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Center for Evidence-Based Practice

Evidence-Based Happenings

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What's this Clinical Outcome Stuff?

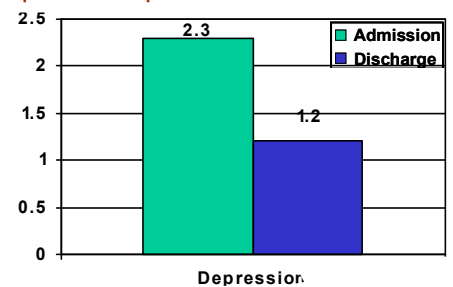
One of the main functions of the Center is to collect and evaluate Clinical Outcomes at ABBHH.

What are Clinical Outcomes? *Clinical outcomes* are changes in our patients after receiving treatment. Did symptoms get better? Is their life better? At ABBHH, we always try to find out if a patient's symptoms have improved, if their quality of life has improved, and if they are less impaired or disabled after treatment.

How Do We Get Clinical Outcomes? We get clinical outcomes from patients who complete *Outcomes Measures* at admission and discharge. Some programs (Adult PHP, SIRS) also collect outcomes on a weekly basis. Sohail, the Project Coordinator, collects, scans, and processes these outcome measures.

What is done with the Clinical Outcomes? After processing the outcome measures, Sohail runs statistical programs to calculate the results of the outcome measures. He then creates an *Interpretative Report* and sends it back to the program staff. This report interprets the patient's responses so that they are clinically useful. For example, in Chemical Dependency, the report tells staff about a patient's level of psychological flexibility and craving for alcohol or drugs. This information is used to individualize and plan treatment. The Center also produces quarterly and yearly reports of clinical outcomes. The reports help with program development, business development, and answer questions staff have. For example, this graph answers the question of how much depression im-

proved for patients in Adult PHP:



As you can see, the answer is, "a lot!" The Adult PHP program has a large effect on depression (Effect Size = 1.21). In fact, the Adult PHP programs reduces depressive symptoms, an average, better than the average outpatient program in the country, despite having patients entering the program with higher levels of depression. Indeed, the improvement is statistically and clinically significant (more on that later!) Questions? Ask Jason or Sohail!

Non-Suicidal Self-Injury in Males

ABBHH will be a key partner in the first ever study specifically looking at Non-Suicidal Self-Injury (NSI) in males. Even though males make up more than 11% of patients with NSI, very little is known about them. In partnership with the Dr. Muehlenkamp from the University of Wisconsin Eau Claire, and Dr. Lofthouse at Ohio State University, the Center obtained

a \$24,000 grant to collect information about NSI in males. Working with the SIRS Program, including Drs. Aldridge, Gebhardt, Juzwin, and Styer, we will recruit up to 100 male and female patients at ABBHH to participate in the study. We are also working with Diane Haas and Steve Hunter to recruit a local high school to collect data from students in the com-

munity. By collecting both clinical and community data from males and females, we will be able to make multiple comparisons that have never been made before. We hope to better understand what NSI looks like in males, as well as develop ideas for better treatment for males. We also hope this project leads to a larger study funded by the National Institute of Health.



Keep a Look Out!!

Sohail and our undergraduate intern from NIU, Sarah Hotopp, are putting together a Quiz about the Center for Evidence-Based Practice. If you complete the Quiz and get all the answers correct, you will be put in a lottery to win a gift certificate to P.F. Chang's Restaurant!!

Managing Money to Help Substance Abuse?

Substance abuse is a costly disease; it can literally rob patients of the money they need to pay bills. A recent study examined the efficacy of a money management program on substance abusers as part of their overall treatment.

The research team implemented the use of the ATM (advisor-teller money manager) intervention on a population of 184 veterans being treated for substance abuse. The ATM intervention consisted of trained staff members who acted as money managers and stored patients' money, trained them to manage their money, and made sure their spending fit with their treatment goals.

Patients who participated in the ATM intervention had lower scores on the Addiction Severity Index after treatment than those patients who did not participate in the ATM intervention. Even though participation was involuntary at the beginning of treatment, those who stuck with the treatment found it to be beneficial in helping them manage their personal finances.

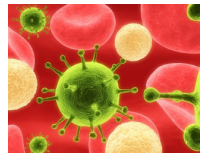
Rosen, et al., (2009). *Psychiatric Services*, 60(4), 498-504.



Detecting Metabolic Syndrome & Infectious Disease

A recent study found Psychiatric treatment teams missed 95% of cases of Hepatitis B, 50% of Hepatitis C, 21% of HIV cases, 89% of cases of elevated total cholesterol, and 97% of cases of elevated triglyceride levels. Not only does this study show a high level of infectious disease and metabolic syndrome in psychiatric inpatients, but it also shows they are usually missed!

Rothbard, et al. (2009). *Psychiatric Services*, 60(1), 534-537.



Assessing the obsessions and compulsions in Eating Disorders

Eating disorder behavior can often take on an obsessive-compulsive quality. The Yale-Brown Cornell Eating Disorder Scale (YBC-EDS) was developed to assess the severity of eating-disorder preoccupations and rituals. This study supports the YBC-EDS as an assessment of eating disorder-related preoccupations and rituals, as well as depressive and anxiety symptoms.

Jordan et al. (2009). *Int. J. of Eating Disorders*, 42(3), 267-274

Increased Self-Harm When First Treating Complex Depression

Recent warnings from the FDA suggest that antidepressants may increase risk for suicide in some child and adolescent patients. What is not known, however, is what predicts such events. A recent study examined event predictors for suicide in a population of adolescents who had not responded to Selective Serotonin Reuptake Inhibitors (SSRIs). Patients consisted of 335 adolescents who met criteria for major depressive disorder. Patients were randomly assigned to one of four groups: 1) Change to another SSRI; 2) Change to Venlafaxine; 3) Change to another SSRI plus Cognitive Behavioral Therapy (CBT); and 4) Change to Venlafaxine plus CBT.

Results show a total of 108 incidents of self-harm events in 68 patients. Of these, 48 participants displayed suicidal behavior, and 17 made suicide attempts. Patients treated with Venlafaxine were more likely to experience a self-harm event (37.2%) than those treated with an SSRI (23.3%). Benzodiazepines (anti-anxiety medications) increased risk for suicide attempts and non-suicidal self-injury. Patients on Benzodiazepines also more quickly became suicidal than those on other medications.

With regard to predicting self-harm events, systematic assessments were better at predicting events than spontaneous reports. Specifically, a high level of suicidal ideation and depression, self-reported family conflict, and drug or alcohol use at baseline were the best predictors of self-harm events. This finding suggests the importance of targeting these domains early in treatment and monitoring these domains throughout treatment.

Brent, D. A., et al. (2009). *American Journal of Psychiatry*, 166(4), 418-426.

