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Perceptions of ‘Evidence-Based Practice’ among the Consumers of Adolescent Substance Use Treatment

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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 age 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 two of the 53 participants had ever heard the term EBP, and only one 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.

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

Keywords

evidence-based practice; education; substance use disorders; young people

Substance use among young people remains a significant and persistent problem in the USA. According to data from the most recent US National Survey on Drug Use and Health (NSDUH), 12.9% of adolescents between aged between 12 and 17 years (approximately 3.2 million youth) reported using alcohol and 9.5% (about 2.4 million youth) reported using illicit drugs during the past year, with 6.1% of this age group meeting diagnostic criteria for a substance use disorder (Substance Abuse and Mental Health Services Administration, 2013). Relative to adults with substance use disorders, adolescents have more rapid progression from first use to a diagnosable disorder and more co-occurring problems (Chan et al., 2008; Clark et al., 1998; Kandel et al., 1997). When left untreated or ineffectively treated, substance use disorders among adolescents are associated with a range of negative long-term outcomes including school failure, accidents, criminal involvement, unintended pregnancy and even death (see CASA, 2011). Fortunately, recent systematic reviews (Becker and Curry, 2008; Hogue et al., 2014; Waldron and Turner, 2008) have identified several types of therapy as efficacious in improving the outcomes of adolescents with substance use disorders, which have been designated as evidence-based practices (EBP). These therapeutic models have been found to be more effective than standard therapy approaches and include: family therapy (both behavioural and ecological approaches), cognitive behavioural therapy (both individual and group), and motivational approaches.

Given the pernicious consequences of substance use in adolescents, increasing the utilisation of EBP among this cohort has been recognised as a public health priority in the USA by clinicians, researchers, and policy makers alike (National Institute on Drug Abuse, 2014). The US Institute of Medicine released a landmark report in 1998 that cited insufficient utilisation of EBP as a critical problem contributing to deficiencies in the public substance use treatment system (Lamb et al., 1998). Since the release of this report, the two institutes of the US National Institute of Health focused on substance use disorders (the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse) have both made increased utilisation of EBP part of their strategic plans (National Institute on Alcohol Abuse and Alcoholism, 2008; National Institute on Drug Abuse, 2010). In addition, the Substance Abuse and Mental Health Services Administration, the US federal agency charged with overseeing service delivery in the public mental health and substance use systems, has developed and maintained a National Registry of Evidence-based Programs and Practices to encourage EBP adoption (see <http://www.nrepp.samhsa.gov>).

In the USA, efforts to promote the utilisation of EBP by adolescents with substance use disorders have predominantly been directed toward community practitioners and agencies in order to encourage them to offer EBP in community settings (see Tabak et al., 2012; Wells et al., 2010). As noted in recent commentary by Gallo and colleagues (2013), the most common approach to encouraging the use of EBP has been “top-down” with a focus on increasing awareness and adoption of EBP among treatment providers. This approach reflects an implicit assumption that the primary barrier to the use of EBP is provider knowledge, training, and competency. While a “top-down” approach is certainly of value, an alternate approach that has received far less attention in the literature is a “bottom up” approach that aims to increase patient knowledge and awareness of EBP. In the most recent NSDUH (Substance Abuse and Mental Health Services Administration, 2013), fewer than 10% of adolescents who met criteria for a diagnosable substance use disorder reported

receiving *any* form of specialty treatment in the past year. The most common reasons reported for failing to seek treatment were: belief that problems can be handled without treatment and lack of knowledge about where to go for help. These data suggest that treatment consumers often lack basic information about how to seek treatment and what types of treatment might be most beneficial. Increasing treatment consumers' knowledge and awareness of EBP could potentially serve to shape their treatment seeking behaviour, by encouraging them to seek out EBP over other non-evidence based treatment approaches. Such an approach not only recognises the role of treatment consumers in treatment selection, but is also consistent with principles of patient-centred care such as enhanced communication, patient empowerment, self-direction, and personal responsibility (Bechtel and Ness, 2010).

In recent years, a few national organisations in the USA have started investing in the development of health education materials about EBP for substance use disorders and other mental health disorders. For instance, the American Psychological Association and the Association for Behavioral and Cognitive Therapies have partnered to create an informational website for parents/caregivers, educators, and professionals who care for young people with these disorders (<http://www.effectivechildtherapy.com>). On the page for parents, EBP is defined as treatment based on "scientific evidence," and parents are explicitly encouraged to "ask about the type of treatment" that a mental health or substance use treatment provider "will offer for their child." The website also has a Find a Therapist link that advises parents to "make sure your child's therapist is trained in the most current, scientifically-based approaches." The National Institute on Drug Abuse has created an informational website for parents and educators (<http://www.drugabuse.gov/parents-educators>) that similarly defines EBP as "treatment backed by scientific evidence." This website also has links to reports, brochures, and other educational materials designed for substance use treatment consumers, many of which use the phrase EBP.

As noted by Gooding and colleagues (2006), health education efforts can be designed to address a range of goals ranging from increased knowledge to social change, each of which represents a potentially important (albeit limited) aspect of an overall health promotion strategy. The health education materials that have recently been disseminated by national organisations in the USA predominantly appear to target knowledge, decision-making and behaviour change goals, by encouraging treatment consumers to seek out EBP over other available treatment approaches. An important step towards meeting these goals is ensuring that the terms and definitions currently used in the educational materials are understandable and appealing to the target treatment consumers.

Unfortunately, there is some evidence that potential consumers of health care in the USA respond to the term "evidence-based" with skepticism. Carman and colleagues (2010) conducted interviews, focus groups, and an online survey with over 1,600 adults with health insurance in the USA and found that many of the adults' beliefs and preferences were at odds with the concept of evidence-based care. Many adults were confused by the term "evidence-based", and assumed that "evidence" referred to each patient's specific history or symptoms. When EBP was defined as an approach informed by the best available research, participants expressed concerns that the approach would be inflexible, would enable

physicians to cut costs or limit services, and would be invoked to protect physicians from lawsuits. Another study in the USA by Tanenbaum (2008) explored the attitudes of patients with serious mental illness toward the concept of “evidence” and found similar concerns. While the mental health consumers wanted to know which treatment approaches have helped others, they had misgivings about using the aggregate results of research studies to treat unique persons. The Carman et al. (2010) and Tanenbaum (2008) studies focused broadly on healthcare consumers (adults who had insurance with no requirement of a specific illness) and mentally health treatment consumers, respectively. The current study aims to explore whether similarly negative perspectives and assumptions about the term EBP would be held by consumers of adolescent substance use treatment, a population that has been the focus of recent health education efforts in the USA.

The primary goal of this study was to examine how adolescents (young people age 12 to 17 years) with substance use disorders and their primary caregivers perceive, understand, and react to the concept of EBP. Understanding the impressions and communication preferences of substance use disorder treatment consumers is a critical first step in informing the development of effective health educational materials about EBP. This qualitative study represents the first phase of a larger programme of research (Becker, in press) examining whether direct-to-consumer education and marketing strategies can increase the utilisation of EBP among adolescents with substance use disorders.

Methods

Target Population

This study aimed to recruit adolescents with substance use disorders and their caregivers. To qualify for the study, the caregiver needed to be the parent or legal guardian of an adolescent aged between 12 and 17 years, to speak English fluently, and to report significant concern about their teen’s substance use. Adolescents automatically qualified for study inclusion if their caregiver met the aforementioned criteria. The decision to base eligibility upon the caregiver’s concern about the teen’s substance use, rather than an objective assessment or diagnostic interview with the adolescent, was based on research demonstrating that parents and caregivers are more likely than teenagers to make decisions associated with treatment selection and utilisation (Kazdin et al., 1997; Nock and Ferriter, 2005). The target sample size was based upon guidelines published in a recent review by the National Centre for Research Methods (Baker and Edwards, 2012): we aimed for at least 12 participants per group (caregivers vs. teenagers) and strived for saturation of key themes, defined as the point at which new data collection did not shed further light on the research question.

Recruitment

Recruitment for this study occurred between November 2012 and December 2013 in the northeast region of the USA. To ensure a breadth of perspectives, we conducted purposive recruitment across a range of community and treatment clinics including: one adolescent primary care clinic, one outpatient mental health clinic, one emergency department, one outpatient substance use programme, and one residential substance use programme (which had separate facilities for boys and girls). Treatment providers in these clinics invited

potentially suitable caregivers to complete a Consent-to-Contact form indicating their willingness to be contacted by project staff to schedule a study session. In addition, study advertisements were displayed in these clinics with information on how to contact study staff directly.

Procedure

Study procedures were conducted in accordance with a hospital-approved Institutional Review Board protocol (Assurance ID 340013). The initial plan was to offer all participants individual, face-to-face interviews. However, based on feedback from treatment staff at the residential centres, adolescents and caregivers recruited from the residential programme were offered the choice of participating in an individual interview or a focus group discussion with 4–6 other participants. Focus group discussions were offered during a weekly “family night” that consisted of caregiver- and adolescent-only discussion groups followed by family visits. The decision to offer focus groups during a pre-established visitation schedule was made to minimise participant burden by reducing the number of appointments per family. Separate focus groups were held for adolescents and caregivers in order to promote participant comfort and reduce concerns about confidentiality between adolescents and their caregivers.

Prior to each discussion, participants were given written information about the study goals, potential benefits and risks, and procedures. Both adolescents and caregivers were informed that any information the adolescents shared would be kept confidential, with the exception of disclosures indicating that the young people were at imminent risk of harm to themselves or others, which would be shared with caregivers and treatment providers (as applicable). Caregivers and teenagers were also informed that they could choose not to answer any questions and could withdraw from the interview or focus group at any time. Caregivers provided written consent for themselves and the teenagers, while the teenagers provided written assent.

Individual interviews were 60–75 minutes, while focus groups were 75–90 minutes. All discussions were facilitated by a licensed clinical psychologist with over 10 years of experience conducting qualitative interviews. A trained Research Assistant (RA) took detailed process notes during the focus groups to ensure accurate transcription. Each participant received a gift card for their participation, consistent with the typical reimbursement rates for qualitative studies of adolescents and their caregivers approved by the hospital’s Institutional Review Board.

Discussion Guide

Semi-structured focus group and interview protocols were used to guide discussions. The focus of this analysis was a series of open-ended questions that explored whether participants were familiar with the term EBP, what participants assumed EBP meant, how participants perceived a common definition of EBP, and how participants would recommend describing EBP to other treatment consumers. Other topics discussed during the protocol, but not addressed in this analysis, included how and when caregivers and adolescents with substance use disorders prefer to receive treatment information, how they select a provider,

and how they evaluate treatment quality. Prior to the start of the discussions, adolescents and caregivers completed a brief set of questionnaires to provide information about the adolescents' demographic and clinical characteristics.

Coding and Data Analysis

Discussions were digitally recorded and transcribed verbatim by the study RA, who received extensive training in medical transcription. Consistent with the goals of the interview and structure of the interview guide, four *a priori* major themes were identified: familiarity with EBP; assumptions about EBP; impressions of EBP after reading a definition; and language recommended to describe EBP. These major themes were divided into subordinate themes using principles of thematic analysis (Braun and Clarke, 2006). Confidence in qualitative validity was bolstered by triangulation across two independent coders, two informant groups (adolescents and caregivers), two data collection methods (structured interviews and focus groups), and multiple treatment settings (Golafshani, 2003).

Thematic analysis proceeded in an iterative process involving two coders. Discussions with five participants (10% of the sample) were randomly selected for independent review by the two coders. The coders then met to discuss emerging subordinate themes, determine a set of subordinate categories for coding, and develop coding criteria for each category. Remaining discussions were analysed independently by the coders using this scheme as a starting point. Coders met regularly to compare coded transcripts, resolve any lack of correspondence, and generate a master coded transcript for subsequent analyses. Emerging subordinate themes were added as identified and transcripts were re-analysed as needed. Coded transcripts were separately analysed for caregivers and adolescents. Due to well-documented gender differences in the symptom presentation and treatment-seeking behaviour of adolescents with substance use disorders (Dakof, 2000; Wallace et al., 2003), exploratory analyses were conducted to examine whether the themes differed by gender. Verbatim comments were tracked and tabulated using Microsoft Excel, consistent with the guidance provided by Meyer and Avery (2009).

Results

Description of Participants

A total of 29 caregivers consented and completed the study. An additional three caregivers gave their contact information to clinical staff at the recruitment venues, but then could not be reached by study staff to confirm eligibility. Five of the 29 caregivers declined to have adolescents in their care participate in the study for the following reasons: because they were engaged in treatment that made it difficult to attend a study session ($n = 3$) or because the adolescent was not willing to provide assent ($n = 2$). The final sample therefore consisted of 29 caregivers (18 caregivers of boys, 11 caregivers of girls) and 24 adolescents (17 boys, 7 girls). Discussions with these participants consisted of 31 individual interviews and 4 focus groups.

Demographic and clinical characteristics of the caregivers and adolescents are presented in Tables 1 and 2, respectively. Across the 53 participants, the majority were Caucasian, with

modest representation of Hispanic/Latino and African-American racial/ethnic groups. Reflecting this study's recruitment across the full continuum of care, adolescents' rates of current treatment utilisation were high. Per caregiver report (n = 29), 12 of their teenagers were currently in residential substance use treatment, 10 were in outpatient substance use treatment, three were in outpatient mental health treatment, and four were not in any treatment. Furthermore, adolescents' responses (n = 24) to a brief diagnostic screening tool (the Global Appraisal of Individual Needs-Short Screener; Dennis et al., 2008) indicated that they had high severity of substance use disorders: two-thirds of the sample met criteria for the more severe substance use diagnosis of substance dependence (n = 16), with the remaining participants evenly split between meeting criteria for the less severe diagnosis of substance abuse (n = 4) or reporting high-risk use that did not meet full diagnostic criteria (n = 4; e.g., hiding substance use from others, weekly substance use, etc.). Thus, in contrast to the Carman et al. (2010) sample of general health consumers and the Tanenbaum (2008) sample of mentally ill consumers, the current sample represented a targeted sample of adolescents in need of substance use disorder treatment and their caregivers.

Familiarity with EBP

Familiarity with the term "evidence-based practice" (or the variants "evidence-based therapy" or "evidence-based medicine") was extremely low in this sample and did not appear to vary by the gender. Only two caregivers indicated that they had ever heard of the term EBP, one of whom was a mental health counselor and one of whom was a nurse. The mental health counselor accurately described EBP as treatment "based on research," while the nurse inaccurately described EBP as treatment based on the therapist's personal experience and success with clients. None of the other 27 caregivers or 24 adolescents had heard of the phrase.

Assumed Definitions of the Term EBP

When asked what they would assume the phrase EBP meant if they heard it or read it in an organisational advertisement, caregivers and adolescents spontaneously offered a range of definitions, none of which (other than the mental health professional) had to do with the use of research evidence from clinical trials. The most common definition was that "evidence-based" referred to the use of evidence from the patient's medical history. For instance, one mother of a 15-year-old boy in mental health therapy said, "It sounds like it means take into account what you actually see in the patient and then figure out what kind of therapy they need from there." As another example, a mother of a 17-year-old girl in residential treatment said that she assumed EBP meant that therapists would "base therapy on what they see... on what they've seen from the kid." Several teenagers similarly commented that EBP sounded as if it were based on "all my past records," "information off of you," and "by examining you."

Two other commonly presumed definitions of EBP were: a) the treatment was based on forensic or legal evidence; and b) the treatment was based on measurable data from former patients. First, the idea that EBP pertained to legal evidence or proof was articulated by multiple caregivers and adolescents and was the most common definition proposed by adolescents. One grandmother of a 13-year-old boy in outpatient substance use treatment

said, “It has to do with the police, evidence, right? That’s what it sounds like. This makes no sense to do anything with the child as far as helping them mentally.” Meanwhile, several teenagers made comments suggesting that EBP was related to the legal system or physical proof of substance use: “sounds like the police,” “its like an investigation,” “they catch you using,” and “like you hear something or you see something [and] go tell someone.” Of note, all but one of them who thought EBP referred to legal evidence reported that they had been involved with the legal system, suggesting that this misperception might be common among criminally involved youth.

Second, the idea that EBP was based on data from former patients was mentioned by several caregivers and one adolescent. One mother of a 15-year old boy in outpatient substance use therapy assumed that EBP was treatment based on a therapist’s “positive outcomes” with former clients, while a mother of a 16-year-girl in residential treatment supposed that EBP was therapy that required the therapist to “have ways of quantitatively measuring” their patients’ outcomes and then “doing it [therapy] based on this quantitative” data. Only one teenager, another 17-year-old boy not currently in treatment, articulated this perspective by saying, “they have evidence of people that are probably all better now from their problems.”

Impressions of EBP after Reading a Common Definition

After exploring participants’ familiarity with EBP, participants were asked to read the description of EBP from the American Psychological Association’s website that referred to EBP as treatment backed by scientific evidence. Participants were then asked to share their reactions and impressions of the concept. Consistent with the findings of Carman and colleagues (2010), participants’ reactions revealed several negative impressions of EBP, which did not appear to vary by the adolescent’s gender.

The most frequently reported impression was that EBP was inflexible or too rigid to be tailored to individual patients. Specific phrases that demonstrated this view of EBP included “textbook,” “everything by the book,” “cookie cutter,” “rigid,” and “stereotyping.” Related to this impression, several caregivers and adolescents made comments suggesting that the use of EBP would prevent therapists from being able to meet the needs of individual patients. For instance, one mother of a 15-year-old girl in mental health treatment said, “People aren’t textbooks, everyone is different. So you can’t assume this one is going to be like this one, and this one is going to be like this one.” In the same vein, a mother of a 16-year-old boy in residential treatment expressed the following concern about EBP, “Not one way will work for everybody and if you’re a therapist you have to think outside the box and try different things with different families or individuals to see what would work.” Multiple teenagers expressed similar opinions, with example comments including “nobody is the same,” “everyone’s different,” and “they should do it based on what you need.”

Another negative impression of EBP was that it was simply regular therapy described using complex terms. Phrases used by caregivers and teens to describe EBP included “jargon,” a “real fancy” way to describe treatment, and “just fancy words for trying to help parents and their kids out with everyday problems.” Two other impressions expressed by at least two participants were that EBP referred to the use of statistical evidence or to genetic evidence of substance use.

Suggestions to Describe EBP

Because many caregivers and adolescents had unfavourable and/or inaccurate impressions of the phrase EBP even after reading common definitions, they were asked to recommend alternate language to explain the concept to other consumers of adolescent substance use treatment. Numerous caregivers and adolescents gave the general advice that the description should use more simple and more descriptive language. Specific suggestions made by caregivers included “just say it,” “keep it simple,” “more specific,” “more friendly,” and more “helpful to understand,” whereas specific recommendations made by adolescents included “less boring” and “in a very easy way where even teenagers could understand.” These suggestions did not appear to be associated with the adolescent’s gender.

Additionally, multiple caregivers and adolescents suggested specific wording that could be used to describe EBP. The most popular phrases were “proven therapy” and “proven to work.” Another popular suggestion, which was the most common among adolescents, was to describe the therapy as “better” or as having “better results.” Other phrases, each of which were nominated by at least three participants, included “successful therapy,” “effective therapy,” and “therapy that works.” One 17-year-old boy who was not currently in treatment proposed the following EBP description, which addressed the common assumption that EBP was inflexible: “Studies of different kids have shown that this effectively works for different people. So all kids are different, but this treatment works.”

Discussion

The current study examined how adolescent substance users and their caregivers perceive, understand, and react to the concept of EBP, a concept that has recently been used in health education materials by national organisations in the USA. Although qualitative data was formally stratified by age group (caregivers versus teenagers) and analysed for gender differences, results indicated a high level of concordance across participants. With few exceptions, participants had low familiarity with the concept of EBP, inaccurate assumptions about EBP, and negative impressions of EBP as a treatment approach when reading common definitions. In Carman and colleagues (2010) study, they similarly found that consumers of health insurance had low levels of familiarity with EBP, assumed that “evidence-based” referred to the patient’s medical history, and believed that EBP would interfere with the provider’s ability to tailor treatment effectively. Tanenbaum (2008) also found that mental health consumers were skeptical about whether aggregate research results could be effectively applied to treat individual persons. Taken together, these data highlight significant concerns about the current approach to educating health consumers about EBP across the general health care, mental health, and substance use disorder treatment fields in the USA.

In addition to extending the findings of Carman and colleagues (2010) and Tanenbaum (2008) to a new sample, the current study makes several new contributions to the literature. First, an important and unexpected finding that a significant number of caregivers and adolescents with substance use disorders assumed that EBP referred to treatment that relied on legal evidence or proof of substance use. This misperception was predominantly articulated by caregivers and adolescents who reported current or past involvement with the

legal system. It is well-established that approximately half of all adolescents in substance use disorder treatment in the USA are initially referred by juvenile justice system (Center for Behavioral Health Statistics and Quality, 2012), making the justice system the most common pathway into treatment. Our qualitative findings suggest that the term “evidence” might have particularly negative connotations for young people who are criminally involved. A key implication of these results is that agencies and organisations that serve adolescents with substance use disorders should be wary of using the phrase “evidence-based practice” in educational materials, especially if the organisations are seeking to engage justice involved youth.

Second, this study was the first to document that most caregivers and adolescents with substance use disorders continue to have concerns about the concept of EBP even when reading a brief definition of the approach as “supported by scientific evidence.” Specifically, many caregivers and adolescents were worried that the approach would be inflexible and would not adequately address patients’ unique needs. These data have significant implications for agencies and organisations that wish to educate the public about EBP. In particular, our results suggest that pairing the term EBP with a brief definition that references research or scientific findings is likely to be ineffective unless it explicitly addresses the flexibility of the approach. Based on our findings, two alternate approaches that might be more promising would be to: a) describe effective treatment options and how they were tested without using the term EBP, or b) ensure that any use of the term EBP is paired with a definition that clearly address the ability of the treatment approach to be tailored to unique patients.

Finally, this study identified specific phrases that caregivers and adolescents with substance use disorders would recommend using in educational materials about EBP. Popular phrases included “proven,” “successful,” “better,” and “therapy that works.” Given the connotations of EBP as associated with the legal system, health educational materials might be more effective if they used these terms instead of the label EBP. For instance, the following descriptions of EBP are consistent with the phrases recommended by participants: “proven therapy that is individually tailored for your child” or “effective therapy for teenagers that is customised for your unique teenager.” An important direction for future research would be to explore the extent to which including targeted messages such as these in health education materials could influence the willingness of treatment consumers to seek out EBP.

Results of this qualitative study need to be considered in light of several limitations. First, this study used purposive sampling to recruit caregivers and adolescents with substance use disorders. Participants had to learn about the study via our specified recruitment methods, and then had to be able and willing to participate in an interview or focus group. It is possible that our recruitment methods did not reach other families who might have different perspectives on the concept of EBP. Second, we offered both focus groups and individual interviews to families in residential care, and only individual interviews to other families. While the guides were identical, it is possible that the social facilitation in the focus groups might have influenced the number of participants who expressed a specific point of view. Finally, participants in the current study were recruited from the northeast region of USA, an area in which there are several community agencies that provide treatment for adolescents

with substance use disorders. Impressions of treatment in general, and EBP in particular, might differ in regions of the USA with less access to treatment. In addition, an interesting question for further research is whether treatment consumers in other countries would have similar impressions of EBP.

In conclusion, results from this qualitative study of caregivers and young people indicated that most substance use disorder treatment consumers had low familiarity with the term EBP, inaccurate assumptions about EBP, and negative impressions of EBP even after reading a commonly used definition. The most frequent assumptions about the term EBP were that it referred to treatment based on: the patient's medical history, forensic evidence of substance use, or the clinician's prior experience. In addition, providing a basic definition of EBP frequently resulted in negative impressions that the approach could not be tailored for individual patients. These findings highlight the need to take into account the potential pitfalls of using the term "evidence-based practice" as opposed to using simpler terms such as "effective" or "successful." Furthermore, our findings demonstrate the importance of emphasising the flexibility of effective treatment approaches in health educational materials.

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Table 1

Demographics of the Caregiver Sample (N = 29)

Characteristic	N (%) or M(SD)
Gender	
Male	2 (7%)
Female	27 (93%)
Age	42.4 (8.0)
Race/ethnicity	
White/Caucasian	20 (69%)
Hispanic	6 (21%)
African-American	2 (7%)
Other	1 (3%)
Use of treatment	
Not in any treatment	4 (14%)
Outpatient, mental health	3 (10%)
Outpatient, substance use	10 (34%)
Residential substance use	9 (31%)

Note: Percentages may not sum to 100 due to rounding

Table 2

Demographics of the Adolescent Sample (N = 24)

Characteristic	N (%) or M(SD)
Gender	
Female	7 (29%)
Male	17 (71%)
Age	16.1 (1.2)
Race/ethnicity	
White/Caucasian	16 (67%)
Hispanic	3 (13%)
African-American	4 (17%)
Asian-American	1 (4%)
Past year substance use symptoms	
No diagnosis	4 (17%)
Substance abuse	4 (17%)
Substance dependence	16 (67%)

Note. Percentages may not sum to 100 due to rounding