What Does It Mean to Become a Certified Evidence Based Practitioner (CEBP) Or, Giving Up Your "Guy-in-a-Diner" Card

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If you get the chance to go to your local family style restaurant and observe, you will notice there is always one table where a few distinguished men of retirement age (a recent accomplishment for me) sit together and visit. Their conversation often turns to politics, social problems, world affairs, and family members worthy of discussion. In other words, they are using their collective experiences, intuition and opinions to solve the problems of the universe. Often, they include science in their conversation, which sounds a bit like this: "And that's proved!" Or, "Everyone knows that." "Scientists have proven that!" "It happened to my cousin!" "I read it in the paper!" All of course are intended to give weight to their observations and ideas. Practitioners most resemble a

guy in a diner when they operate in clinically driven situations from their opinion, intuition or assumptions. Like the guy in a diner, the clinical examination and consideration of deeper issues, and the corresponding approach or intervention, cannot be effectively developed. The end result is that the guy in a diner belief, which is rarely helpful and may contribute to treatment failures, informs the practitioner's future with that person.

Recently, I began working with Medication Assisted Treatment (MAT) programs in Michigan for the purpose of influencing practice. MAT clinics provide Methadone, Suboxone, and Vivitrol to persons with Opioid type of addictions comorbid with Mental Illnesses. They are designed to make use of the increased benefit of providing both medication and treatment in one location to persons with this type of addiction. The research clearly demonstrates that combining medication and counseling (treatment) in one setting to people with both mental illness and substance use disorders is more effective by far than either one alone.

The source guidelines call for the use of the medications and counseling using strength-based strategies and motivational interventions. The degree to which actual service delivery includes strength-based strategies and motivational interventions is far from the standard that we hope to achieve over time. Yet the sense of moving in the right direction exists. In fact, I used the Video Assessment of Simulated Encounters – Revised (VASE-R) to determine the degree to which staff (including nurses and counselors) show competency with Motivational Interviewing, and about a third scored high enough to be consider competent or approaching competence. Another third had some knowledge of the method, and the final third showed the need for some basic training.

For MAT clinics, the challenges and pressures of providing the medication (often called "dosing"), as well as the strong influence of the DEA rules for participation and handling of Methadone, create a supervised probation type of activity with a strong focus on "compliance," suspicion, rule violations, consequences and even punishment. Interestingly, the research on these practitioner tactics for people in treatment for alcohol use disorders has demonstrated that they are as effective as "no treatment" at all. Yet, we continue to approach treatment for substance use disorders with a "tough love" approach, and the person with the disorder as someone who is expected to manipulate, violate rules and resist treatment.

The Tough Love approach is in fact a method that had as its practice functions mandating abstinence, confronting denial and resistance, with no enabling behaviors on the part of the practitioner, and requiring proof of abstinence through drug screens, etc. During the tough love "era," people who made multiple attempts at treatment achieved durable periods of abstinence after 3 to 5 years. Interestingly, people who got into trouble and tried to quit on their own repeatedly achieved durable abstinence in…. (Yup!) 3 to 5 years.

Practitioners who become intuitively reactive to resistant behaviors, and respond in ways they think will extinguish them, are practicing from their guy-in-a-diner

platform. We logically and intuitively see resistance in treatment as a barrier to wellness and progress, which provokes a feeling of frustration in the practitioner. That response results in an intuitive judgment about the behavior, which is assigned to the person's character. Most people would understand this as labeling. Once labeled, the practitioner's approach to the person is influenced by it, and the "tool for change" is weakened. Most modern evidence-based practitioners will recognize the "tool for change" as the assistive collaborative relationship that is always the first focus of any helping strategy. Without this tool for change, the person in care cannot fully level with disclosures, so the practitioner cannot truly help with deeper issues motivating behaviors.

To be considered an "evidence-based practitioner", one has to be able to practice *from evidence*. Practice from evidence is "intentional" rather than intuitive. It's not that there is resistance, it's "what is the reason for the resistance." We see the resistance but avoid the intuitive response with its deficit-based characteristics, including labeling of any kind. The evidence-based practitioner seeks to know how the resistant behavior makes sense to the person displaying it. In this way, we avoid judging and label to reduce frustration and instead create an opportunity for strengthening the tool for change in an effort to assist the person in overcoming the reason for it. It takes practice.

So how does the practitioner shift from techniques that are intuitive to intentional, so that they can throw away their "Guy-in-a-diner" card? A few steps would seem fundamental. Don't judge, don't label, don't share "ain't it awful" stories about the person with other staff, all would be a good start. Instead, slow down, facilitate the kind of discussion that will allow the person to discover, and describe the reason for the behavior.

Example:

Derek came one day early to pick up his "take-home" methadone for 10 days. He had asked if he could come a day early in order to save on the stress of a transportation issue and was told he could. However, he was told not to take his medication until he got to the clinic. When he stepped up to the dosing window the supervising nurse noticed it had already been opened. She told him to stop but he downed the remaining Methadone and handed her the empty container. The nurse immediately told him he violated the DEA rules for dosing and told him he could not take his medication at home any longer.

Derek got angry and began shouting and using vulgar language throughout the building. Later he called to apologize and the Clinical Case Manager who took the call accepted it. Still, he was told he could not dose at home at this time. He blew up again and she hung up on him. He drives 90 minutes round trip to pick up his daily doses and was angry about having to do so. He explained that he was following his usual morning routine, which includes taking his methadone in the morning. When he realized that he was supposed to wait until he got to the clinic he stopped and saved the rest to take at the clinic. He anticipated that he would be in trouble, so he tried to down the medication

as quickly as possible hoping to get by. The nurses believed that he had diverted a half dose and was lying.

The nurses had had other experiences with Derek in which he lost his temper and ended up getting his way. They felt unsupported and not included in decisions about Derek's treatment. Of course, when they told him they were revoking the "take home" privilege because he didn't follow the request, Derek's counselor was angry with them for making this decision without involving her. Derek is divided from the nursing staff, who are divided from the clinical staff, who now have challenges to address with Derek. The nurses see this as a type of "consequence" that will impact Derek's behavior. A type of punishment that meets the "guy-in-a-diner" philosophy for handing behavior problems. Intuitive and not well thought out. They were also discussing him in meetings and including pejorative remarks that were critical and even ridiculing, evoking an increased defensiveness from the clinical staff.

Derek involved the state employee managing the MAT clinic program who interceded and worked with the clinical staff to resolve the situation and return the "take home" privileges to Derek. Of course, this was done without input from the nurses who were surprised when he showed up to pick up his take homes. More resentment toward the clinical staff, not only for leaving them out, but for over-riding their decision and for not even telling them his privileges were reinstated. One of the nurses thought he was just being enabled by the clinical staff (remember tough love?) and when it was said that punishment does not truly "change" a behavior, she replied that she had seen it work.

At this point a consultant (yours truly) was asked to step in and work with the staff to begin developing a method of practice that could replace the "tough-love." In order to promote an "intentional" approach, we chose the examination (as in seeking evidence) of the nurse's comment: "I've seen it work!"

To do this we analyzed the meaning in this context of "work." To her it meant to stop him from breaking rules and stop him from yelling obscenities at them when he was angry. Pretty quickly this definition and technique fell by the way side because the nursing staff described him as having done this several times in the past, resulting in consequences. The theory that punishments worked was pretty much discounted by their own descriptions of past behaviors and consequences. Interestingly, the staff were able to make distinctions between behaving with resentment to avoid being harmed by someone who can cause problems for you, versus working with someone who helps you examine your behaviors and make changes because they matter to a personal set of values and desires. "He's not changing because you can punish him. He's changing because he cares about his behavior."

Co-occurring Treatment

The next step was to factor in diagnosis to see if a clue to the behavior (reason for resistance) might be found there. It was immediately revealing that he had his opioid dependence diagnosis and one for a comorbid Bi-Polar Disorder. This sparked a discussion to consider how much of his behavior was "symptomatology" rather than pejorative. If it was a bi-polar symptom then what kind of evidence is there for that and

what would the triggers be? From there, what would a clinical approach be beginning with the request to pick his "takes homes" up early, and then for each step of the way to the point where his privileges were given back.

One of the first steps was to look at past episode of explosive verbal reactions as "evidence" of a pattern that can be addressed differently. Interventions for treatment of the bi-polar disorder were discussed, as was therapy to help the team and Derek understand how explosions are triggered and develop strategies for discussing problems differently, including reviewing the program activities, rules, and participation, plus developing an understanding of each one in a way that takes care of him rather than tries to control him. Also, discussing with practitioners how the program staff can assist him in managing situations more collaboratively. Even role-playing possible problems. This became the staff answer to "co-occurring treatment" that is actually intended to be part of Derek's treatment.

Strength-based

It was decided that using the rules as leverage was not anything that would resemble "strength-based." At first the staff struggled even to define strength-based. Most initial definitions wobbled around something like, "help them find and use their strengths". With more facilitation staff began to see that "strength-based" has more than that one dimension. It includes the approach of the practitioner and has elements like:

Do I see this person as worthwhile?

Is my role one of dominating and controlling or assisting and supporting?

Do I want the active role and push the person to the passive role, or do I trust this person to be in the active role versus the passive role?

If I take the assistive/collaborative role, will I really be helping?

Do I need total cooperation or is there room for patience and compassion?

Do I need to confront resistance, or can I slow down and see if there is a reason for the resistance that makes sense and that I can help with?

By dissecting this incident, staff were able to identify several options for every situation that had a chance of "working."

Discoveries:

We were punishing him for having bi-polar symptoms that we may have triggered.

We didn't have to make a decision at the dosing window when we discovered he had taken half his dose. We could have let him know that we needed some time with him and the counselor to make sure we were doing everything necessary to help have a successful outcome for his recovery.

Decisions should be made with the inclusion of everyone on the team. Nurses and practitioners can work together, with the person, so that a consensus on how to handle the situation can be arrived at.

If handled as collaborative partners, the person may have been able to discuss diversion of the first dose, if that is what happened. No way to do this if he is made to be defensive because of premature focus on consequences and fear of being expelled as punishment.

Summary:

The way to give up your guy-in-a diner card and become a card carrying CEBP is to avoid reacting. Take time to analyze and determine all of the factors that occur when people have behaviors influenced by symptoms and conditions. Shift the focus from resistance to the reason for the resistance and try to help with that. Don't be a guy in a diner!