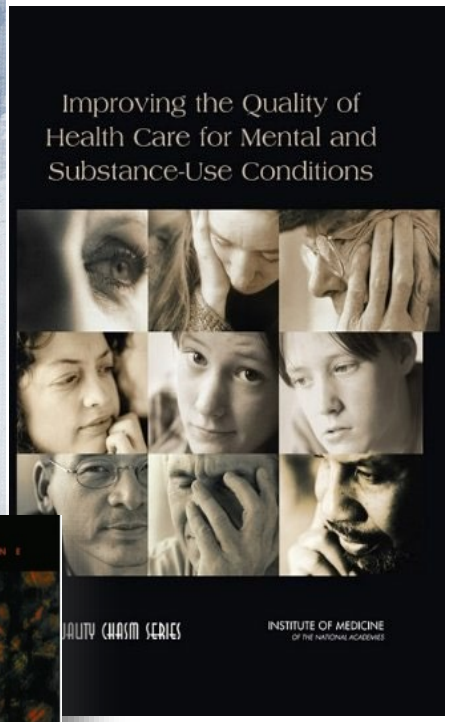
NIH PAR-16-236

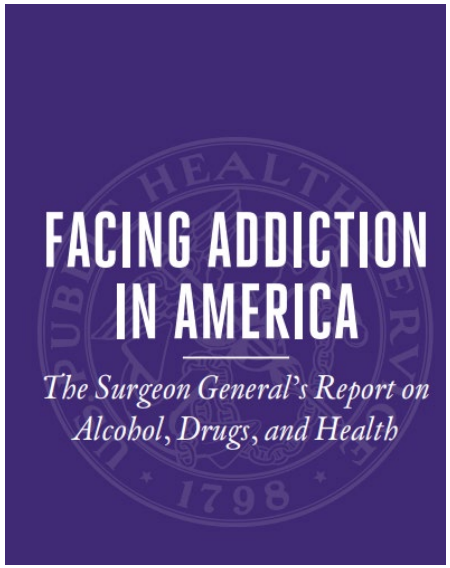
WHY: Youth SU Treatment System

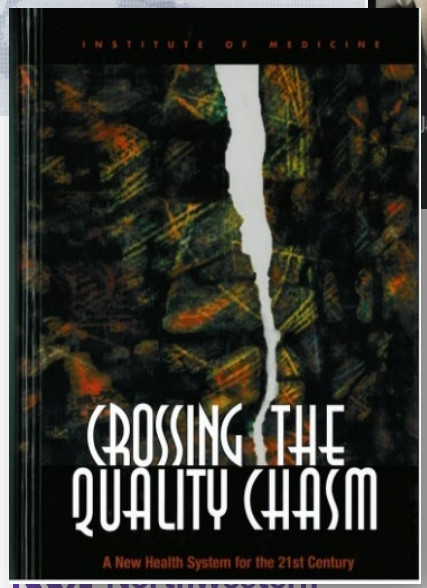
Gap 1: Care that "Could Be" vs. Care that "Is" (Public Health Supply)

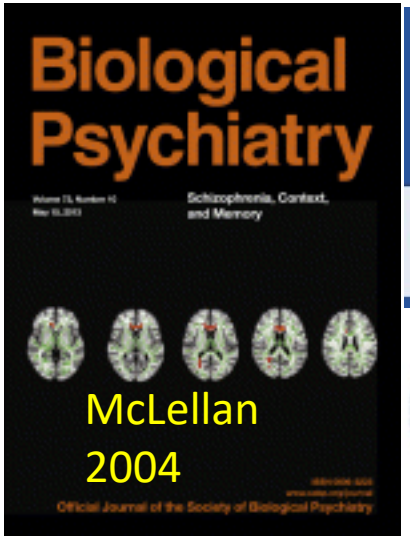
IOM Report, 1998





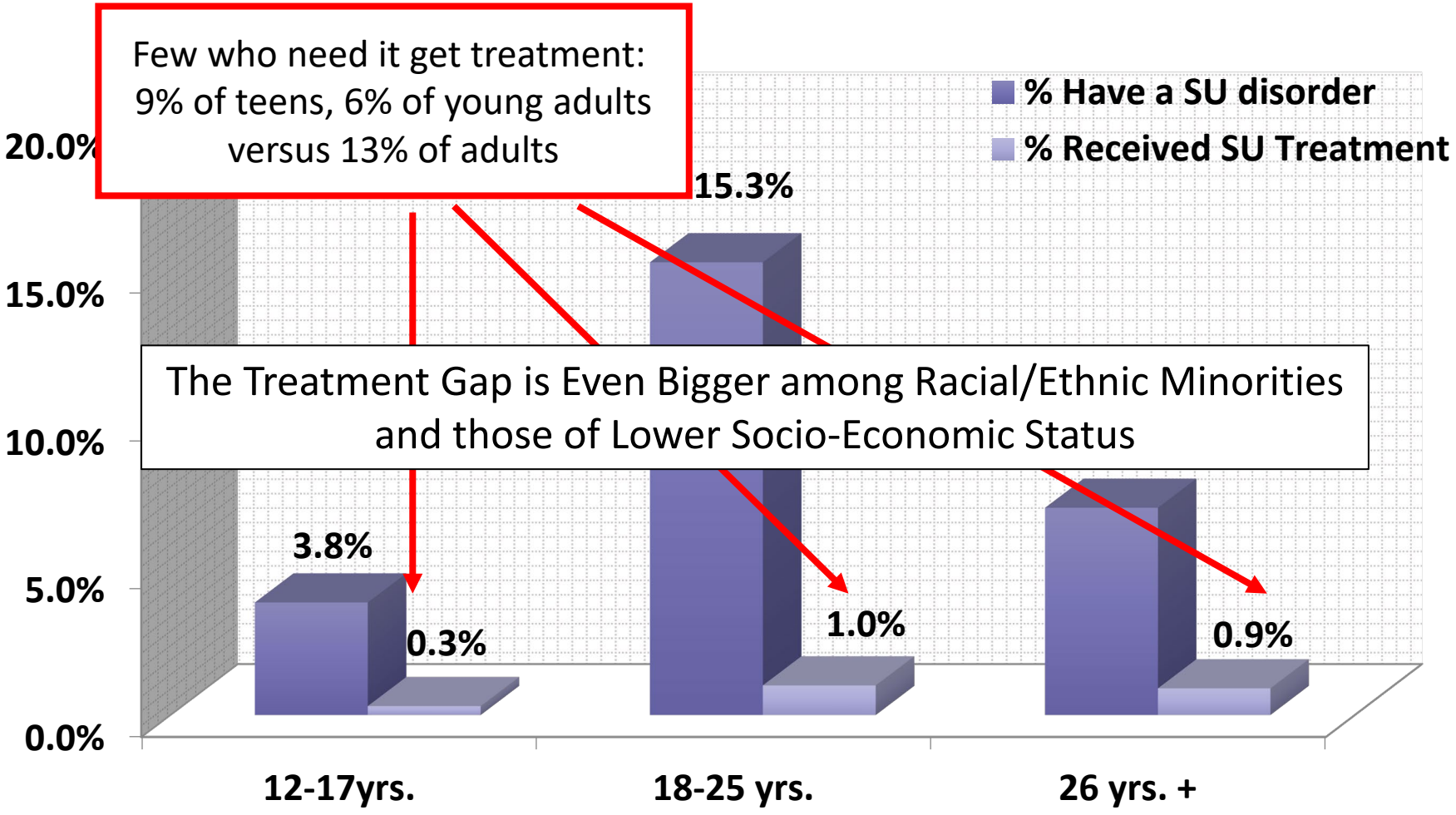






Center for Dissemination and Implementation Science

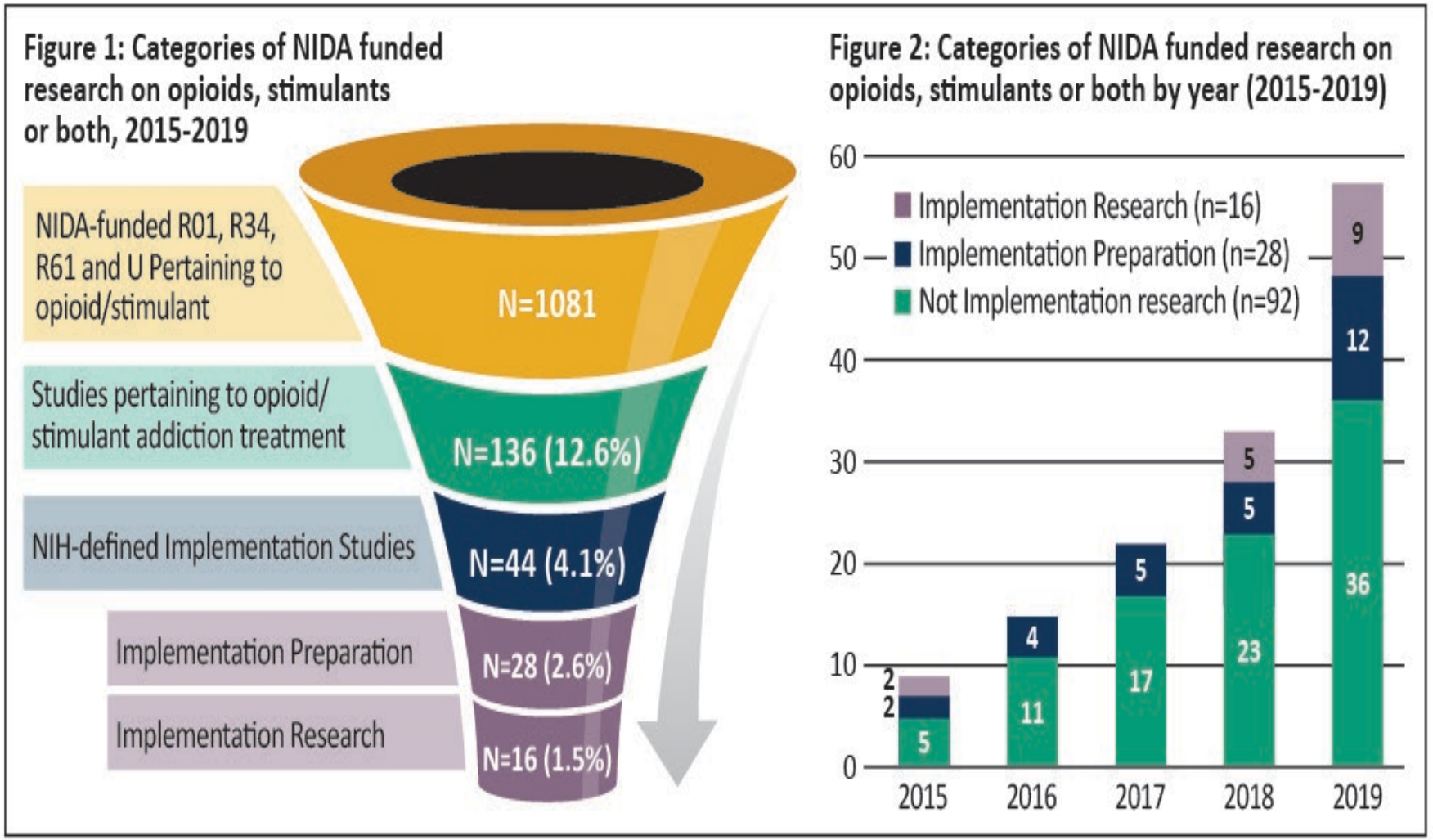
Gap 2: Level of Need vs. Level of Care (Public Health Demand Gap)



Source: National Survey on Drug Use and Health, 2019.

Primary Reasons for Not Seeking Substance Use Treatment: “Not ready to stop using”, “Didn’t think treatment was needed” and “Didn’t know how to get help”

Gap 3: Implementation Research is Still Rare



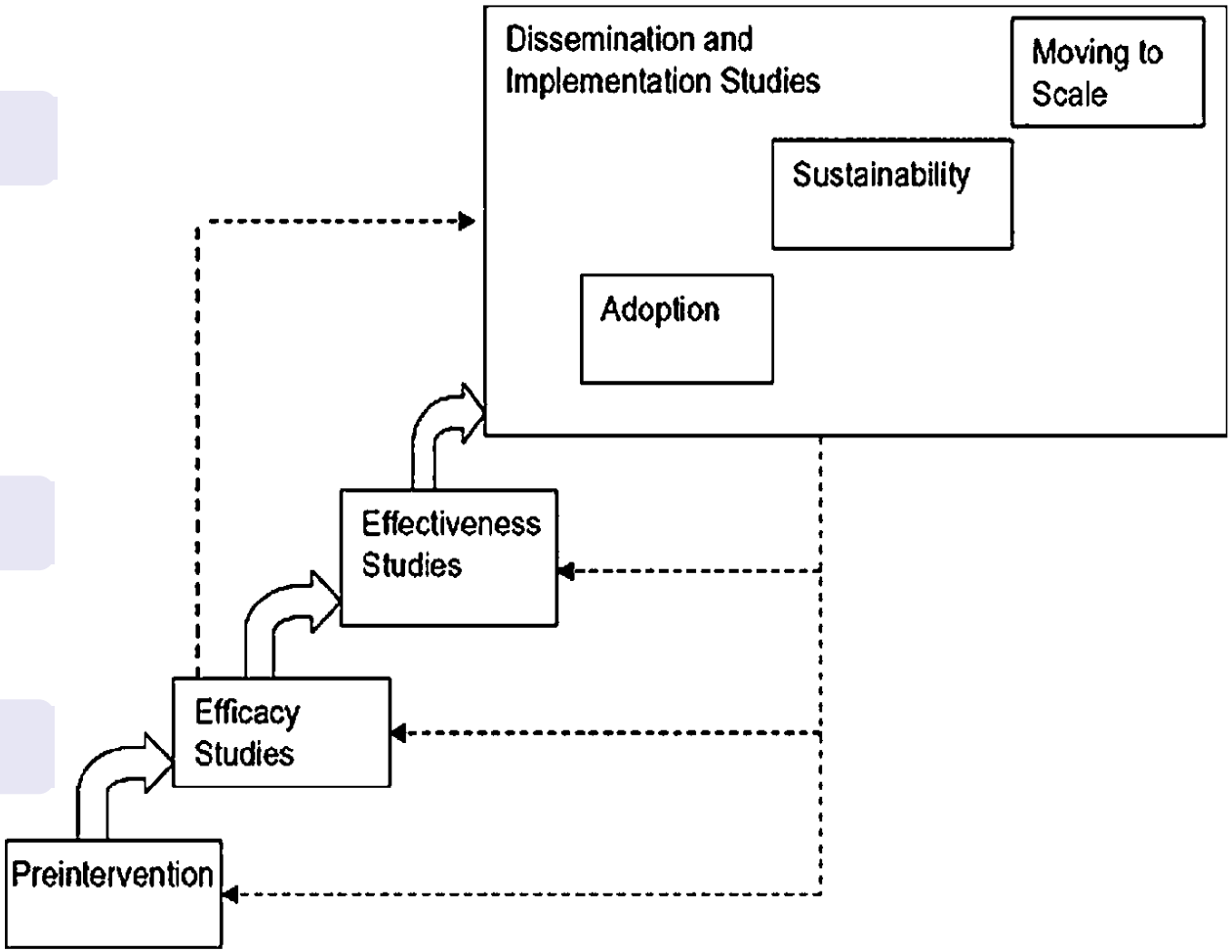
From P50 proposal, McGovern et al

The Status Quo: Typical Phases of Research

How to deliver?

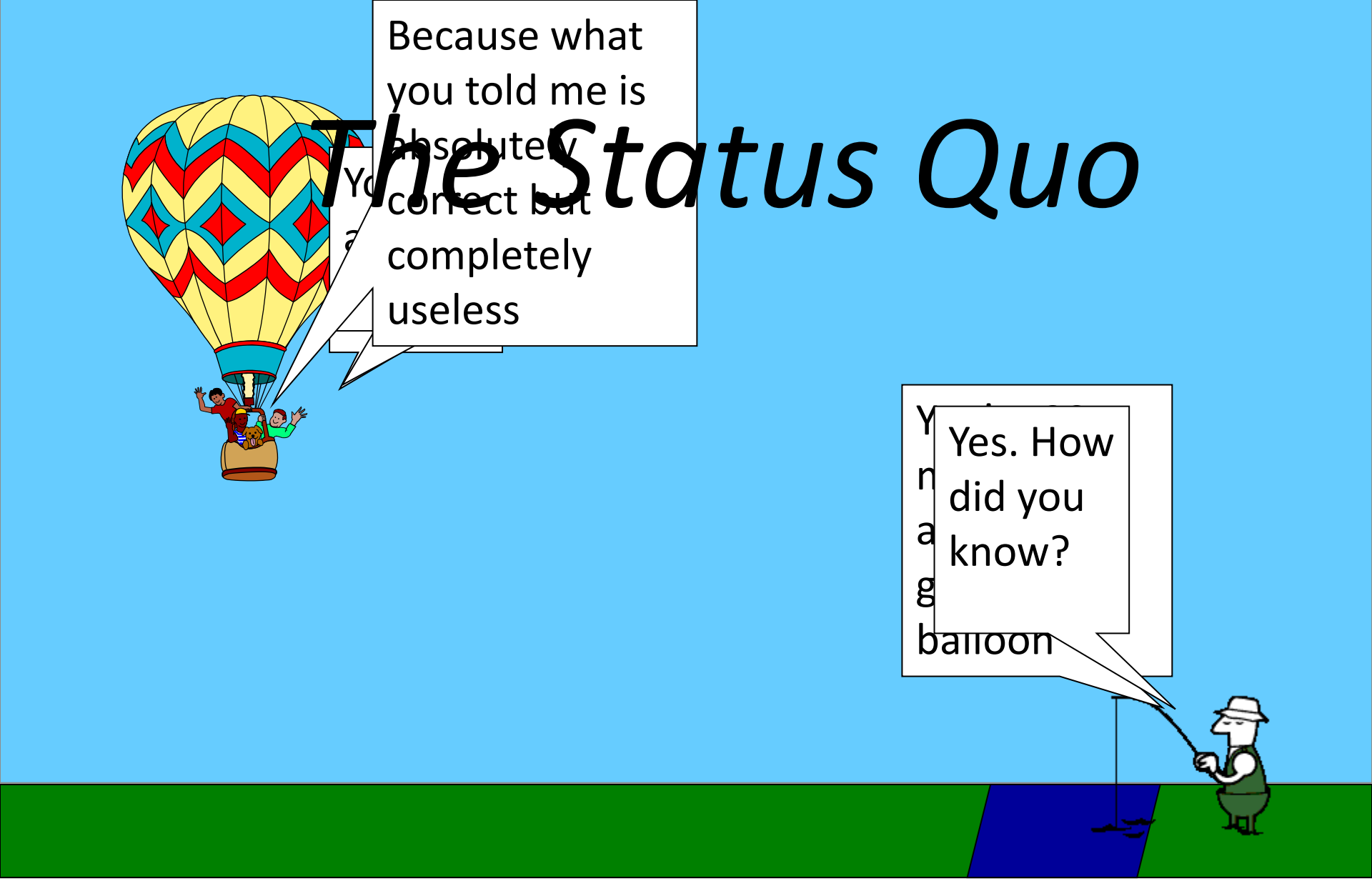
What to deliver?

What to target?



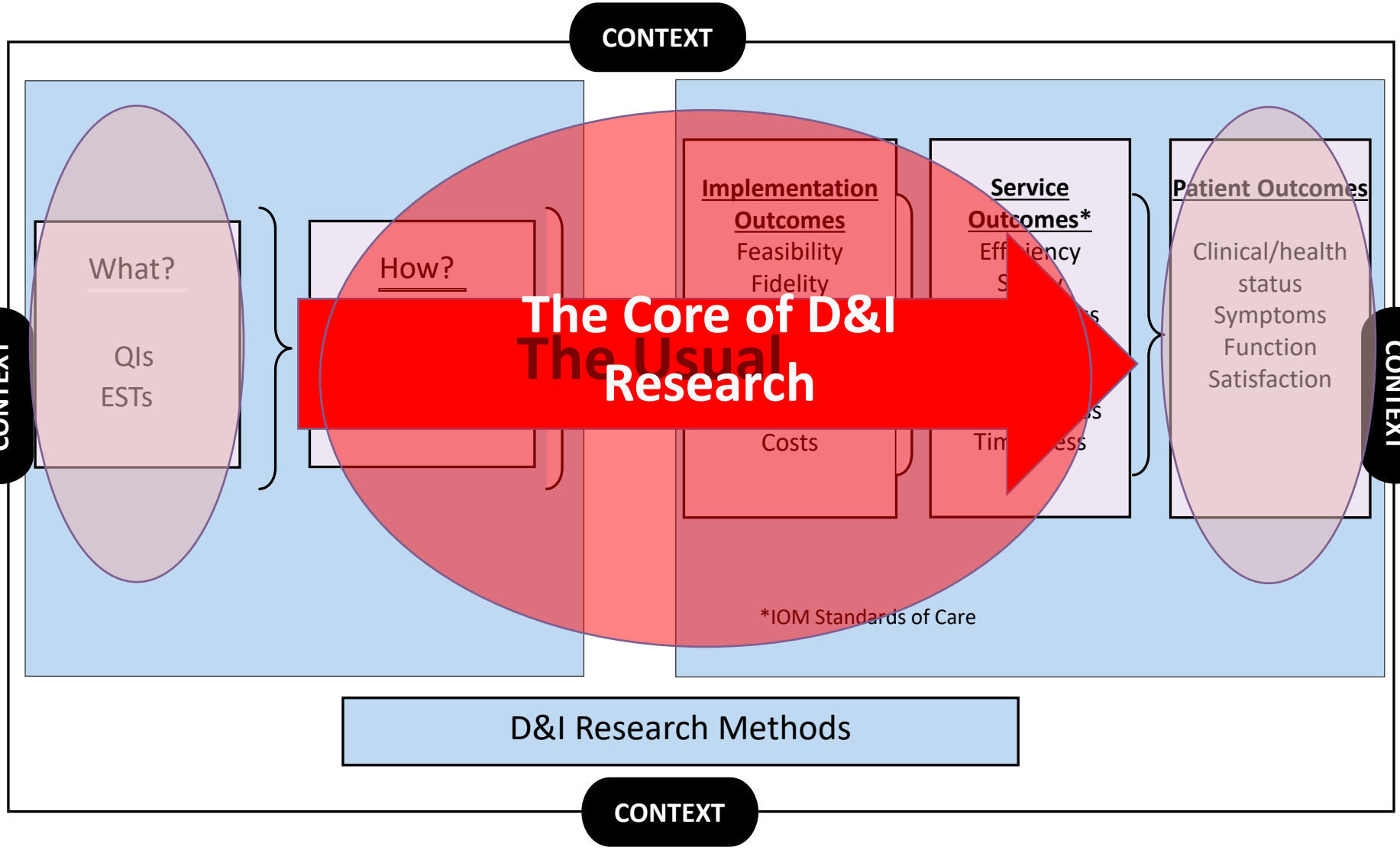
"It takes 17 years to turn 14% of original research to the benefit of patients" – Balas, 1998

The Status Quo



From Larry Green TIDIRH 2011, initially presented by Jonathan Lomas, retired director of the Canadian Health Services Research Foundation, presented at European Public Health Assn Conference, Amsterdam, 2011.

HOW: Conceptual Model of D&I Research



Proctor et al. (2009). *Administration and Policy in Mental Health and Mental Health Services Research, 36, 24-34.*

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Case Examples

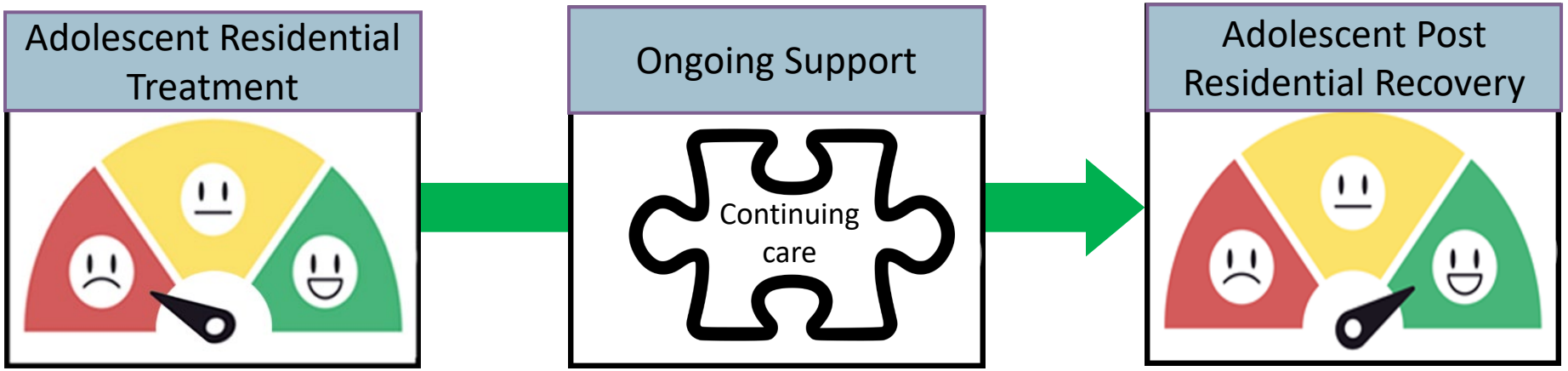
Study 1: Designing for D&I

Adolescents in residential treatment for SU have the most serious problems and functional impairment

See Becker et al., 2017; Becker et al., 2022

Need for Scalable Parenting Interventions

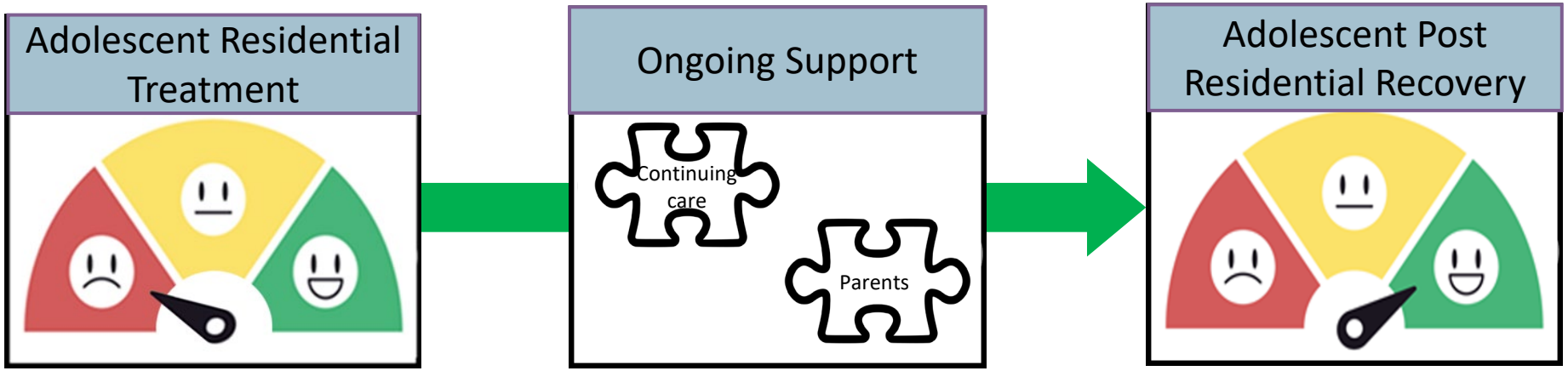
Residential treatment is associated with acute reductions in SU and co-occurring mental health symptoms



But long-term results are less encouraging… over 50% of adolescents will relapse within 90 days of discharge, in part because only 35-45% of youth receive ANY continuing care.

See Becker et al., 2017; Becker et al., 2022

Need for Scalable Parenting Interventions

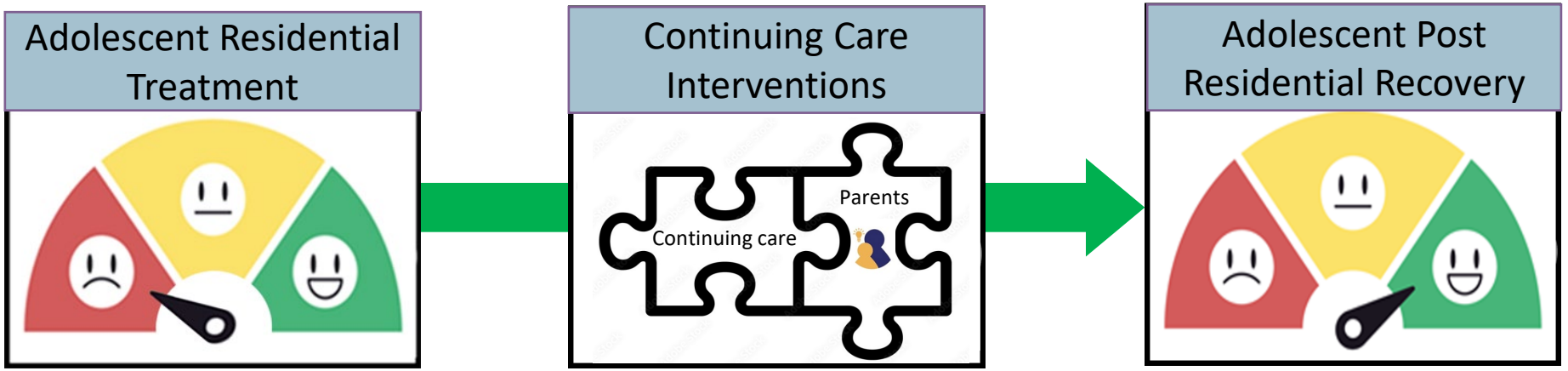


For this reason, it has been recommended by the Residential Care Consortium that residential facilities prioritize parent engagement "prior to and following discharge to the community."

Affronti et al., 2009; Becker et al., 2022

Need for Scalable Parenting Interventions

BUT… engaging parents in traditional office-based continuing care has been a challenge!



Parent SMART

The Foundation: An Off-the-Shelf, Evidence-Based Parenting Intervention

Https://teen.parentingwisely.com

The Delivery: Refined using Formative Research

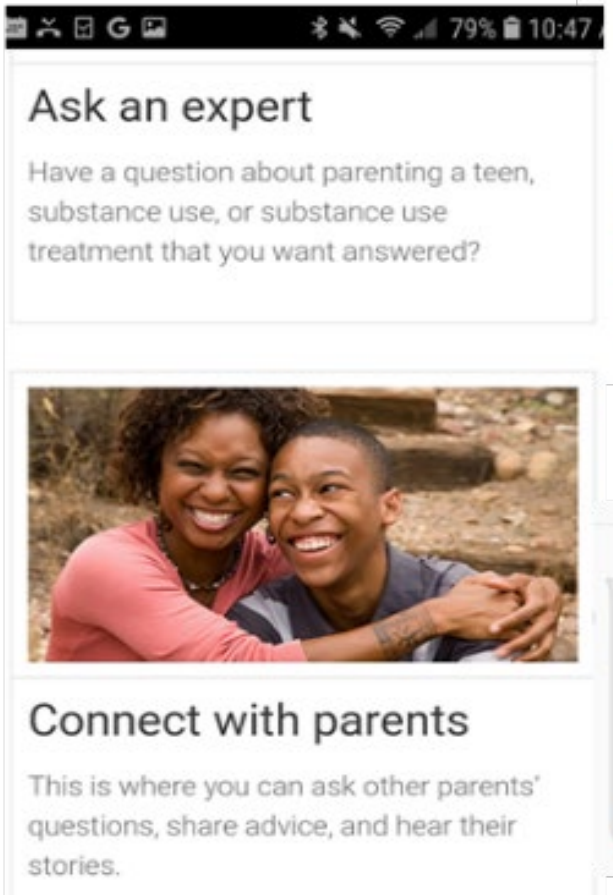
Interviews/Focus Groups with 13 parents, 11 teens, and 3 residential staff

Theme	Enhancement
Delivery	• "Show me don't tell me": daily reminders with video vignettes • "Hold my hand": coaching sessions to demo the technology
Networking	• "Connect me with others like me": networking forum • "Give me advice *when* I need it": expert forum
Notifications	• "Remind me to use it": push notifications • "Tip of the Day!" and notifications whenever anyone posts
Anonymity	• Parents create their own personal (but private) userID
Timing	• Post-discharge period identified as especially overwhelming • Treatment initiated ***during*** adolescent's residential treatment with continued availability post-discharge

Initial Parent Networking App

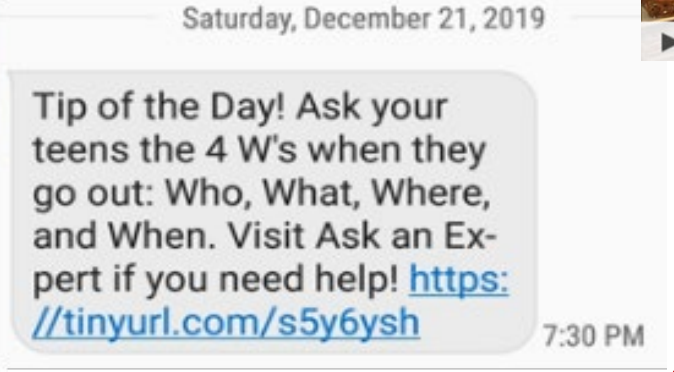
Figure 2. App

Home page



Forum example

Text example



See Becker et al., 2017

Our Specific Aims

Specific aim 1

To examine the **feasibility and acceptability** (**primary outcomes**) of Parent SMART.

Specific aim 2

To examine the **preliminary effectiveness** of Parent SMART on **adolescent** SU and high-risk behaviors (**secondary outcomes**).

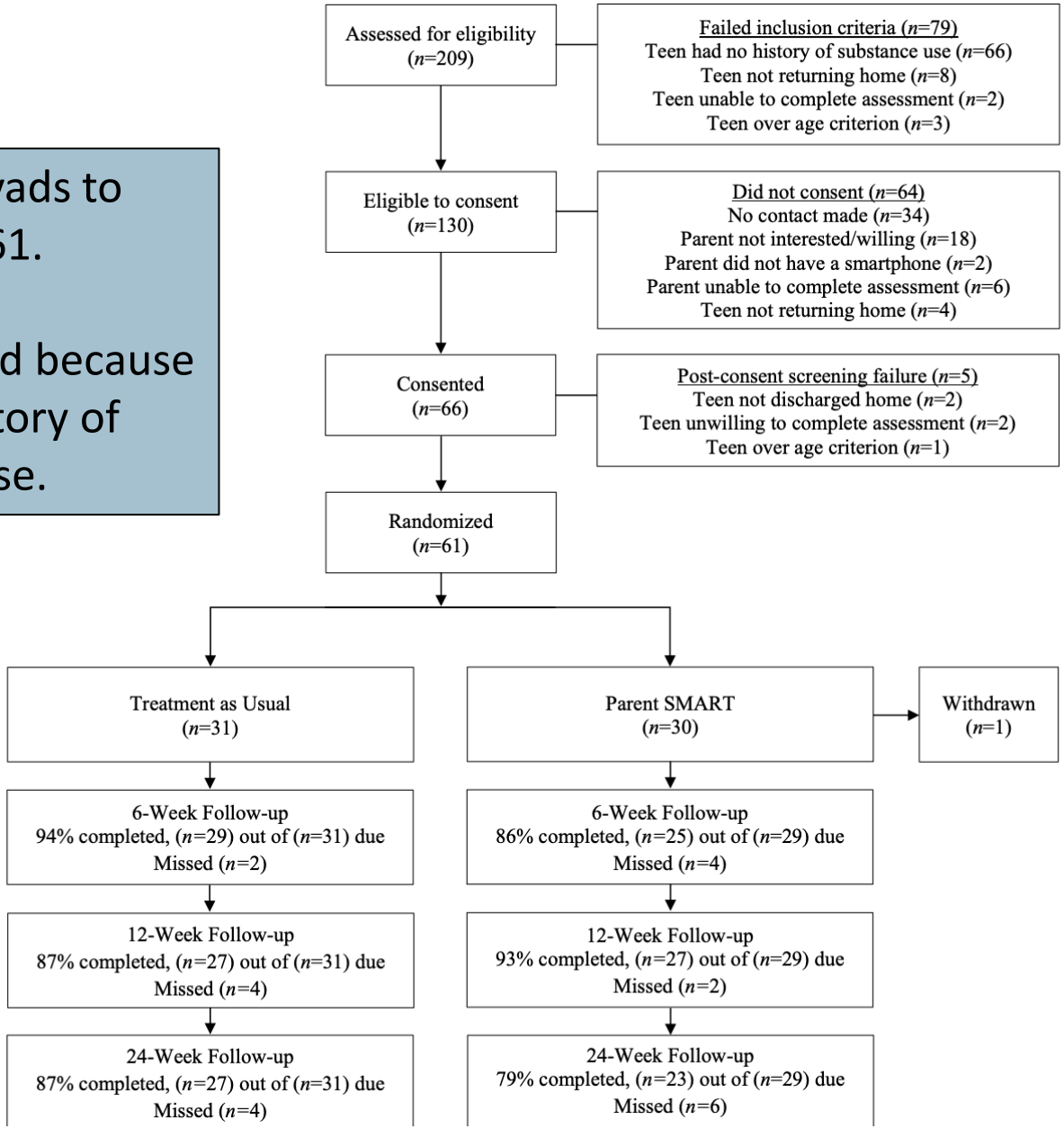
Specific aim 3

To examine the **preliminary effectiveness** of Parent SMART on **parental monitoring and communication** (**putative mediators**).

Pilot R34: CONSORT Diagram

Assessed 209 dyads to randomize 61.

Most dyads excluded because teen had no history of substance use.



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Pilot R34: Goals vs. Results (Aim 1)

Pre-Specified Goal	Pilot Trial Results
Enrollment:	
• 60 parent-adolescent dyads	• **61** parent-adolescent dyads
• < 20% withdrawal rate	• **2%** of parents withdrew
Retention:	
• 80% of parents	• **90%** at 6 weeks, **90%** at 12 weeks, **85%** at 24 weeks
Session delivery:	
• 80% elements covered	• **92%** of elements covered across sessions
• 80% sessions with skill	• **100%** of sessions met skills target (M = 4.9/6.0)
Engagement:	
• ≥ 75% parents 2 sessions	• **86%** parents attended 2 or more sessions
• ≥ 75% parents 2 PW modules	• **86%** parents completed 2 or more modules
• ≥ 75% login twice	• **100%** read content, **70%** posted **1-14** times
Satisfaction:	
• ≥ 80% parents satisfied	• **88%** parents satisfied or very satisfied
• Satisfaction > TAU	• **88%** PWB vs. **59%** TAU, Chi-square = 5.5, ***p* = .02**
• ≥ 80% would recommend	• **80%** parents would recommend to a friend
• Recommend > TAU	• **80%** PWB vs. **41%** TAU, Chi-square = 8.3, ***p* = .005**

Pilot R34:
YOUTH Effectiveness Outcomes (Aim 2)

No time * condition interactions across sites

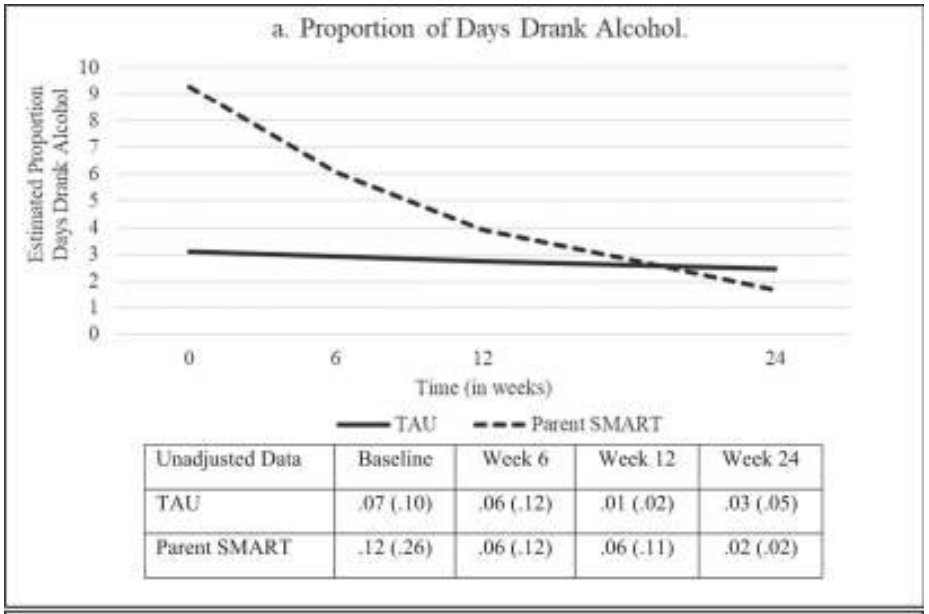
Multiple **time effects** across sites

- Youth had reduced days of marijuana and AOD use, substance-related problems, and externalizing behavior

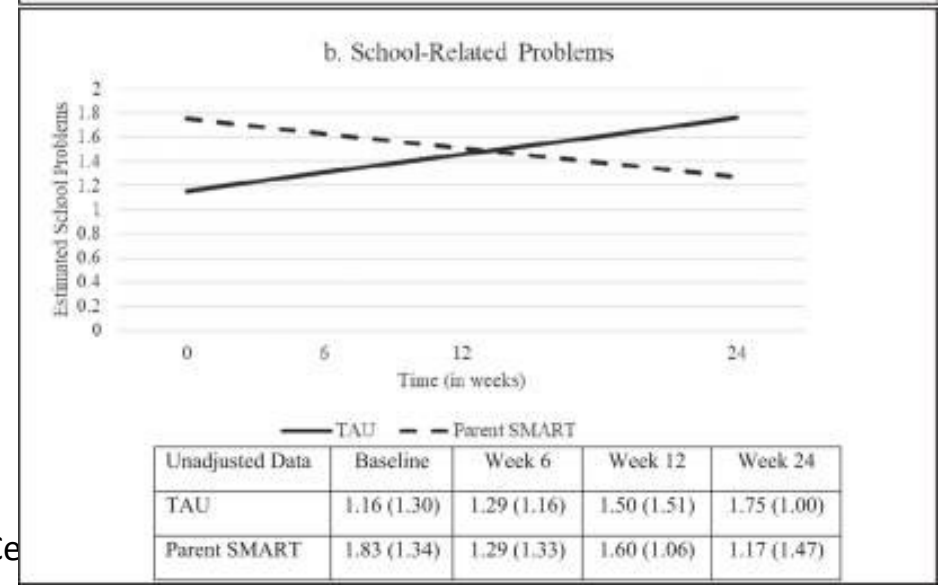
When analyzing results by site, **TWO** significant time*condition effects were found in the short-term facility.

Both **favored Parent SMART**!

- Days drank alcohol
- School-related problems



Unadjusted Data	Baseline	Week 6	Week 12	Week 24
TAU	.07 (.10)	.06 (.12)	.01 (.02)	.03 (.05)
Parent SMART	.12 (.26)	.06 (.12)	.06 (.11)	.02 (.02)



Unadjusted Data	Baseline	Week 6	Week 12	Week 24
TAU	1.16 (1.30)	1.29 (1.16)	1.50 (1.51)	1.75 (1.00)
Parent SMART	1.83 (1.34)	1.29 (1.33)	1.60 (1.06)	1.17 (1.47)

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Becker et al., 2021a

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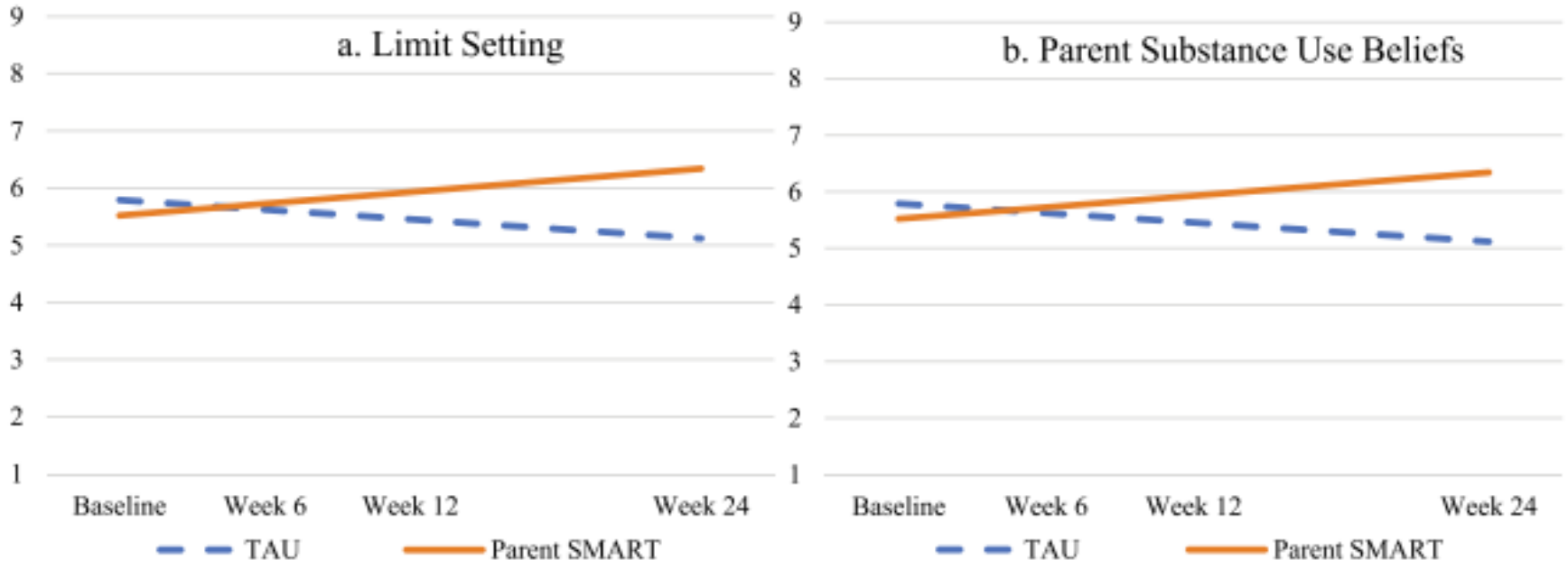
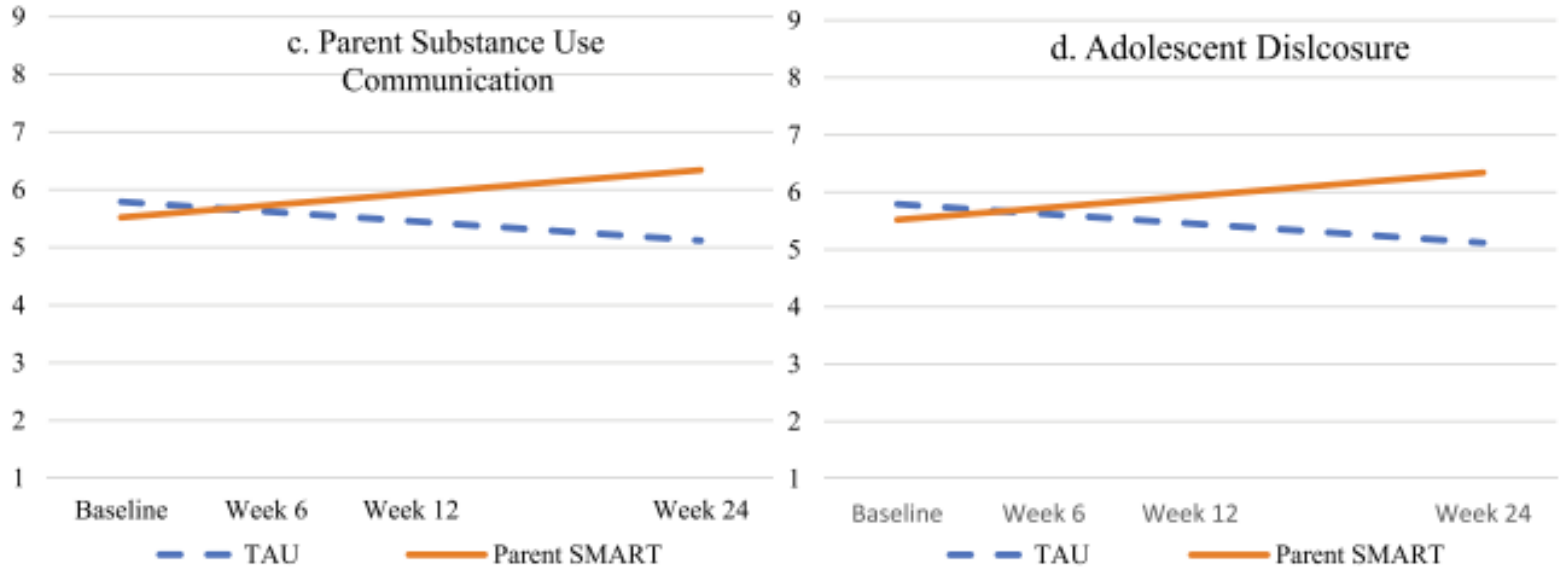
Pilot R34:
PARENT Effectiveness Outcomes (Aim 3)

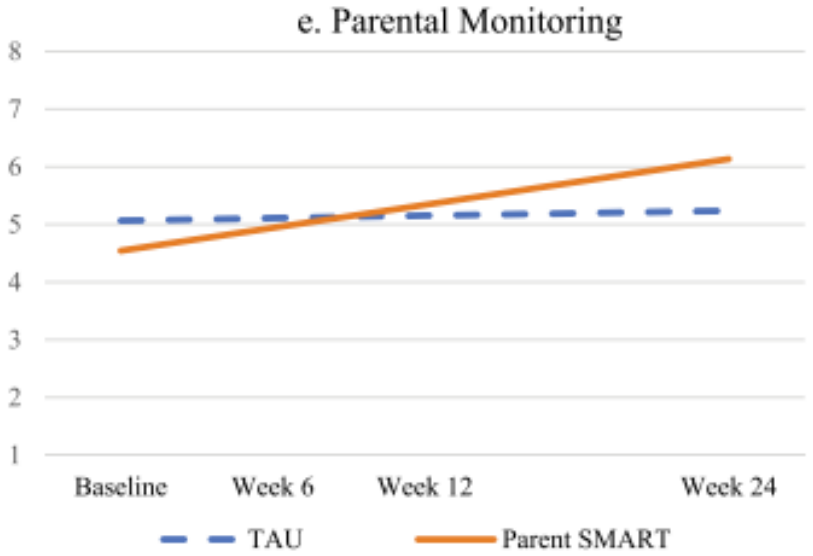
Pooling across sites, there were significant time*condition interactions on all 5 scales of the parent-adolescent interaction task (Family Assessment Task). All interactions **favored Parent SMART**!



Becker et al., 2021b

Pilot R34:
PARENT Effectiveness Outcomes (Aim 3)





Identical pattern was found when analyzing results separately by facility!

Becker et al., 2021b

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What's Next?
R37 Testing Parent SMART in 220 Dyads

Figure 3. Overview of Aims

Proximal Outcomes

Distal Outcomes

Parenting SMART

- Off-the-shelf PW program
- Coaching sessions
- Networking app

Primary Aim 1

Parenting Processes

- Monitoring
- Communication

Exploratory Aim

Adolescent Substance Use

- Self-reported use (overall, binge drinking, marijuana, AOD)
- Substance-related problems
- Urine screens

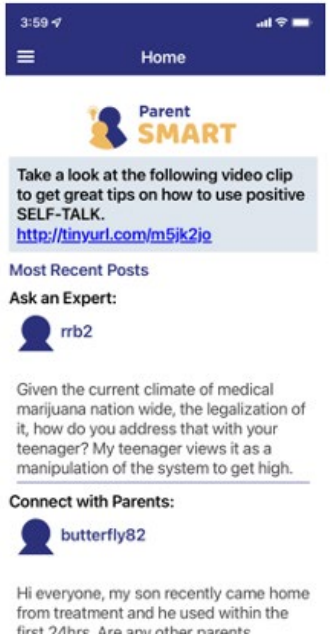
Primary Aim 2

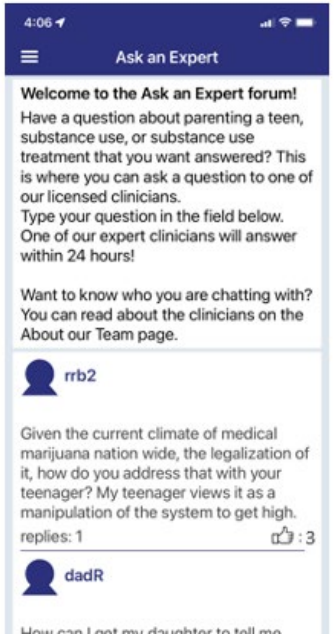
Secondary Aim

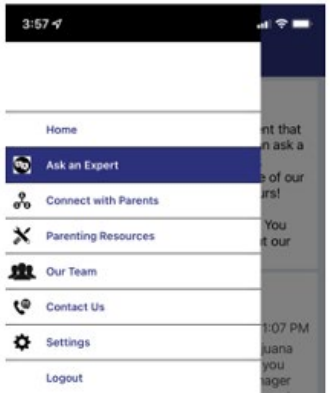
Adolescent Problems

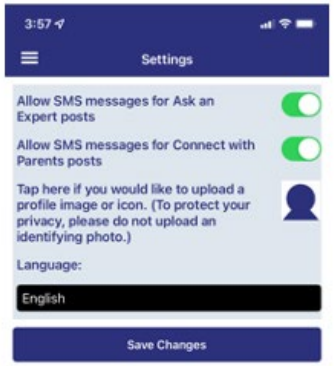
- School problems
- Crime/violent behavior
- Mental health problems
- High risk sexual activity

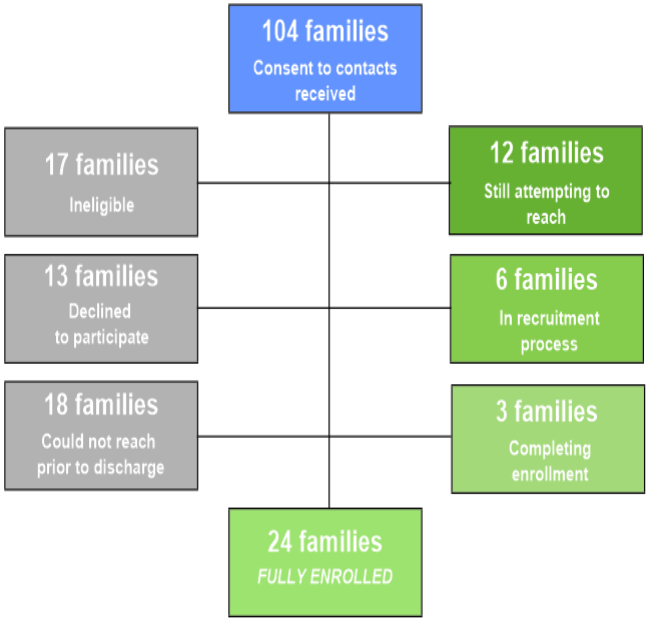
New & Improved Interface! Stay Tuned…



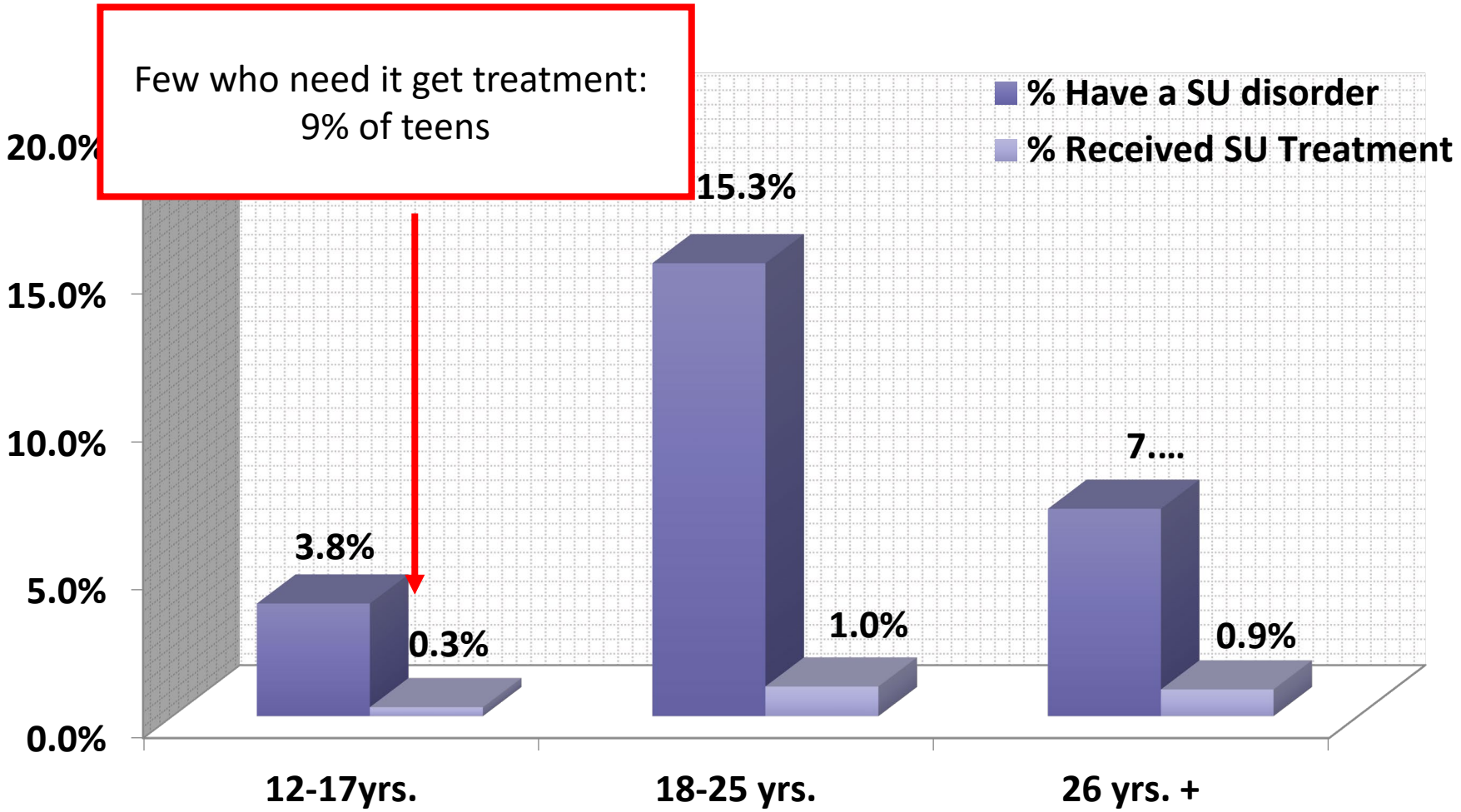








Study 2: Disseminating Effective Treatment



Source: National Survey on Drug Use and Health, 2019.

Primary Reasons for Not Seeking Substance Use Treatment: “Not ready to stop using”, “Didn’t think treatment was needed” and “Didn’t know how to get help”

Push vs. Pull Marketing

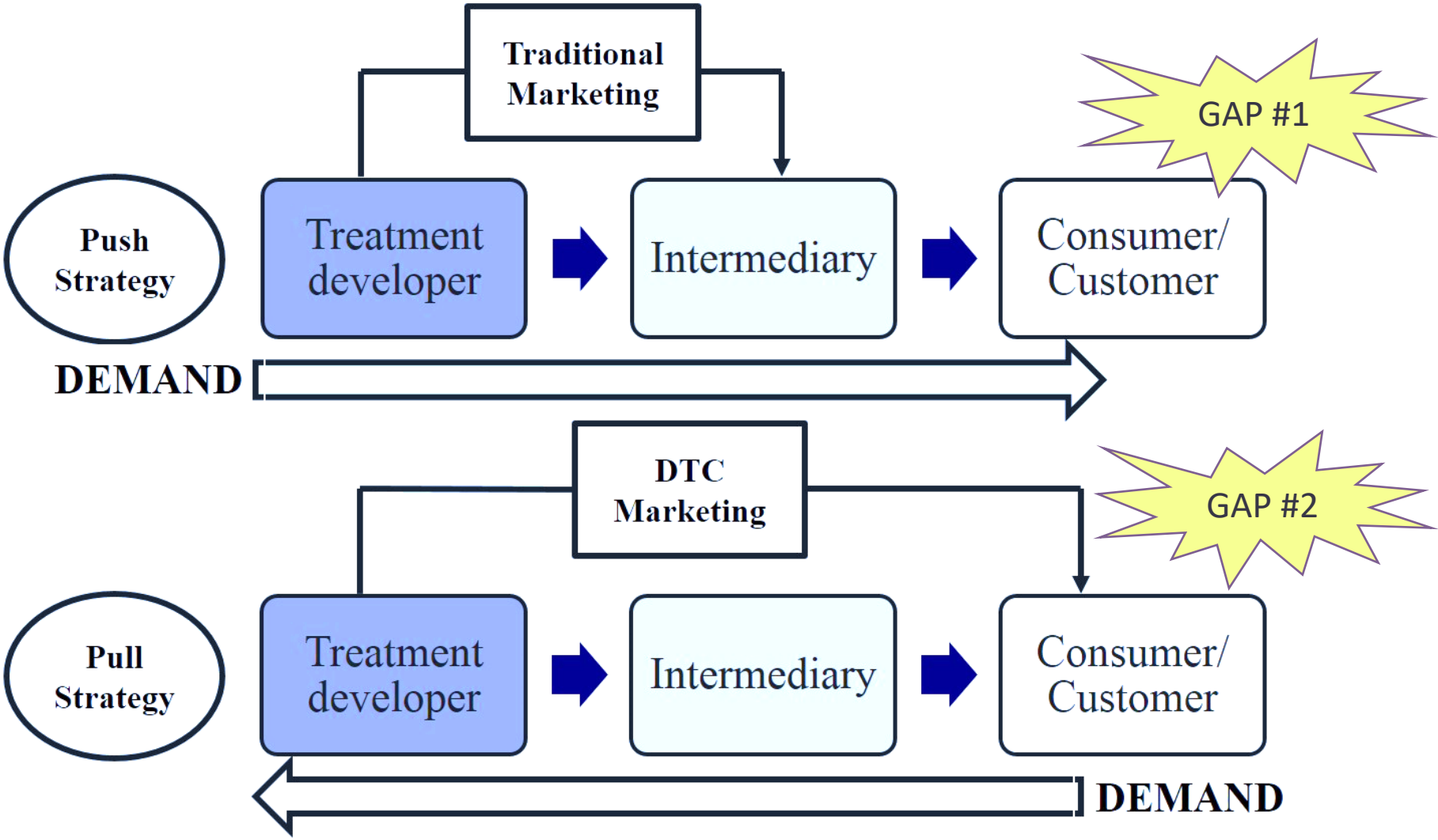
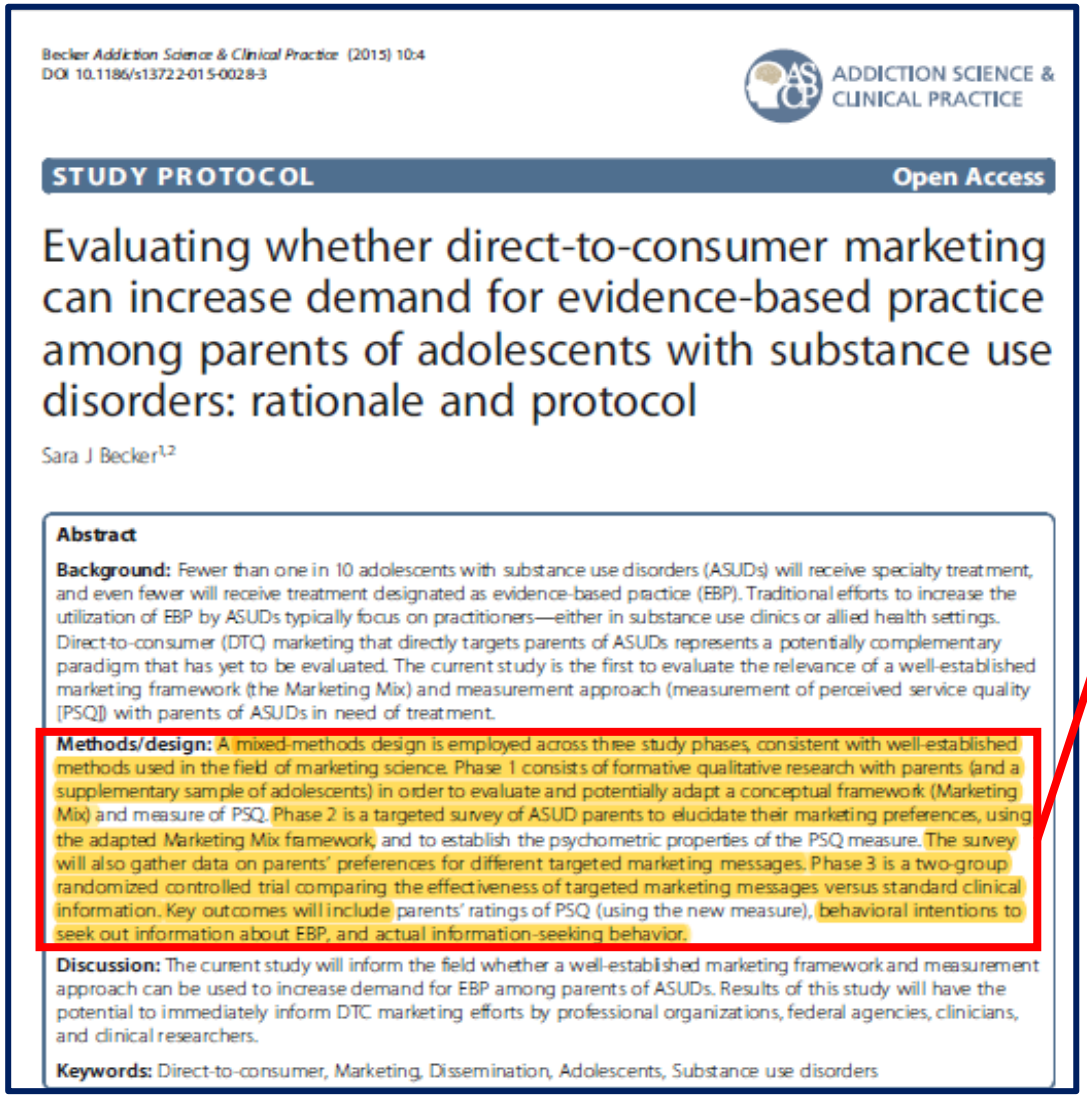


Figure 1. *Becker, 2015, Clinical Psychology: Science and Practice*

Three-Phase Study Protocol



Becker *Addiction Science & Clinical Practice* (2015) 10:4
DOI 10.1186/s13722-015-0028-3

ADDICTION SCIENCE & CLINICAL PRACTICE

STUDY PROTOCOL Open Access

Evaluating whether direct-to-consumer marketing can increase demand for evidence-based practice among parents of adolescents with substance use disorders: rationale and protocol

Sara J Becker[1,2]

Abstract

Background: Fewer than one in 10 adolescents with substance use disorders (ASUDs) will receive specialty treatment, and even fewer will receive treatment designated as evidence-based practice (EBP). Traditional efforts to increase the utilization of EBP by ASUDs typically focus on practitioners—either in substance use clinics or allied health settings. Direct-to-consumer (DTC) marketing that directly targets parents of ASUDs represents a potentially complementary paradigm that has yet to be evaluated. The current study is the first to evaluate the relevance of a well-established marketing framework (the Marketing Mix) and measurement approach (measurement of perceived service quality [PSQ]) with parents of ASUDs in need of treatment.

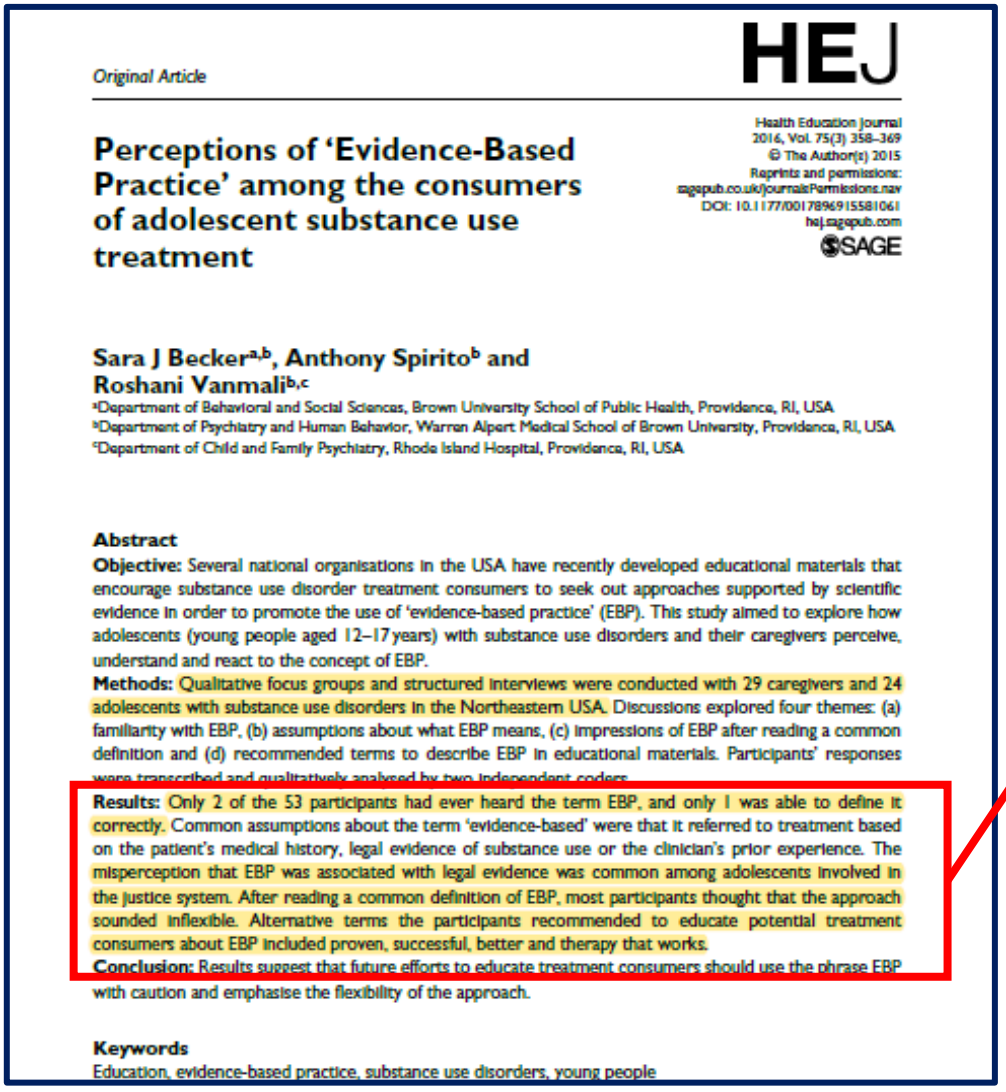
Methods/design: A mixed-methods design is employed across three study phases, consistent with well-established methods used in the field of marketing science. Phase 1 consists of formative qualitative research with parents (and a supplementary sample of adolescents) in order to evaluate and potentially adapt a conceptual framework (Marketing Mix) and measure of PSQ. Phase 2 is a targeted survey of ASUD parents to elucidate their marketing preferences, using the adapted Marketing Mix framework, and to establish the psychometric properties of the PSQ measure. The survey will also gather data on parents' preferences for different targeted marketing messages. Phase 3 is a two-group randomized controlled trial comparing the effectiveness of targeted marketing messages versus standard clinical information. Key outcomes will include parents' ratings of PSQ (using the new measure), behavioral intentions to seek out information about EBP, and actual information-seeking behavior.

Discussion: The current study will inform the field whether a well-established marketing framework and measurement approach can be used to increase demand for EBP among parents of ASUDs. Results of this study will have the potential to immediately inform DTC marketing efforts by professional organizations, federal agencies, clinicians, and clinical researchers.

Keywords: Direct-to-consumer, Marketing, Dissemination, Adolescents, Substance use disorders

"Mixed-methods design… **Phase 1** consists of formative qualitative research… **Phase 2** is a targeted survey… **Phase 3** is a two-group randomized controlled trial comparing the effectiveness of targeted marketing messages versus standard clinical information"

Phase 1: Qualitative Market Research



Original Article

HEJ

Health Education Journal
2016, Vol. 75(3) 358–369

DOI: 10.1177/0017896915581061
hej.sagepub.com
SAGE

Perceptions of 'Evidence-Based Practice' among the consumers of adolescent substance use treatment

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[b]Department of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, Providence, RI, USA
[c]Department of Child and Family Psychiatry, Rhode Island Hospital, Providence, RI, USA

Abstract

Objective: Several national organisations in the USA have recently developed educational materials that encourage substance use disorder treatment consumers to seek out approaches supported by scientific evidence in order to promote the use of 'evidence-based practice' (EBP). This study aimed to explore how adolescents (young people aged 12–17 years) with substance use disorders and their caregivers perceive, understand and react to the concept of EBP.

Methods: Qualitative focus groups and structured interviews were conducted with 29 caregivers and 24 adolescents with substance use disorders in the Northeastern USA. Discussions explored four themes: (a) familiarity with EBP, (b) assumptions about what EBP means, (c) impressions of EBP after reading a common definition and (d) recommended terms to describe EBP in educational materials. Participants' responses were transcribed and qualitatively analysed by two independent coders.

Results: Only 2 of the 53 participants had ever heard the term EBP, and only 1 was able to define it correctly. Common assumptions about the term 'evidence-based' were that it referred to treatment based on the patient's medical history, legal evidence of substance use or the clinician's prior experience. The misperception that EBP was associated with legal evidence was common among adolescents involved in the justice system. After reading a common definition of EBP, most participants thought that the approach sounded inflexible. Alternative terms the participants recommended to educate potential treatment consumers about EBP included proven, successful, better and therapy that works.

Conclusion: Results suggest that future efforts to educate treatment consumers should use the phrase EBP with caution and emphasise the flexibility of the approach.

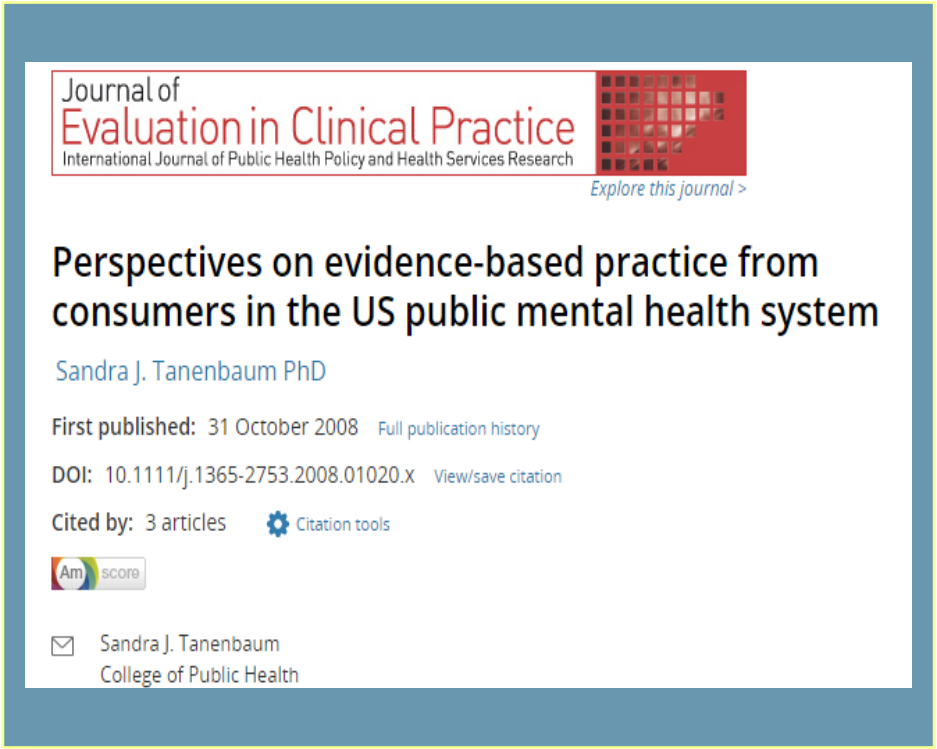
Keywords

Education, evidence-based practice, substance use disorders, young people

"Only 2 of the 53 participants had ever heard the term EBP and only 1 was able to define it correctly… Misperception that **EBP was associated with legal evidence was common**… most participants though the approach **sounded inflexible**. Alternate terms the participants recommended…"

Results Were NOT a Fluke!

1,600 general health consumers



77 mental health patients

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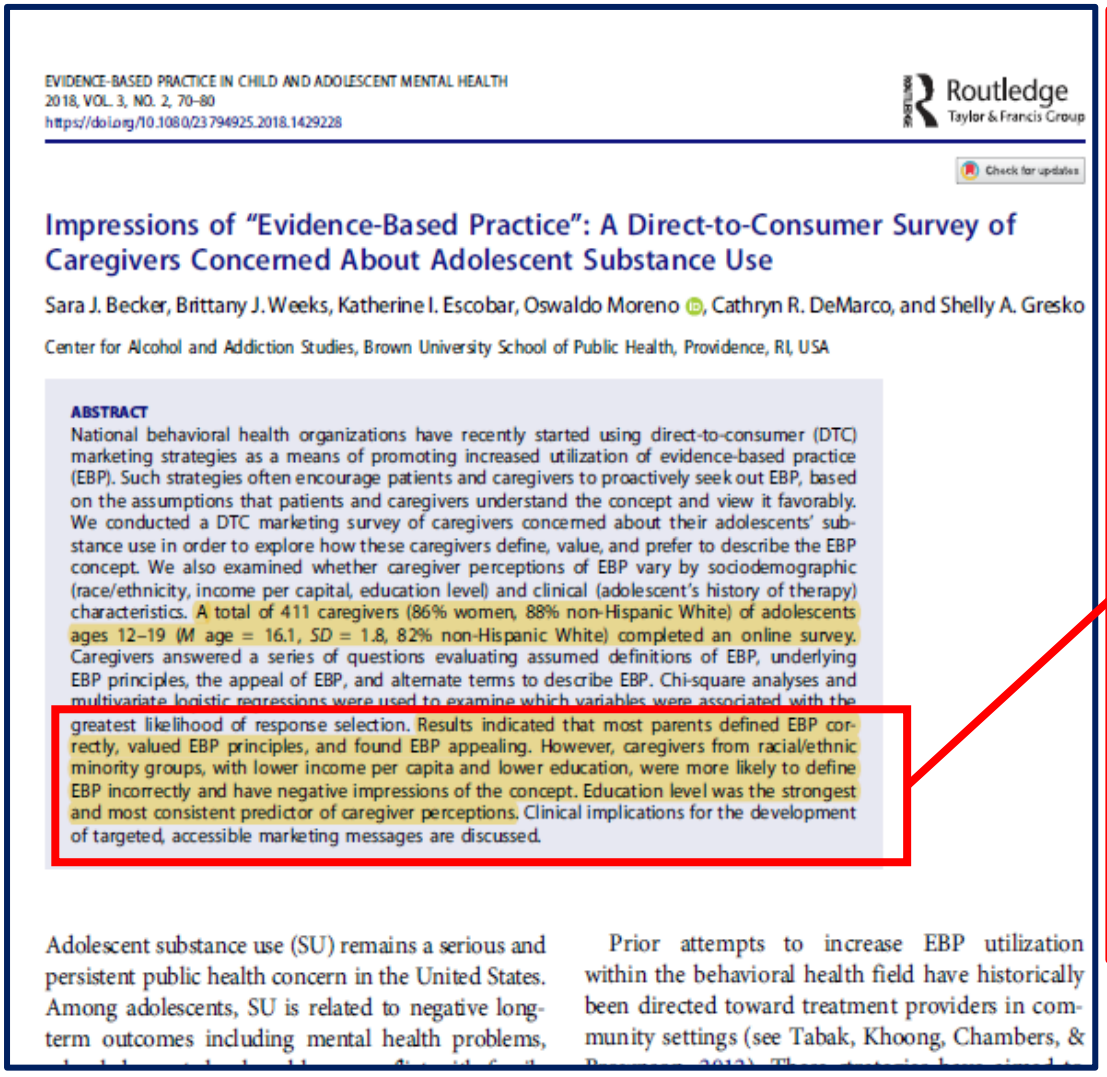
Phase 2: Quantitative Market Research Survey



EVIDENCE-BASED PRACTICE IN CHILD AND ADOLESCENT MENTAL HEALTH
2018, VOL. 3, NO. 2, 70–80
https://doi.org/10.1080/23794925.2018.1429228

Routledge
Taylor & Francis Group

Check for updates

Impressions of "Evidence-Based Practice": A Direct-to-Consumer Survey of Caregivers Concerned About Adolescent Substance Use

Sara J. Becker, Brittany J. Weeks, Katherine I. Escobar, Oswaldo Moreno, Cathryn R. DeMarco, and Shelly A. Gresko

Center for Alcohol and Addiction Studies, Brown University School of Public Health, Providence, RI, USA

ABSTRACT

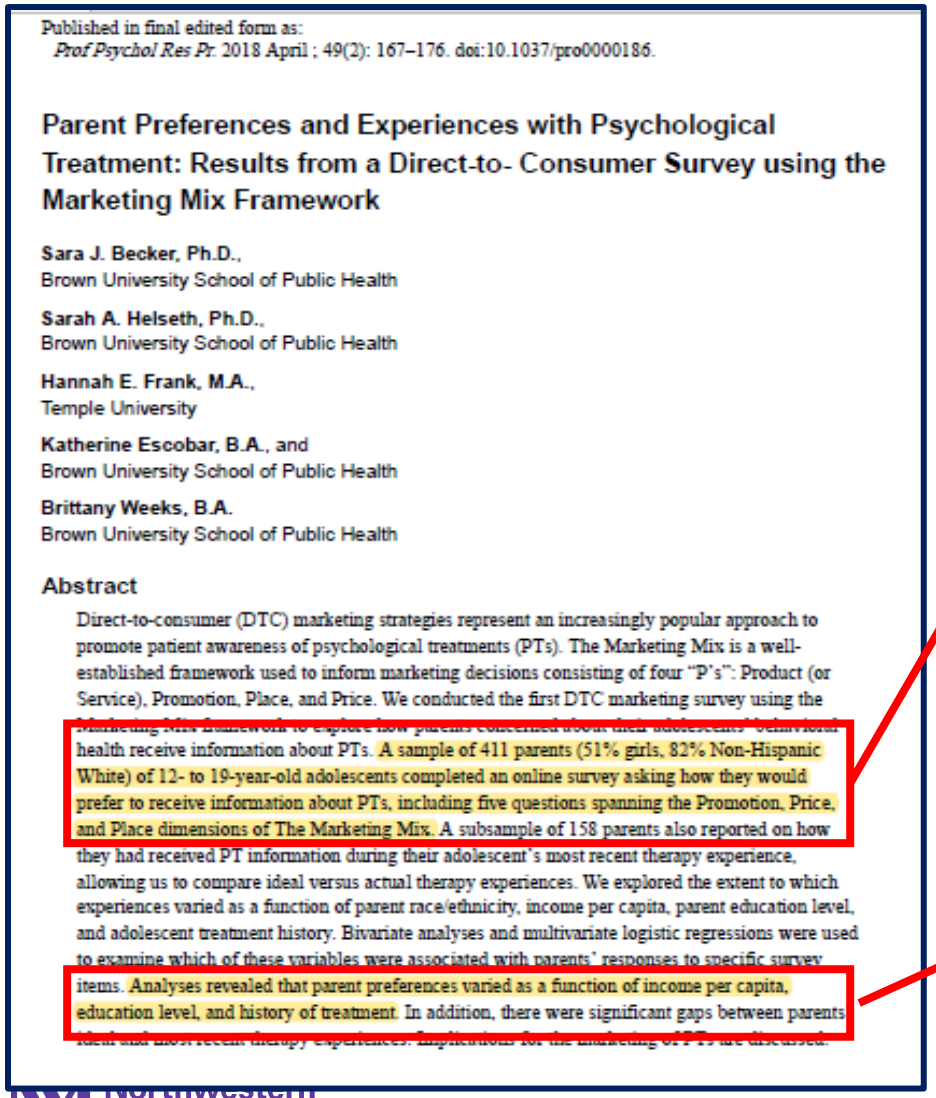
National behavioral health organizations have recently started using direct-to-consumer (DTC) marketing strategies as a means of promoting increased utilization of evidence-based practice (EBP). Such strategies often encourage patients and caregivers to proactively seek out EBP, based on the assumptions that patients and caregivers understand the concept and view it favorably. We conducted a DTC marketing survey of caregivers concerned about their adolescents' substance use in order to explore how these caregivers define, value, and prefer to describe the EBP concept. We also examined whether caregiver perceptions of EBP vary by sociodemographic (race/ethnicity, income per capital, education level) and clinical (adolescent's history of therapy) characteristics. A total of 411 caregivers (86% women, 88% non-Hispanic White) of adolescents ages 12–19 (*M* age = 16.1, *SD* = 1.8, 82% non-Hispanic White) completed an online survey. Caregivers answered a series of questions evaluating assumed definitions of EBP, underlying EBP principles, the appeal of EBP, and alternate terms to describe EBP. Chi-square analyses and multivariate logistic regressions were used to examine which variables were associated with the greatest likelihood of response selection. Results indicated that most parents defined EBP correctly, valued EBP principles, and found EBP appealing. However, caregivers from racial/ethnic minority groups, with lower income per capita and lower education, were more likely to define EBP incorrectly and have negative impressions of the concept. Education level was the strongest and most consistent predictor of caregiver perceptions. Clinical implications for the development of targeted, accessible marketing messages are discussed.

Adolescent substance use (SU) remains a serious and persistent public health concern in the United States. Among adolescents, SU is related to negative long-term outcomes including mental health problems,

Prior attempts to increase EBP utilization within the behavioral health field have historically been directed toward treatment providers in community settings (see Tabak, Khoong, Chambers, &

"Caregivers from racial/ethnic minority groups, with lower income per capita, and lower education, were more likely to define EBP incorrectly and have negative impressions of the concept. **Education**… was the strongest and most consistent predictor of caregiver perceptions."

Phase 2: Quantitative Market Research Survey



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Parent Preferences and Experiences with Psychological Treatment: Results from a Direct-to- Consumer Survey using the Marketing Mix Framework

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Abstract

Direct-to-consumer (DTC) marketing strategies represent an increasingly popular approach to promote patient awareness of psychological treatments (PTs). The Marketing Mix is a well-established framework used to inform marketing decisions consisting of four "P's": Product (or Service), Promotion, Place, and Price. We conducted the first DTC marketing survey using the Marketing Mix framework to explore how parents concerned about their adolescents' behavioral health receive information about PTs. A sample of 411 parents (51% girls, 82% Non-Hispanic White) of 12- to 19-year-old adolescents completed an online survey asking how they would prefer to receive information about PTs, including five questions spanning the Promotion, Price, and Place dimensions of The Marketing Mix. A subsample of 158 parents also reported on how they had received PT information during their adolescent's most recent therapy experience, allowing us to compare ideal versus actual therapy experiences. We explored the extent to which experiences varied as a function of parent race/ethnicity, income per capita, parent education level, and adolescent treatment history. Bivariate analyses and multivariate logistic regressions were used to examine which of these variables were associated with parents' responses to specific survey items. Analyses revealed that parent preferences varied as a function of income per capita, education level, and history of treatment. In addition, there were significant gaps between parents' ideal and most recent therapy experiences. Implications for the marketing of PTs are discussed.

"…five questions spanning the Promotion, Price, and Place dimensions of the Marketing Mix."

"Analyses revealed that parent preferences varied as a function of income per capita, education level, and history of treatment."

Phase 3: Randomized Controlled Trial

SPECIFIC AIMS:

1. Compare user-informed vs standard marketing
2. Assess empirically driven moderators of marketing condition on outcome

OUTCOMES:

1. Behavioral intentions – Behavioral intentions scale
2. Actual behavior – Requests for EBP information

Phase 3 Randomized Trial: Conditions

SUBSTANCE USE IN ADOLESCENTS

By the end of high school, MOST students have used alcohol or other drugs.

ALCOHOL	ILLICIT DRUGS	MARIJUANA
61.2%	48.3%	44.5%

1.8 million adolescents meet criteria for a substance use disorder

BUT,

fewer than **1 in 10** adolescents will be treated.

PROTECTIVE FACTORS

- Strong family bonds
- Parental involvement
- Clear expectations and consequences
- Doing well in school
- Healthy friendships
- Community Connections (school, job, religion, sports)

GOOD NEWS: THERAPY CAN HELP!

Some therapies work better than others.

"Evidence based therapy" is therapy that has been tested and shown to work.

Effective therapy models include:

- **Family Therapy**
- **Cognitive Behavioral Therapy**
- **Motivational Enhancing Therapy**

These models work better than **EDUCATION, TREATMENT AS USUAL,** or **NO TREATMENT AT ALL.**

Every Teen is Different

Ask your doctor which therapy model is best for your teen.

Visit NIDA for Parents for more info!
https://teens.drugabuse.gov/parents

Funded by NIDA K23DA031743. PI: S. Becker

Center

What is Evidence-Based Practice?

When parents/guardians look for mental health treatment for a child or adolescent, it is common to search for a therapist who may have availability in their schedule, affordable fees, or is covered by a specific insurance plan. However, it is also important to ask about the type of treatment that a mental health care provider will offer for their child.

Because not all mental health treatments for young people are equally helpful; some therapies may work better than others.

Mental health care providers (i.e., psychotherapists, such as psychologists, social workers, psychiatrists) use different treatment approaches to help children and adolescents who are experiencing mental health problems. Some treatment approaches have a strong backing in scientific evidence and other treatments have less evidence supporting them. Therapists who use treatments based on science use what is called "evidence-based practice" (EBP), that is their way of doing business is based on using scientific evidence. Similarly, treatments with scientific evidence supporting them are called evidence-based treatments (EBTs).

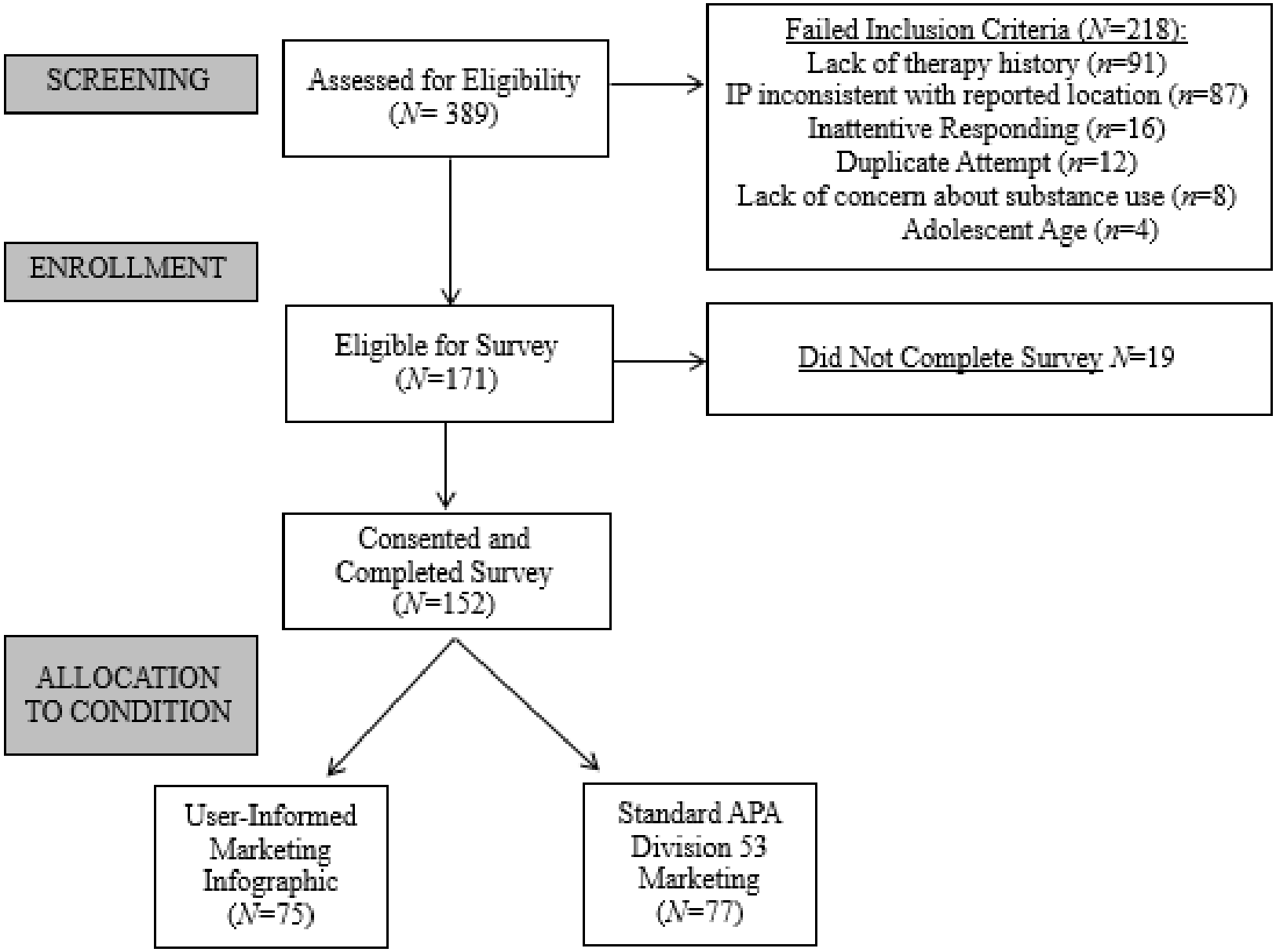
Unfortunately, there is not as much public awareness about EBP and EBTs. As a result, families often do not know to ask whether or not a therapist knows EBTs. Consequently, children and adolescents may remain in long-term psychotherapy for many months or even years without their parents or guardians ever realizing that EBT options are available. **Note that EBTs are listed as 'Best Practice' and 'preferred' approaches for mental health symptom treatment by both the American Psychiatric Association and the American Psychological Association.**

What are EBTs for children and adolescents?

As explained above, EBTs are treatments that are based directly on scientific evidence. In other words, research studies have shown that some treatments work better than others for specific problems that children and adolescents experience. Treatments are compared in large studies called clinical trials that involve dozens of children in each study. These children all have a similar main problem, like depression or delinquent behavior. The researchers randomly assign the children to receive Treatment A or Treatment B (for example). If Treatment A helps children more, then Treatment A gains in stature as a potential EBT. As more studies support Treatment A, its stature grows as an EBT.

In this way, psychologists and other mental health care professionals are dedicated to offering the best level of care available by constantly evaluating and comparing the effects of various treatments for a variety of child and adoloscents mental health problems. In other words, psychologists wish to discover **which treatment is likely to work best for each individual**. While there are many definitions one could use to categorize the level of research support for a psychological treatment, the one utilized by EffectiveChildTherapy.com was adapted from ideas outlined by a group of expert clinical psychologists (Chambless et al., 1998). We use a five level system, where level 1 is the best support, meaning that the treatment has very strong evidence—in other words, it has worked well in many studies. As one example, cognitive-behavioral therapy (CBT) is a level 1 treatment (i.e., "Works Well") for child anxiety. Click here to learn more about how research support is defined and evaluated.

Phase 3 Randomized Trial: Recruitment



Phase 3 Randomized Trial: Sample

	Infographic (n = 75) *M*±*SD or N* (%)	Standard (n = 77) *M*±*SD or N* (%)	*p*
Parent Variables: Socio-Demographics			
Biological Sex (Female)	67 (89.3%)	62 (80.5%)	.130
Age (25-65 Years)	45 ± 7.80	45 ± 7.69	.471
Race/Ethnicity (Non-Hispanic White)	70 (93.3%)	68 (88.3%)	.423
Per Capita Income ($0-		,600	.953
Education (Bachelor's		%)	.079
Adolescent Variables:			
Biological Sex (Female		%)	.415
Age (range 12-19 yrs.)		97	.127
Race/Ethnicity (Non-H		%)	.777
Behavioral Health Prob			
Externalizing		%)	.384
Internalizing		%)	.953
Legal	34 (45.3%)	66 (48.1%)	.737
Substance Use	25 (33.3%)	66 (33.8%)	.955
Process Check Variables			
Correct Definition of EBP	64 (87%)	72 (97%)	.149
Easy to Understand	3.81 ± 1.09	3.88 ± .917	.669
Informative	4.17 ± .844	4.30 ± .817	.340
Clear	3.71 ± 1.21	3.91 ± .873	.247

No significant baseline socio-demographic or clinical differences between conditions

Both conditions found content easy to understand, informative, and clear

Phase 3 Randomized Trial: Results

Logistic Regressions Predicting Self-Reported Behavioral Intentions and Actual Information Seeking about Evidence-Based Practice (n = 152)

	Self-Reported Behavioral Intentions		Actual Information Seeking	
Predictor	***B(SE)***	**Odds Ratio [95% CI]**	***B(SE)***	**Odds Ratio [95% CI]**
Models 1 and 2: Main Effects Only				
Constant	0.69 (0.41)	1.99	-0.89 (0.42)	0.42
Condition	-0.18 (0.35)	0.84 [0.42, 1.60]	0.18 (0.35)	1.20 [0.60, 2.39]
Parent Education	0.23 (0.36)	1.25 [0.61, 2.56]	-0.17 (0.37)	0.84 [0.41, 1.74]
Adolescent Substance Use (SU) Problems	0.25 (0.39)	1.28 [0.60, 2.75]	0.30 (0.39)	1.34 [0.63, 2.86]
Adolescent Legal Problems	-0.31 (0.36)	0.73 [0.36, 1.49]	1.39 (0.36)***	4.02 [1.98, 8.17]

No effect on condition on either study outcome.
One main effect of legal problems on actual behavior.

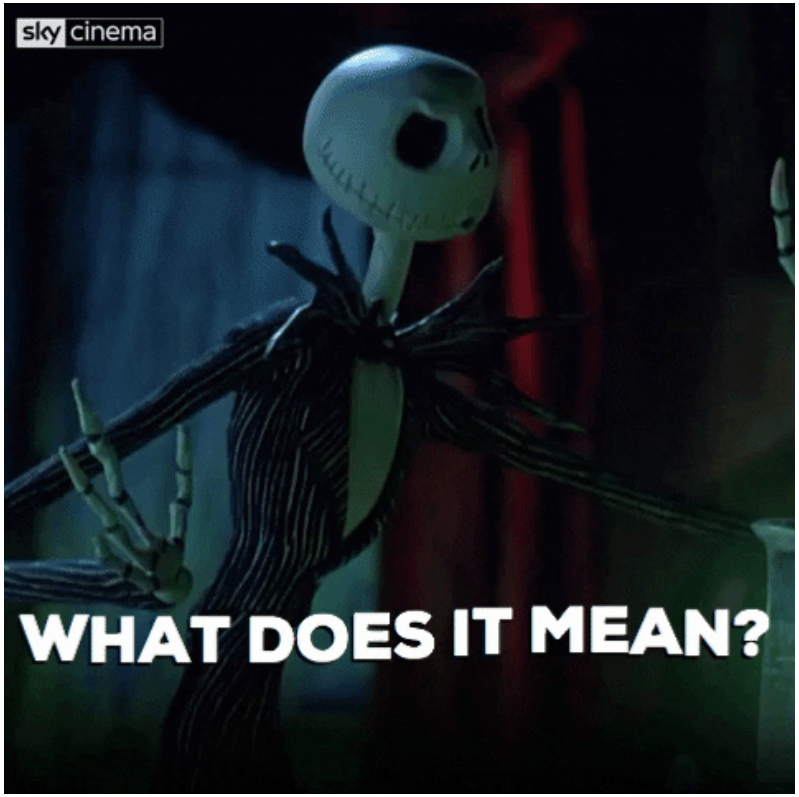
Phase 3 Randomized Trial: Results

Logistic Regressions Predicting Self-Reported Behavioral Intentions and Actual Information Seeking about Evidence-Based Practice (n = 152)

	Self-Reported Behavioral Intentions		Actual Information Seeking	
Predictor	***B(SE)***	**Odds Ratio [95% CI]**	***B(SE)***	**Odds Ratio [95% CI]**
Models 3 and 4: Main Effects and Moderators				
Constant	0.72 (0.56)	2.04	-0.65 (0.55)	0.52
Condition	-0.26 (0.71)	0.77 [0.19 – 3.12]	-0.34 (0.73)	0.71 [0.17 – 3.00]
Parent Education	0.59 (0.55)	1.80 [0.61 – 5.33]	-0.48 (0.56)	0.62 [0.21 – 1.85]
Adolescent Substance Use (SU) Problems	-1.07 (0.60)	0.34 [0.11 – 1.10]	-0.72 (0.66)	0.49 [0.14 – 1.76]
Adolescent Legal Problems	0 .65 (0.64)	1.91 [0.55 – 6.67]†	2.00 (0.62)***	7.37 [2.19 – 24.8]
Condition*Parent Education	-0.72 (0.74)	0.49 [0.11 – 2.07]	0.53 (0.75)	1.69 [0.39 – 7.42]
Condition*Adolescent SU Problems	-0.42 (0.83)	0.66 [0.13 – 3.32]	1.66 (0.84)*	5.28 [1.01 – 27.9]
Condition*Adolescent Legal Problems	1.35 (0.77)	3.87 [0.85 – 17.6]†	-0.77 (0.80)	0.47 [0.10 – 2.22]

Simple Effects: Among those with current SU problems, user-informed marketing → 3.2 higher odds of requesting information

Clinical Implications



Marketing affects information-seeking behavior!

- But only for those targeted
- Specificity matters! (this is a general marketing principle, and well established for drugs)

Parents of adolescents with legal problems responded positively to accurate EBT info in both groups

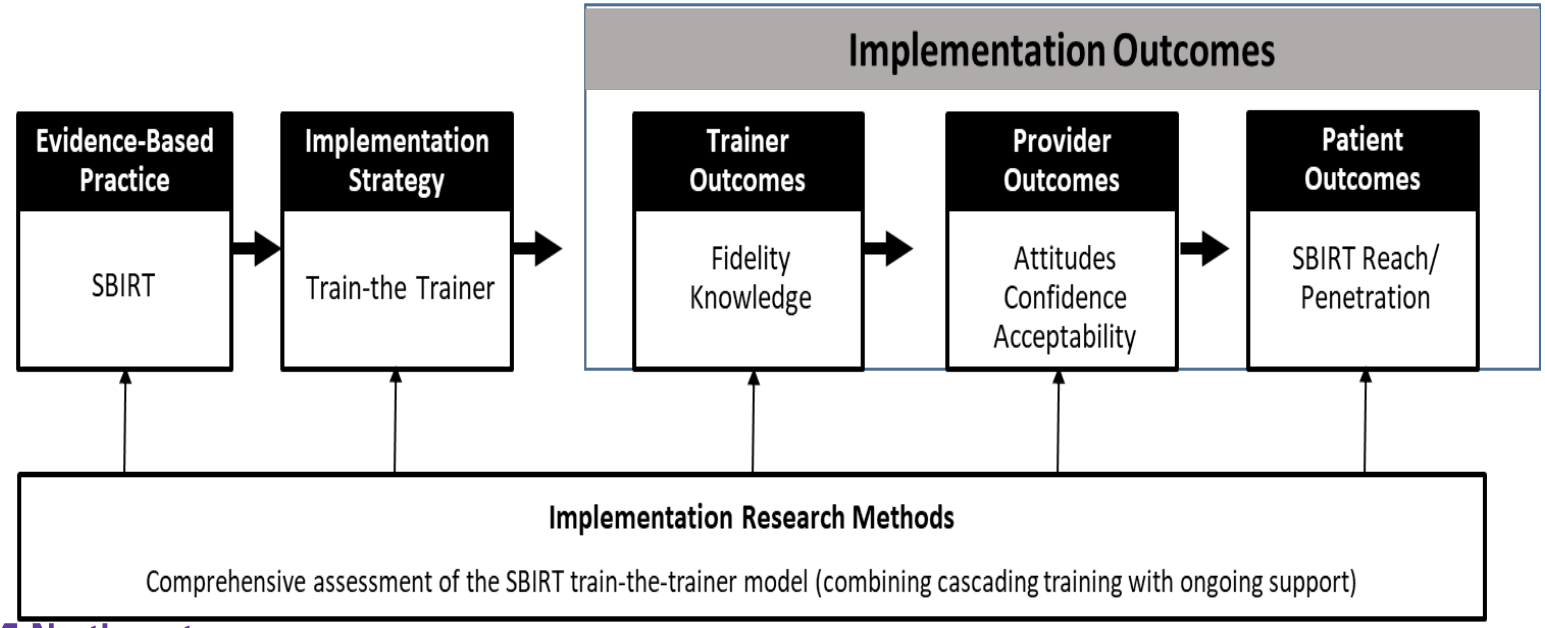
VERY Brief Supply-Side Example: Increasing Screening in Youth HIV Settings in South Africa

Figure 1. Progress Towards 90-90-90 Targets in 2018

Table 1. Needs Assessment Results

Areas of Greatest Training Need	*N* = 67
HIV Prevention	35.0%
HIV Linkage to Care	31.7%
HIV Retention in Care	28.3%
HIV Treatment	18.3%
Alcohol Screening and Prevention	60.0%
Alcohol Treatment	55.0%
Drug Screening/Prevention	70.0%
Drug Treatment	60.0%

Figure 3. Conceptual Model of the Proposed Implementation Research



Progress Thus Far: We are Increasing Supply

11 Master Trainers

August 2021

211 Providers

October 2021-
March 2022

42,693 Patients Screened

October 2021-
September 2022

98.8%

of training elements covered in full during trainings

33.4%

*of patients entering prevention programs received SBIRT**

**as of June 1, 2022*

16x

the number of indicated patients received Brief Intervention

8x

the number of indicated patients received Referral to Treatment

Northwestern Medicine®
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Public Health and Medicine

NIDA-Funded Resource Centers/Networks

The FIRST Network

FIRST Research Network | Family Involvement in Recovery Support & Treatment

Partnership to End Addiction

Mission:

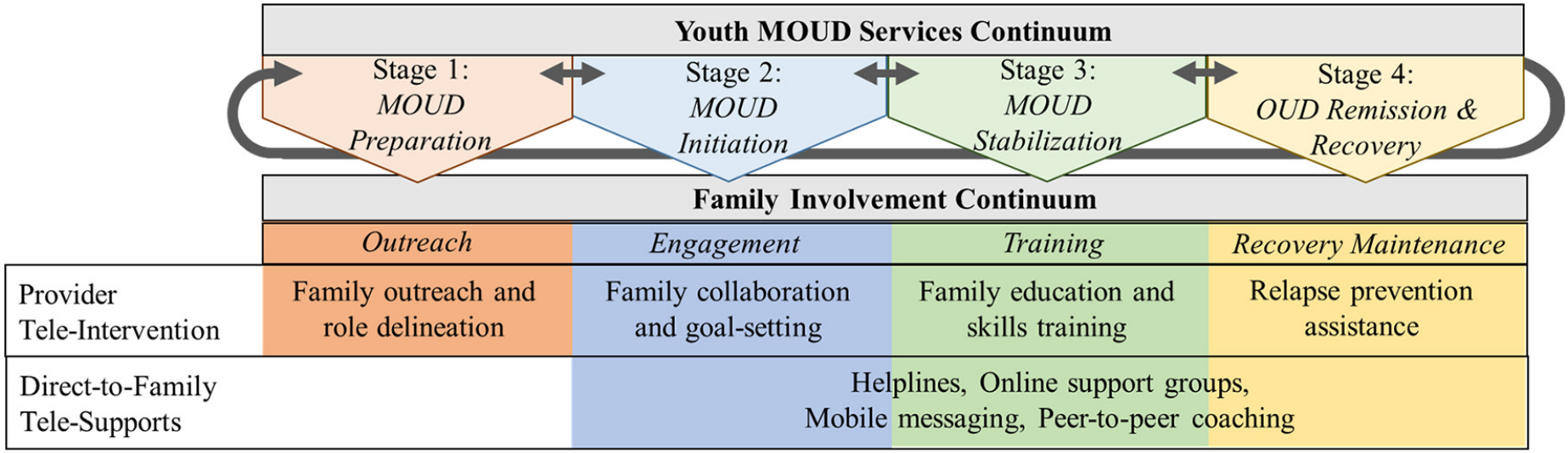
To promote family integration into treatment and recovery support services for youth with substance-related problems

Aim 1: Build infrastructure and sustainability

Aim 2: Develop provider training resources

Aim 3: Develop generalizable direct-to-family resources

Conceptual Model for Family Integration



Provider Training and Direct-to-Family Resources

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https://drugfree.org/first-research-network/

FIRST Scholars

We will fund projects on a rolling basis for $10,000 to $20,000 per award, depending on the scope of work. Priorities include focus on involvement of families and concerned significant others in substance use services for youth ages 13-25. Projects examining opioid use disorders and/or recovery support services are especially welcome.

Request applications

Northwestern Medicine®

Two New (Brand New) Centers

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PREPARE IMPLEMENT SUSTAIN

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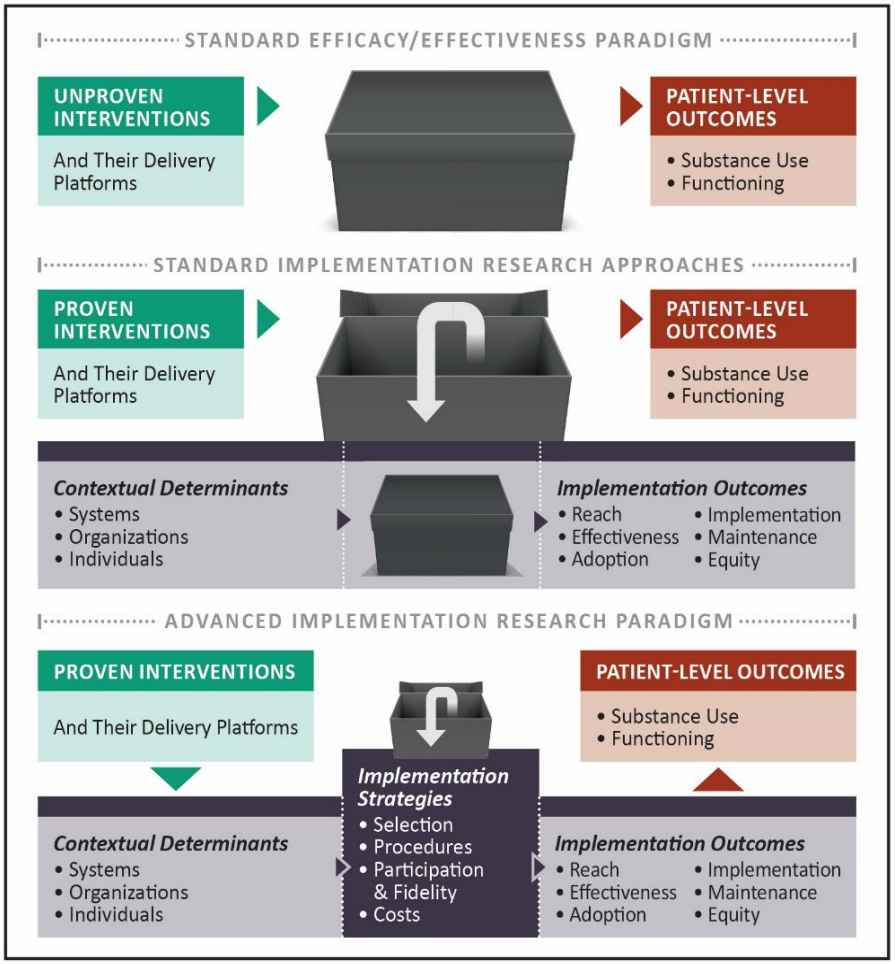

Shameless Plug: A Recent "How To" Guide

Psychol Addict Behav. 2022 Sep;36(6):724-735. doi: 10.1037/adb0000731. Epub 2021 May 3.

You have an effective brief intervention (BI) for young adults, now what? Concrete strategies to advance BI implementation in usual care settings

Sara J Becker [1], Kelli Scott [1], A Rani Elwy [1]

Affiliations + expand

PMID: 33939446 PMCID: PMC8563496 (available on 2023-09-01) DOI: 10.1037/adb0000731

Abstract

Objective: Risky drinking remains high among young adults and is associated with negative health-related consequences. Brief interventions (BIs) are an evidence-based practice for risky drinking that are particularly well suited for young adults. However, the widespread implementation of BIs remains challenging. This article highlights guiding principles for researchers and clinicians seeking to implement BI for young adults. ***Method:*** Five guiding principles for the implementation of BIs for young adults with risky drinking are introduced as follows: (a) selecting an implementation model; (b) considering contextual factors; (c) specifying an implementation strategy; (d) assessing implementation outcomes; and (e) embracing hybrid effectiveness-implementation designs. Advancing health equity is considered a key crosscutting theme. ***Results:*** Multiple implementation models are discussed including process models, determinant frameworks, classic theories, implementation theories, and evaluation frameworks. Contextual factors impacting BI implementation are then considered across multiple levels within an organization. Next, we present methods for selecting implementation strategies and discuss implementation outcomes that can be measured during preimplementation, implementation, and sustainability phases. Finally, we encourage employing hybrid effectiveness-implementation designs to reduce the BI science-practice gap. Guiding principles are illustrated with examples from two National Institute on Alcohol Abuse and Alcoholism-funded studies exploring BI implementation domestically and internationally.
Conclusions: This article introduces foundational principles and emerging strategies to nonspecialist researchers, clinicians, and policymakers seeking to enhance the dissemination and implementation of BIs. Advancing the dissemination and implementation of BIs is essential to ensure that investments in BI research are fully realized to equitably improve public health. (PsycInfo Database Record (c) 2022 APA, all rights reserved).

Acknowledgments

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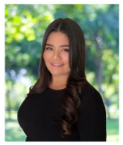

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