

Data Matters

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To Be or Not To Be... Evidence-Based?

Larke Nahme Huang, Ph.D. Kathy S. Hepburn, M.S., Rachele C. Espiritu, Ph.D.
*National Technical Assistance Center
for Children's Mental Health
Georgetown University*

This is the question confronting providers, families, payers, policy makers, researchers, and advocates in the field of children's mental health. Evidence-based practice is an emerging concept and reflects a nationwide effort to build quality and accountability in health and behavioral health care service delivery. Underlying this concept is (1) the fundamental belief that children with emotional and behavioral disorders should be able to count on receiving care that meets their needs and is based on the best scientific knowledge available, and (2) the fundamental concern that for many of these children, the care that is delivered is not effective care. Some have identified this movement to evidence-based practice as the new "revolution" in health care that focuses on assessment and accountability (Kiesler, 2000). While there is much reason for optimism and hope in this movement towards evidence-based practice in children's mental health, there is also reason for much concern and caution. Some of these concerns and challenges are presented below.

Moving from Science to Service

All too frequently, children and their families receive care that is based

on outdated practices and narrowly defined outcomes as opposed to care that is based on increasing evidence of effectiveness and a wider spectrum of desired functional and quality of life outcomes. The field continues to rely on practices that have little supporting evidence or, at worst, have poor outcomes. The care that is often provided is based on "that's what we've always done" rather than on an emerging evidence-base for "what works." Research on the effectiveness of clinical treatments, service modalities and preventive interventions continues to grow at a rapid rate. This research has spurred new excitement and hope for making a difference in the lives of these children. However, there continues to be a significant gap between what we know works and what is practiced in the field.

Changing practice is a formidable task that occurs at a painstakingly slow pace, often requiring not only changes in practice behaviors, but restructuring programs and allocating an infusion of upfront resources. In addition, implementation of new practices can be especially difficult in an environment of shrinking state and local budgets and competing priorities. Implementation often involves significant organizational change, provider re-training and changes in public and private reimbursement. Clearly, a challenge is to promote the effective dissemination and

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implementation of proven interventions, the task often described as moving “science to services.”

Practice-based Evidence or From Service to Science

Evidence-based practices are not available for all problems and needs and, even when available, do not necessarily work uniformly across all families and communities. Many communities and provider organizations have developed innovative strategies and “promising practices” that lack a systematically developed evidence base. In particular, services targeting ethnic and racial minority communities have often developed culturally-driven practices or have incorporated cultural adaptations to existing evidence-based practices to better serve their children and families, however, they may lack the capacity and resources for research and evaluation. The evidence base needs to be developed for these services and their communities. If we limit the building of the evidence base to a one-way “science to services” approach, we risk stifling innovation and recognition of potential practice-based evidence.

What Constitutes Evidence?

In the field of children’s mental health, “evidence base” refers to scientifically obtained knowledge about the prevalence, incidence or risks for mental disorders or about the impact of treatments or services on these problems (Burns and Hoagwood, 2002). It denotes quality, robustness and accountability. But establishing the criteria for what constitutes an evidence-based practice varies among different child-serving systems and provider groups. Different levels of

evidence, based on the rigor of the research design (for example, number of controlled studies, randomization of participants in studies, number of single-case studies, etc.) have been put forth by various research organizations and public policy programs. These range from “evidence-based” practice grounded in systematic randomized clinical trials, to “evidence-informed” practice based on meta-analyses of existing research studies, to “evidence-suggested” practice based on consensus groups



and expert opinion (Evans, 2003). Similarly, many national efforts and provider systems have constructed their own criteria and cataloguing of evidence-based practices. These represent critical efforts to identify services that produce positive outcomes for youth and warrant the expenditure of shrinking fiscal and human resources. However, the multiple efforts and criteria for identification of evidence-based practices raise potential confusion and dilemmas for practitioners, policy makers, families and consumers. More clarity is needed to ensure informed decision-making. And, as we await the findings from practice-based research,

we must continue to proceed with the best existing knowledge, expert consensus, and experience.

And Whose Evidence Is It?

Concerns have been raised that much of the research on practice and service in children’s mental health has occurred in academic laboratory-type settings with children who display a single, well-circumscribed disorder. The intent of designing research studies in this manner is to prevent the intrusion of “confounding” variables. However, these variables often reflect real-life situations and need to be incorporated into the examination of effective practice. Failure to attend to these variables, which affect the conditions of practice, may diminish the relevance of this research. These practices may work only in a controlled research setting, not in real-life clinic settings. Additionally, children often present with complex disorders that do not easily fall into a single diagnostic category. For example, co-occurring disorders, whether a combination of emotional disorders or emotional and substance abuse disorders, are becoming increasingly prevalent. Children with these disorders are particularly challenging to a research endeavor that traditionally isolates a condition in order to determine diagnostic-specific treatments. And finally, much of this research does not include racially and ethnically diverse populations, so the generalizability of these evidence-based practices remains to be determined.

Family Choice

In the last decade, a strong family movement has highlighted the positive impact of family involvement and family choice in the treatment planning and decision making for their children with serious emotional

disorders. Major advocacy and provider groups endorse families as partners in planning. The field is no longer concerned with whether to involve families, but how best to do this. With the movement to evidence-based practice, how does this affect the role of families in decisions regarding treatment and intervention? How will the strength of science-based practices be integrated with family choice? Families often present first-hand evidence of what works for their child in the context of their family and community and concerns have been raised that this “evidence” will be minimized in favor of “scientific evidence.” At the least, families should be informed of evidence-based practices. But beyond this, families need to also have a role in actively shaping and evaluating practice. While families want to know what works and what practices are effective, they also need to have a voice in determining what practices, services and supports address their needs and should be the focus of research endeavors. For example, while researchers may focus on the effectiveness of psychotherapy, families may prioritize building the evidence base for effective respite care services.

The Fit with Systems of Care

Questions have been raised about the compatibility of evidence-based practice and systems of care. Some concerns have been expressed that the movement to evidence-based practice will supersede or displace the systems of care approach. A system of care approach and evidence-based practice are not competing efforts but complementary. Systems of care focus on improving access, developing a broad array of services and ensuring coordination; it provides the context for evidence-based practices. The system of care provides the service delivery vehicle for clinical treatment and support services and neither the system nor the practice alone is likely

to yield positive results for children and their families (English, 2002). It is these two concepts working in tandem that provide the hope for improved access and quality of care. Thus, the movement toward evidence-based practice converges well with a system of care approach.

Will Funding Follow the Evidence Base?

In 1998, approximately \$11.75 billion was spent for mental health services for children in the specialty mental health and general health sectors alone. This represents a three-fold increase since 1986 (Sturm, et al., 2001). It also raises the question of how these dollars are being spent. Given a continued reliance on traditional services that lack a strong evidence base, are we utilizing resources for effective practices? Historically, large amounts of federal and state dollars were spent to pay for more restrictive and less effective services. As the evidence increases to identify “what works”, policy must address both the selection and funding of the most effective services. An important caveat in the funding picture is that we still need to learn more about the generalizability of the current evidence to children with complex disorders and children from diverse communities. Conversely, we need to be careful not to de-fund or under fund services and supports that are promising but lack the evidence base or to fund only a single component of an evidence-based multimodal service. For example, where pharmacological interventions are adjunctive to psychosocial therapies, some payment models fund only the medication component of the treatment, reducing costs but ignoring fidelity to the evidence-based intervention.

Overview of Data Matters #6

With the increasing momentum of evidence-based practices, a broad

array of stakeholders is contributing to the discussions and debates on this topic. We are excited about this issue of *Data Matters* which provides a forum for the perspectives of these diverse stakeholders. The articles in this issue discuss issues being addressed by leading researchers in the field, cataloguing of practices by different child-serving systems, family accolades and cautions regarding evidence-based practices, challenges in working with providers as the “consumers” of these practices, state and local community efforts to implement evidence-based practices, and implementing an evidence-based practice in systems of care. While the voices are variously supportive or cautious, all share in common the desire for high quality, effective services to improve the lives of children with emotional and behavioral disorders. We are pleased to bring you this issue and hope you find it informative. ♦

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Evidence-Based Practice in Children's Mental Health Services

WHAT DO WE KNOW? WHY AREN'T WE PUTTING IT TO USE?

Kimberly Hoagwood, Ph.D.
*New York State Office of Mental Health
 and New York State Psychiatric Institute
 Columbia University*

The research base on the risks for mental disorders or conditions, on the efficacy of mental health treatments and preventive strategies for youth, and on the effectiveness of services has expanded enormously in the past decade. There has been a doubling of research studies on child and adolescent mental health at the National Institute of Mental Health (NIMH) and a tripling of funds for research on these issues over this period of time (Blueprint for Change, NIMH, 2001). Yet this research-based knowledge on the evidence about the impact of mental health interventions has been largely ignored. So what gives?

In this article, I describe some of the reasons why research knowledge on evidence-based practice is not reaching its intended audience—i.e., children and adolescents with mental health needs, their families, and providers of mental health care. Closing the gap requires acknowledging the existing evidence about specific mental health practices and redirecting research studies to link policy initiatives about service delivery and the science base.

Dissemination and Implementation Issues: Some Reasons Why Research-Based Knowledge Is Not Used

- **No Consensus on What an Evidence-Based Practice Is**

There is currently no consensus on how to define “evidence-based”, or

on when the evidence base, however it is defined, is ready to be deployed, moved out, and used in community settings. Numerous and discrepant criteria are being used by professional associations and by the scientific community to denote evidence-based from non-evidence based. The varying definitions make it difficult for policy-makers or practitioners to decide which amongst the practices to adopt in any given circumstance. There are

In general, “evidence-based practice” refers to a body of scientific knowledge about service practices, about the impact of treatments on child or adolescent mental health conditions, or about the impact of preventive interventions on the course of children’s development.

attempts currently by foundations and federal agencies to create agreed-upon criteria and to create an archive of research-based practices which can be updated and provide assistance to field practitioners and the scientific community on the quality and strength of the evidence about mental health care.

- **Little Evidence-Based Help for Severe, Co-Occurring Mental Health Problems**

The strength of the evidence in research-based knowledge largely centers on discrete treatment for discrete disorders (Weisz et al., 1995a, b). Unfortunately, many children present with multiple, chronic, and severe problems. The strength of the evidence about

mental health care for these children with serious emotional or behavioral disturbances is not as strong.

- **Uncoordinated and Fragmented Services**

In addition to this problem of co-occurring disorders, the evidence base about how best to coordinate services for children has lagged behind knowledge about discrete practices. Mental health services for youth are provided in thousands of different settings or locales: schools, clinics, health centers, juvenile probation, etc. Each of these “systems” contains discrete rules governing their administration of mental health care—separate reimbursement policies and incentive structures, different training requirements for providers, and diverse regulations governing entry in the care they provide for the population they serve. The evidence about how best to coordinate evidence-based services and create participatory management teams for youth that involve all key individuals (e.g., family members, providers across all major systems and the child) is almost non-existent.

New Directions for Research and New Models for Intervention Development: Looking at a Revolution in Intervention Development

- **To ensure ecological validity, the research model should include the perspectives of stakeholders, families, and providers**
 If the goal is to enhance the generalizability and uptake of

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research findings into practice, then from the outset, research models should incorporate the perspectives of families, providers and other stakeholders into the design of new treatments, preventive strategies, and services. Only by doing so can issues relating to the relevance of the intervention for stakeholders, the cost effectiveness of the intervention, and the extent to which it reflects the values and traditions of families and community leaders be addressed. These issues are ultimately essential for the evidence base to be of any practical utility.

- **Create clinic and community intervention development and deployment models**

Clinic and community intervention development and deployment models would attend to context variables such as characteristics of the practice setting (e.g. practitioner behaviors, organizational variables, community characteristics) and involvement of families and community in the initial piloting and manualization phase. These models are extremely challenging and can only be accomplished with adequate resources and committed partnership among scientists, families, providers and stakeholders. Such a model has been proposed by Hoagwood, Burns & Weisz (2002) as a way to ensure strong scientifically-based practices and to accelerate the pace of the uptake of research findings into practice.

What is needed is a 180 degree shift in how interventions are developed. Such a shift will foreground context variables (often considered to be “nuisance” variables) instead of putting them at the back end of a string of efficacy trials. Such a shift will focus on strengthening outcomes and accountability by holding constant to the goal of developing a scientifically-informed knowledge base on effective

interventions for children, adolescents and families. Only by doing so, can services research address issues essential to the uptake of evidence-based practices into diverse community settings. Without such a revolutionary shift, the evidence base will sit unused and unread on academic shelves. ♦

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To review the complete journal article from which this newsletter article was excerpted, please see Report on Emotional and Behavioral Disorders in Youth, Vol. 1:4, 2001, pages 84-87, or for more information please contact: Kimberly Hoagwood, hoagwood@childpsych.columbia.edu

WEB-BASED SOURCES

Organizations, resources, and information cited in this issue related to evidence-based practices in behavioral health care

American Youth Policy Forum

www.aypf.org

California Institute for Mental Health

www.cimh.org

Center for Substance Abuse Prevention (CSAP), Department of Health and Human Services, National Registry of Effective Programs (NREP)

<http://modelprograms.samhsa.gov>

Center for the Study and Prevention of Violence, Blueprints Initiative

www.colorado.edu/cspv/blueprints

Communities that Care, Developmental Research and Programs, Inc.

www.preventionscience.com/ctc/CTC.html

CSAP’s Decision Support System (DSS)

www.preventiondss.org

Department of Criminology and Criminal Justice, University of Maryland

www.preventingcrime.org (Direct link to article)

www.ncjrs.org/works/wholedoc.htm (Direct link to lecture)

Department of Education, Safe and Drug-free Schools

www.ed.gov

(At this website, select Visit US Department of Education; use search option for “OSDFS”; select Office of Safe and Drug Free Schools—Publications; go to Publications—online publications—Exemplary and Promising Safe, Disciplined, and Drug-Free Schools Program 2001, Expert Panel)

Office of Juvenile Justice and Delinquency Prevention, National Program Review Committee, University of Utah, and CSAP

www.strengtheningfamilies.org

Prevention Research Center for the Promotion of Human Development, Pennsylvania State University

www.prevention.psu.edu/CMHS.html

U.S. Department of Health and Human Services

www.surgeongeneral.gov/library/youthviolence

Evidence-Based Treatments for Children's Disruptive Behavior Problems

WHAT DO WE KNOW?

Anne W. Riley, Ph.D.
*Johns Hopkins University
 Bloomberg School of Public Health*

Disruptive behavior problems are among the most common problems of youth, are likely to impact children's successful transition to adulthood, and are fairly stable. Youth with behavior problems are more likely to receive mental health treatment than those with emotional problems, yet the treatments they get often are those that lack an evidence base. In particular, 'talk therapy' does not work for youth with significant behavior problems such as oppositional defiant and conduct disorder. Moreover, there is no evidence that residential treatment centers improve the outcomes of youth, and there is some suggestion that youth actually learn to become more deviant in these settings (Dishion, 1999; Bickman et al., 1995; Weisz, 1995; Weisz, Weiss, & Donenberg, 1992).

Evidence-Based Treatments for Disruptive Behavior Disorders

For conduct disorder and severe oppositional defiant disorder the following types of treatments have been shown to work.

- Parent Management Training (PMT)
- Cognitive Problem Solving Skills Training (PSST)
- Combination of PSST and PMT programs
- Multisystemic Therapy (MST)

Parent Management Training seeks to change parent-child interactions in the home, including child-rearing practices and coercive interchanges, by training parents to

manage their child's behavior at home and at school. The techniques are based on social learning principles, and parents are helped to see how positive and negative behaviors are developed and maintained by their consequences. New skills are applied to simple problems before trying to solve more serious behavior problems. Duration of treatment varies with severity. Programs for children with mild oppositional behavior typically last 6-8 weeks. However, typical treatments for clinically referred youth last much longer, 12-25 weeks.

Examples of Parent Management Training Programs:

- *Videotape Modeling Parent Training* (Webster-Stratton, 1994)
- *Parent-Child Interaction Therapy (PCIT)* (Hembree-Kigin, 1995)
- *Defiant Children: A Clinician's Manual for Parent Training* (Barkley, 1987)
- *Helping the Noncompliant Child* (Forehand, 1981)

References for Caregivers

Forehand, R. & Long N. (1996). *Parenting the Strong-Willed Child*. Chicago: Contemporary Books. (312) 540-4500.

Cognitive Problem Solving Skills Training (PSST)

is the program with the best evidence for efficacy when parents are not available or willing to participate in PMT sessions. Positive results have also been obtained when PSST is used in conjunction with PMT. Problem solving skills training focuses on altering the cognitive processes that underlie social behavior. The treatment focuses on cognitive distortions and

impulse control problems common in aggressive youth who are helped to build skills that reduce the extent to which they attribute hostile intent to the actions of others and to develop non-aggressive responses to perceived provocations by peers.

Some programs are designed to be administered in small group settings of 3 to 5 children over a period of 18-22 sessions. The therapist plays an active role as a coach and for modeling the skills taught. The therapist leads role-playing of social situations so that skills are practiced with the therapist providing cues, feedback and praise. However, without the involvement of parents and/or teachers, the generalization of the skills gained in treatment and the duration of treatment effects is somewhat limited.

Examples of Problem Solving Skills Programs (see (Frick, 1998):

- *Self-Instructional Training* (Kendall, 1991, 1985)
- *Anger Coping Program* (Lochman, 1996)
- *Promoting Alternative Thinking Strategies (PATHS) Curriculum—The FAST Track Modification* (Bierman, 1996)

Multisystemic Therapy (MST) is a treatment strategy that focuses on reducing antisocial behavior in adolescents by helping the various "systems" that influence them promote acceptable behavior (Henggeler, 1998). It involves immediate and extended family, peers, schools and neighborhood, thus encompassing the context in which

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the adolescent lives. Goals of treatment are family driven, but overarching goals include: (1) help parents and caring adults shape the adolescent's behaviors (2) overcome difficulties, such as marital problems, that may get in the way of parenting, (3) reduce negative parent-child interactions (4) develop cohesion and emotional warmth among family members. The focus of treatment has typically been on seriously disordered adolescents including juvenile delinquents, and parents are full partners in the treatment.

Treatment may employ different techniques such as: PMT, contingency management, PSSST, marital therapy and others. Treatment is often conducted in homes or at school. The behavior of therapists is governed by a set of 9 treatment principles. Adherence to these guidelines operationalizes fidelity to MST. The administration of MST is demanding. There is significant clinical decision making and multiple interventions need to be implemented. Because of the varying demands of each case, and the intensive interventions used, MST therapists must be capable of applying a range of empirically-based therapeutic approaches (such as structural family therapy, cognitive behavior therapy) and tailoring interventions to the unique needs of the family. MST is conducted by a "team" comprised of 2 to 4 MST therapists and their on-site supervisor. They work together for purposes of group and peer supervision, and to support the 24-hour/7-day/week on-call needs of the team's client families.

Information and Training Resources

- MST Services, Inc.
(843) 856-8226
Fax: (843) 856-8227,
keller@mstservices.com or go to
www.mstservices.com,
www.mstinstitute.org

Summary

Most youth who receive an empirically supported treatment get significantly better and do so more quickly than with other treatments or no treatment (Brestan, 1998; Chambliss, 2001; JCCP, 1998; Spirito, 1999). This is important. We must continue to move toward scientifically supported treatment for **all** mental health problems in children and adolescents, including those with disruptive behaviors. Currently, there is at least one scientifically supported treatment for each of the common mental health problems in children and adolescents, Attention Deficit Hyperactivity Disorder, conduct disorder, major depressive disorder, and anxiety disorders. This paper highlights those shown to be effective for children with disruptive behaviors, and thus expands intervention options. This is the good news. However, the preparation of clinicians, fidelity to the parameters of the treatment protocol, and adapting intervention for the individual family and child can be difficult and remain some of the greatest challenges of transferring the evidence-based treatments into real-world settings. ♦

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For more information on interventions for disruptive behavior go to <http://www.strengtheningfamilies.org>. For more information on the evidence base for children and youth with mental disorders see: *Community Treatment for Youth: Evidence-based interventions for severe emotional and behavioral disorders* (Burns, 2002) or request a copy of a workbook on evidence-based treatments for youth from Dr. Anne Riley, (ariley@jhsph.edu).

A Glimpse at Establishing the Evidence

MULTIDIMENSIONAL TREATMENT FOSTER CARE

Patricia Chamberlain, Ph.D.
Oregon Social Learning Center

Multidimensional Treatment Foster Care (MTFC) provides community-based family care for youth who are having severe emotional and behavioral challenges. MTFC has been identified as an evidence-based practice by the Blueprints for Violence Prevention, the California Institute for Mental Health *Caring for Foster Youth Initiative*, and Burns & Hoagwood (2002). As an alternative to group and residential care and to institutionalization and incarceration, the MTFC program recruits, trains, supports and supervises families in the community to provide placements for youth participating in the program. Intensive services are provided to both the youth and to the members of their family (biological, adoptive, relative) so that after the youth completes the MTFC program, they can return home and continue to be successful. This article briefly outlines research conducted by the author and collaborators and the evidence from pilot studies and larger investigations that established the utility of MTFC as a therapeutic program for youth with severe emotional and behavioral challenges.

The MTFC model was first tested in two studies in the early 1990s to determine the feasibility of using this model for adolescents referred for delinquency and for youngsters leaving the state mental hospital. Results showed that MTFC was feasible and that compared to alternative residential treatment models, it was cost effective and the outcomes for

children and families were better. For example, during a two-year follow-up period, the number of days delinquent youngsters were incarcerated in the state training school was lower for participants in MTFC than for a comparison group of youngsters placed in group-care programs. In the study that examined outcomes for children and adolescents leaving the Oregon State Hospital, we found that youth were moved off of waiting lists and placed in the community more quickly and that they had fewer behavior problems in MTFC than in comparison placements.

These two early studies set the stage for a series of subsequent larger investigations of MTFC in both the



juvenile justice and in the child welfare systems. In the first of these (Chamberlain & Reid, 1998), we looked at outcomes for 79 boys referred because of chronic problems with delinquency. Study boys had an average of 14 police offenses before

placement and had spent an average of 75 days during the previous year in locked detention settings. Boys were randomly assigned to placement in MTFC or Group Care and assessed one year after their placements ended. Compared to boys in Group Care, MTFC boys

- Spent 60% fewer days incarcerated in follow-up;
- Had fewer than half the number of subsequent arrests;
- Ran away from programs 3 times less often;
- Returned to live with parents/relatives twice as many days; and
- Had significantly less hard drug use in follow-up.

In addition to studying outcomes, we were interested in identifying the “active” ingredients of MTFC. What about the MTFC model makes it work? To study this, we assessed boys after they had been in their placements for 3 months. Boys and their caretakers in MTFC or in Group Care (GC) were asked about specific parenting practices that we hypothesized would mediate outcomes. These mediators included key parenting skills that have been noted in the literature as relating to the development of delinquency and antisocial behavior. They included: consistent discipline, close supervision, and positive encouragement and engagement with adult caretakers. We also asked about the amount of time youth spent with delinquent peers. Significant differences were observed between MTFC and GC boys in several

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areas. Most notably, MTFC participants spent more time with their adult caretakers and less overall time without adult supervision; they were disciplined more consistently for rule violations and misbehavior; they spent less time unsupervised with delinquent peers; and reported less influence by delinquent peers (Chamberlain, Ray, & Moore, 1996). The next step was to see if the mediators related to outcomes for boys in follow-up.

To examine this question, we used a data analysis method called structural equation modeling (SEM). In SEM you can look at multiple indicators simultaneously. First, we tested whether boys in MTFC had received better supervision, discipline, adult mentoring, and had less unsupervised contact with delinquent peers than boys in GC. Next, we tested whether boys who had those conditions had better long-term outcomes, regardless of whether they were placed in MTFC or GC. The answer to both questions was essentially “yes.”

The results of this study highlight important components of a therapeutic environment for boys with serious delinquent or antisocial behavior. First, since most juvenile crime is committed by groups of youth and is a social event, parent skills training on supervision and monitoring of peer relationships (although difficult) is crucial. Second, adult support and mentoring is just as important to teens as it is to younger children. Even if teens act like they do not value adult attention—they do. Having a positive relationship with a mentoring adult sets the stage for learning new skills, for modeling appropriate social behavior, and for taking the risks necessary to change one’s way of acting in the community and with peers. These types of engagement opportunities are embedded in the MTFC approach.

Finally, teens need to know what the limits are through consistent discipline and close supervision. In MTFC, foster parents are trained and supported to work with youth in the context of the family and the community with a special focus on parenting skills shown to predict positive outcomes for boys who have been in serious trouble because of delinquency.

Through this process of research and program evaluation, MTFC has been established as an evidence-based practice having a deterrent effect on delinquency and anti-social behavior. The evidence was established through a strong research design (includes control groups with random assignment), results that show consistent and sustained positive outcomes for youth beyond one year of

treatment, and replication in different child systems. Additionally, we are expanding the target population by currently conducting a parallel study for girls referred from juvenile justice. ♦

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For more information on MTFC and related topics, please contact Patricia Chamberlain at pattic@oslc.org.

A CHILD WELFARE RESOURCE REPORT

E*vidence-Based Practices in Mental Health Services for Foster Youth*

(2002), a report written by Lynne Marsenich, LCSW was produced by California’s Institute for Mental Health’s, *Caring for Foster Youth* initiative and funded by the *Zellerbach Family Fund*. Although focused on the promotion of mental health for foster children throughout California, the report holds broader interest and application for those in the mental health and foster care fields in any state.

Designed to initiate and inform interdisciplinary dialogue between mental health and child welfare administrators, and practitioners, researchers, the judiciary, families and foster youth, the report has four primary goals:

- To highlight the available social science evidence on mental health services for foster children, from which service systems models can be developed
- To encourage the integration of known research into the planning, development, and delivery of mental health services to children in foster care
- To dispel some of the prevailing myths and misperceptions about the mental health needs and best treatment options for children in foster care
- To outline some of the implications of this information and offer recommendations designed for the delivery of mental health services to foster children

Ultimately, the report makes recommendations for training, research and program improvements for the delivery of mental health services to foster youth.

Copies of this complete report may be downloaded or ordered from the California’s Institute for Mental Health website, www.cimh.org

Identifying Efficacious Interventions for Children's Mental Health

WHAT ARE THE CRITERIA AND HOW CAN THEY BE USED?

Heather Ringeisen, Ph.D.
National Institute of Mental Health

This is a time of hopeful anticipation in children's mental health.

The past several years have seen dramatic increases in our understanding of successful strategies for the identification and diagnosis of emotional or behavioral disorders in children, as well as strategies for their treatment and service provision. Recent reviews have identified a variety of efficacious treatments, including psychopharmacologic (Vitiello, Jensen, & Bhatara, 1999; Weisz & Jensen, 1999); psychosocial (Journal of Clinical Child Psychology, 1998; Weisz & Jensen, 1999); integrated community and prevention services (Burns, Hoagwood, & Mrazek, 1999; Greenberg, Domitrovich & Bumbarger, 2001); and school-based approaches (Rones & Hoagwood, 2000). We have learned that current treatments can successfully reduce symptoms of child psychopathology, improve adaptive functioning, and sometimes serve as a buffer to further long-term impairment. This is not to imply that the knowledge base is complete, or even sufficient. Information surrounding children continues to lag behind the empirical evidence about adult mental illness and treatment. Nevertheless, important groundwork for further research in child mental health has been laid.

Consequently, child mental health practice is becoming part of a new emphasis in the development and implementation of treatments that are supported by positive research findings. Many national efforts have established different sets of review criteria for determining when a particular type of intervention is supported by sufficiently positive scientific results. These efforts have increased attention to the quality of particular interventions and provide



criteria by which to understand, evaluate and select treatments for various mental health problems. Here, efforts by the American Psychological Association, International Psychopharmacology Algorithm Project, and prevention scientists will be described to illustrate such criteria.

Psychosocial Treatments— American Psychological Association

In an effort to identify specific empirically-supported psychosocial interventions for children, a special task force of the American Psychological Association (APA) modified adult treatment criteria previously set by the APA Society for Clinical Psychology (Chambless et al., 1996) for “well-established” and “probably efficacious” child treatments (Lonigan, Elbert, & Johnson, 1998). These criteria resulted in the publication of a series of reviews in 1998 that examined the efficacy of a number of treatments for children. This series appeared in Volume 27 of the *Journal of Clinical Child Psychology*. According to these criteria, treatments are to be supported by either group-design or single-subject experiments. Such research studies must also clearly describe subject characteristics. Unlike other evidence-based practice criteria, the APA standards stress replication by independent research teams and prefer that identified interventions have treatment manuals. The APA task force defined two categories of psychosocial treatment by these criteria with examples as follows:

- “Well-established” treatments are required to have two or more studies conducted by different research teams that demonstrate their superiority to medication, placebo, or an alternative treatment; equivalence to an already established treatment; or 9 single-subject case studies.

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“Well-established” treatments were identified for attention-deficit/hyperactivity disorder, or ADHD, conduct problems and phobias.

- “Probably efficacious” interventions are required to have two or more studies that demonstrate their superiority to wait-list control, one experiment meeting the criteria for a “well-established” treatment, or three single-case studies. “Probably efficacious” treatments were identified for the treatment of depression, anxiety disorders, ADHD, conduct problems, and phobias.

Psychopharmacological Interventions—International Psychopharmacology Algorithm Project

Weisz and Jensen (1999) recently reviewed evidence on the efficacy of child pharmacotherapy utilizing criteria established for the International Psychopharmacology Algorithm Project (Jobson & Potter, 1995). By these criteria, a drug is considered efficacious if studied through random assignment and control group comparison, and with replicated results in one or more similarly well-controlled studies. Here, replication by other investigators is not a criterion and drugs can be considered efficacious following one randomized trial. The review identified several psychotropic medications with empirical support for both childhood externalizing and internalizing disorders. In addition, the National Institute of Mental Health (NIMH) commissioned six scientific reviews of published research on the safety and efficacy of psychotropic medications for children. Categories of drugs reviewed include: stimulant medications, mood stabilizers, selective serotonin reuptake inhibitors, tricyclic antidepressants, and antipsychotic agents. These reviews can be found in Volume 38 of the *Journal of the American Academy of Child and Adolescent Psychiatry*.

Preventive Interventions—Greenberg, Domitrovich, and Bumbarger

Recently, Greenberg, Domitrovich and Bumbarger (2001) published a review to identify universal, selective and indicated prevention programs that reduce symptoms of both externalizing and internalizing childhood mental disorders. They focused specifically on interventions for school-age children (5-18 years). In order to be included as efficacious programs, program evaluations required well-structured study designs, clear specification of study participants, a written manual that specified intervention procedures and outcome effects on measures related to mental disorders. In the prevention review, a minimal number of studies was not specified, but a manual was required. This review published in Volume 4 of *Prevention and Treatment* identified 34 programs that met such criteria.

Conclusions

It is important to stress what these various criteria for efficacious child interventions *do* and *do not* tell a mental health consumer—whether an administrator, practitioner, or family member.

The various criteria for “efficacious” child mental health interventions focus on scientific validation, or data-based empirical support. They set criteria to ensure that scientific studies have adequate power to detect meaningful differences, sufficient research methods, and statistically significant findings. So, the criteria set a scientific standard of empirical support. These criteria do not necessarily summarize an intervention’s readiness for broad-scale implementation or an intervention’s applicability for diverse groups (e.g., age, ethnicity, geographic location), and they do not take individual consumer preferences into consideration.

Lists of efficacious interventions can be incredibly helpful in determining interventions with the strongest scientific support; however, such lists must be individually interpreted within a local framework. Knowledge of local needs, resources and target audiences are key tools in maximizing the usefulness of efficacious treatment criteria. When examining empirically-supported practices identified through various sources, administrators should still ask, “are these results applicable to my “local” population?” Practitioners should wonder, “are the results applicable to my particular client?” Families should question, “are these practices right for my child?” Such consideration of both scientific standards, local needs, and consumer fit will enable both researchers and consumers to help child mental health practice do more of the “right things” right. ♦

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SAMHSA's National Dissemination System for Model Prevention Programs

THE NATIONAL REGISTRY AND DISSEMINATION OF EFFECTIVE PROGRAMS

Paul Brounstein, Ph.D.,
Deborah Stone, Ph.D., Ann Acosta, M.A.,
and Stephen Gardner, D.S.W.
*Division of Knowledge Application and
Systems Improvement
Center for Substance Abuse Prevention
The Substance Abuse and Mental Health
Services Administration*

Steven P. Schinke, Ph.D.
Columbia University School of Social Work

Within the Substance Abuse and Mental Health Services Administration (SAMHSA), the Center for Substance Abuse Prevention (CSAP) has made a concerted effort to develop a comprehensive system to connect “science-based” substance abuse and mental health treatment and prevention programs with practice. The primary vehicle for this effort has been the National Dissemination System (NDS); the engine for this vehicle is the National Registry of Effective Programs (NREP—located on the World Wide Web at: www.modelprograms.samhsa.gov). The NREP helps move both the prevention field and government agencies, charged with bridging the gap between research and practice, towards greater accountability in public and private sector funding. By offering easily accessible information on programs with proven evaluation results, efforts have been made to help prepare the prevention community for the new performance results-oriented environment. The purpose of the NREP and the NDS includes:

- Making science-based programs the foundation for national, state and community efforts;

- Recognizing that intervention efforts must be comprehensive, yet tailored to meet local population needs;
- Supporting the implementation of scientifically defensible model programs across the country; and
- Creating a system of public and private partners working to develop capacity and the infrastructure necessary to identify, implement and monitor effective prevention programs.

The NREP identifies three types of science-based programs through an expert review process—**Promising programs** are those that have generally been well-implemented and evaluated but whose results are not consistently positive across domains of measurement or replications; **Effective programs** are well-implemented, well-evaluated and have demonstrated consistent positive outcomes across domains of measurement and/or replications; **Model programs** share the characteristics of Effective programs but also include the *proviso* that program developers work with CSAP in the active dissemination of the program, providing materials, training and technical assistance thereby ensuring localities replicating/adapting the program, when adapted, will not violate the model of change used in the program and that the program will be implemented with strong fidelity. The agreement with developers to provide both training opportunities and technical assistance is a crucial aspect of the NDS.

To date, the NREP has identified 49 Model Programs, 38 Effective and

40 Promising programs. The 49 Models are currently being actively disseminated, supported by print and web-based resources (www.modelprograms.samhsa.gov) as well as by training and technical assistance made available for each specific model. Other Federal agencies, such as the Department of Education, are also beginning to incorporate CSAP's Model Programs in their lists of programs for implementation. The NREP has also broadened its scope by including programs to prevent or treat HIV/AIDS transmission, gambling, workplace substance use, post-traumatic stress disorder and violence, and in the coming months, will include co-occurring substance abuse and mental health disorders programs. The broadening of NREP's scope and the increasing endorsement by other larger Federal agencies will have a far reaching impact by significantly increasing the number of scientifically defensible prevention programs implemented in communities across the country.

Review Process

Published (e.g., peer reviewed journal articles) and unpublished program materials (e.g., grant final reports, manuscripts under development) are submitted to NREP and distributed to teams of scientists for review. Team members work independently to read, analyze, and score each program according to 15 criteria, summarized in the box. Review team members regularly meet to compare their assigned ratings, clarify any areas of disagreement, and undergo supervision for their program rating reliability.

ESTABLISHING CRITERIA & CATALOGUING EBPs

NREP reviewers include doctoral-level scientists, experts in prevention research methodology and programs, and they prepare for their task through extensive training plus illustrative program reviews and critiques. Currently, 27 scientists conduct NREP reviews. Reviewer backgrounds span such fields as psychology, sociology, social work, education, public health, biostatistics, and public affairs. NREP reviewers are largely employed in academia, but a number are with private research and development firms, think tanks, consulting, health services, and private practice. Approximately one-half of all reviewers are women, and 15 of the 27 reviewers are Black, Hispanic, or Asian.

Criteria and Selection Process

Three trained reviewers independently rate programs on a series of criteria designed to reflect quality of implementation, user-friendliness (e.g., translations) and solidity of the causal link demonstrated between intervention and outcomes. Criteria used may vary a bit depending upon the topic area, but always reflect these three more general items. Most often, ratings are made on the 15 dimensions listed in the box. If all raters score within one point and on the same side of the midpoint, averages are used, otherwise consensus conferences are held.

The final two criteria are used as subjectively scaled criteria and are used in making the determination of program review status. To be identified as an *Effective* or potential *Model* program, both utility and integrity scores must exceed 4; these scores must both exceed 3 to be identified as a promising program.

Other Supports

SAMHSA/CSAP has learned that local planners and implementors need more than written information. To

CRITERIA

- *Theory*—the degree to which programs reflect clear, well-articulated principles about substance abuse behavior and how it can be changed.
- *Intervention fidelity*—how the program ensures consistent delivery.
- *Process evaluation*—whether program implementation was measured.
- *Sampling strategy and implementation*—how well the program selected its participants and how well they received it.
- *Attrition*—whether the program retained participants during its evaluation.
- *Outcome measures*—the relevance and quality of evaluation measures.
- *Missing data*—how the developers addressed incomplete measurements.
- *Data collection*—the manner in which data were gathered.
- *Analysis*—the appropriateness and technical adequacy of data analyses.
- *Other plausible threats to validity*—the degree to which the evaluation considers other explanations for program effects.
- *Replications*—number of times the program has been used in the field.
- *Dissemination capability*—whether program materials are ready for implementation by others in the field.
- *Cultural- and age-appropriateness*—the degree to which the program addresses different ethnic-racial and age groups.
- *Integrity*—overall level of confidence of the scientific rigor of the evaluation.
- *Utility*—overall pattern of program findings to inform prevention theory and practice.

respond to these needs, CSAP has created the Dissemination System which boasts the following supports:

- **Achieving Outcomes (AO)** training activities in community-based strategic planning and CSAP's Decision Support System (DSS—www.preventiondss.org)—together comprise a systematic approach that guides the field to program selection;
- Program promotion using collaboration with national partners, web-based technology at: www.modelprograms.samhsa.gov, and print materials (e.g., Here's Proof: Prevention Works; CSAP Annual Report);

- Training and technical assistance through the program developers;
- Capacity building through CSAP's State Incentive Grants and Block Grants; and
- Prevention Program Outcome Monitoring System (PPOMS) described below.

Prevention Program Outcome Monitoring System (PPOMS)

To complete the system and help to provide feedback to the identification and dissemination efforts, CSAP will launch PPOMS in the fall of 2003. PPOMS will help

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SAMHSA continued from page 13

measure the impact of the dissemination of prevention programs to the field, by attempting to quantify the extent to which programs are disseminated, how they are adapted for the field, and what outcomes the programs produce. Data generated by PPOMS will allow CSAP to quantify the market penetration, processes, and effectiveness of its science-based program replications. The national PPOMS assessment will ask prevention practitioners about their use of, modifications to, and satisfaction with science-based and other prevention programs.

PPOMS information will allow CSAP to better direct its dissemination of NREP-identified programs and provide access to targeted training and technical assistance for practitioners. Equally important, PPOMS findings will shed new light from the field on the core components of science-based programs and how fidelity and adaptation contribute, and are related, to programmatic outcomes.

Advancing Science Institute

This past year, CSAP held its first Advancing Science Institute in which programs, not meeting the criteria for Promising program status were invited to review their intervention and evaluation designs with an eye towards building their evidence base. This activity will be broadened to bring more “home grown” programs into the fold of effective, evidence-based efforts. In accomplishing this, CSAP will both provide information for service to inform science as well as provide communities with a broader selection of readily implementable, effective programs. ♦

Blueprints for Violence Prevention

THE IDENTIFICATION OF EFFECTIVE PROGRAMS

Sharon F. Mihalic, M.A.
*Center for the Study and
Prevention of Violence*

Blueprints for Violence Prevention began at the Center for the Study and Prevention of Violence (CSPV), as an initiative of the State of Colorado, with initial funding from the Colorado Division of Criminal Justice, the Centers for Disease Control and Prevention, and the Pennsylvania Commission on Crime and Delinquency. With later support from the Office of Juvenile Justice and Delinquency Prevention, Blueprints has evolved into a large-scale prevention initiative, in both identifying model programs and providing technical support to help sites choose and implement programs with a high degree of integrity.

The identification of effective programs has been in the forefront of the national agenda on violence prevention for the last decade. Today, after reviewing over 600 violence prevention programs, the Blueprints initiative has identified 11 model programs and 21 promising programs. Taken together, these programs target populations spanning the developmental age range, from birth to 19 years. In addition, these programs both prevent violence and treat youth already displaying problem behaviors.

Over the past decade, many organizations have produced lists of programs and practices that demonstrate at least some evidence of

effects on violence/aggression, delinquency, substance abuse, and their related risk and protective factors. Although these lists provide a valuable resource for the community, they can be confusing to the public. First, most differ in focus, with some lists being quite narrow; for example, limiting their descriptions to drug abuse, family strengthening, or school-based programs only. Secondly, and perhaps more importantly, the criteria for program inclusion vary tremendously from list to list, with some agencies adopting a more rigorous set of criteria than others.

The Blueprints initiative likely utilizes the most rigorous set of criteria in the field. However, this high standard is necessary if programs are to be widely disseminated, for when this occurs, it will not always be

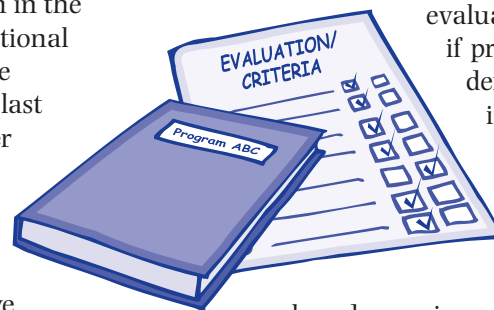
possible to conduct local evaluations to determine if programs are demonstrating the intended results.

Therefore, it is important that programs demonstrate effectiveness,

based on a rigorous evaluation, prior to their widespread dissemination.

Blueprints Selection Criteria

Blueprints model programs meet such a standard, and there is widespread consensus that Blueprints programs are effective interventions. Although a program model can rarely, if ever, be proven superior to all others, a particular model elicits greater confidence after its theoretical rationale, goals and objectives, and



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outcome evaluation data have been carefully reviewed. In turn, a community that implements such a strategy has a greater likelihood of a successful violence prevention effort.

Blueprints programs meet rigorous tests of effectiveness in the field by identifying three important factors when reviewing program effectiveness: evidence of deterrent effect with a strong research design; demonstration of a sustained effect; and multiple site replication. Programs meeting all three of these criteria are classified as “model” programs, while programs meeting at least the first criterion are considered “promising.” A summary of the criteria is provided below.

- **Evidence of Deterrent Effect with a Strong Research Design**

All Blueprints programs must demonstrate evidence of a *deterrent effect on problem behavior*—violence (including childhood aggression and conduct disorder), delinquency, and/or drug use. This evidence must be based on a strong research design, as this is the most important of the selection criteria, through *sufficient quantitative data* to document effectiveness in preventing or reducing these behaviors and the use of *experimental designs with random assignment or quasi-experimental designs with matched control groups*.

Further, the programs must have the following quality factors: 1) *sample sizes* large enough to provide statistical power to detect at least moderate sized effects, 2) *low attrition* to ensure integrity of the original randomization or matching process to allow generalization of findings, and 3) *consistent measures and administration*.

- **Sustained Effects**

Many scholarly reviews classify a program as effective if it demonstrates success by the end of

the treatment phase. However, it is also important that program effects endure beyond treatment, and from one developmental period to the next. For these reasons, designation as a Blueprints program requires a *sustained effect at least one year beyond treatment*, with no subsequent evidence that the effect is lost.

- **Multiple Site Replication**

Replication is an important element in establishing program effectiveness and understanding what works best, in what situations, and for whom. Some programs are successful because of unique characteristics in the original site that may be difficult to duplicate in another location (e.g., the presence of a charismatic leader or extensive community support and involvement). Replication establishes the strength of a program and its prevention effects by demonstrating that it can be successfully implemented in other sites.

Programs that have demonstrated *success in diverse settings* (e.g., urban, suburban, and rural areas) and with *diverse populations* (e.g., different socioeconomic, racial, and cultural groups) create greater confidence that such programs can be transferred to new settings. Becoming a Blueprints model program requires at least one replication with fidelity demonstrating that the program continues to be effective.

Summary

The Blueprints selection criteria establish a high standard of program effectiveness that has proved difficult for most programs to meet, thus explaining why only 11 model programs have been identified to date. Although rigorous, this standard reflects the level of confidence necessary for recommending that these programs be widely disseminated

and to provide communities that replicate these programs with reasonable assurances that they will prevent violence when implemented with fidelity. The Blueprints initiative was never intended as a means of compiling a comprehensive list of all programs that had some evidence of effectiveness. Instead, the model programs, in particular, were selected to reflect programs with very strong research designs that demonstrated evidence of effectiveness in delinquency, violence, or substance abuse prevention and reduction.

It is important to remember that programs **not** on this list are not necessarily ineffective. In fact, it is likely that there are many good programs that have not yet undergone the rigorous evaluations needed to qualify as a Blueprints program. Similarly, there are other programs that have demonstrated effectiveness in outcomes not considered by the Blueprints. Nonetheless, our work has revealed that many prevention and intervention programs are ineffective, and a few are iatrogenic (i.e., harmful). Thus, it is critical that outcome evaluations are performed and results made available to the community. Without this information, we cannot determine what programs work, nor can we be confident that children are benefiting from these efforts. CSPV continues to review new research findings, and we hope to continue to expand our list of Blueprints programs to include other credible, effective interventions that can be confidently implemented by communities. CSPV also reviews on-going evaluations of all the Blueprints programs, to refine our knowledge of their sustained effects, as well as their adaptability to other populations and settings. ♦

For further information, please visit our website www.colorado.edu/cspv/blueprints/ or email blueprints@colorado.edu

AGENCY AND PRACTITIONER RATING CATEGORIES AND CRITERIA FOR EVIDENCE BASED PROGRAMS

Compiled by Sharon F. Mihalic, M.A.
Center for the Study and Prevention of Violence

The following chart identifies a sample of federal and private agencies who have rated the effectiveness of prevention programs designed to reduce or eliminate problem behaviors, such as delinquency, aggression, violence, substance use, school behavioral problems, and risk factors identified as predictive of these problems. This chart describes the set of criteria that has been identified for program inclusion by each agency and also describes the focus of each work (i.e., school-based programs, violence programs, substance abuse programs, etc.).

The actual **Matrix of Programs**, not presented in this document, is a table listing approximately 300 programs that have been rated by each agency as effective. The Matrix of Programs can aid the practitioner by showing how various programs have been rated across different agencies. Look for the Matrix of Programs, developed by Sharon Mihalic at www.colorado.edu/cspv/blueprints.

CENTER FOR SUBSTANCE ABUSE PREVENTION (CSAP) DEPT. OF HEALTH & HUMAN SERVICES, NATIONAL REGISTRY OF EFFECTIVE PROGRAMS		http://modelprograms.samhsa.gov
RATING CATEGORIES	FOCUS AND CRITERIA	
<ul style="list-style-type: none"> • Model • Promising • Effective 	CSAP focuses on the effectiveness and impact of substance abuse prevention efforts. Programs are scored on a 5 point scale based on 15 criteria with 1 being the lowest and 5 being the highest score. <i>Model</i> programs are well implemented and evaluated according to rigorous standards of research, scoring at least 4.0 on the 5-point scale. <i>Promising</i> programs have been implemented and evaluated sufficiently and are considered to be scientifically defensible, but have not yet been shown to have sufficient rigor and/or consistently positive outcomes required for Model status. <i>Promising</i> programs must score at least 3.33 on the 5-point scale. <i>Effective</i> programs meet all the criteria as the Model programs, but for a variety of reasons, these programs are not currently available to be widely disseminated to the general public.	
DEPARTMENT OF EDUCATION, SAFE AND DRUG-FREE SCHOOLS		www.ed.gov (Visit U.S. Department of Education and search for OSDFS)
<ul style="list-style-type: none"> • Exemplary • Promising 	Relevant outcomes are related to making schools safe, disciplined, and drug-free: reducing substance use, violence, and other conduct problems and promoting positive changes in scientifically established risk and protective factors. Program criteria is carefully and thoroughly described on the website, and includes (1) evidence of efficacy/effectiveness based on a methodologically sound evaluation that adequately controls for threats to internal validity, including attrition; (2) the program's goals with respect to changing behavior and/or risk and protective factors are clear and appropriate for the intended population and setting; (3) the rationale underlying the program is clearly stated, and the program's content and processes are aligned with its goals; (4) the program's content takes into consideration the characteristics of the intended population and setting; (5) the program implementation process effectively engages the intended population; (6) the application describes how the program is integrated into schools' educational missions; and (7) the program provides necessary information and guidance for replication in other appropriate settings.	
STRENGTHENING AMERICA'S FAMILIES		www.strengtheningfamilies.org
<ul style="list-style-type: none"> • Exemplary I • Exemplary II • Model • Promising 	The National Program Review Committee, the University of Utah, and CSAP reviewed the programs that focused on family therapy, family skills training, in-home family support, and parenting programs. Each program was rated on theory, fidelity, sampling strategy, implementation, attrition, measures, data collection, missing data, analysis, replications, dissemination capability, cultural and age appropriateness, integrity, and program utility and placed into the following categories: <ul style="list-style-type: none"> • Exemplary I: Program has experimental design with randomized sample and replication by an independent investigator. Outcome data show clear evidence of program effectiveness. • Exemplary II: Program has experimental design with randomized sample. Outcome data show clear evidence of program effectiveness. • Model: Program has experimental or quasi-experimental design with few or no replications. Data may not be as strong in demonstrating program effectiveness. • Promising: Program has limited research and/or employs non-experimental designs. Data appears promising but requires confirmation using scientific techniques. 	
SURGEON GENERAL'S REPORT (2001)		U.S. Department of Health and Human Services • www.surgeongeneral.gov/library/youthviolence
<ul style="list-style-type: none"> • Model • Promising: <ul style="list-style-type: none"> – Level 1: Violence Prevention – Level 2: Risk Factor Prevention 	The primary focus of the report by the Surgeon General is violence prevention and intervention. The criteria the Surgeon General set were appropriately rigorous methods of inquiry and sufficient data to support the conclusions. <i>Model</i> programs have rigorous experimental design (experimental or quasi-experimental), significant effects on violence or serious delinquency (Level 1) or any risk factor for violence with a large effect size of .30 or greater (Level 2), replication with demonstrated effects, and sustainability of effect. <i>Promising</i> programs meet the first two criteria (although risk factors of .10 or greater are acceptable), but programs may have either replication or sustainability of effects (both not necessary).	

A Family Perspective on Evidence-Based Practices

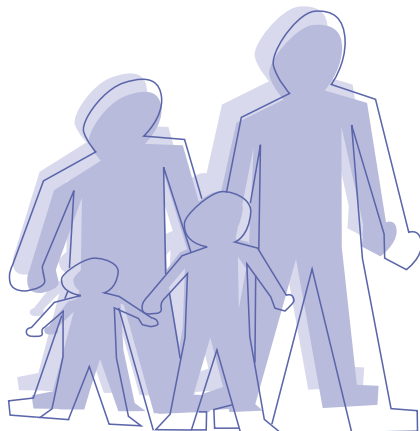
A. Elaine Slaton
National Federation of Families for
Children's Mental Health

As a parent whose son received psychotropic medications for which there was no research base for use in children—and therapy for which there was no evidence base to indicate a high likelihood that it would help, not harm, I am indeed invested in the search for evidence of effectiveness in children's mental health. As a children's mental health advocate I am further invested in not wasting ever-shrinking funds for services. I am, however, alarmed about—even frightened of—the current push to bring evidence-based practices (EBP) to scale.

Evidence-based practices, as I understand them, are

- service programs that have met strict scientific standards of effectiveness;
- programs that require intensive training and supervision to ensure fidelity to the model;
- a fairly short list, including Multisystemic Therapy (MST); Functional Family Therapy (FFT); and Multidimensional Therapeutic Foster Care (MTFC); and
- “proof” of what works and is cost effective for decision makers.

“Strict scientific standards of effectiveness” are largely mainstream academic research criteria that lack the depth of diverse “ways of knowing.” I am concerned that the experience, cultures, traditions, and knowledge of families of children and youth with emotional and behavioral disorders have not significantly impacted the designs of the practices,



the research, or the criteria by which these practices have been deemed evidence-based. Voices of youth, of community elders, of natural healers are missing in the “evidence” defined by strict scientific standards of effectiveness. My son and our family, like many others, found our most significant healing through ceremonies in Indian Country. We were welcomed, despite our whiteness, to participate in healing ways that centuries of natural healers knew worked. There was no scientific research behind these ceremonies, but deep indigenous knowledge of their effectiveness. These are the kinds of services that will go unfunded and unrecognized if EBPs continue to be defined as they are currently. Native children and their families—as well as children and families of other cultures—will be further denied access to their indigenous ways of healing.

“Fidelity to the model” means that the model practice must be implemented in exactly the same way—regardless of the race or culture of the people, the geographic location, the presence of natural helpers and healers, or the traditional ways of

healing indigenous to the families.

The “short list” of practices approved as evidence based to date, does not include the services and supports families across this country have come to identify as critical to the healing process for their children and families. That is, the list does not include respite, wraparound, traditional native ceremonies, or equine therapy¹. As funding for children's mental health services tightens, what will happen to the services we have defined as critical to our healing if they are not on the EBP list?

Questions we families—and those who support us—must ask:

- Who developed the programs? (By “who”, I mean their race, culture, relationship to children with emotional and behavioral disorders, and if their knowledge base is academic or experiential or both?)
- Who selected the outcomes?
- Who defined terms, such as effectiveness and success?
- Who was included in the research? Who was not included?
- Who defined the criteria by which a practice is deemed Evidence-Based?
- Whose money paid for the program development and the research—and, who will benefit financially from the replication of these practices?

As a trainer of the Federation of Families for Children's Mental Health Evaluation Skills Training for Families and Youth, I have become keenly aware that families and youth fear the potential racist implications—evident or not—in research. If families are left out until a practice has been deemed evidence based, they/we will not trust it and will not readily advocate for it. If the program development, the research, and the EBP criteria are not inclusive of all voices, they have not

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¹Animal assisted therapy where horses and humans interact through defined stages and activities that can benefit individuals with both physical and emotional difficulties. This method has been applied to individuals with physical disabilities, alcohol dependency, drug abuse, and those involved with the juvenile justice system.

MANAGING SUCCESS TOGETHER

The Evidence Base for MST from One Family's Perspective

Jan Kamarad
Grand Island, Nebraska

My son, Brent is a child with ADHD. I was quick to learn about the ADHD disorder; however, what was learned was not completely applied. I had often found myself using phrases “how many times have I told you,” or “if I have told you once I have told you a thousand times.” We had been treating his ADHD with both behavior modification and medication with limited success. Our family reached a crisis point when Brent became involved in the Juvenile Justice system and was about to be removed from our home. Brent’s probation officer suggested MST therapy as something he had heard about and could only tell me that it was family-based therapy. We were desperate and would try anything.

When our therapist first met with me, I asked some basic questions like: “OK now tell me about this, what does MST stand for? What are your objectives or goals for my son and my family? How do I know that this therapy works?” He was very knowledgeable about the therapy model, and so positive. I don’t remember any research data or specific evidence to convince me that MST would work. What I do remember most was his positive approach; wanting me to make my own determination—of what my goals were for my son and for my family; and his support for the fact that I know my child best!

MST is a strengths focused program. The strengths of the individuals and family unit were

pointed out and they became our focus and we built on them. During strengths discovery I was asked to list my goals as a parent. Each goal started with “Brent needs to...” or “I want Brent to...” With the strengths discovered and the goals stated we went into a 5-month intensive process. As we were preparing for release our therapist once again asked me to write my goals for parenting. A few of my goals are: listen well, talk openly, lighten up and don’t sweat the small stuff. As our therapist and I discussed these goals I realized how the focus had shifted from Brent to me. I no longer rely on Brent to meet my goals!

Multi Systemic Therapy (MST) helped me to gain an understanding of my son. I now understand how to work with Brent using straightforward, clear directives and an immediate-gratification learning style. This helped bring ADHD from a diagnosis to the reality of life.

Through MST, I changed my style of interacting with my children and problem solving. Our therapist’s instructions were “Do not engage in battle.” When you find yourself engaging, you have reacted to the problem, not solved it. I know I am reacting when I use phrases like “Why did you?” or “What were you thinking?” With this silly question the answer was of course, “I don’t know.” My reaction would be stronger and the battle would be on. “Do not engage” is the hardest step. First, I have to decide if the battle is mine, and if it is, do I want to take it on. Second, I have to learn to slow down, that if a problem isn’t solved in an hour, it is okay. I think the word the therapist used here is patience and I am continually working on that. Our therapist taught me to look for the cause of a problem rather than to simply react. He would say “Gee, Jan, what do you think is causing this?” He made me examine what was taking

Editor’s Note: Ms. Kamarad has shared her personal family story to illustrate the impact of one evidence based practice that helped her to reach her personal and family goals. Her evidence or measures of success were “listening well, ...talking openly, ...problem solving, ...decision making, ...empowerment, ...relaxed parenting, ...and fun with my children.” Is this the language of evidence base? From this parent’s perspective, yes. In addition, her story raises many important questions related to the family perspective on evidence based practices: How do families find out about evidence based practices? What do families want or need to know about evidence based practices? How can information about the practice and the “evidence” be made most meaningful to families? What is “informed consent” to pursue a particular therapeutic approach when a decision based on evidence is desirable? How do families define their own evidence and whether a particular practice will be or was helpful to them? These and other questions should be considered by both families and clinicians as they enter a therapeutic relationship and engage in intervention and strategies toward change.

place. I learned that I was quick to blame Brent as the problem rather than to find the cause of the problem and resolve it.

With that said how do you find the cause of the problem and solve it? I use a technique that I call the “decision making process.” In the center of a circle I write the problem, I have feelers coming out of the circle where I put the triggers of the problem and under the trigger I list possible solutions. Resolve the trigger, you resolve the problem. With some problems you will have several triggers, remember patience and work on one at a time! I ask my children to contribute their ideas and solutions during the process. This process helps me enormously and I use it in both my work and personal life. At times, the solution is not immediate and you may have to try different strategies but the end result is always positive.

One of the family gains from MST is the empowerment. As a parent, sitting across from any professional can be a very intimidating experience. MST’s strong statement that “you know your child best” taught me that I can advocate for my children in the school, in the justice system and in the community. If I don’t try to set my children up for success, who will?

What I enjoy most that MST has taught me is relaxed parenting. I have fun with my children; I no longer control their lives but contribute to their decision making. My children look to me to guide them and offer support. After our release from MST, I wrote the director to thank him and told him MST should not be known as Multi Systematic Therapy but as Managing Success Together. With Brent now a junior in our public high school and his sister, Shayla, in her first year at middle school, this is what our family does. This is not to say we do not have our conflicts—we do—we just know how to manage them now! Our family is evidence that MST is effective. ♦

What About Promotoras, Shamans, and Kru Khmers?

THE NEED TO EXPAND THE EVIDENCE BASE FOR DIVERSE COMMUNITIES

Rachele C. Espiritu, Ph.D.
National Technical Assistance Center
for Children’s Mental Health
Georgetown University

Where’s the evidence?

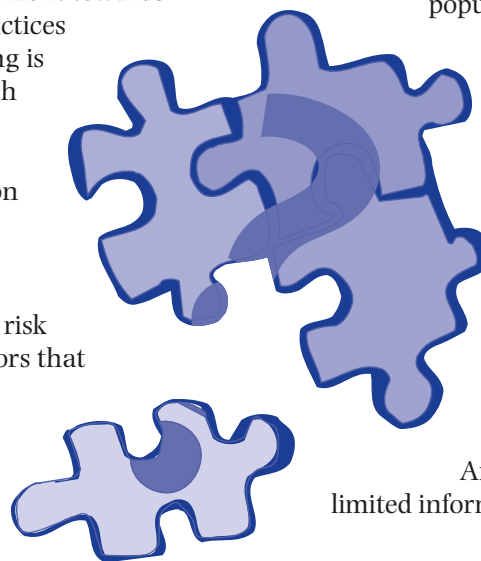
The evidence base for racial and ethnic minorities is alarmingly incomplete. According to a special analysis performed for the Surgeon General’s Report on *Mental Health: Culture, Race, and Ethnicity* (2001), information on race or ethnicity was not available for nearly half of the 10,000 participants included in clinical trials used to generate treatment guidelines. Furthermore, very few minorities were included in trials reporting data on ethnicity and *not a single study* analyzed the efficacy of the treatment by ethnicity or race. Unfortunately, very little is known about the effectiveness of treatments for ethnic minorities (Bernal, 2001). As the strong movement towards evidence-based practices continues, one thing is clear: more research is needed to understand the impact of culture on mental health and access to effective mental services. Understanding the risk and protective factors that cut across cultures and those factors that are unique to specific cultures is

critical to the development of successful program practices for all people seeking help, regardless of race or ethnicity.

Why is it missing?

There are several reasons for the disparity of information on the mental health needs and evidence-based practices (EBPs) for racial and ethnic minorities. *Methodological challenges* such as identification and recruitment of participants, and reluctance and resistance on the part of diverse populations are often encountered when studying the mental health of minorities. For these reasons and others, most of the efficacy studies on treatment interventions included, if any, *very small numbers* of racial and ethnic minorities. Therefore, group-specific analyses to determine efficacy were not possible and results not generalizable to these sub-

populations. Growing effort by federal funding agencies and the research community to increase the number of racial and ethnic minorities included in research will advance our knowledge for this growing population. Another reason for limited information on EBPs for



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communities of color is related to exclusion. The *standards of evidence-based practices* often exclude the few existing efficacy studies on specific sub-groups due to their small sample size. As Bernal & Scharron-del-Rio (2001) point out, the criteria of efficacy research often emphasizes internal validity (whether observed changes can be attributed to interventions) over external validity (generalizability).

What do we know?

What do clinicians, agencies, organizations, administrators do if faced with a clinical problem for which there are no randomized, controlled trials and no good evidence-based opinions? What types of programs exist for communities of color?

While various federal agencies and research organizations have established different levels of evidence based on the evaluation design, outcomes, replication and dissemination, the criterion of cultural appropriateness is often missing. Fortunately, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Substance Abuse and Mental Health Service Administration's Center for Substance Abuse Prevention (CSAP) did include cultural and age appropriateness as criteria in their process of identifying effective programs. They state that cultural- and age-appropriateness are a hallmark of programs that have been tested with diverse groups of participants. For example, the "best practice" family strengthening programs identified by OJJDP in collaboration with CSAP includes Functional Family Therapy (FFT), an empirically-grounded, family-based intervention program for acting-out youth. While FFT was originally designed to treat middle class families

with delinquent and pre-delinquent youths, according to the website, the program has recently included poor, multi-ethnic, and multi-cultural populations. Further, almost all of the *model programs* identified by CSAP's National Registry of Effective Programs indicate use with multiple ethnic groups.

What about curanderismo, qi gong, or talking circles? Building from the ground up

The movement towards evidence-based practices may leave behind traditional therapies, such as curanderismo (folk/medical beliefs, rituals practices that address the psychological, social and spiritual needs of Mexican and Mexican populations), "talking circles" of the Native Indian community, and other traditional remedies. Additionally, well before there were social workers, psychologists, and psychiatrists, traditional, faith-based healers such as the Cambodian Kru Khmer and shamans were around. Despite having many years of practice-based evidence and experience to support these therapies, the lack of "credible scientific evidence" often devalues the use of traditional treatments. Communities of color often don't have the capacity to build the necessary research.

While research is warranted on the adaptability of evidence-based practices for other racial or ethnic groups, Bernal and Scharron del Rio (2000) suggest a different focus. Rather than using a comparative approach, they suggest a focus on the treatment of specific ethnic minority groups. In other words, rather than making ethnic comparisons across treatment outcomes, documenting why or what makes a treatment work is more important.

What is needed?

Research is necessary to understand factors that might influence the efficacy of interventions within a specific racial or ethnic group, and the adaptability of interventions to other racial or ethnic groups. While fidelity to the EBP intervention is often required, language and the acculturation levels of the population served often necessitate modifications to the delivery of the service and translations of materials. Understanding the traditional values and beliefs about mental health of racial and ethnic minorities can also help the program developers and group leaders improve the program's effectiveness for these populations. Additionally, workforce training for providers and researchers, new training models, and the enhancement of consumer/family advocacy for communities of color can help improve the capacity to provide culturally competent services.

Summary

Key questions regarding the nature of evidence remain: in addition to evidence of effectiveness and efficiency, evidence related to the transportability, implementation, dissemination of EBP to communities of color, are important to examine. The provision of the highest standard of mental health services that are culturally and linguistically appropriate and accessible for all individuals regardless of race or ethnicity should continue to challenge the EBP movement. ♦

Reference

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The New Consumers of Evidence-Based Practices

REFLECTIONS OF PROVIDERS AND FAMILIES

Michael Hurlburt, Ph.D.
Children's Hospital, San Diego

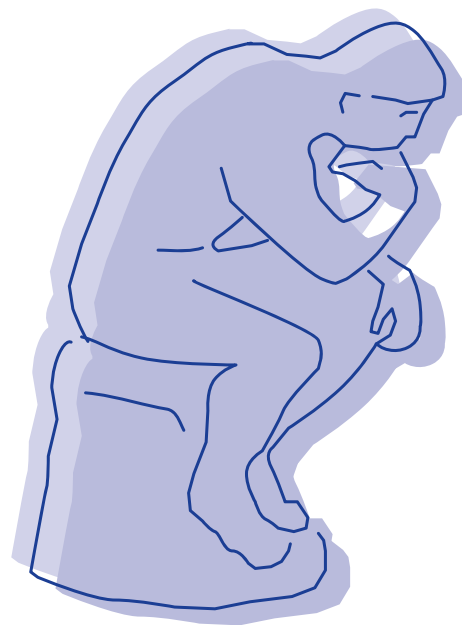
Penny Knapp, M.D.
California Department of Mental Health

There is a growing recognition of the importance of using evidence-based practice in mental health. However, evidence-based practices (EBPs) are variously defined as: a) practices that major organizations have endorsed, b) practices that arise from a strong foundation of basic research, c) practices that have some kind of outcome evidence to support their use, and/or d) practices that meet a defined threshold of sufficient outcome evidence to support their use. The phrase evidence-based practice is regularly used to mean one or more of these different things and it seems unlikely that consensus will be reached about any single definition for the term.

Given a term with many potential meanings, it should not be surprising that there is no single answer to the frequently asked question: "Why, given the presence of evidence, are evidence-based practices not employed as frequently as might seem appropriate?" In fact, the very breadth of the term "evidence-based practice" is certain to result in different answers to this question and to differences of opinion across individuals.

Our approach to answering this question was to discuss specific examples of evidence-based practices with potential consumers defined as

individuals or groups having a significant stake in whether particular practices are adopted, including at a minimum, administrators in mental health service systems, program managers (i.e., supervisors in service delivery organizations or units), clinical staff members, and families of children receiving services. In our research activity, we talked with these potential consumers about their evaluations of the evidence for specific practices and about barriers to and facilitators of their use. This article describes our research that took place in California.



In 2000-2002, in partnership with researchers from a consortium of

four mental health service research centers¹, the California Department of Mental Health undertook a large study of specific aspects of outpatient mental health care quality for children and adolescents in California. Given the likelihood that future improvements in services could be driven by EBPs, one component of the research led by this consortium focused on understanding how potential consumers of such practices evaluate the relevant evidence and what they perceive as barriers to and facilitators of the use of specific EBPs.

Potential EBP consumers were selected from three counties in California. The counties were chosen for their diversity along a number of different dimensions, such as the racial/ethnic composition of the populations they served and the total county population size. Within each county, a structured process was used to select a representative from each of the constituent groups mentioned above; members were not selected based on their opinions about the concept of evidence-based practice. In fact, an explicit goal was to hold discussions with individuals who had not necessarily adopted or considered adopting any EBP. In total, about 15 people participated in a series of five, four-hour meetings taking place over five months. The meetings focused on three psychosocial interventions for youths with disruptive behavior problems that have a relatively solid evidence base under any of the criteria listed at the outset, including Parent Child Interaction Training (PCIT), The Incredible Years Basic program, and

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¹Research Center on Managed Care for Psychiatric Disorders, UCLA; Child and Adolescent Services Research Center, Children's Hospital, San Diego; National Research Center on Asian American Mental Health, UC Davis; Center for Mental Health Services Research, UC Berkeley, and UC San Francisco.

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Cognitive Problem Solving Skills Training (see e.g., Kazdin, Siegel, & Bass, 1992; Schumann, Foote, Eyberg, Boggs, & Algina 1998; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989).

Prior to and during meetings, research team members provided participants with a detailed summary of one of these practices and the research evidence supporting its use. We felt that it was crucial for participants to discuss information about specific practices rather than consider the less well-defined concept of evidence-based practice. The bulk of time in each meeting was devoted to discussing participants' evaluations of the research evidence and their opinions about things that would facilitate or impede the use of each intervention in their organization and/or county public mental health system. Research team members facilitated the meetings and, when necessary, assumed the role of clarifying information about the three practices. They explicitly avoided serving as advocates for any of the three practices, spending most time facilitating the discussion and probing participants' comments. Each meeting was guided by a small number of prompts intended to facilitate discussion of the essential questions outlined above.

As in any group discussion, full consensus did not occur on every issue, but some important central observations emerged from the series of meetings.

Lack of familiarity

Although participants reported familiarity with the term "evidence-based practice," most participants were not aware of the interventions discussed in the meetings. Those that were familiar had limited knowledge of the research and outcomes associated

with each practice. Despite efforts by the research team members to summarize results relevant to each intervention in a consistent, digestible manner, it was clear that evaluating the evidence and its implications was a difficult and time-consuming activity that participants did not regularly have time to undertake in their own schedules.

Results not convincing

Participants did not generally feel that the studies summarized in support of each intervention provided compelling evidence that the practices would be effective with the children and families served in their settings or would be worth the investment required. In particular, participants were concerned that the clinical complexity of families served in their own service populations would be significantly greater than that of families served in research settings, and that interventions had not been used with the array of racial/ethnic groups served in California. Participants also felt that the specific procedures employed in several of the interventions were too costly and not broadly applicable without modification.

Priorities

In an exercise asking about priorities for improving services, participants listed many of their own important priorities for improving care. This exercise was conducted in the initial meeting and at the end of the series of meetings. Participants rarely mentioned incorporating EBPs as one of their top priorities, even after reviewing data for these three interventions. Participants reported having a number of other priorities to which they devoted time. These varied somewhat by individuals' roles, but

included priorities such as: 1) improving the System of Care culture, 2) human resources: improving access for non-English speakers and finding sufficient psychiatry time, 3) setting standards, 4) increasing consumer involvement in service planning, 5) expanding access to services, and 6) decreasing use of residential treatment services.

Locus of responsibility

When asked how changes in practices might come about, participants generally reported that individual service delivery organizations were responsible for initiating efforts to utilize effective practices. In the face of competing priorities, staff members and program managers indicated that it was difficult to initiate, sustain, and modify new practices without broader support from some level higher than the individual service organization. It appeared that there was not yet a widely recognized locus of responsibility, either within counties, or across counties, for encouraging and supporting the use of EBPs.

In addition to the participant responses that contributed to these four central observations, other important perspectives also emerged. Participants were able to suggest additional data collection that would make research more compelling to potential consumers, and they were able to make suggestions for modifications of interventions that they felt would increase their potential applicability. For example, participants felt that the placement of EBPs in their priority list would increase if research responded better to the specific questions of interest to them (e.g., "Can PCIT be delivered effectively in a single room or in someone's home?"; "How would reports of satisfaction

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differ if an independent consumer advocate interviewed individuals who had received a specific kind of service?”), and if a clear and sustainable locus of responsibility existed for encouraging and supporting adoption and application of EBPs.

Many of the lessons enumerated here may not come as a surprise. However, to the degree that they are accurate, there are important implications. First, closer and ongoing partnering of researchers with potential consumers of EBPs may be crucial to helping consumers to make decisions in light of available evidence. Second, closer and ongoing partnering of researchers and consumers would likely suggest avenues for research (both the type of data collected and the variations of practices developed and tested) that would yield findings more relevant to consumers in their roles as advocates and decision

makers. Third, it may be very helpful to have clear and sustainable local loci of responsibility for encouraging and supporting systematic use of EBPs in defined geographic areas. Obstacles to self-initiation on the part of individual service organizations appear to be large.

In closing, it is worth noting that these discussions intentionally focused on a small subsample of practices that could be called evidence-based. The findings are not likely to be applicable to all practices that could be labeled evidence-based. However, we believe that the most important results have to do with differences in questions and objectives held by researchers and potential consumers of EBPs that contribute to the gap between research and practice. Active models of ongoing collaboration may be a central component to broader or more rapid experimentation with EBPs in service systems. ♦

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Correspondence related to this article can be directed to Michael Hurlburt at mhurlburt@casrc.org or at the Child and Adolescent Services Research Center; 3020 Children's Way, MC 5033: San Diego, CA 92123

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been examined with the racial lenses essential to ensuring safety for all.

Until we find a better way, a way that honors all people, their cultural traditions, their race, their ways of knowing and of healing, we must stay vigilant. We must ask questions. We must learn the language of research and evaluation in order to speak the language of EBP. We must create partnerships—across racial and cultural lines, across the boundaries drawn between professionals and families—to affect the systems change that will help our children, our families, and our communities. We must advocate for research bases for the services and supports that are

important to us. And we must participate in that research.

Richard Sclove² recently said that research, science and technology should serve communities and humanity and not exacerbate contemporary crises. The Surgeon General's *National Action Agenda* refers to children's mental health as a public crisis³. This contemporary public crisis reaches every community in this country and I am not convinced research and science—as being applied in EBP—will not make it worse. Will we revert to expert-based decision-making and ignore the progress made toward more democratized development, implementation and

evaluation of services for children with mental health issues and their families? The family movement, numerous private foundations, and the Federal government, have committed to finding more appropriate and accessible services that are family-driven, individualized, and culturally competent in an effort to rectify the crisis in the children's mental health system. We must not let go of these goals while focusing on EBPs. ♦

²Author of *Democracy and Technology* and founder of the Loka Institute, board meeting, 2002.

³Report of the Surgeon General's Conference on Children's Mental Health, 2000.

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Evidence-Based Interventions within the Comprehensive Community Mental Health Services for Children and Their Families Program

E. Wayne Holden, Ph.D.
ORC Macro

The effectiveness of psychosocial interventions for children's mental health disorders has become a topic of considerable debate. A number of evidence-based treatments have been shown to be efficacious within research settings for specific presenting problems. Less is known, however, about the effectiveness of these evidence-based treatments in complex community settings. This has led to a concern that evidence-based treatments supported by the results of research are not being implemented well in "real world" settings. A clearer understanding of the factors that influence delivery of these services in the community will assist in understanding how to improve effectiveness. The development of treatment manuals and practice guidelines to guide the delivery of services in the community is one approach to improving the implementation of evidence-based treatments. Evaluating these evidence-based, manualized approaches as they are implemented in the community will provide information on real-world effectiveness.

A treatment effectiveness study is currently underway as part of the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program. This study examines the effectiveness of an evidence-based treatment provided to a

selected group of children with specific diagnoses served within CMHS-funded systems of care. The goal of the study is to examine whether children who receive evidence-based treatment delivered in systems of care experience better outcomes and maintain those outcomes longer than children in the same system who do not receive the evidence-based treatment. Within this study, a treatment fidelity substudy is being conducted to assess whether the evidence-based treatments are implemented as intended, and whether system-of-care principles were evident in the care received by these children and their families. This will be accomplished by administering the System-of-Care Practice Review, a measure specifically developed for the national evaluation that assesses services experiences at the interface between service providers and families.

The study reflects an integrated process that dovetails with the general

child and family outcomes study for the national evaluation. This involves initially identifying sites for the study, documenting procedures for the specific intervention to be studied, assessing whether the intervention was implemented as designed, and utilizing a methodology and data collection strategy that builds upon the framework for the child and family outcomes study to follow cases across time. The design allows for the testing of the effects of an evidence-based intervention integrated into the system-of-care approach versus system-of-care services as usual. Both groups participating in the study will continue to be eligible for other system-of-care services.

The two grantee communities initially selected for participation in this study are the Bridges Program in eastern Kentucky, and the Clackamas County Partnership in Portland, Oregon. Service providers in the community will provide Parent-Child Interaction Therapy (PCIT) to children between the ages of 5 and 9 who are referred for the treatment of disruptive behavior disorders. The study will examine the effectiveness of this treatment.

PCIT was designed for young children with disruptive behavior disorders. This evidence-based treatment typically includes 8 to 12 weekly family therapy sessions and involves (a) initial assessment, feedback, and joint development of therapy goals by the clinician



and caregiver(s); (b) behavioral play therapy followed by a caregiver teaching session; (c) direct coaching in the next several sessions to master behavioral play therapy goals; and (d) interactive discipline training for caregivers followed by several coaching sessions. Direct consultation and coaching with the child's classroom teacher is also available as a component of the treatment. A post treatment evaluation is then conducted and changes from pretreatment are reviewed with the family to reinforce the improvements made. Finally, booster sessions are conducted with families over the subsequent 12-month period to maintain positive skills. PCIT has been found to be effective for significantly reducing problems for up to 18 months in the home and school, and positively affecting outcomes for untreated siblings.

PCIT shares some of the key system-of-care principles, most notably a recognition of the importance of the family's role in serving children, sufficient flexibility to attend to the individual needs of the child and family, and integration of assessment data to monitor progress and reinforce gains. PCIT also addresses disruptive behavior disorders, the most prevalent problem among children served in CMHS-funded systems of care. Additionally, PCIT is geared toward younger children, allowing intervention at early stages of the disorders and possibly averting deleterious long-term impact of disruptive behavior disorders.

Work on this study has already yielded interesting information about the implementation of evidence-based interventions within systems of care. The outcomes of this study over the next several years will assist in understanding how the effects of evidence-based interventions can be maximized within systems of care. ♦



Evidence-Based Practices: Essential Elements of Reform

Even in Tough Economic Times

George P. Gintoli, M.S.
*South Carolina Department
of Mental Health*

John A. Morris, M.S.W.
*SC Center for Innovation in
Public Mental Health*

Context and the Concept

South Carolina is and has been an interesting laboratory for change. As a relatively poor, largely rural state, mental health professionals, consumers and advocates have had to be especially creative in designing and implementing any change agenda. While no one would choose to experience the kinds of budget cuts that South Carolina—like many of its sister states—has faced and continues to face, it does focus the attention of leadership like a laser. There is simply no excuse for spending a nickel on programs that don't have a high likelihood of success.

In the past eighteen months, our system has adopted a new template for change, published in a planning document entitled *Making Recovery Real*¹. Adopted by the SC Mental Health Commission, it lays out an ambitious agenda for modifying the state's service mix for children and adolescents, their families, and adults with serious mental illnesses. It explicitly drives the public service delivery system, one of the few vertically integrated/state-operated systems, on the use of evidence-based models. In instances where there are not services that meet the gold

standard of evidenced-based practice (randomized, controlled studies in real practice settings), then promising and emerging practices are highlighted. This quote captures the foundation principle of the operational plan:

"The content of this plan was developed within the context of three core themes: the realities of resource constraints, including money (given the state's current budgetary crisis), human resources (given the historic difficulties in recruiting and retraining adequate numbers of trained staff, especially in rural communities), and time. These constraints demand planning for services that exemplify two characteristics: **a high probability of success**, which means evidence-based or promising/best practices, and **consistency with a recovery philosophy...**"

Some key questions in moving the plan forward are: How ready is the system? Are new resources available, or must we redirect existing ones? How do we sell best practices and build consensus? Who are our partners and what new relationships must be formed? How do we measure progress? How do we address sustainability?

Structural Resources

Against a backdrop of decreasing state mental health revenues, the Department of Mental Health is joining with the state's academic institutions to move the plan forward; building on new resources from grants; contracts and collaborative

¹South Carolina Department of Mental Health (2002). *Making Recovery Real: A planning document for the SC Department of Mental Health*. Morris, JA (Ed.), 65 pp.

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relationships; new Medicaid service lines; reallocation of existing resources; and the **essential** support of key advocate and consumer groups (NAMI, FFCMH, MHA, P& A, SC SHARE)².

Much of the work of implementing best practices, whether in pilot projects or via statewide replication, will be facilitated by the SC Center for Innovation in Public Mental Health, which is a partnership between SCDMH and the Department of Neuropsychiatry and Behavioral Sciences at the USC School of Medicine. In addition, there are active public/academic relationships with the Family Services Research Center at the Medical University of South Carolina in Charleston; the Institute for Families in Society at USC; and the Institute for Family and Neighborhood Life at Clemson University. Several projects are building relationships with SC's traditionally black colleges and universities, as well. The final essential link for measuring progress is our partnership with South Carolina's unique multi-agency Data Warehouse, which has the capacity to provide unduplicated data on clients across the health and human service spectrum. We can track real world outcomes (school performance, juvenile justice involvement, health status) as we implement best practice interventions.

Making Change Happen

Effective linkages between the practice world and the research world don't happen automatically, so the role of the Center for Innovation is to facilitate the public system/academic linkage process. Conscious, concerted effort is required to make the bridge work. We use a variety of strategies to make this happen, but the most critical element in our success is a

commitment to listening to what end users (provider organizations, clinicians, and consumers) tell us they need. We help build task specific coalitions, assist with grants development, and bring our resources to bear to assist with program, budget and policy elements of evidence-based rollouts. We try to consciously use the resources of sister institutes and research groups as partners for external evaluations, for conceptual support and other ways.

The most challenging part of this effort has often been the simultaneous translation function and mediation between researchers and practitioners. Researchers and practitioners often don't understand each other because of their different frames of reference and the needs that drive what they do every day. The Center for Innovation accepts as a part of our role preparing each group to work with the other, creating common ground for discussion, and ensuring that there is sufficient common purpose to maintain a practical coalition.

A variety of specific activities or tasks undergird the change process, all designed to make the change process less scary and burdensome. Some examples include:

- **Planning for Change:** We used distance education technology (our closed circuit system) so that we could involve lots of local folks, limit expense, and eliminate travel. We supported the work of a stakeholder steering committee by setting a reasonable and meaningful set of tasks (designing a new mission statement for DMH, identifying core values, reviewing draft plans); by setting a firm set of timelines that were honored (so that it didn't

become the much-dreaded Endless Committee); and by committing to keep the plan small and to the extent possible, not written in "bureaucratese."

- **Resource Development:** Change processes sometimes need a boost, and resources are chronically scarce. Using the Center for Innovation and its partners, we have been aggressive in seeking grant support, and are relentless in pushing for sustainability as part of any new initiative. South Carolina is fortunate to have an excellent working relationship with the state Medicaid authority, and they have supported many of our best practice efforts.
- **Training and Technical Support:** Initial training in a best practice is an essential but not a sufficient condition for system change. As we move to scale on evidence-based practices, whether for adults or children and their families, we try to create peer support teams among the sites and offer on-going technical assistance and problem solving. For example, when new procedures or forms are required, we try to take the onus of making these changes off the backs of clinicians, helping the system adapt to new ways of doing business.
- **Tracking Outcomes:** There are few things that support enthusiasm for new ways of providing services than evidence that people's lives are improving. For each new practice, we work to build in outcome indicators that can be used to determine effectiveness. The Center for Innovation has designed the DMH system of "dashboard indicators," which will be implemented during 2003.

²National Alliance for the Mentally Ill, Federation of Families for Children's Mental Health, SC Mental Health Association, SC Protection and Advocacy for Persons with Disabilities, SC Self Help Association Regarding Emotions

Sustaining Change

From the Department of Mental Health's perspective several other planning and implementation issues are directly linked to system supports that can put permanency planning up front and sustain change. Financial viability and continuing to build the skills, knowledge, and **ownership** of clinicians and provider organizations are critical. It is important to anticipate the costs of dissemination; the skills, time, and effort required for a lengthy, system-wide transition; and management strategies at the system, agency, and supervisory levels. Nuts-and-bolts issues such as cost-effective training, retraining and supervision; performance contracting; improved data systems; attention to degree of fidelity to the evidence-based practice; quality of care; and outcomes are important to consciously address and build adequate infrastructure for sustained change.

Keeping the Focus

Budget realities may slow implementation schedules, but there continues to be strong consensus among the state's advocacy community, the Medicaid authority, and sister agencies (Juvenile Justice, Alcohol and Other Drug Services, Vocational Rehabilitation, State Sheriff's Association and others) to support DMH leadership's emphasis on producing outcomes that matter in the lives of children, adolescents and their families in South Carolina. Results improve when leaders establish a clear vision with a convincing reason to embrace the vision. The Center for Innovation in Public Mental Health has a key role to play, and the more often we can find ways to work collaboratively to make "recovery real," the better. ♦

For more information, contact John Morris, JAM66@WSHPI.dmh.state.sc.us or George Gintoli, GPG97@dmh.state.sc.us.



School-Based Services in the Context of System of Care Development

Building Bridges Between the Home, School, & Community

Elizabeth V. Freeman, L.I.S.W., M.S.W.,
Louise K. Johnson, M.S., and
George Gintoli, M.S.
*South Carolina Department
of Mental Health*

The System of Care in South Carolina

In South Carolina, the Department of Mental Health (SCDMH) and the Division of Children's Services have taken a stance to develop a seamless, state-wide system of services for children and families which is family-focused, community-based and culturally competent. SCDMH has been instrumental in developing the vision of coordinated system of care since as early as 1991. The process of developing this vision evolved in 1999 through the Governor's Safe Schools Task Force targeting evidenced-based violence prevention initiatives. State and non-profit organization partnerships have been strengthened to focus on the system of care goals and objectives to: 1) Improve clinical outcomes; 2) Cost-share/maximize resources; 3) Promote culturally appropriate community-based interventions; 4) Promote evidence-based practices through training professionals/organizations, developing and funding programs that have proven effective with youth and are outcome driven; and 5) Decentralize crisis/acute care services.

Focusing on What Works

Within this context, the Governor's Safe Schools Task Force

assessed activities and strategies already in place in the state proven to decrease and/or prevent youth violence. A review of evidence-based programs and outcome data were used to determine the additional resources needed in SC to address youth violence. The results of the task force produced the following goals:

- Implement more school-based prevention strategies/programs.
- Increase community involvement in preventing youth violence.
- Identify high-risk students for committing assaultive/violent behavior and provide effective intervention/treatment strategies.
- Improve the system's overall effectiveness through increased coordination of policy development, training and technical assistance.

Why choose school-based services?

South Carolina chose school-based services as one mechanism for offering coordinated and evidence-based services within the system of care with several goals in mind.

- To increase the accessibility of mental health services for children and families in need of these services in a non-stigmatizing environment.
- To provide mental health programs that address early intervention and prevention services for schools and the community.

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- To provide consultation for teachers and other school staff on mental health issues.
- To increase partnerships between the school and community which promote emotional health.

These goals are part of the reason why school-based services work for SC. Mental health services are provided under DMH confidentiality guidelines by mental health professionals (MHP), at the school (a non-stigmatizing environment), as requested with no appointment necessary.

School-based services: From research to practice

SCDMH guides communities/schools interested in implementing school-based programs through several important planning steps necessary for a successful partnership and the selection of an appropriate, community-specific, violence prevention initiative as outlined below.

- Contact the local community mental health center to set up meetings with the Director and Children Services Director
- Develop a community advisory team to assess the community/school's strengths and needs
- Outline the anticipated benefits of mental health efforts for the community/school
- Assess the population to be served, the cost of program services, the school site, and partnership needs
- Based on needs assessment, select the most appropriate prevention program (further description below)
- Establish memoranda of agreement and/or contracts between agencies

Through this process, community/school advisory teams have used resources within their community to begin violence prevention initiatives. As needed,

partnerships were also created to develop new resources within the community. After carefully researching the needs of their particular students and community, each community/school advisory team chose a model that would best suit their needs. The SCDMH and state advisory team members from the Governor's Safe Schools Task Force provided information on model programs (e.g., EAST, PACT and Youth leadership). The community/school advisory team also considered programs that had been promoted by their local school district. Each team then determined how the initiative would be implemented in the school. Usually, the principal of each school set the tone for successful implementation of the school-based program.

The following list is a sample of programs that were used in various projects across the state depending on the intervention that the community selected:

- School-wide Bullying Program (USC Institute for Families in Society),
- Get Real About Violence, Peaceable Schools,
- Seals Skills Streaming for elementary and middle schools,
- Positive Adolescent Choices Training,
- Families And Schools Together program,
- Peer Mediation,
- Prudential Youth Leadership training,
- Youth Courts,
- Drug Courts,
- Juvenile Arbitration programs, and
- Diversion Programs with middle school youth.

Benefits outweigh the challenges

As with any system change, there have been challenges encountered at the state and local level. Some of these

challenges include: obtaining stakeholder participation and partnerships, limited resources, overcoming turf issues within schools and communities, understanding limits and duties of each stakeholder, and overcoming mental health stigma.

Both the state level and community level advisory teams play critical roles in creatively addressing challenges. First, a *shared vision* for all partners at the state and community levels has been imperative. Monthly meetings among advisory teams provide a vehicle for encouragement, support, and learning among the partners to share challenges and develop strategies to address the barriers. *True partnerships* have been formed to overcome the historical autonomy of schools and community agencies. A concerted effort to obtain stakeholder participation and partnerships at various levels (e.g., sharing costs and duties of a program, acceptance of a 'system of care' perspective, sharing cross-training responsibilities between agencies and professionals) takes several years and is ongoing. In a time of budget deficits, both the state and community level advisory teams work to create mechanisms to share program costs through *shared/blended funding streams*. The state level advisory team sought ways to change policy and procedures to share funding between agencies/non-profits (e.g., contracts, Memorandum of Agreements (MOA), state health/human service department policies), while community level advisory teams sought contracts and MOAs between school districts, community mental health centers, non-profits, city government, foundations, etc.

Despite these challenges, the benefits to students, families, and schools have been tremendous. In

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Connecting Systems of Care with Evidence-Based Practices

Patrick J. Canary, M.Ed.
Center for Innovative Practices, Ohio

The Center for Innovative Practices (CIP) was established with funding from the Ohio Department of Mental Health as a component of its overall Coordinating Centers of Excellence (CCOE) initiative. The CCOE initiative is designed to promote the dissemination of evidence based and best practices in the field of mental health. CIP's focus is those services and interventions specific to youth and family populations. The goals of CIP are:

- To partner with organizations, connected to or developers of, evidence based and promising practices
- To integrate Evidence-Based/Promising Practices with Systems of Care development by assisting communities and organizations with assessment of systems' needs and use of evidence-based services
- To identify other evidence-based/promising practices for potential development in Ohio
- To participate and provide technical assistance related to policy, financing, and program issues
- To be complementary to/supportive of other CCOEs and initiatives that promote evidence-based practices.

The initial evidence-based practice with which CIP is partnering for statewide dissemination is Multisystemic Therapy (MST). CIP has a partnership agreement with MST Services, Inc., that provides the infrastructure for statewide dissemination of MST. As a licensed training organization of MST Services, Inc., CIP is qualified to provide all the clinical and administrative consultation

and support needed by providers to develop and sustain MST teams. CIP has fostered steady growth in awareness and development of MST teams. There are currently 9 counties with 8 teams working with CIP. Dissemination efforts have been steady and discussions with additional communities are in progress. In 2003, CIP will identify and foster similar partnerships with other EBPs, such as Functional Family Therapy and the Oregon Model of Therapeutic Foster Care.

CIP has been an active participant in inter-state and national discussions related to implementation challenges of EBPs. CIP catalogs on an ongoing basis its 'Lessons Learned' in regards to the challenges of wide scale dissemination of EBPs. Some of the key lessons learned/challenges include:

- A 'center' model provides for an **overarching structure that highlights EBP and allows for the development of a cohesive and quality based network approach to dissemination.** The CCOE model is designed to bundle skills and information into an accessible resource for various constituents. A Center can also act as a 'hub' through which a variety of entities (providers, planners, policy makers) can intersect and be connected. This type of an organized and outcome driven approach can help highlight and operationalize the dissemination process.
- **Evidence of clinical and cost effectiveness is not sufficient to influence change in treatment and funding patterns.** Experience is showing us that it is extremely challenging to re-route funding patterns, despite cost and clinical evidence.

From a funding perspective, the complexity of public systems' funding and service patterns requires an individualized approach to realize cost benefits and redirect funds. Localities and states operate with a variety of formulas and patterns; therefore, dissemination of EBPs requires understanding those patterns and working with stakeholders to find the right 'fit.' A more cohesively funded system, serving youth and families at all levels, would greatly enhance the capacity of communities to develop a broader array of effective services.

From a treatment perspective, we need to further develop our levels of care and our array of services at each level. We owe our youth and families effective interventions that are rationally organized in a true system; one that respects their individuality and responds in ways that strengthen the goal of a healthy, strong family. Behavioral health outcomes achieved through best practices and interventions need to be directly linked to their impact and effectiveness across all other critical life domains of the youth and family. Strong advocacy among families, partners, providers, and key stakeholders is needed in order to disseminate the "outcome news" of EBPs.

- **Identifying 'champions' (national/state/local) who can provide leadership for systems change is critical.** The System of Care movement, for example, has the benefit of inspiring champions of systems change, inclusive of parents, providers, funders, and policy makers. Advocating for more

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effective services requires that same configuration of support from the same base of stakeholders who see the relationship between the system of care and evidence-based practices as highly interdependent. It is in this way that systems of care and EBPs are complementary and reinforce one another. A good system of care, guided by clear values, should be organized to support youth and families and built on strong, proven, and effective interventions and practices. This synergy between the organizational and operational components results in a truly effective system of care.

As one of its primary goals, CIP supports integrating evidence-based/promising practices with systems of care development in its work with local communities and champions for systems change. These lessons learned influence CIP's role in providing technical assistance and leadership in the ongoing discussion of how to support the development and dissemination of EBP in the field via presentations and participation in key forums. While CIP is a resource for the state of Ohio, it is an active participant in the national dialogue on EBP through forums, conferences, and other venues focused on the development and dissemination of EBPs.

Future plans include developing more system specific information for decision-makers, launching a website, enhancing the network relationship with in-state MST teams, continuing to provide real world examples of dissemination, and outreach to other best, promising, and evidence-based practices that will enhance the state's system of care for youth and families. ♦

For additional information on CIP, please contact Patrick J. Canary, Director, at patrickk@cipohio.org or pjkanary@core.com



Implementation of an Evidence-Based Intervention in Systems of Care

The Evolution of the Nebraska Model

Rick Ferguson, M.S., L.M.H.P.
*Mid-Plains Center for Behavioral
Healthcare Services*

Beth Baxter, M.S.
Region III Behavioral Health Services

Wraparound in Central Nebraska began in 1995 as a statewide primary intervention initiative focused on children and adolescents who experienced serious emotional disorders and their families, but who were not Medicaid eligible. Through our evaluation, a population of youth (juvenile offenders) was identified who were not experiencing as strong, positive outcomes as other youth in the program. In order to improve the effectiveness of wraparound for these youth and their families, representatives from our local site—Region III Behavioral Health Services, the Nebraska Department of Health and Human Services, the University of Nebraska, and a clinical consultant embarked on a process to select an appropriate therapeutic component for these youth.

Selection Criteria

A good “fit” between the selected intervention and wraparound in Nebraska was important to the team to facilitate a successful ecological approach. Therefore certain intervention criteria were defined for the selection process. Some of the criteria included a family focus, community- and home-based approach, team oriented, demonstrated outcomes, and a

compliment to the wraparound approach. After a review of evidence-based interventions, Multisystemic therapy (MST) was selected to be the therapeutic component.

The Process of Implementing EBP in Systems of Care

The process of implementing MST in wraparound involved issues at the system partners level, the wraparound provider level (Region III), the contracting agency level (Mid-Plains), and the EBP developer level. Some of the issues are briefly highlighted below.

In order for the Nebraska model to be effective, MST Services, Inc. (MSTS) and Region III Behavioral Health Services had to work collaboratively to implement and operationalize the model. While the implementation of MST within wraparound involved many challenges, the system partners were committed to making the model work. Conflict resolution and decision-making processes were developed to help address the differences encountered between the proponents of wraparound and MST.

Initially, there were some struggles for MSTS to integrate the intervention within the Wraparound Model of service delivery, most likely due to an initial misunderstanding of the wraparound elements. There were also concerns over who was “in charge” of the process and difficulty defining roles and responsibilities of the wraparound versus MST service providers. The system partners and MSTS worked to overcome these barriers through lots of

HIGHLIGHTING THE FIT WITH SYSTEMS OF CARE: STATE & COMMUNITY LEVEL EFFORTS

frank and direct communication during meetings with our site's leadership and MSTs, a clear articulation of our site's expectation of MST, and a centered focus on positive outcomes for children and their families.

Mid-Plains Center also encountered challenges in becoming a licensed MST provider. Initially, it was difficult to obtain administrative support for the funding of a best practices program that appears on the surface to be expensive. While cost comparisons indicated that MST could save dollars, convincing the ones who pay the bill was a struggle. Fortunately in 1997, Mid-Plains Center received the contract from Region III's CMHS grant to develop the capacity for MST.

Another upfront struggle was the recruitment of therapists who were willing to work 24/7 with high intensive families. Finally, in February 1998, two MST Therapy Teams were trained and began serving families soon thereafter. Fortunately, the grant also paid for the training for each therapist. Without this support, the training at \$2500 per therapist would have been difficult to provide. Seeking to become a self-sustaining program has been a struggle, as the added expense of paying for all fees including licensing and consultation can quickly drain the budget. The negotiation of contracts with payor sources is also an ongoing event, as the expenses need to be covered with the rate. Mid-Plains Center also educates referral sources to generate appropriated referrals to the MST program. It took several months for the program to have enough referrals and was a big budget concern.

Fortunately, the commitment of the systems partners to integrate MST with wraparound continued to move forward despite these barriers. The evolution of this integration became known as "The Nebraska Model." Ultimately, a Program Guidelines

document was created for the wraparound/MST Nebraska Model that outlines the intake and referral process and the evaluation of outcomes, describes the integrated models, and defines the roles and responsibilities of wraparound and MST therapists.

Evolution of MST in The Nebraska Model

The efforts of the initiative to integrate MST and wraparound are characterized by four models, each evolving to varying degrees through our collective experience.

- The "**alternative model**" provides each approach independently from the other, either MST or wraparound. In part, this approach was developed early in the Initiative due to difficulties conceptualizing how the two approaches could work together. While much progress has been made in determining the collaborative roles of MST and wraparound therapists, some children and their families participate in this model due to their unique needs.
- The "**sequential model**" was similar to the alternative model in that the two approaches would not be conducted at the same time. However, a family in wraparound who may benefit from MST would suspend wraparound services to complete MST. After MST concluded, wraparound would resume. This model was the least satisfying for both the professionals and families and was ultimately discontinued.
- The "**blended model**" focused on providing wraparound providers with MST training in an effort to enhance or improve their abilities to provide wraparound. The MST ecological orientation and use of empirically supported, behaviorally oriented treatments helped focus the wraparound process into a disciplined, deliberate approach.

- The "**integrated model**" focuses on how MST as a clinical intervention fits into the wraparound process. The collaborative implementation of MST as part of the wraparound process is based on mutually agreed upon practices and procedures.

In the Nebraska Model, adherence to the evidence-based intervention is critical. Therefore, several implementation procedures are important to note:

- A supervision/consultation process was established with MST for the first three years of program implementation
- Training requirements for all therapists include an initial 5 day training with MST Services in South Carolina and ongoing training (2-day booster every quarter)
- Families complete a Therapist Adherence Measure on their therapists
- Weekly tapings of supervision and consultation are reviewed to provide evidence of adherence to the model and provide opportunity for skill development

As our therapists work with youth and families, the attitude that we have toward them is a great determining factor to success. We approach each of our families with a true belief that they are people of great value and have wonderful resources and strengths that have been untapped. We bring a ray of hope into their lives, seeking to find what is good about them, rather than what is wrong with them. Through the trial and error of implementing an EBP in an existing wraparound process, we found that the only effective way was working together for the good of the family. The true reward of providing MST to these extremely struggling families is being able to see their youth remain in the home. ♦

HIGHLIGHTING THE FIT WITH SYSTEMS OF CARE: STATE & COMMUNITY LEVEL EFFORTS

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2002, over 12,000 children/youth received mental health services, with 43% of these services provided in the schools. Positive outcomes for students include: increased school attendance (93%), decrease in discipline referrals (56%), increased length of stay in family home and community programs (92%), decreased inpatient/hospitalizations (12%), and decreased juvenile justice referrals (99% remain out-of-trouble). Families have easy access to service, to teachers, and to student assistance teams; crises episodes are handled immediately; and treatment durations

have decreased. Schools have a MH counselor on site to handle crises episodes and work daily with students who have difficulties.

Currently, over 250 MHPs are located in over 448 South Carolina schools (40%). SCDMH is dedicated to the development of school-based programs and aims to provide a MHP in every school in South Carolina. The implementation of school-based services offers the opportunity for evidence-based treatment services within each community to be accessible to students, families, and schools. ♦

CORRECTION TO ISSUE #5 LIST OF WEB-BASED RESOURCES

The **Council on Quality and Leadership** is a non-profit organization with a mission to increase the responsiveness and accountability of individuals, organizations and systems to people with disabilities. This is pursued through accreditation, monitoring, evaluation, training, and consultation to human service organizations. For over 30 years, the Council has worked to implement person-centered solutions for service and support organizations, state and national government agencies, regional systems, and networks, and professionals and self-advocates. The Council's web site is: www.the.council.org

Data Matters



National TA Center for Children's Mental Health

Georgetown University Center for Child and Human Development
3307 M Street, NW, Suite 401
Washington, DC 20007