Selecting and Adopting Evidence-Based Practices for Disruptive Behavior Disorders

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Logic Model:
Selecting and Adopting Evidence-Based Practices for Disruptive Behavior Disorders

Context

DBD is a high need, high prevalence disorder impacting children and families across multiple contexts and service sectors

Selection and Development Activities

- Stakeholder survey to assess perceived needs for Implementation Resource Kit (IRK) focus on DBDs
- Review of literature to identify EBPs for DBDs
- EBP developer surveys
- Consensus Panel review and recommendations on IRK purpose, content, and format

Toolkit Features

- Needs of children & youth with DBD
- Selecting EBPs
- Description of EBPs for DBDs, and
  - Research base/outcomes
  - Training, coaching, technical assistance (TA)
  - Availability of the developer
  - Measuring fidelity/outcomes
  - Costs of starting and sustaining the intervention
  - Financing
  - Acceptability of the EBP to families and practitioners
  - Barriers to implementation and how these have been overcome
- Medication management
- Implementation considerations

Proximal Outcomes

Families/Youth

Increased awareness and knowledge of:
- Options for treatment
- Possible outcomes
- Expectations of family involvement
- Cultural competence and adaptability

Practitioners & Supervisors

Increased awareness and knowledge of:
- EBPs for DBDs
- Entry level and advanced skills needed
- Training, TA provided
- Expectations for practitioner & supervisor involvement
- Cultural competence and adaptability

Administrators

Increased awareness and knowledge of:
- EBPs for DBDs to assist in planning and decision-making
- Costs for start-up and on-going implementation, and methods of financing
- Accessibility of developers at start-up and on-going throughout implementation
- Expectations of developers/purveyors regarding ongoing relationship with site

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- Increased selection and adoption of EBPs for DBDS by all constituencies
- Increased uptake rate of EBPs to address DBDs by states and communities

Distal Outcomes

Increased likelihood of improving outcomes for children with DBDs and their families

Evidence-Based and Promising Interventions for Children and Youth with Disruptive Behavior Disorders

MULTI-LEVEL PREVENTION PROGRAMS

- Positive Parenting Program – Levels 1-5 (Ages 0 to 13)
- Promoting Alternative Thinking Strategies (PATHS) (Ages 3 to 12)
- Project Achieve (Ages 3 to 14)
- Second Step (Ages 4 to 15)
- First Steps to Success (Ages 5 to 16)
- Early Risers "Skills for Success" (Ages 6 to 11)
- Adolescent Transition Program (Ages 11-14)

INTERVENTIONS

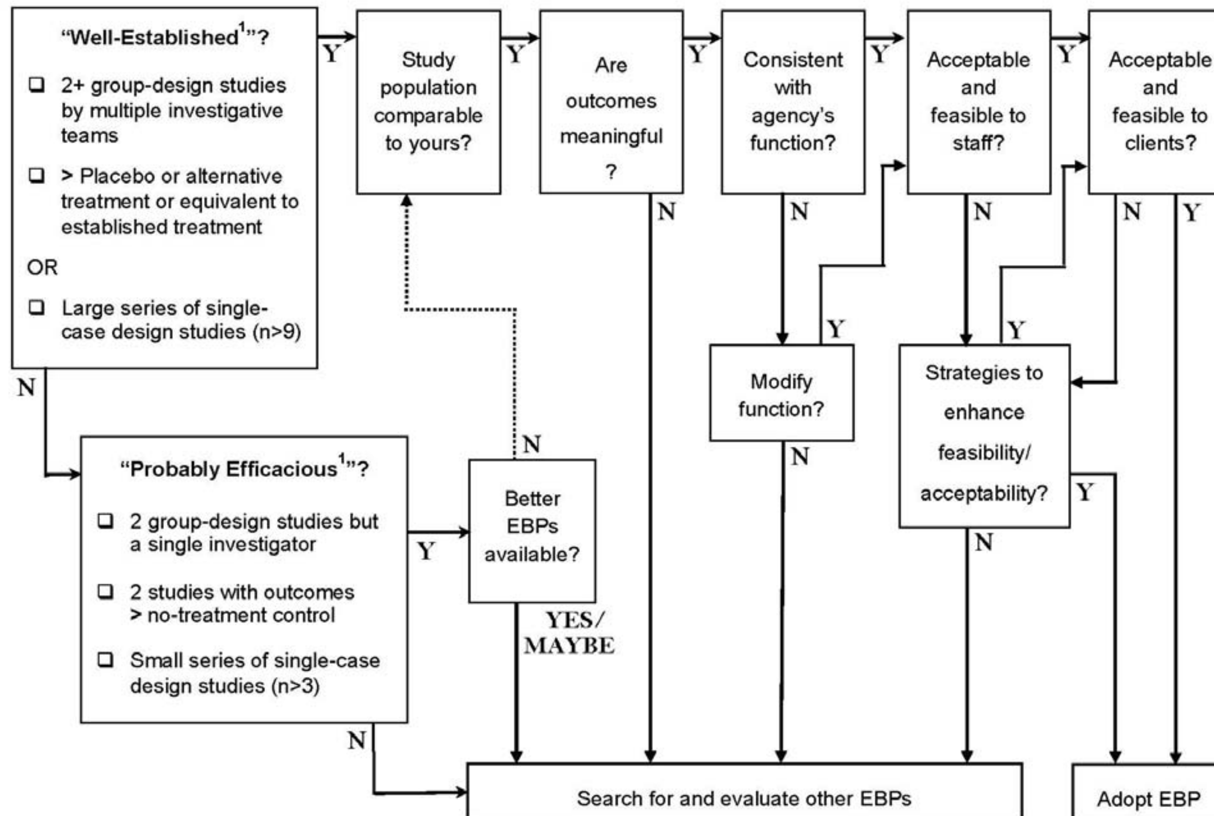
- Incredible Years (Ages 2 to 9)
- Helping the Noncompliant Child (Ages 3 to 9)
- Parent-Child Interaction Therapy (PCIT) (Ages 3 to 7)
- Parent Management Training – Oregon (Ages 3 to 14)
- Brief Strategic Family Therapy (Ages 6 to 18)
- Problem-Solving Skills Training (Ages 7 to 14)
- Coping Power (Ages 9 to 12)
- Mentoring (Ages 6 to 18)
- Multisystemic Therapy (Ages 10 to 18)
- Functional Family Therapy (Ages 11 to 18)
- Multidimensional Treatment Foster Care (Ages 12 to 18)

Brief Descriptions of Preventive Evidence-Based Interventions for Disruptive Behavior Disorder

Multi-level Prevention	Brief Description
Positive Parenting Program (Triple P)	Multi-level, parenting and family support strategy to prevent severe behavioral, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents.
Promoting Alternative Thinking Strategies (PATHS)	Multi-year (5 years) targeted to mainstream & special ed. students to improve social and emotional competencies and reduce aggression. 5 major domains are addressed: self-control; emotional understanding; self-esteem; relationships; problem-solving skills.
Project ACHIEVE	School-based prevention program targeted to academic engagement and achievement, positive behavioral support systems, school safety, and parent and community involvement. Used in preschool, elementary, and middle.
Second Step	Classroom-based prevention program targeting 3 skill-building areas: empathy; impulse control and problem solving; and anger management.
First Steps to Success	3-interconnected modules: screening, school, and home targeted for children displaying aggression at school. Skill-building and reward system are built into the program at school and home.
Early Risers: Skills for Success	School-based, multi-component and competency-based program targeting four areas: academic competence; behavioral self regulation; social competence; parent investment. Manualized program delivered over the summers and school.
Adolescent Transitions Program	Parent training program for youth with oppositional problems and substance use. Skills are learned through group and individual work focused on encouragement, limit setting and supervision, problem solving, and improved family relationship and communication patterns.

Brief Definitions of Evidence-Based Interventions for Disruptive Behavior Disorder

INTERVENTION	BRIEF DESCRIPTION
Incredible Years	Video presentations in the context of group therapy for parents and children addresses effective parenting and child behavior issues.
Helping the Noncompliant Child	The aims are to reduce coercive parenting, to increase praise, ignore inconsequential behaviors, and utilize time-out via role playing and modeling.
Parent-Child Interaction Therapy (PCIT)	Parents have a microphone in their ear and a therapist coaches them during parent and child-directed play to more effectively praise and/or set limits.
Parent Management Training – Oregon	Skills are taught to increase parent ability to reward positive behavior, set limits with consequences, and prevent conflict from escalating.
Brief Strategic Family Therapy	Family members are coached to develop a therapeutic alliance, diagnose family strengths and problem relationships, and develop a change strategy and implement those strategies.
Problem-Solving Skills Training	Youth are taught to identify problems, find solutions, evaluate the pros and cons, and make decisions about behaviors which will yield better outcomes.
Coping Power	Youth are taught skills such as effect regulation, self-control, and social problem-solving in groups at school and linked training is provided to parent groups.
Mentoring	Youth are matched with adult role models for the purposes of developing and maintaining supportive relationships.
Multisystemic Therapy	Youth and parents receive intensive home-based strategies to identify “drives” causing trouble; a contract for behavior change with rewards and consequences is articulated and implemented; and opportunities for prosocial activities are incorporated.
Functional Family Therapy	A focus on enhancing protective factors and reducing risk factors consists of five phases: engagement, motivation, assessment, behavior change, and generalization.
Multidimensional Treatment Foster Care	The child lives in the home of professional parents who are trained and supervised to utilize parent management skills and to provide a supportive relationship for the child.



Adapted from Areán and Gum (2006). Selecting an evidence-based practice (pp. 1-12). In: S.E. Levkoff, H. Chen, J.E. Fisher, & J.S. McIntyre (eds.) Evidence-based behavioral health practices for older adults. New York: Springer.

[1]Lonigan, C.J., Elbert, J.C., Johnson, S.B. (1998). Empirically supported psychosocial interventions for children: An overview. *Journal of Clinical Child Psychology*, 27:138-145.

Decision-Making in Selection of Evidence-Based Practice

Is Study Population Comparable to Yours?
- Age
- Gender
- Race/Ethnicity
- Clinical Profile

Are Outcomes Meaningful?

Do Intervention Characteristics Fit with Agency and Community?
- Setting: Clinic, School, Home
- Length of Intervention
- Family Component
- Individual or Group
- Level of Training Required

Does Intervention Fit with Agency Needs and Resources?
- Training Available
- Location of Training
- Length of Training
- Cost
- Follow-up Coaching/Consultation

Do Monitoring and Reimbursement Requirements Fit with Agency?
- Fidelity Measure Available
- Fidelity Required
- Specification of an Outcome Measure
- Medicaid Reimbursement

Does Intervention Fit with Clinicians?
- Openness to Evidence-Based Practice
- Compatibility with Theoretical Orientation
- Expectation of Parent Involvement in Treatment

Does Intervention Fit with Youth and Family Values and Preferences?
- Individualized
- Family-Centered
- Choice
- Flexibility
- Culture

Is Study Population Comparable to Yours?

PREVENTION	Level of Evidence	Age Range	Gender Boys or Girls	Race/Ethnicity White – Black –Hispanic Native Am. - Asian Am.
Positive Parenting Program (Triple P)	GOOD	0 to 16	B and G	W B N A
Promoting Alternative Thinking Strategies (PATHS)	GOOD	5 to 12	B and G	W B H N A
Project ACHIEVE	MODERATE	3 to 14	B and G	W B H N A
Second Step	GOOD	4 to 14	B and G	W B H
First Steps to Success	MODERATE	5 to 6	B and G	W B H N
Early Risers: Skills for Success	GOOD	6 to 12	B and G	W B
Adolescent Transitions Program	GOOD	11 to 18	B and G	W B H N

Are Outcomes Meaningful to Agency Mission?

PREVENTION	*CHILD OUTCOMES*
Positive Parenting Program (Triple P)	Increase in parental confidence; improvement in dysfunctional parenting styles; reduction in child behavior problems
Promoting Alternative Thinking Strategies (PATHS)	Increase in ability to label feelings; reductions in classroom aggression; decrease in teacher-reported internalizing & externalizing disorders.
Project ACHIEVE	Decrease in discipline problems; decrease in special education referrals and placements; increase in positive social climate; improvements in academic achievement.
Second Step	Increase in empathy and positive social behavior; improvement in self-regulation of emotions; decreased verbal and physical aggression.
First Steps to Success	Decrease in aggression, increase in time spent on academics, more positive behavior demonstrated.
Early Risers: Skills for Success	Gains in academic achievement, reductions in self-regulation problems, improved social skills and adaptability.
Adolescent Transitions Program	Reduction in negative parent-child interactions; decreases in antisocial behaviors at school; effective in reducing youth smoking.

Fit with Agency Resources ? Training and Coaching/Consultation

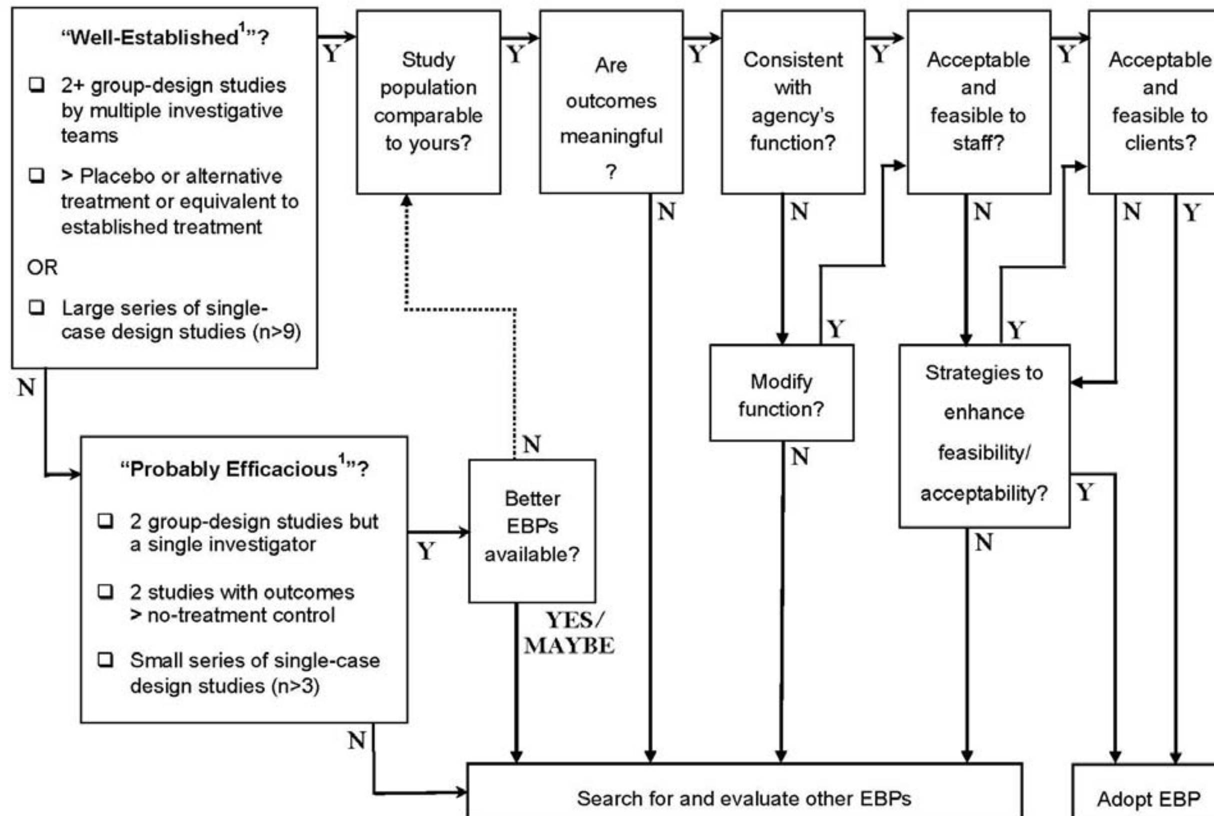
PREVENTION	Is Training Provided by Developer?	Where is Training Provided?	What is Length of Training?	How Much Does Training Cost?	Is Follow-Up Coaching Available?
Positive Parenting Program (Triple P)	Yes	On-site and Regional	2 sets of 2-3 days (4-6 weeks between sets)	Approximately $1,000/per person (20 person maximum)	Yes
Promoting Alternative Thinking Strategies (PATHS)	Indirectly	On-site and Regional	2-3 days	Option A:1 trainer, 2 days, and 30 participants and on-going technical assistance for $4,000-$5000 plus travel Option B: No on-going technical assistance for $3,000	Yes
Project ACHIEVE	Yes	On-site	YR1: 5-8days; YR2: 4-8days; YR3: 4-6days	Average$25,000/yr $75,000 total	Yes
Second Step	Yes	On-site or off-site options	2.5 days or 1 day option	OptionsA:$399-$499 per person B: onsite for $6,475 + travel for up to 40 people C: $1600 1 day version on site	Yes
First Steps to Success	Indirectly	On-site	2 days for consultants/case workers1 day for teachers	$1000-1500 per day plus travel for up to 30 coaches and 50 teachers	Yes
Early Risers: Skills for Success	Yes	On-site	4 (3-day) workshops	$5,000-8,000	Yes
Adolescent Transitions Program	Yes	On-site and Off-site	4-5 days	Varies by curriculum & dependent on number being trained (range $500-1,850/person)	Yes

Fit with Agency? Intervention Characteristics

PREVENTION	*What is Setting?* Clinic School Home	*What is Length?*	*Who Delivers?*	*Format?* Individual or Group
Positive Parenting Program (Triple P)	**C S H**	Varies due to level implemented (from 1-2 sessions to 8-10 sessions)	Paraprofessionals, Masters level, Doctoral level, Nurses, Physicians	**I G**
Promoting Alternative Thinking Strategies (PATHS)	S	5 years, 3 times/week for 20-30 minutes	Teachers and Counselors	G
Project ACHIEVE	S	3 years	School Administrators, Teachers and chosen facilitators	G
Second Step	S	School year	Teachers and Counselors	G
First Steps to Success	S H	3-4 months	Consultants/Caseworkers/Coaches with MA degree	I
Early Risers: Skills for Success	S H	3-6months for recruitment/screening2-3 years for the intervention	Trained family advocate	I
Adolescent Transitions Program	S	4 months	Trained Paraprofessionals	I G

Fit with Agency? Monitoring and Reimbursement

PREVENTION	Is There a Fidelity / Adherence Measure?	If Yes, What is the Expectation of Use?	Is an Outcome Measure Specified?	Financing Option
Positive Parenting Program (Triple P)	Yes	Voluntary	Yes	?
Promoting Alternative Thinking Strategies (PATHS)	Yes	Voluntary	Yes	Safe and Drug Free Schools, school board funds, grants
Project ACHIEVE	Yes	Required	Yes	Special education funds, school improvement funds, Safe school grants, foundations, & partial Medicaid
Second Step	Yes	Voluntary	Yes	Safe and Drug Free Schools
First Steps to Success	Yes	Voluntary	Yes	School Districts, grants
Early Risers: Skills for Success	Yes	Voluntary	Yes	Local Grants, County funds
Adolescent Transitions Program	Yes	Voluntary	Yes	Federal grants



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Is Study Population Comparable to Yours?

INTERVENTION	*Level of Evidence*	*Age Range*	*Gender* Boys or Girls	*Race/Ethnicity* White – Black –Hispanic Native Am. - Asian Am.
Incredible Years	GOOD	2 to 12	B and G	W B H A
Helping the Noncompliant Child	MODERATE	3 to 9	B and G	W B
Parent-Child Interaction Therapy (PCIT)	GOOD	2 to 7	B and G	W B H A
Parent Management Training – Oregon	BEST	4 to 12	B and G	W B H N A
Brief Strategic Family Therapy	GOOD	6 to 18	B and G	W B H
Problem-Solving Skills Training	GOOD	6 to 14	Mostly B	W B
Coping Power	GOOD	9 to 11	B and G	W B
Mentoring	MODERATE	6 to 18	B and G	W B H N
Multisystemic Therapy	GOOD	12 to 17	B and G	W B
Functional Family Therapy	GOOD	11 to 18	B and G	W B H N A
Multidimensional Treatment Foster Care	GOOD	3 to 18	B and G	W B

Are Outcomes Meaningful to Agency Mission?

INTERVENTION	*CHILD OUTCOMES*
Incredible Years	increases in parent's use of positive praise versus criticism, effective disciplinary strategies, satisfaction; improvement in teacher's use of praise and reward, improved cooperation between teacher and student; reductions in conduct problems at home and school; improvement in child's problem-solving skills
Helping the Noncompliant Child	improvement in parenting skills; improvement in child's behavior and compliance
Parent-Child Interaction Therapy (PCIT)	improvement in parent-child interaction style; child behavior problems decreased
Parent Management Training – Oregon	significant reductions in child's behavioral problems; positive effects in reducing coercive parenting, and increasing effective parenting
Brief Strategic Family Therapy	reduction of drug-abusing behaviors; reduction of problem behaviors; improved family-functioning; reduction in socialized aggression and conduct disorder
Problem-Solving Skills Training	improvement in behavior as rated by teachers and parents; family life functioning improvement.
Coping Power	decrease in substance abuse; improvement in social skills; less aggressive belief system
Mentoring	less likely to use drugs and alcohol; less likely to physically lash out; increase in school attendance; better relationship with peers and family
Multisystemic Therapy	improved family relations; decreased behavior problems and association with deviant peers; improved parent-child interactions; reduced sexual offending, other criminal offending, alcohol and marijuana use and drug-related arrests.
Functional Family Therapy	reduction in recidivism and out-of-home placements; improvements in family communication style, family concept, and family interaction
Multidimensional Treatment Foster Care	decrease in arrest rates; decrease in violent activity involvement; fewer runaways; less chance of incarceration after completion of program; fewer permanent placement failures

Fit with Agency? Intervention Characteristics

INTERVENTION	What is Setting? Clinic School Home	What is Length?	Is there a Family Component?	Who Delivers?	Format? Individual or Group
Incredible Years	S H	< 22 weeks	Y	Parents, Teachers, counselors, or Master's level therapist	G
Helping the Noncompliant Child	C H	8-10 sessions	Y	Master's level therapist	I
Parent-Child Interaction Therapy (PCIT)	C H	10-16 sessions	Y	Master's or Doctoral level therapist	I
Parent Management Training – Oregon	C H	20 sessions over 13 months	Y	Trained Master's level therapist	I
Brief Strategic Family Therapy	C	12-16 sessions over 3 months	Y	Master's or Doctoral level therapist	I
Problem-Solving Skills Training	C H	20 sessions	Y	Master's level therapist	I
Coping Power	S H	15-18 months	Y	Master's or Doctoral level therapist, school counselor	G
Mentoring	S H	1 year or longer	N	Trained adults	I
Multisystemic Therapy	S H	4 -6 months	Y	Master's, Ph.D.	I
Functional Family Therapy	C H	8-12 one hour sessions	Y	Paraprofessionals and Master's level	I
Multidimensional Treatment Foster Care	C S H	6-9 months	Y	Trained foster families	I

Fit with Agency Resources? Training and Coaching/Consultation

INTERVENTION	Is Training Provided by Developer?	Where is Training Provided?	What is Length of Training?	How Much Does Training Cost?	Is Follow-Up Coaching Available?
Incredible Years	Yes	On-site, Off-site and Regional	2-3 days	$300-400/person off-site $1,500/day on-site	Yes
Helping the Noncompliant Child	Yes	On-site	2 days minimum	$1500/day plus expenses	Yes
Parent-Child Interaction Therapy (PCIT)	Yes	Off-site	5 days	$3,000	No
Parent Management Training – Oregon	Yes	On-site	18 workshop days spread over 1 year	$25,000 per trainee	Yes
Brief Strategic Family Therapy	Yes	On-site	4 (3-day) workshops	$60,000 (includes coaching)	Yes
Problem-Solving Skills Training	*Soon	----	----	----	----
Coping Power	Yes	On-site	3 days	$5,000 plus travel expenses and materials	Yes
Mentoring	No	Regional	varies by model	varies by model, some free	Yes
Multisystemic Therapy	Yes	Regional	5 days for staff 2 days for supervisors	$26,000 for a team of 4-6 staff)	Yes
Functional Family Therapy	Yes	On-site and Off-site	2 days onsite plus 2 days off-site; follow-up training of 3 on-site per year-2 days each	Approximately $35,000/year 1; 12,00/year 2 for 3-8 therapists	Yes
Multidimensional Treatment Foster Care	Yes	On-site and Off-site	4-5 days for staff 2 days for parents	$40-50,000 per site	Yes

Fit with Agency? Monitoring and Reimbursement

INTERVENTION	Is There a Fidelity / Adherence Measure?	If Yes, What is the Expectation of Use?	Is an Outcome Measure Specified?	Financing Options
Incredible Years	Yes	Voluntary	Yes	Grant, state funds
Helping the Noncompliant Child	Yes	Voluntary	Yes	Grants, state, private insurance, Medicaid
Parent-Child Interaction Therapy (PCIT)	Yes	Voluntary	Yes	Grants, state, private insurance, Medicaid
Parent Management Training – Oregon	Yes	Expected	Yes	Grants, state, private insurance, Medicaid
Brief Strategic Family Therapy	Yes	Required	Yes	Grants, state, private insurance, Medicaid
Problem-Solving Skills Training	Yes	----	No	Grants, state, private insurance, Medicaid
Coping Power	Yes	Voluntary	No	Safe & Drug Free schools, local grant funding
Mentoring	Yes	Voluntary	Yes	Grants
Multisystemic Therapy	Yes	Required	Yes	Grants, State, Medicaid
Functional Family Therapy	Yes	Required	Yes	Grants, State, Medicaid
Multidimensional Treatment Foster Care	Yes	Required	Yes	Grants, State, Medicaid

The Evidence Based Practice Attitude Scale

0	1	2	3	4
Not at All	To a Slight Extent	To a Moderate Extent	To a Great Extent	To a Very Great Extent

Item	Subscale	Question
1.	3	I like to use new types of therapy/interventions to help my clients.
2.	3	I am willing to try new types of therapy/interventions even if I have to follow a treatment manual.
3.	4	I know better than academic researchers how to care for my clients.
4.	3	I am willing to use new and different types of therapy/interventions developed by researchers.
5.	4	Research-based treatments/interventions are not clinically useful.
6.	4	Clinical experience is more important than using manualized therapy/interventions.
7.	4	I would not use manualized therapy/interventions.
8.	3	I would try a new therapy/intervention even if it were very different from what I am used to doing.
		For questions 9-15: If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:
9.	2	it was intuitively appealing?
10.	2	it "made sense" to you?
11.	1	it was required by your supervisor?
12.	1	it was required by your agency?
13.	1	it was required by your state?
14.	2	it was being used by colleagues who were happy with it?
15.	2	you felt you had enough training to use it correctly?

Note: Subscale 1 = Requirements; 2 = Appeal; 3 = Openness; 4 = Divergence.

Aarons, G.A. (2004). Mental health provider attitudes toward adoption of evidence-based practice: The Evidence Based Practice Attitude Scale. Mental Health Services Research, 6:61-74.

Fit with Youth and Family?

- Is intervention palatable, feasible, relevant, and helpful?
- Consideration of preferences and culture
- Importance of engagement

Sources of Information

- Brestan & Eyberg (Journal of Clinical Child Psychology, 27:180-189,1998)
- Eyberg, Nelson, & Boggs (under review)
- School-Based Mental Health (Kutash, Duchnowski, & Lynn, 2006)
- Developer Interviews (National Implementation Research Network at USF)
- Blueprint for Change (www.nimh.nih.gov/publicat/nimhblueprint.pdf)
- OJJDP Model Programs Guide (www.dsgonline.com/mpg2.5/mpg_index.htm)
- SAMHSA National Registry (www.modelprograms.samhsa.gov/)
- Input from Consensus Panel Meeting on Implementation Resource Kit
- Synthesis of Other Reviews (NRI Matrix)