Ten Trends Shaping Child Mental Health Care (and Evidence-Based Practice)

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CHILD STEPS

Research Network on Youth Mental Health
Funded by the
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- **Members: Bruce Chorpita, Robert Gibbons, Charles Glisson, Evelyn Polk Green, Kimberly Hoagwood, Peter Jensen, Larry Palinkas, Kelly Kelleher, John Landsverk, Steve Mayberg, Jeanne Miranda, Sonja Schoenwald, John Weisz (PI and Network Director).**
- **Associates: Kristin Hawley, Michael Hurlburt, Michael Southam-Gerow, Karen Wells**

CHILD STEPS:

System and Treatment Enhancement Projects

Clinic Treatment Project
- **Effectiveness Trial**
- **Dissemination & Implementation Study**

Clinic Systems Project
- **CEO/Director Survey**
- **Practitioner/Organizational Assessment**

CHILD STEPS

- **Phase I: Planning, meetings, lit review**
  - Which evidence-based treatments (EBTs) are (a) best-supported scientifically, and (b) most deployable?
  - What obstacles prevent their clinical use?
  - Strategies for addressing obstacles, supporting use?
- **Phase II: Surveys, Effectiveness Trial, D&I Study**
  - Test strategies; do EBTs improve clinical practice outcomes with children?
  - Map characteristics of clinics/systems that are relevant to dissemination & use of EBTs?
  - Survey Family Advocacy organizations
- **Phase III: Implementation in New Settings**
  - Extend to Child Welfare population, add system supports
  - ME and CA studies

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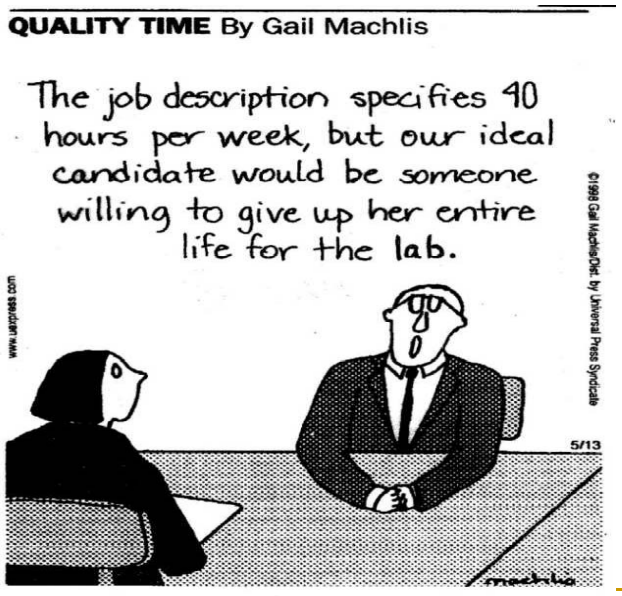

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Youth Mental Health Care in America

- 6-13% of American youth per year
- Annual cost: $11.75 billion
- Most of the cost: psychotherapy
- Massive changes since origins in the time of Freud, early 1900s
  - Clinical judgment….scientific study
  - Broad theories….microtheories
- Ten current trends are reshaping the field

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Ten Trends

1. Pooling Pubs: Meta-Analysis to ID EBTs
2. Upping the Ante: Can EBTs Beat UCC?
3. Practice-Friendly Treatment Design
4. NIRN: Learning How to Spread EBTs
5. Intuitive Appeal of SOC & Wraparound
6. Policy by Force: Class action Lawsuits
7. $hrinking Resources: Few Funds for EBP
8. Skills for Sale: Commercializing EBTs
9. Monitoring Movement: The Core of EBP
10. Potent Partners: Govt-Providers-Researchers

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1. Pooling Pubs: Meta-Analysis to ID EBTs and Broad Patterns

- One study can't usually tell us all that much
  - Too many idiosyncracies
  - Samples tend to be too small to be very reliable
  - Replications needed for confidence
  - Mean ES across multiple trials can tell a rich story
- Meta-analysis can capture trends in the field
  - Examples: next slides

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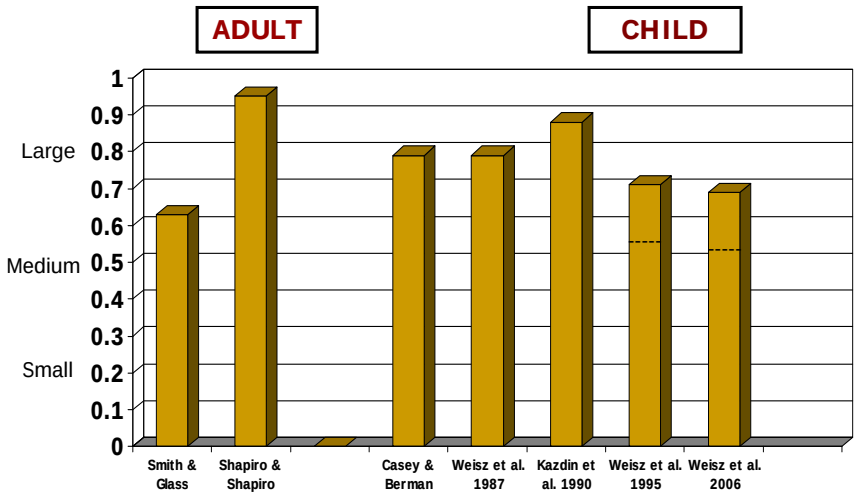
MEAN EFFECT SIZES IN META-ANALYSES OF ADULT AND CHILD STUDIES



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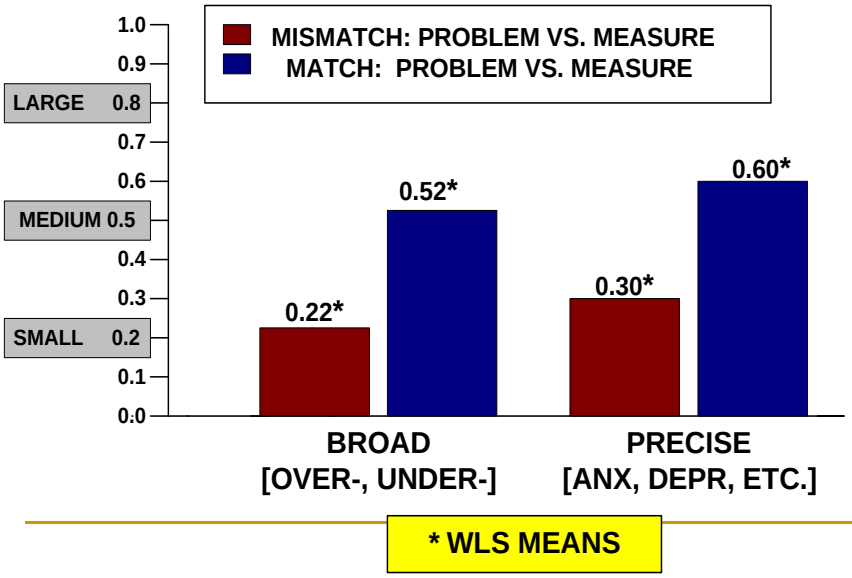
SPECIFICITY OF TREATMENT EFFECTS



* WLS MEANS

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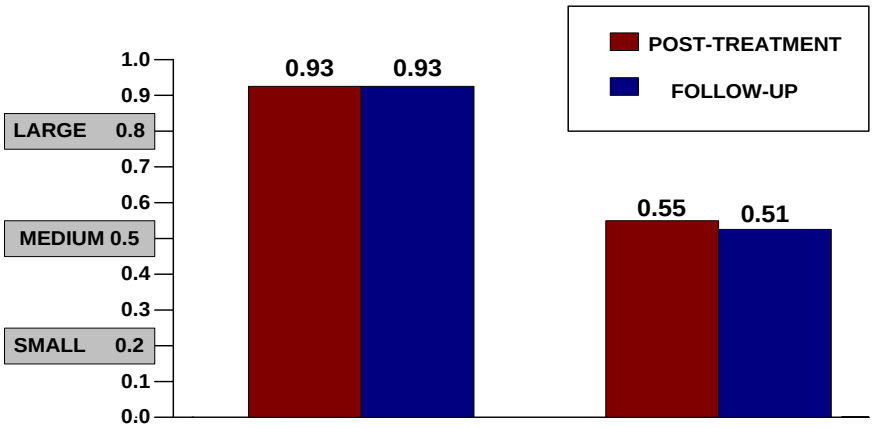
DO TREATMENT EFFECTS LAST?



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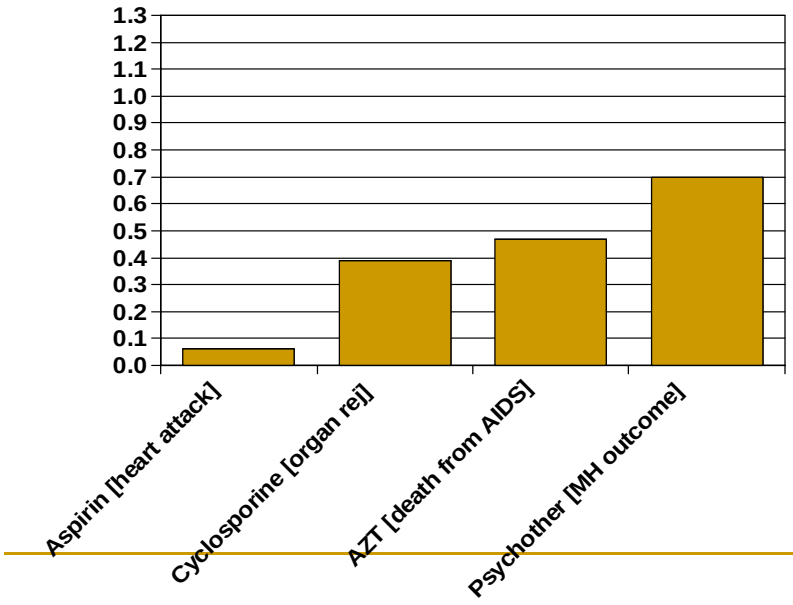
ES: Med vs. Psychotherapy (see R. Rosenthal)



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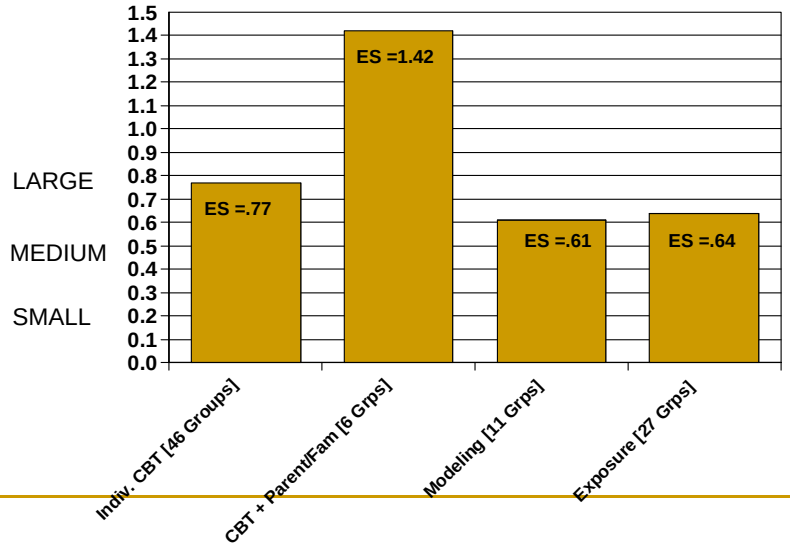
Mean ES: Anxiety Treatments



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2. Upping the Ante: Can EBTs Beat UCC?

- It's nice when EBTs outperform no treatment, waiting list, or attention control (typical RCT)
- But maybe not so relevant to clinicians, clinical directors, policy-makers, who need to know…
  - Can this treatment do better than what is currently done in usual clinical care [UCC]?
  - If the "EBT" isn't more effective, or more cost-effective, it may not be worth the cost required to bring on line
- We've encouraged, done, and synthesized research comparing EBTs to UCC
  - I'll summarize tomorrow, but a key point for today is shown in the next two slides: Not all "EBTs" can beat UCC
- Bottom line: EBT vs. UCC research → savvy shopping

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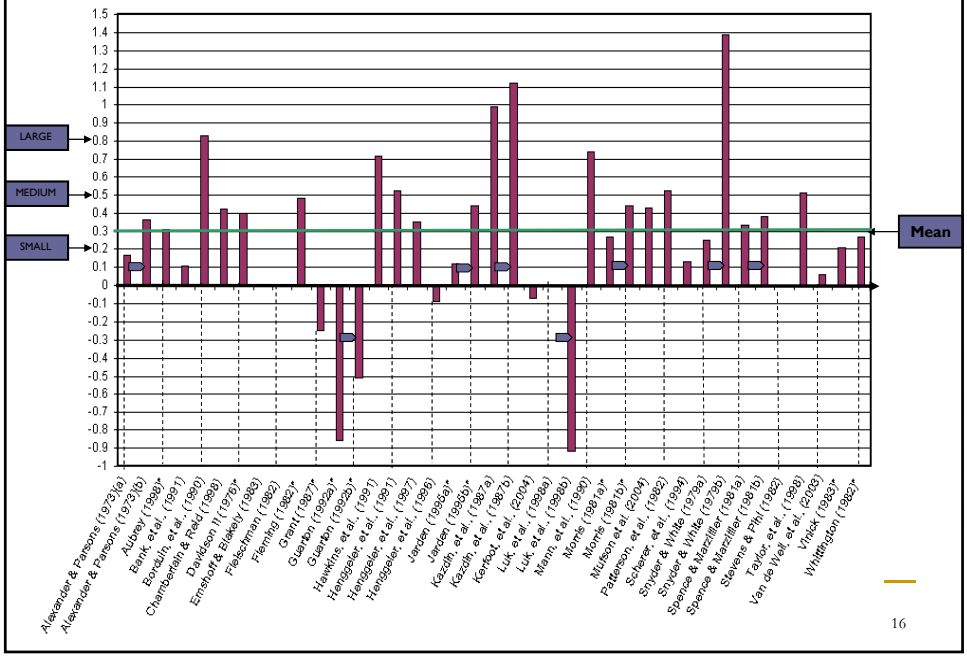
EBT Versus Usual Care Effect Sizes



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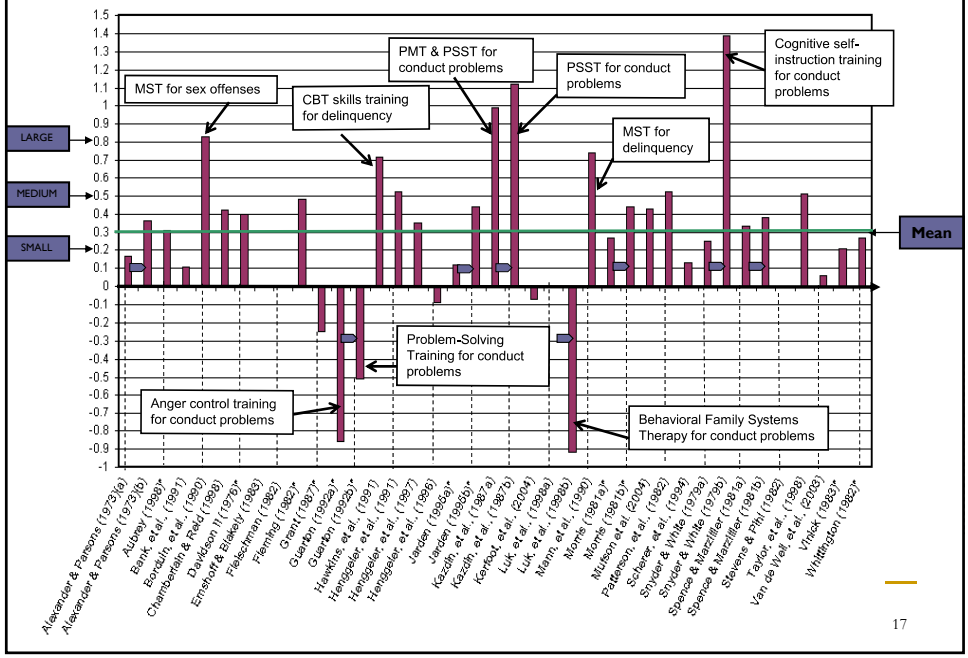
EBT Versus Usual Care Effect Sizes



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3. Practice-Friendly Treatment Design

- Practitioners raise several concerns about many of the current EBTs—e.g…..
  - **Uptake concerns**
    - Lengthy, detailed manuals—too much time to learn, easy to forget where you are & what comes next
    - "Academic" tone—can make it hard to engage kids
    - Addressed in part via technology, video—example tomorrow
  - **Child mismatch and clinical use concerns**
    - **Single-disorder EBTs don't fit comorbidity, flux (2 slides)**
    - **Lockstep sequential manuals don't fit clinician style or build on clinician judgment**
    - **Addressed in part via modular design: example next slides**

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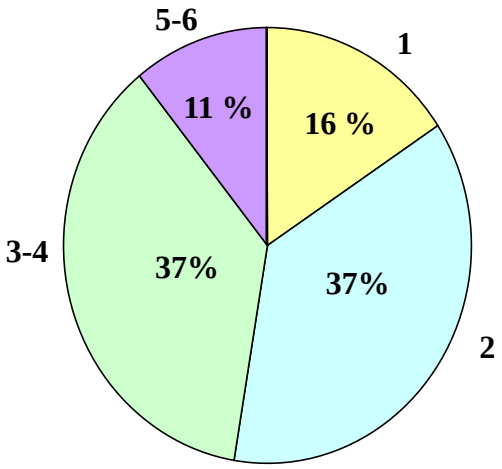
DIAGNOSES: ANXIOUS YOUTH



MEAN: 2.7

+ ODD, CD, ADHD: 68%

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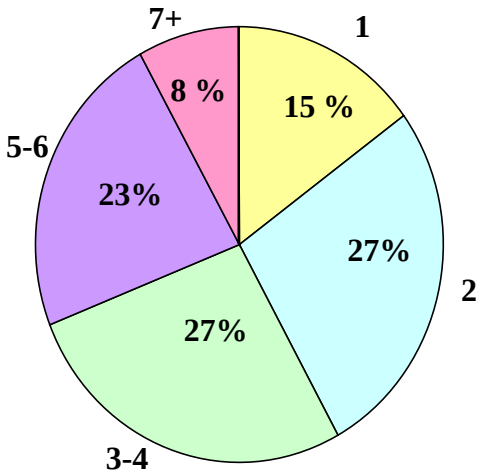
DIAGNOSES: DEPRESSED YOUTH



MEAN: 3.4

+ ODD, CD, ADHD: 81%

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Modular Manual for 3 Problem Clusters

Chorpita & Weisz (2009) *MATCH-ADC*

CBT for Anxiety (including PTS)

CBT for Depression

BPT for Conduct

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Introduction
About Anxiety
About Depression
About Disruptive Behavior
Cognitive Behavior Therapy
Behavior Management Training
Modular Cognitive and Behavior Therapy
References
Flowcharts
Main
Anxiety
Depression
Disruptive Behavior
Therapist Modules: General
1. Home Visit (*shared across all 3 areas*)
2. School Visit (*shared across all 3 areas*)

Therapist Modules: Anxiety
1. Getting Acquainted
2. Fear Ladder
3. Learning About Anxiety – Child
4. Learning About Anxiety – Parent
5. Practicing
6. Maintenance and Relapse Prevention
7. Cognitive Restructuring: FEAR
8. Wrap-up (*shared by anxiety and depression*)

Therapist Modules: Depression
1. Learning About Depression – Child, Parent
2. Problem Solving
3. Activity Selection
4. Relaxation
5. Secret Calming
6. Talents and Skills
7. Positive Self
8. Cognitive Coping (BLUE)
9. Cognitive Coping (FUN)
10. Three Step Plan
11. Wrap-up (*shared by anxiety and depression*)

Therapist Modules: Conduct
1. Engaging Parents
2. Why Children Misbehave
3. Paying Attention
4. Commands
5. Praise
6. Active Ignoring
7. Rewards
8. Time Out
9. Anticipating Problems
10. Handling Future Problems

Therapist Modules: PTS
1. Learning About Trauma – Child, Parent
2. Trauma Narrative
3. Safety Planning

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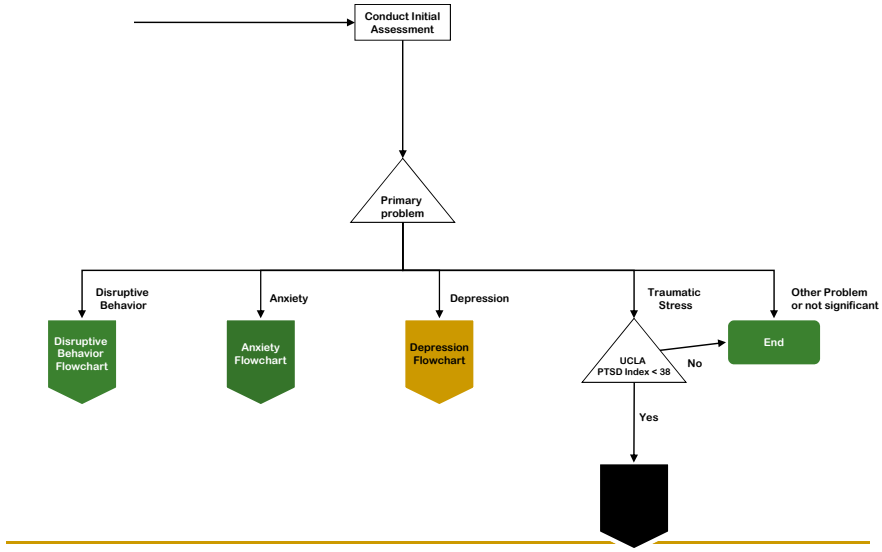
Main Flowchart



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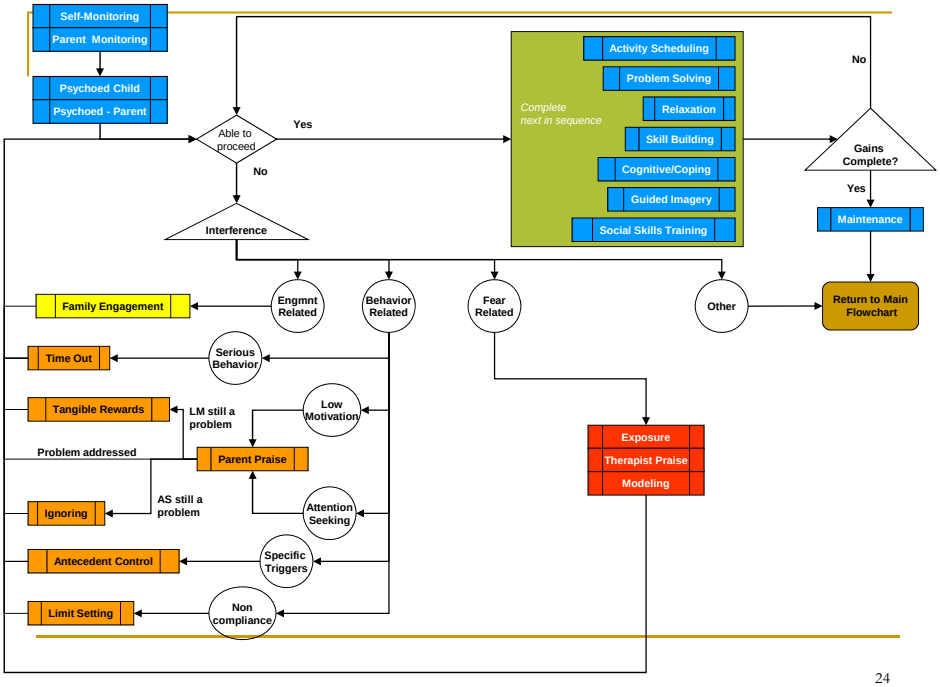

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4. NIRNing: Learning How to Implement & Transport EBTs

- We are learning a lot from efforts by treatment developers to spread their methods, protocols with high fidelity required
  - Multisystemic Therapy—county, judicial district, state, regional, international
  - Similar for MTFC, PMTO, FFT, TF-CBT, others
- A complementary, tiered *Public Health Model* guides the work of Matt Sanders and his colleagues in the Positive Parenting Program (Triple P)
- And we owe a lot to Dean Fixsen et al. and NIRN for synthesizing much of the payoff of implementation studies. Among the lessons…
  - Requirements for successful implementation
    - Training ***plus ongoing coaching*** [fits our experience]
    - Individuals in the org know the intervention from a practice perspective & implement skillfully
    - Selection, training, coaching, & performance assessment are ongoing
- Lots of work ahead—to identify what's necessary *and sufficient* for..
  - fidelity, skilled use, good outcomes [how much T, C, other?]
  - and sustainability of all three over time

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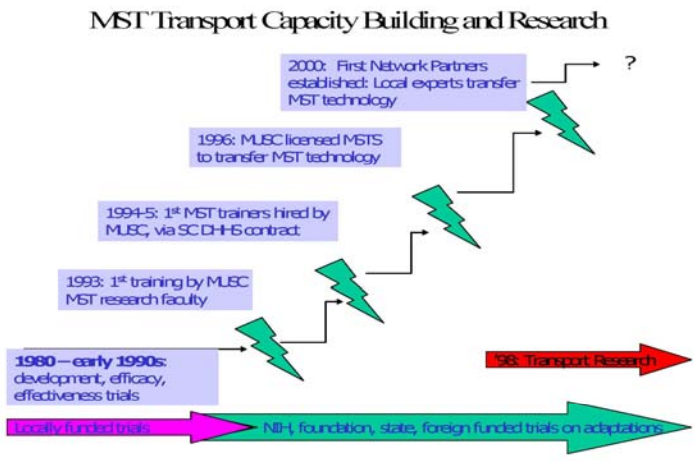

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Key Components of Successful Implementation [From Fixsen et al. and NIRN]

Components	Critical Features and Functions
Purveyor Organization	Composed of individuals who (a) know *interventions* from a practice point of view, (b) use *implementation* methods skillfully, (c) do CQI
Operational Definition	Implementation begins with a clear understanding and description of the intervention. Must know what "it" you are trying to do.
Creating Competency	Fundamental goal: Practitioners (e.g. caseworkers, foster parents, physicians, teachers, therapists) will use innovations fully and effectively. This requires reducing variability.
Organization Supports	Selection, training, coaching, and performance assessments must be initiated and continue to be supported and improved.
Leadership	Different people must show different kinds of leadership as needed to establish and sustain effective programs as circumstances change.

5. Intuitive Appeal of SOC & Wraparound

- SOC & Wraparound: Subjects of controversy, some null findings (e.g., Bickman studies, Farmer review**)**
- More recently, efforts to strengthen empirical foundation—e.g., Eric Bruns' work → slides…
- In some settings, wraparound focuses mainly on structure and organization of services, not as much on content
- There may be real potential in linking the wrap model with empirical lit on specific EBTs—blending these two may combine excellent structure with excellent content
- Example: Rosie D/CBHI project → see slide
- Challenge: Where to insert EBP within the layers of wrap
- By the way, wraparound is sometimes the focus of legal action aimed at putting it into place…which leads us our next trend…. (next slide)

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Bruns Found 7 Published Comparison Studies of Wraparound

Study	Target population	Control Group Design	N
1. Bickman et al. (2003)	Mental health	Non-equivalent comparison	111
2. Carney et al. (2003)	Juvenile justice	Randomized control	141
3. Clark et al. (1998)	Child welfare	Randomized control	132
4. Evans et al. (1998)	Mental health	Randomized control	42
5. Hyde et al. (1996)	Mental health	Non-equivalent comparison	69
6. Pullman et al. (2006)	Juvenile justice	Historical comparison	204
7. Rast et al. (2007)	Child welfare	Matched comparison	67

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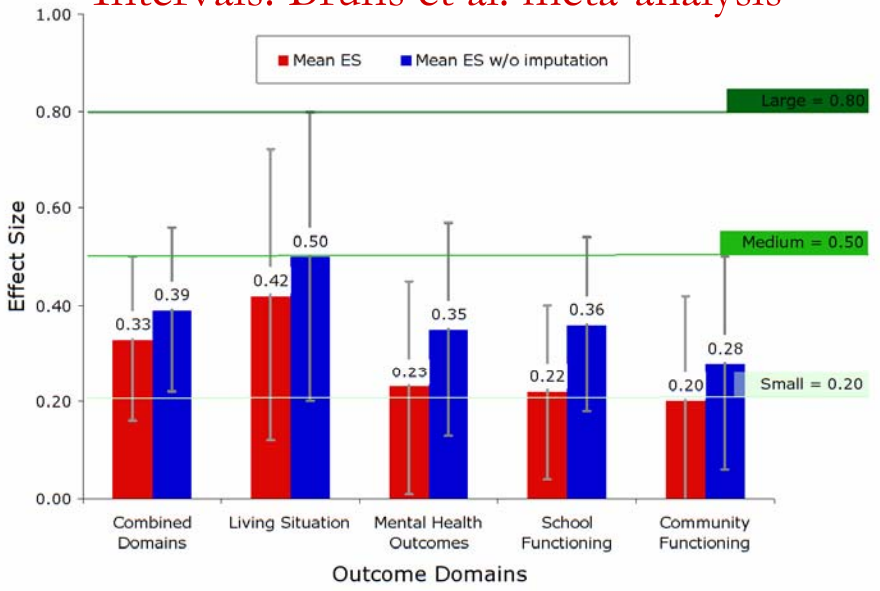
Mean Effect Sizes & 95% Confidence Intervals: Bruns et al. meta-analysis



Findings from Bruns et al. meta-analysis of seven controlled studies

- Medium effects of wraparound for Living Situation outcomes (placement stability and restrictiveness)
- Small to medium effects for:
  - Mental health (behaviors and functioning)
  - School (attendance/GPA), and
  - Community (e.g., JJ, re-offending) outcomes
- The overall effect size across all outcomes (.35), similar to that for EBTs vs. UC in Weisz et al. (2006)

Suter & Bruns (2008)

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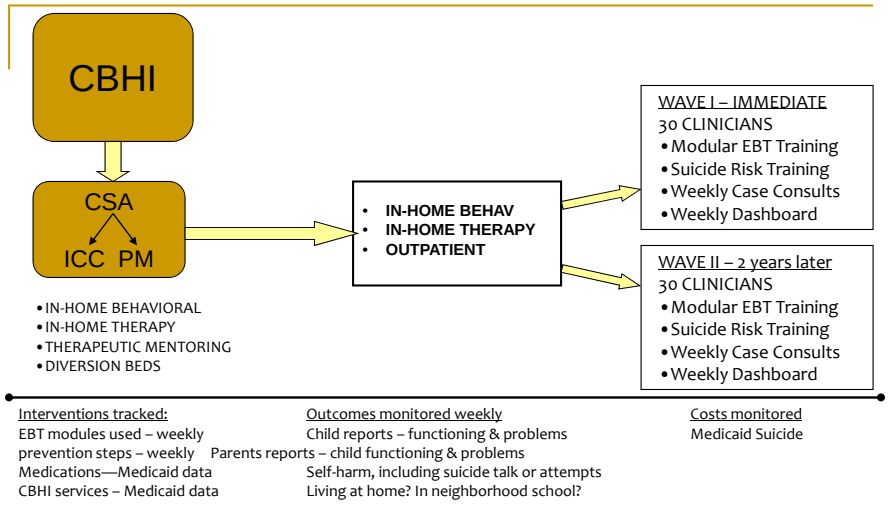

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6. Policy by Force: Class Action Lawsuits

- EBT options structured/constrained by class action suits, court judgments, consent decrees
- Examples:
  - Felix consent decree in Hawaii
  - Katie A in California
  - RC in Alabama
  - Rosie D in Massachusetts
  - Litigation-driven system reform in Utah
- Pro: Forces attention to & funds for kids
- Con: (a) Hydraulic system means more for some is less for others, (b) solutions may reflect what attorneys want but not necessarily what evidence says is best for kids, (c) odd rigidity side effects [e.g., CBHI example]
- Are law suits a good way to make policy?—worth discussing in this meeting

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7. $hrinking Resources: Few Funds for EBP

- Warren Buffetism: "When the tide goes out…"
- Constriction of reimbursement, plus econ turmoil, shows EBP with skimpy beachwear
- MA math: $80 - $50 = $30 x no-show rate
- Clinics in deficit: Network CEO survey →next
- Bottom line: Tough climate for new skill-building
  - Service organizations
    - Hard to find funding for training, much less extended coaching
    - Even if "free," clinicians in training/coaching mean lost billables
  - Service providers/clinicians
    - Hard to find funds to pay on their own
    - Time in training/coaching means lost income
- How to cope: Money talks; CEOs and clinicians can do the math; incentives must outweigh disincentives
  - Options: special rates, certification leads to raises or promotions (e.g,, to supervisory roles) or opportunities to be trainer or coach, other?—group ideas?

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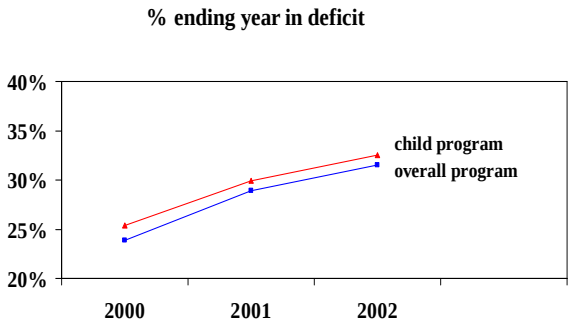
Percent of Orgs Ending Year in Deficit: Overall Programs & Child Programs



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8. Skills for Sale: Commercializing EBTs

- Success sells. Some of the most successful EBTs are now being marketed, at what may seem like high prices…
  - Multisystemic Therapy (MST)
  - Multidimensional Treatment Foster Care (MTFC)
  - Functional Family Therapy (FFT)
  - Trauma-Focused CBT (TF-CBT)
- Good thing or bad thing? Some of each, as with psychopharm?
- Whether good or bad, easier to make the case for problems that cost society big-time than for less disruptive (such as anxiety or depression). E.g., MST → slides…

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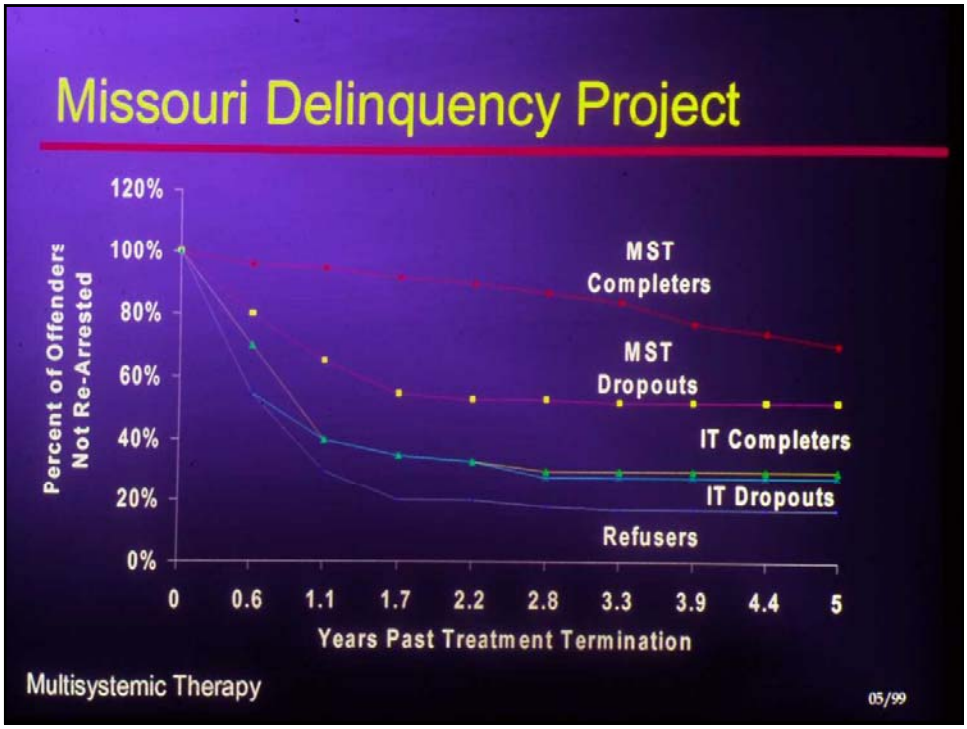
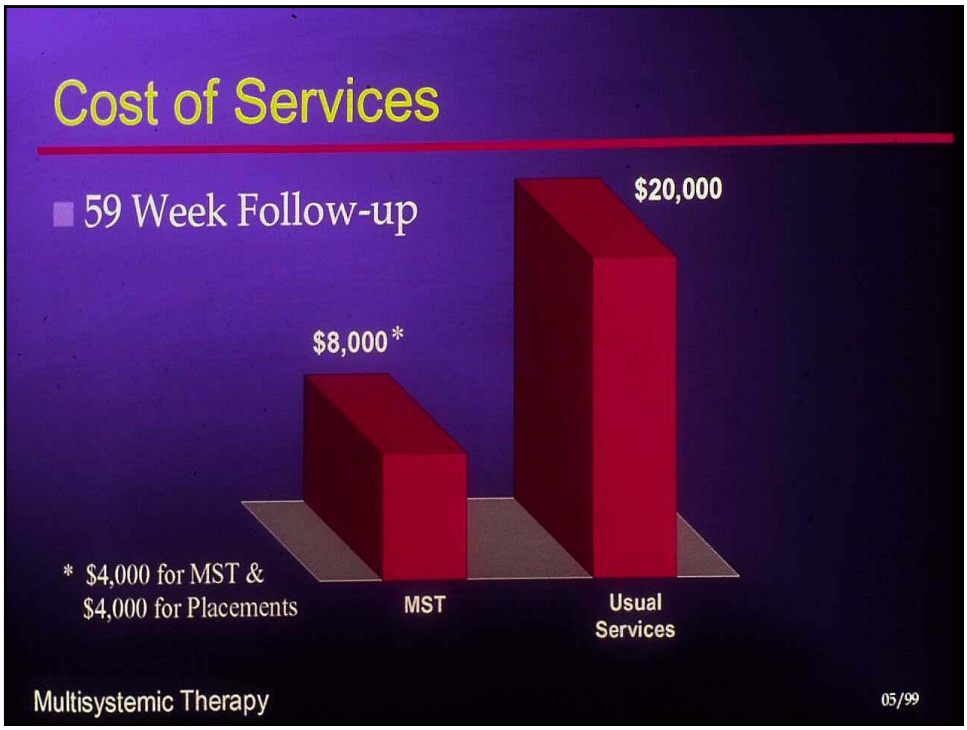

Missouri Delinquency Project
120%
100%
80%
60%
40%
20%
0%
Percent of Offenders Not Re-Arrested
MST Completers
MST Dropouts
IT Completers
IT Dropouts
Refusers
0
0.6
1.1
1.7
2.2
2.8
3.3
3.9
4.4
5
Years Past Treatment Termination
Multisystemic Therapy
05/99


Cost of Services
59 Week Follow-up
$20,000
$8,000 *
* $4,000 for MST &
$4,000 for Placements
MST
Usual Services
Multisystemic Therapy
05/99

9. Monitoring Movement: The Core of EBP

- If an organization could only afford to take one step toward EB practice, this one gets my vote
- Systematic monitoring of child/family response to treatment is key to….
  - Identifying what's working and doesn't need changing [remember EBT vs. UC slide—some UC works]
  - Identifying what's most broken and most needs to change
- Multiple ways to do it [e.g., OQ]; our way illustrated in next slide

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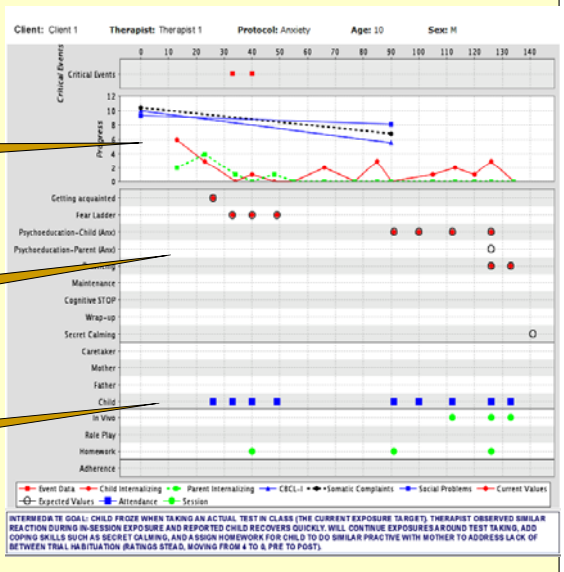
Individual Child Dashboard (Internalizing)

Are results on track?

Do the practices fit the problem?

Is family engagement OK?



10. Potent Partners: Government, Providers, Research Centers/Universities

- Good examples can be found in many states, including NE
- The one I know best: Child STEPS network
- Links multiple states [Massachusetts, Hawaii, Maine, California—and 34 other states in surveys]
- With multiple universities & research centers [Harvard, Judge Baker, MUSC, SDSU, UCLA, UCSD, U of Maine, USC, U of Tennessee]
- Enormous potential for synergy….
  - Answering questions of direct relevance to the public good
  - Using infrastructure and fund-finding potential of research orgs
  - In real-world contexts and conditions, enhancing research validity

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CHILD STEPS

Study Practice Conditions

Goal: Investigate (in 100-200 clinics, 38 states) climate, org, system factors, fiscal issues RE provider use of EBTs

- **Survey Clinic CEOs**
- **Survey clinicians**
- **Survey FA Orgs & their practices**

Launch Effectiveness Trials

Goal: Put EBP into mental health clinics, test impact on practice patterns, clinician response, child outcomes

- **Usual practice conditions**
- **Usual MH referrals**
- **Staff clinicians**
- **Compare SMT, MMT to UC**
- **Mixed methods (anthro)**
- **Now extend to CW kids**
- **Add system supports (FPs, org assess/consult)**

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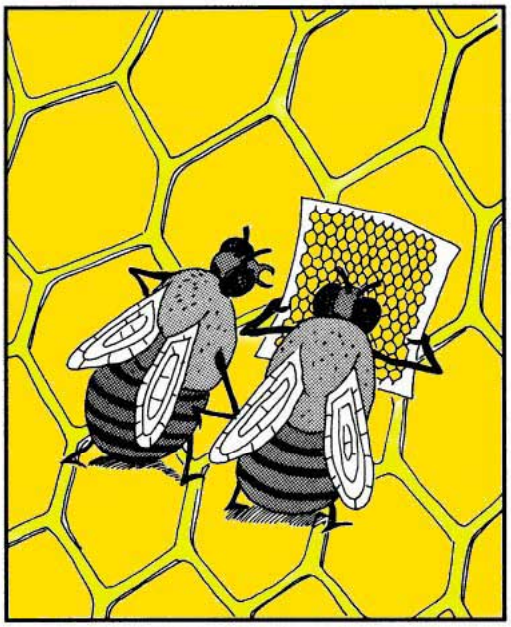

So, Where are we exactly?

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A Vision for the Future of EBP

- All programs **monitor changes** (e.g., weekly), plot trajectories, learn what works & doesn't
- For programs that don't work, use **meta** findings to select best-fit EBTs, **EBT>UCC,** and with **practice-friendly design**
- W/**training, coaching, other NIRN elements,** build sustainable skills in those EBTs
- If there is a **wraparound** system, embed EBTs within
- Use **Government-Provider-Researcher** partnership to ***find funding*** & ***study effects***
- (and pray there is no **lawsuit** that shifts funding away)

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