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## When we become the barriers to progress

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At first, it all seems so easy. The large institution or agency decides they are going to get serious about professional development and quality improvement. “I’ve done some research on evidence-based practices and have concluded that we need to implement the Forensic Version of the XYZ-PSB model. It has all the qualities that we’re looking for, combining elements of all the popular models that are available, and even has some mindfulness. The fact that there are some deep breathing exercises at the start of some sessions qualifies it as a biopsychosocial approach.”

We’re kidding, of course. It often seems to us that the latest/greatest models make the largest promises until the implementation effort begins. The history of psychotherapy is certainly replete with examples of fad treatments, each one appearing to be bigger, better, faster, or just plain more. Many a well-intended agency and director (including the first author, David) have sought training in a particular method because it had worked in some other setting or been proven in a study or two, only to find out that the old adage is true: All too often what is new is not what makes a treatment approach effective. At the same time, what makes the same treatment effective is not new.

The above example of the fictitious XYZ-PSB: FV is ironic because there is a chance that it will work if implemented with diligence, confidence, and a shared belief between therapists and clients that it will work (Wampold & Imel, 2015). In other words, the belief that something will work very often contributes to its success. This is one reason why we have science: to understand not only what works, but how and in what ways.

The rest of the picture may not be so pleasant, however. The unfortunate reality at the front lines, often not reported in research, is that there are any number of ways that good treatment can go bad under the wrong conditions. Let’s take the above director’s plan for implementing XYZ-PSB: FV. Even



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*We are longtime members of ATSA dedicated to furthering the causes of evidenced-based practice, understanding, and prevention in the field of sexual abuse.*

*The Association for the Treatment of Sexual Abusers is an international, multi-disciplinary organization dedicated to preventing sexual abuse. Through research, education, and shared learning ATSA promotes evidence based practice, public policy, and community strategies that lead to the effective assessment, treatment, and management of individuals who have sexually abused or are risk to abuse.*

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before implementation, what kinds of exploration of the agency's needs and staff attitudes takes place? Are the staff excited for the opportunity or feeling beleaguered that they are having to learn yet another approach at high risk of passing into history like the others?

Other questions follow. Will the director participate in the training? The absence of key decision-makers from the process itself can have a significant effect on staff, even though it is not mentioned in any manuals. Likewise, does the agency or institution bring in an outside trainer who trains, perhaps does some consult calls, and leaves without a succession plan? Some way to keep the spirit and practice of the treatment alive? And then during the initial phases of this implementation, what other barriers occur, such as the director getting a new job, or another influential actor going out on medical leave?

Of course, the picture can become even more pernicious. Are there other challenges competing with the meaningful implementation of a high-quality approach? For example, many agencies experience severe pressure to ensure complete adherence to complicated licensing requirements or accreditation. At what point is the search for excellence – that burning desire to become more effective – compromised by the need to ensure timely documentation? Does adherence to regulations end up compromising adherence to a new model? Do we then expend so much effort pursuing fidelity to the model that we then forget to maintain fidelity to the actual client and his or her individual characteristics?

These are questions too often omitted from any manual or introductory training, but they threaten treatment integrity nonetheless. This is why collaboration between researchers, trainers and professionals is so important in the creation of evidence-based practice that is fit for purpose in the real world (see another blog by Kieran on the importance of co-creation). One of the sadder outcomes of implementation efforts, in our view, is when professionals work treatment jargon into case notes as a signal to auditors and licensors that they were using a model when in fact they really weren't.

We (David and Kieran, along with our collaborator Danielle Harris) have argued in our training, and in a recent paper, that we can learn a lot about improving services by listening to the voices of the service user. Yet, most treatment providers work in environments where the same service user has little or no voice in their treatment planning.

Our hope is that by raising these questions we may better inspire dialog among professionals, researchers, and trainers as to how we might better anchor our practice in the evidence. All too often the enemy to successful implementation is ourselves.