Using Evidence-Based Practices for Systems Change: Addressing the Needs of *Katie A.* Youth and Families

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CiMH
Helping You Make the Difference

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Getting to Know You

- Please let us know if you are with:
  - A. Mental Health
  - B. Child Welfare
  - C. Other

Getting to Know You

- Please let us know if you are:
  - A. Consumer/Family Member
  - B. Administrative Director/Manager
  - C. Training Director/Manager
  - D. Direct Service Provider
  - E. Other

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Getting to Know ALL about you

- Please let us know if you are implementing EBP(s)
  - A. 1-2 EBP
  - B. 3-5 EBP
  - C. More than 5 EBP
  - D. No EBP

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Overview

- Core Practice Model Framework
- Evidence Based Practices Elements
- Evidence-Based Practice Models
- Implementation Method
- Evaluation

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Core Practice Model

- The Core Practice Model (CPM) vision is of a system where children, youth and families, child welfare and mental health staff work within a team environment to build a culturally relevant and trauma-informed system of supports and services that is responsive to the strengths and underlying needs of families being served jointly by child welfare and mental health. (CPM Guide, p.3.)
- The goal of the CPM is to achieve positive results to strengthen and reunite families.

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CPM Framework

1. The CPM envisions a single system with a unified approach to services. Children, youth and families have their mental health needs identified, assessed and addressed in a timely manner. The process is streamlined, with minimal duplication and no competing demand by the agencies so that families can receive effective and responsive services.

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CPM Framework

2. The CPM represents a shift from organizations, agencies and individuals working independently to a team environment, where children, youth and families, child welfare and mental health staff are part of a team, organized to help children, youth and families achieve their goals.

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CPM Framework

3. The CPM embodies the concept of partnership. This means partnerships at all levels within child welfare and mental health and partnership with children, youth and families.

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CPM Framework

4. The CPM promotes a collaborative system with a supportive organizational structure where child welfare (CW) and mental health (MH) work together at all organizational levels regarding children and families in both systems.

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CPM Framework

5. The CPM includes the concept of a trauma-informed system.

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CPM Framework

6. The CPM is a model where data is shared across organizations.

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CPM Framework

7. Under the CPM, CW and MH have joint accountability.

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CPM Framework

Evidence-Based Practices - Evidence-based practices are those that have empirical research supporting their efficacy. Child welfare and mental health agree on the importance of using practices that have proven effectiveness; both systems have identified a number of evidence-based practices relevant for use in both systems' service delivery. (CPM Guide, p.2.)

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What Are Evidence-Based Practices?

- The American Psychological Association defines EBP as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences”.
- The Institute of Medicine (IOM) defines EBP as “the integration of best-researched evidence and clinical expertise with patient values.”

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Why Evidence-Based Practices Now?

- A growing body of scientific knowledge
- Increased interest in consistent application of quality services
- Increased interest in outcomes and accountability by funders
- Past missteps in spreading untested “best practices” that turned out not to be as effective as advertised
- Because they work !!

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Why Is the Effectiveness of a Practice Important?

- Emotional, behavioral and mental health conditions can be complicated, severe, and difficult to treat.
- The causes of these conditions are not fully understood.
- Treatments do not result in full recovery of all individuals.
- Some treatments are more successful than others.

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Benefits of Effective Practice

- Results in more individualized and hopeful care decisions
- Reduces adverse consequences of imprecise care
- More likely to be effective
- Achieves outcomes sooner
- Outcomes last longer
- Ethical
- Cost effective; limited resources can be used to serve more children and families

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Adverse Consequences of Imprecise Treatment

- **UNDER-SERVING**
  - Outcomes are not achieved
  - Wasted expenditure of time and resources
  - Unrealized hopes
  - Loss of confidence in effectiveness of future interventions
- **OVER-SERVING**
  - Exposes child and family to overly intrusive and restrictive interventions
  - Unnecessary costs
  - Fosters dependence and undermines child and family autonomy

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Levels of Effectiveness

- The degree to which research indicates that a service is effective, or responsible for achievement of an outcome
- Levels of evidence are on a continuum
  - Level of evidence is related to the quality of the research
  - Success of a practice depends on fidelity or model adherence

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Levels of Effectiveness

- **Effective**
  - Achieves outcomes, random clinical trials, independent replication in real world settings
- **Efficacious**
  - Achieves outcomes, random clinical trials, independent replication in study settings
- **Not Effective**
  - Significant evidence of no, negative, or harmful outcomes
- **Promising**
  - Positive outcomes, quasi-experimental research support or expert consensus
- **Emerging Practice**
  - Recognizable as a distinct practice based on a reasonable theory or rationale
- **Not Evaluated**
  - Has not been evaluated; level of effectiveness is not known

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Which Level of Effectiveness to Select

- Higher levels mean more confidence that if implemented in your community (with high model adherence) similar good outcomes will be achieved.
- Consider lower levels of science when there is no alternative for a higher level, or interested in a practice-to-science service.
- Practice-to-science involves the deliberate evaluation of an existing valued service that has otherwise not been subject to effectiveness research

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Quality of Research

- There is a tendency to assume that if a treatment was provided and there is improvement, then the treatment caused the improvement.
- However, good child and family outcomes may be achieved as a result of a number of factors unrelated to treatment.
  - Spontaneous recovery: Individuals naturally strive for health, try strategies and seek social support to reduce distress and achieve their goals; often this is successful!
  - Placebo effect: Improvement associated with non-specific aspects of treatment, for example, the expectation of improvement, which is independent of the unique characteristics of the specific practice; also can be successful!

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Quality of Research

- Research is needed to clarify the effect of a practice independent of other factors that lead to health, and independent of a proponent's bias in favor of the practice.
- The quality of research studies are variable.
- The higher the quality of research, the greater the confidence in the conclusions of the study.

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CIMH Recommended Evidence-Based Practices for Katie A Class

- Multidimensional Treatment Foster Care
- Functional Family Therapy
- Aggression Replacement Training
- Multidimensional Family Therapy
- Multisystemic Therapy
- Trauma Focused- Cognitive Behavioral Therapy
- Incredible Years
- Triple P
- Brief Strategic Family Therapy
- Parent-Child Interaction Therapy

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Trauma Focused- Cognitive Behavioral Therapy (TF-CBT)

Population	3-18 year olds who have been trauma exposed and their caregivers
Cultural Evidence	Adaptation for Native American Children, Latino Population
Level of Evidence	Effective
Outcomes	1. Decreased child behavior 2. Decreased trauma symptoms 3. Decreased depression 4. Improved social competence
Description	Conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral problems related to traumatic life events. 1. 1. Treatment incorporates trauma-sensitive interventions with cognitive behavioral, family and humanistic principles. 2. Treatment lasts approximately 12-18 sessions 3. Can be provided in groups 4. Homework is a component of treatment.

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Aggression Replacement Training®

Population	12-17 year old youth who are aggressive
Cultural Evidence	National data not reported, however, California implementation is 49% Latino youth, 25% Caucasian youth, 17% African American youth, 8% Asian/pacific Islander youth, and 1% Native American youth
Level of Evidence	Promising
Outcomes	1. Reduced impulsiveness 2. Improved interpersonal skills 3. Decreased recidivism
Description	Psycho-Educational Intervention incorporating 3 specific interventions: 1. Skill-Streaming: Uses modeling, role-playing, performance feedback and transfer training to teach pro-social skills. 2. Anger Control: Uses modeling, role-playing, performance feedback and transfer training to decrease incidents of aggression and to control aggressive behavior. 3. Moral Reasoning: Uses moral vignettes to enhance youths sense of fairness and justice regarding the needs and rights of others

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Functional Family Therapy (FFT)

Population	Youth 11-18 years old with aggressive, conduct and substance use/abuse problems
Cultural Evidence	National data not reported, however California implementation data reflects approximately 43% Latino youth, 21% African American youth, 21% Caucasian youth, 6% Biracial youth, and 1% Asian/Pacific Islander youth
Level of Evidence	Effective
Outcomes	1. Reduced re-arrests 2. Improved family functioning
Description	FFT is a family-based prevention and intervention program. The model includes specific phases: 1. Engagement and Motivation: Decreasing intense negativity and blame often characteristic of high-risk families. Reframes negative behavior to "noble" intention. 2. Behavior Change: Reduce and eliminate problem behaviors and accompanying family relational patterns through individualized behavior change interventions 3. Generalization: Increase the family's capacity to adequately use multisystemic community resources and to engage in relapse prevention.

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Triple P-Positive Parenting Program

Population	Parents and caregivers of children birth through age 18.
Cultural Evidence	One study carried out in Hong Kong and a prevention trial underway in South Carolina with a significant percent of African American participants.
Level of Evidence	Effective
Outcomes	1. Decreased child behavior problems 2. Increased parental competence 3. Decreased parental stress 4. Higher levels of parental self-efficacy in handling home and work responsibilities
Description	Multi-level system of parenting and family support: ▪ Level 1: Universal implementation is a media-based information strategy. ▪ Level 2: Selected implementation provides specific advice on how to solve common developmental issues and behavior problems – includes parent tip sheets and videos delivered in 1-2 brief 20 minute consultations. ▪ Level 3: Primary implementation focuses on mild to moderate behavior problems and includes active skills training – delivered through brief consultation of four 20 minute sessions. ▪ Level 4: Standard implementation is an intensive strategy for parents of children with more severe behavior problems – delivered in 10 individual or 8 group sessions totaling 10 hours. ▪ Level 5: Enhanced implementation is a family strategy for families in which parenting difficulties are complicated by other sources of family distress – includes practice sessions, mood management strategies, stress coping skills – includes standard implementation and adds 3-5 sessions tailored to the needs of the family.

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Multidimensional Treatment Foster Care (MTFC)

Population	Youth 11-18 years old and are placed out of home - as an alternative to residential and group care who are on probation, have emotional and behavioral problems.
Cultural Evidence	Most research participants have been Caucasian
Level of Evidence	Effective
Outcomes	1. Decreased hard drug use 2. Decreased recidivism 3. Fewer days in locked settings 4. Significantly fewer psychiatric symptoms 5. Improved school adjustment
Description	Behavioral treatment alternative to residential placement: 1. MTFC Parents: Youth are placed in a foster family setting with specially trained foster parents for 6-9 months 2. The Family: The family receives family therapy and parent training 3. The Treatment Team: Led by a program supervisor who provides intensive support and consultation for the foster parents, also includes a family therapist, a child skills trainer, and daily telephone contact.

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Incredible Years (IY)

Population	2-12 year old children at risk for school failure and juvenile justice involvement
Cultural Evidence	Study comparing outcomes among the following groups: 22% Asian, 19% Latino, 10% African American, 4% Native American
Level of Evidence	Effective
Outcomes	1. Increase in positive and nurturing parenting 2. Decrease in harsh discipline 3. Reduction in child behavior problems at home and school 4. Improvements in child social competence and school readiness 5. Improved parent-child bonding 6. Improved parent-teacher-school involvement
Description	Three program components: 1. Parent Training Intervention focusing on strengthening parent competencies 2. Dinosaur Child Training Curriculum to strengthen child social and emotional competencies 3. Teacher Training Intervention focusing on strengthening teachers classroom management strategies

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Parent-Child Interaction Therapy PCIT)

Population	Families with children ages 3-6 years how are experiencing emotional or behavioral problems. There is an adaption for parents who have physically abused their children who are ages 4-12 years.
Cultural Evidence	40% of the research participants in one study were African American. Adaptations for Native American children and their parents "Honoring Children, Making Relatives" and for Mexican American children, parents and extended family "Guiando a Ninos Activos (GANA) Program"
Level of Evidence	Effective
Outcomes	1. Decreased child behavior problems 2. Decreases in re-reports of child abuse 3. Parents report using higher levels of praise and lower levels of criticism
Description	This model uses a transmitter and receiver system with the parent coached in specific skills as they interact in specific play with their child behind a one-way mirror. 1. Parent receives highly specified, step-by step, live-coaching sessions 2. Emphasis on changing negative parent child patterns 3. Can be conducted with parents, foster parents, or others in a parent/caregiver role 4. Daily homework assignments

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Multisystemic Therapy (MST)

Population	Youth 11-18 years old who are at risk for out of home placement and on probation
Cultural Evidence	Five studies report ethnicity data. The range of African American participants is from 50 to 81 percent.
Level of Evidence	Effective
Outcomes	1. Decreased re-arrest rates 2. Significantly fewer criminal arrests as an adult 3. Decreased alcohol and drug use 4. Decreased peer aggression
Description	Family based intervention typically using a home-based service delivery model to reduce barriers that keep families form accessing services. 1. Therapists are available 24/7 2. Empowering parents by identifying strengths and developing natural supports 3. Use of Behavioral, Cognitive-behavioral, and family therapy.

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Brief Strategic Family Therapy (BSFT)

Population	Families with children and adolescents (ages 6-18) with behavioral and substance abuse problems
Cultural Evidence	Studies primarily on Latino youth. Developed to enhance bicultural skills and problems associated with minority status and/or migration-related stresses
Level of Evidence	Efficacious
Outcomes	1. Reductions in conduct and emotional problems 2. Reductions in association with antisocial peers 3. Drug use improvements in self-concepts 4. Improved family functioning 5. Engagement into family therapy
Description	Designed to focus on communication and management of problem behavior within the Family, typically delivered in 12-16 family sessions: 1. Prevents and reduces behavior problems such as drug use, conduct problems, delinquency, aggressive/violent behavior 2. Improve pro-social behaviors such as school attendance and performance 3. Improve family functioning, including effective parental leadership , positive parenting and parental involvement with the child and his /her peers and school.

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Implementation Strategy and Accountability

- Community Development Team

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Community Development Team

- The **Community Development Team (CDT)** is a ***dissemination process*** for 1 or more evidence-based practices (EBPs)
- There is more to implementing evidence-based practices than simply attending a training.
- The goal of CDT: To help coordinate and support the implementation of EBPs so that they are more likely to be sustained.

Development Team Goals

- High quality, model adherent (high fidelity) and sustainable implementation of EBPs
  - Prepare practitioners to be proficient in the use of EBPs
  - Prepare agencies to support and sustain EBPs

Development Team Features

- Development Teams are a training and technical assistance process to promote adoption of a practice
- Consists of a team of agencies committed to adopting a practice in common
- Combines five features:
  - Clinical training
  - Administrative supports
  - Site specific planning
  - Peer-to-peer assistance
  - Program Performance Evaluation

Expectations

- Each agency is committed to participating fully in all training and consultation activities
- Each agency is committed to implementing each EBP with fidelity
- Each agency will diligently use the evaluation outcomes

The Work of CDT

What does CDT do?

1. Coordinates and Leads Upfront Planning
   - Introduction Meeting
     - The evidence-based practice is introduced, model is explained, training protocol (including outcome evaluation) and expectations of agencies are discussed.
   - Implementation Planning Meeting
     - CDT unites all agencies who plan on implementing a particular EBP and has them present their implementation plans to one another.
     - Assists agencies with thinking through potential challenges and barriers (or threats) to successful and sustainable EBP implementation.
       - » e.g., limited or inappropriate referrals, insufficient training and coaching, staff attrition, inconsistent management level support, absent or minimal evaluation of fidelity and outcomes.

The Work of CDT

2. Coordinates Training Protocol
   - CDT coordinates all training events
     - Communicates directly with model developers on behalf of agencies
     - Locates and secures training venues
     - Makes sure all participants have training materials (required books, handouts, manuals, videos, etc.) in advance of the EBP trainings

3. Provides Organizational Support
   - CDT coordinates all technical supports for agencies
     - Makes sure all clinical consultation calls between model developers and agencies are arranged (ensures that training protocols are followed)
     - Sets up monthly administrator consultation calls between agency EBP administrators and CDT
     - Assists agencies with obtaining referrals through marketing of the EBPs to potential referral sources
     - Outcome evaluation support (analysis and reporting)

The Work of CDT

4. Addresses Systems Issues
   e.g., referrals, interagency collaboration, DMH paperwork & billing requirements

5. Organizes Peer-to-Peer Assistance Program

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The Benefits of CDT for EBPs

1. The assistance provided by CDT greatly increases the likelihood of successful implementation and sustainability of an EBP.
2. CDT synchronizes implementation of EBPs
   - Prevents developers from being overwhelmed by a multitude of individual agencies needing training and technical assistance for a particular EBP.
   - Important for large-scale implementation of EBPs (which is common for the LA area)
3. CDT is a Cost-savings
4. CDT works out all the details of the planning and coordination required of EBP trainings
5. CDT interfaces with the system at large to support an EBP and their agencies

CIMH Program Performance Dashboard Reports

- Functional Family Therapy
- Aggression Replacement Training
- Trauma focused-Cognitive Behavioral Therapy
- Triple P
- Incredible Years

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Finding EBP's

- Office of the Surgeon General
  - **http://www.surgeongeneral.gov/index.html**
- Strengthening America's Families (OJJDP & CSAT)
  - **http://www.strengtheningfamilies.org**
- SAMHSA's National Registry of EBP
  - **http://www.NREPP.SAMHSA.gov**

Finding EBP's

- Evidence-Based Practices in Mental Health Services for Foster Youth – California Institute for Mental Health
  - **http://www.cimh.org**
- National Clearinghouse on Child Abuse and Neglect Information
  - **http://cbexpress.acf.hhs.gov/**
- The California Evidence-Based Clearinghouse for Child Welfare (CEBC)
  - **http://www.cebc4cw.org/**

Finding EBP's

- The Guide to Community Preventive Services: Systematic Reviews and Evidence-Based Recommendations (Public Health Resources)
  - http://www.thecommunityguide.org/
- Promising Practices Network on Children, Families and Communities
  - http://www.promisingpractices.net

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