

The Society for Clinical Child and Adolescent Psychology (SCCAP): Initiative for Dissemination of Evidence-based Treatments for Childhood and Adolescent Mental Health Problems

With additional support from Florida International University and The Children's Trust.



Keynote

Evidence-Based Practices in Child and Adolescent Mental Health

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Distinguished Professor of Psychology and Psychiatry

Florida International University



Why are EBPs important?

- They are based on systematic research—that is, on science
- EBPs in Medicine—what you expect from your children's (and your) doctor
- EBPs in Education—what you expect from your children's teachers
- EBPs in industry—what you expect when you buy a product (e.g., automobiles)
- Why not emphasized in mental health?

Surgeon General's 2000 National Action Agenda for Children's Mental Health

Mental health is a critical component of children's learning and general health. Fostering social and emotional health in children as a part of healthy child development must therefore be a national priority. Promotion of mental health in children and the treatment of mental disorders should be major public health goals. Guiding principles:

1. Promoting the recognition of mental health as an essential part of child health
2. Integrating family, child, and youth-centered mental health services into all systems that serve children and youth
3. Engaging families and incorporating the perspectives of children and youth in the development of all mental healthcare planning
4. Developing and enhancing a public-private health infrastructure to support these efforts to the fullest extent possible.

Goals

1. Promote public awareness of children's mental health issues and reduce stigma associated with mental illness.
2. Continue to develop, disseminate, and implement **scientifically-proven** prevention and treatment services in the field of children's mental health.
3. Improve the assessment of and recognition of mental health needs in children.
4. Eliminate racial/ethnic and socioeconomic disparities in access to mental healthcare services.
5. Improve the infrastructure for children's mental health services, including support for **scientifically-proven interventions** across professions.
6. Increase access to and coordination of **quality** mental healthcare services.
7. Train frontline providers to recognize and manage mental health issues, and educate mental healthcare providers about **scientifically-proven** prevention and treatment services.
8. Monitor the access to and coordination of **quality** mental healthcare services.

Why is the emphasis on scientifically-proven, evidence-based practices (EBPs)?

What is the alternative?

What do parents prefer?

How are we currently doing?

Do EBPs work better than treatment as usual?

The Rise in Popularity of the term “Evidence-Based”

(Hoagwood & Johnson, 2003)

	EBT	EBP	EBM
1900-1990	0	0	0
1990-1995	3	7	76
1995-2002	63	459	5,425

How are We Currently Doing?

- **80% of treatment offered children in community mental health settings is not evidence based**
- **Current practices are not effective and sometimes even harmful**
- **More of what we currently do or a better system of care alone is not better**
 - Ft. Bragg Study—Bickman et al
 - Stark County Study—Bickman et al

Would EBPs Do a Better Job?

- **Very large evidence base demonstrates effectiveness in controlled settings**
- **Rapidly growing evidence base shows that they have similarly large effects when employed in routine practice**
- **Emphasized in the new national healthcare Affordable Care Act**

Effect Size

Expresses magnitude of treatment differences
in terms of standard-deviation **change**

Typical formula:

$(\text{Treatment mean} - \text{control mean}) / \text{control SD}$

Interpreting Effect Sizes

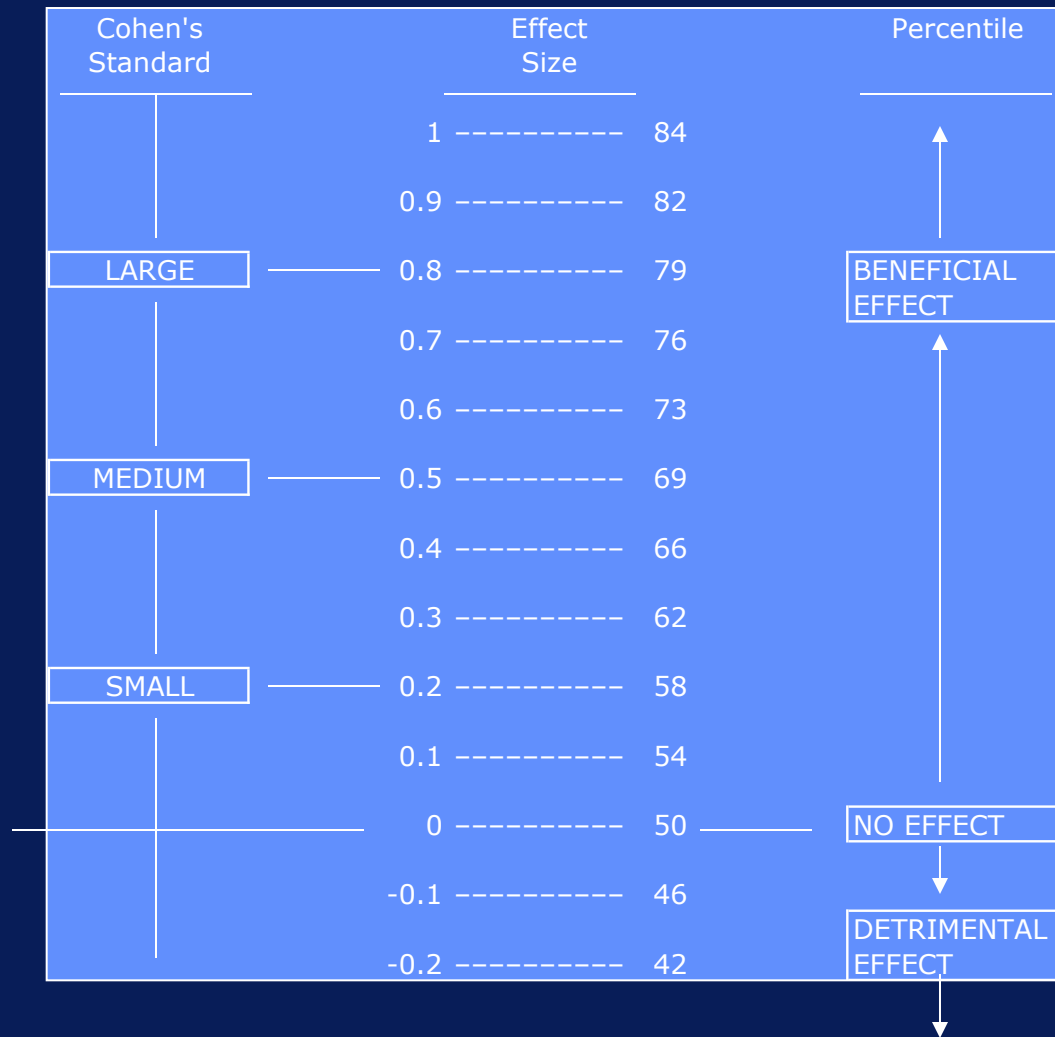
Cohen (1988):

0.20 = “small” effect

0.50 = “medium” effect

0.80 = “large” effect

ES values correspond to percentiles of average treated child relative to untreated group



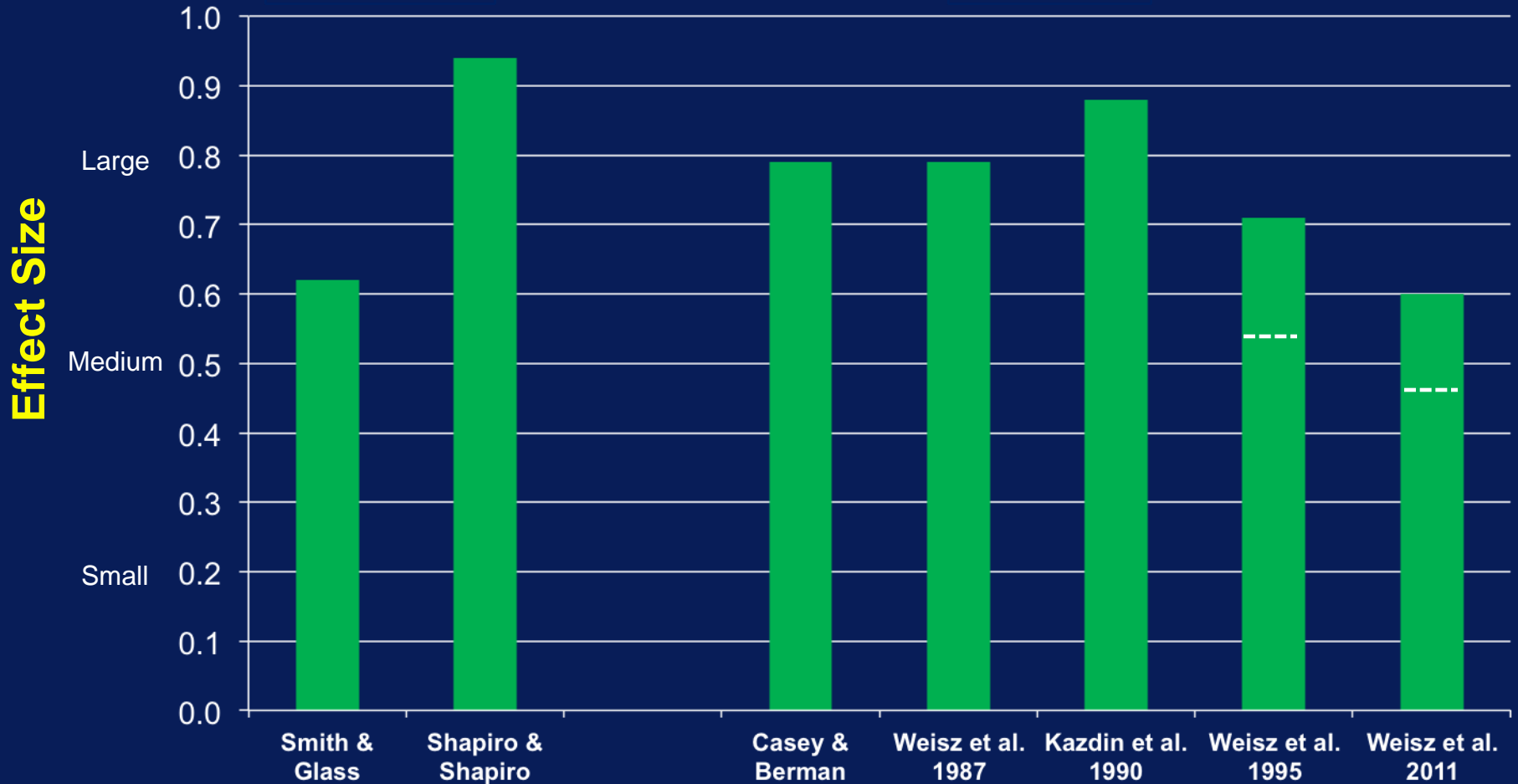
Weisz, Weiss, Donenberg, Han, & Weiss (1995)

Mean Effect Sizes in Meta-Analyses of Adult and Child Studies

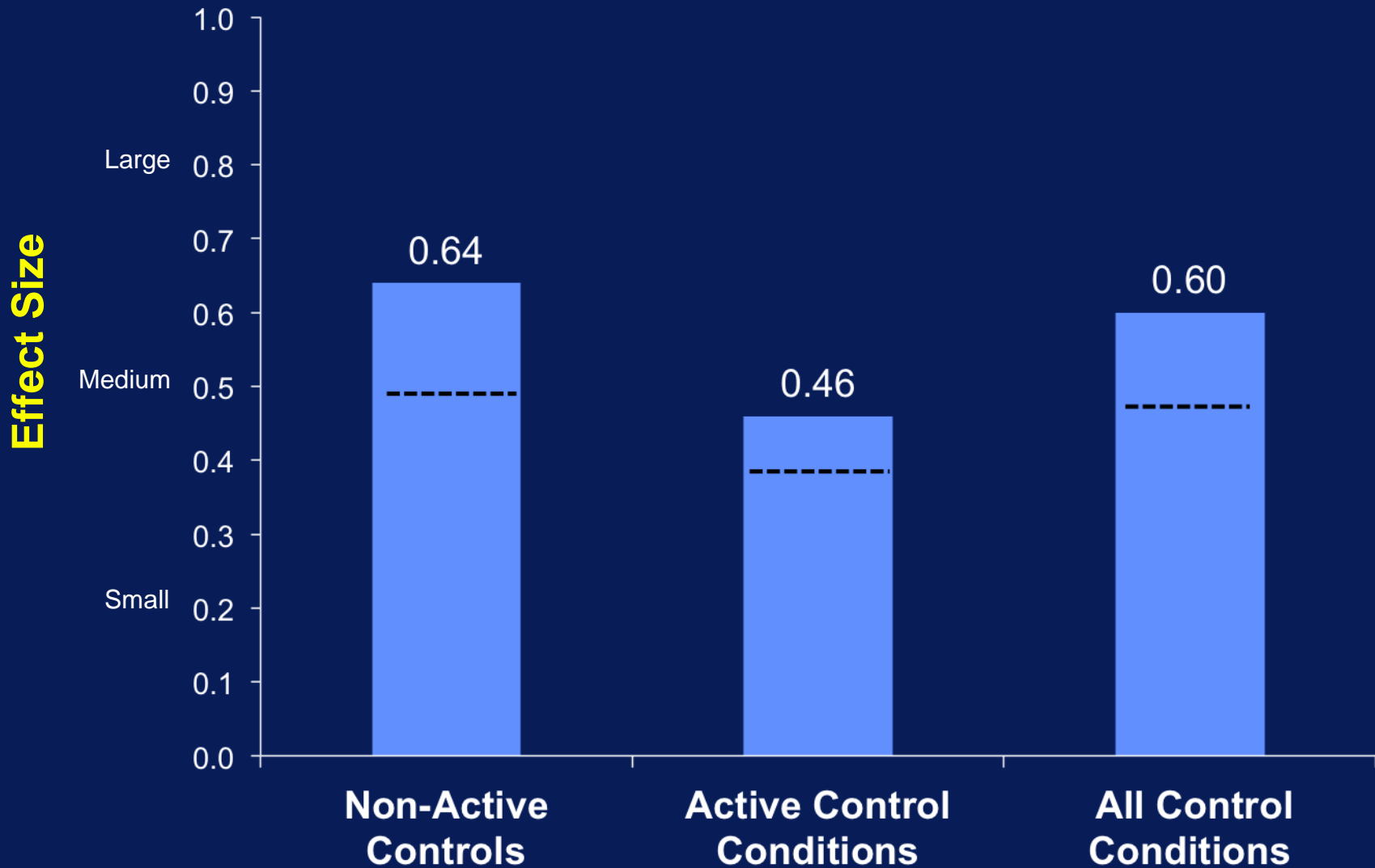
(Weisz, 2011)

ADULT

CHILD

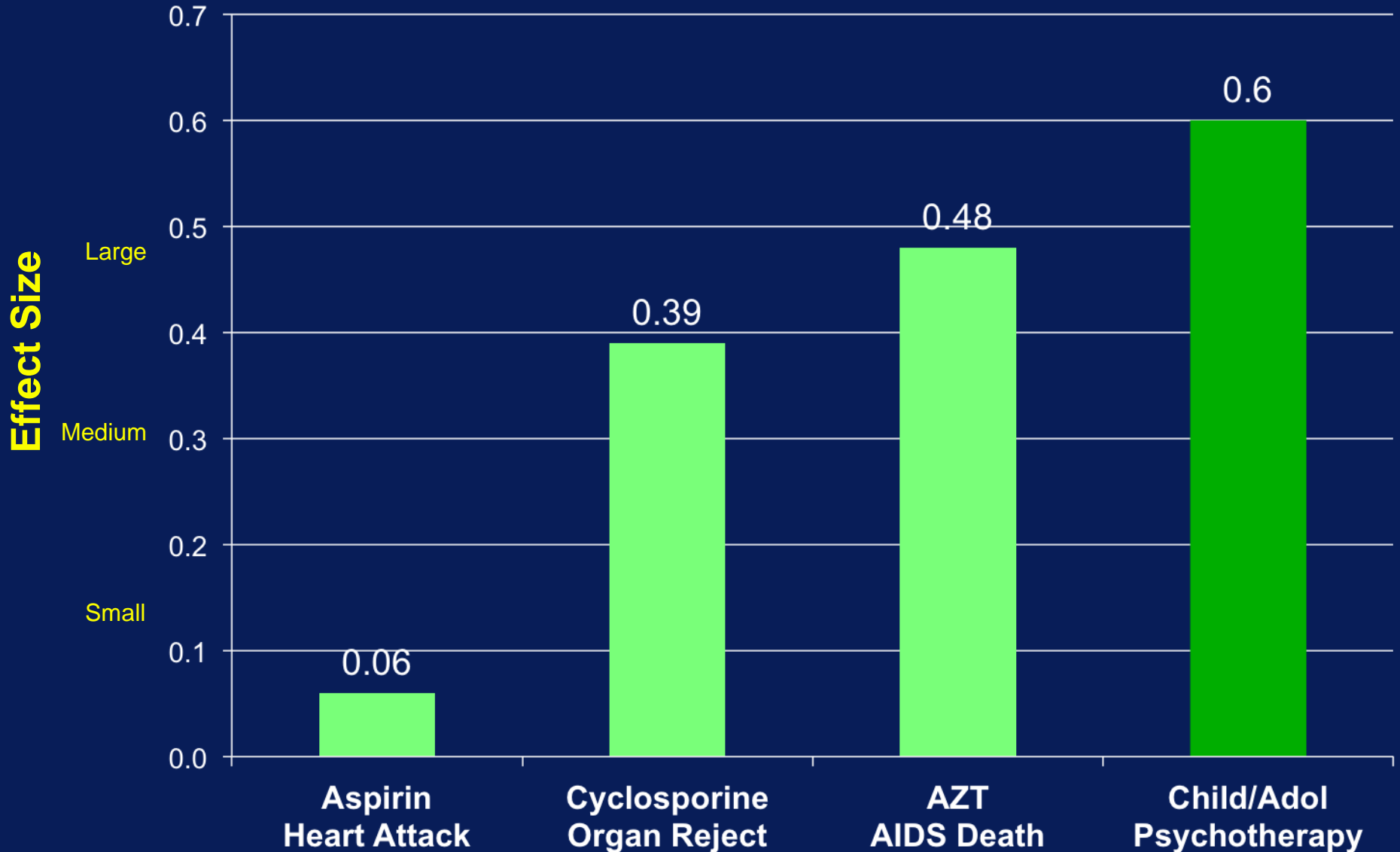


Mean Effect Sizes in Meta-Analysis of Child and Adolescent Studies (Weisz, 2011)



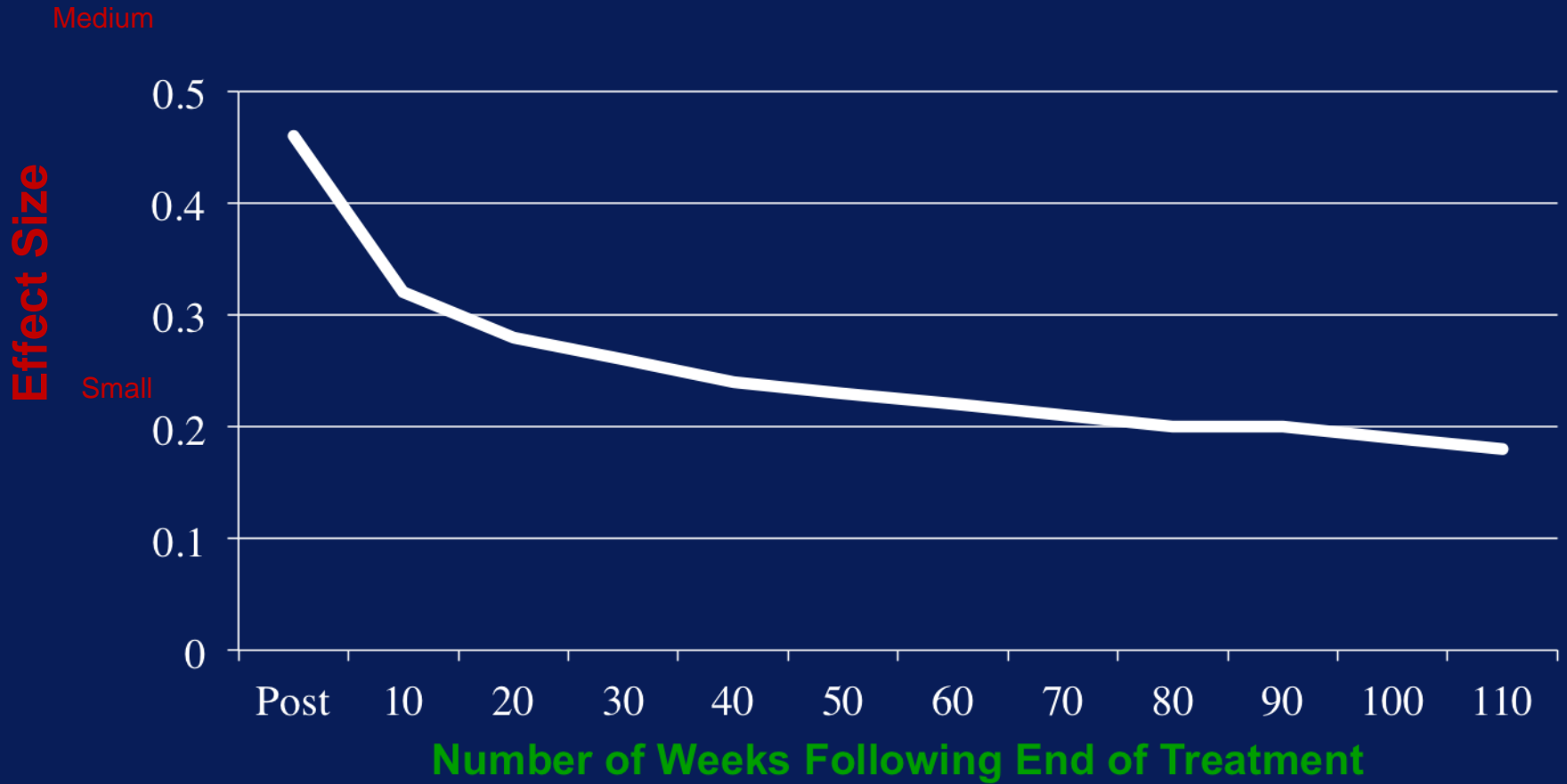
How Good is .60/.47?

(Weisz, 2011)



Do EB Treatment Effects Last?

(Weisz, 2011)



So...EBPs work better than “usual care” provided in MH settings.

How are EBPs Defined?

Common Features of Evidence-Based Treatments for Childhood Mental Health Disorders

(Pelham & Burrows-McLean, 2005)

- Extensively studied, efficacy documented, and listed in professional association or other reputable guidelines
- Based on behavioral, cognitive-behavioral, or behavioral-family framework
- Precisely described in treatment manuals
- Focus on clearly described behaviors that are targeted for change, reducing impairments, building adaptive skills, and improving functional outcomes tied to specific therapeutic activities
- Involve parents and teachers as implementers or facilitators and use MA/BA clinicians and group treatments to reduce costs and maximize transportability
- Employ a functional analytic approach to develop, monitor, and modify intervention as necessary with each child
- Include procedures for generalization, maintenance, and relapse prevention

Many Different Criteria and Lists for EBP

Nat' l Registry of Evidence-based Programs and Practices (NREPP)
of CSAP (Mental health/substance use):

<http://www.nrepp.samhsa.gov/>

IES--What Works Clearinghouse (Education):

<http://ies.ed.gov/ncee/wwc/>

American Academy of Child and Adolescent Psychiatry (AACAP):

<https://www.aacap.org/>

American Academy of Pediatrics (AAP): <http://www.aap.org/>

American Psychological Association (APA): <http://www.apa.org/>

National Academy of School Psychologists (NASP):

<http://www.nasponline.org/>

University of Colorado Blueprints for Healthy Youth Development:

<http://www.colorado.edu/cspv/blueprints/>

Reviews in Journals (e.g., *Journal of Clinical Child and Adolescent Psychology*)

Reviews by Nonprofit entities/academic centers (e.g., Cochrane Collaborative, SCCAP, Child Trends)

But many similarities among criteria and results

Grading the Quality of Evidence-- Example

Biglan, Mrazek, Carnine, Flay (AP 2003)

Grades 1-7

1=multiple RCTs or multiple time series exp by 2 or more indep teams + implementation effectiveness

2=1 without implementation effect

3=no indep teams

4=1 RCT or time series

5=comparisons w/o randomization

6=pre-post

7=endorsement by authorities

**Definitions of Evidence-based Practices
Society for Clinical Child and Adolescent
Psychology; SCCAP (Div 53 of APA)
(JCCAP 1998, 2008)
and www.effectivechildtherapy.com**

- 1. At least two well-conducted group-design studies, conducted by different investigators, showing the treatment to be either**
 - (a) superior to pill placebo or alternative treatment
or
 - (b) equivalent to an established treatment in studies with adequate statistical power.

OR

Criteria for Well-Established Psychosocial Interventions

- 2. A large series of case studies that both**
 - (a) use good experimental design and
 - (b) compare the intervention to another treatment.

AND

- 3. Treatment manuals used for the intervention preferred.**

AND

- 4. Sample characteristics must be clearly specified.**

Criteria for Probably Efficacious Psychosocial Interventions

1. Two studies showing the intervention more effective than a no-treatment control group.

OR

**2. Either (a) two studies meeting criteria for well-established treatments but conducted by the same investigator, OR
(b) one well-designed study demonstrating effectiveness meeting all other criteria for a well-established treatment.**

Criteria for Probably Efficacious Psychosocial Interventions

OR

- 3. At least two good studies demonstrating effectiveness but flawed because of sample heterogeneity.**

OR

- 4. A small series of case studies that otherwise meet criterion 2 for well-established treatment.**

Criteria for Probably Efficacious Psychosocial Interventions

AND

3. Treatment manuals used for the intervention preferred.

AND

4. Sample characteristics must be clearly specified.

Adapted from Task Force on Promotion and Dissemination of Psychological Procedures (1995, p. 21).

What works for ADHD and Conduct Problems, for example?

- (A) Behavioral Parent Training**
- (B) Classroom Behavior Modification
(teacher-implemented)**
- (C) A variety of child-focused behavioral and cognitive behavioral treatments for peer problems done in school, after school, or summer settings—rarely in clinic sessions**

What works for Anxiety and Depression, for example?

CBT in various forms with or without parent training

Multiple components (see below)

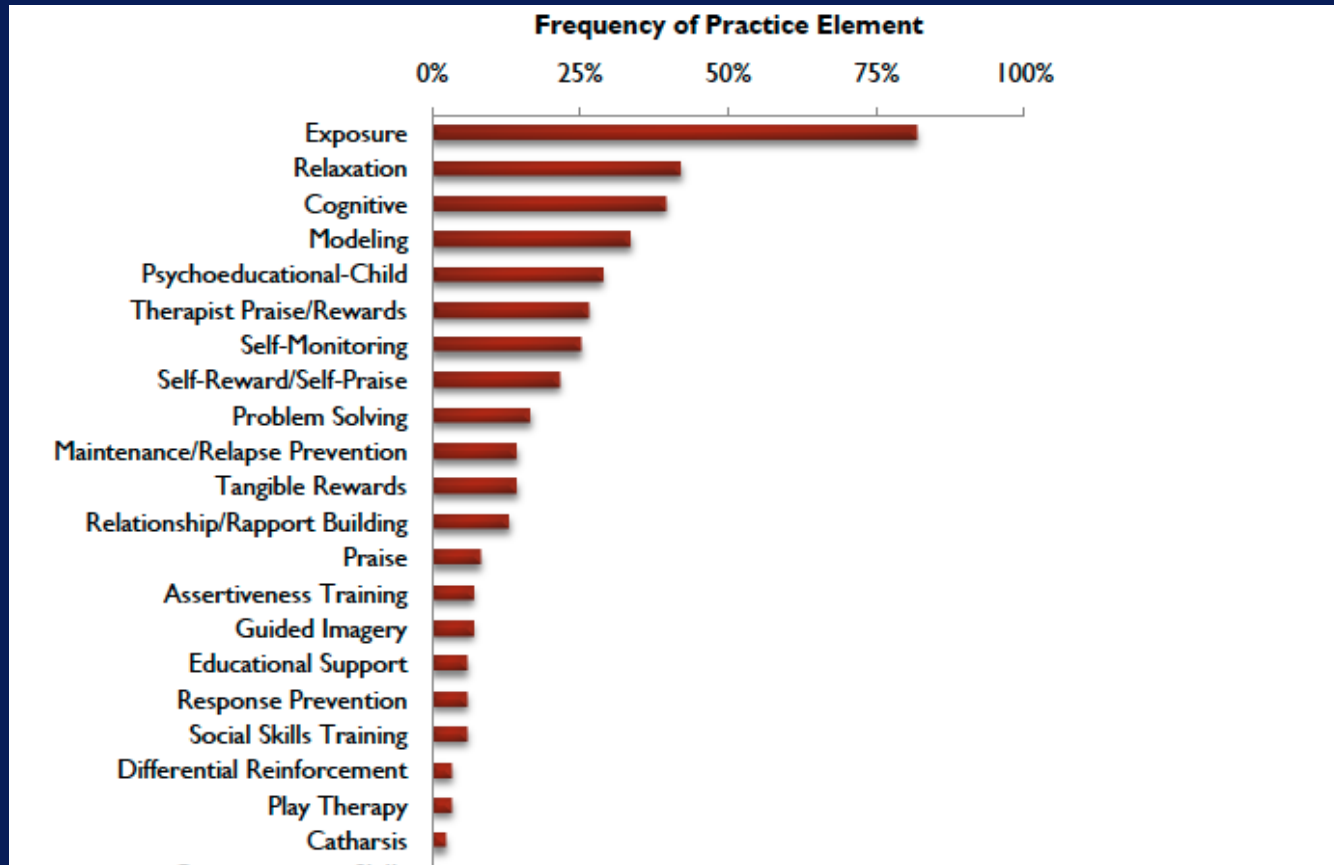
2008 Update in Journal of Clinical Child and Adolescent Psychology

- **ADHD** (Pelham & Fabiano, 2008)
 - More studies on PT and SI
 - Summer Treatment Programs/Social skills
- **Conduct disorder/ODD/aggression** (Eyberg, Nelson, & Boggs, 2008)
 - More studies of PT and SI
 - Interpersonal problem solving combined with PT and SI
- **Depression** (David-Ferdon & Kaslow, 2008)
 - Weisz child treatment (CBT)
 - Adolescents: more CBT, IPT
- **Anxiety** (Silverman et al., 2008)
 - More studies of CBT--individual and group
- **Autism** (Rogers & Vismara, 2008)
 - Intensive behavioral treatment and some other intensive programs

**ARE THERE COMMON
ASPECTS OF THESE
EVIDENCE BASED
TREATMENTS?**

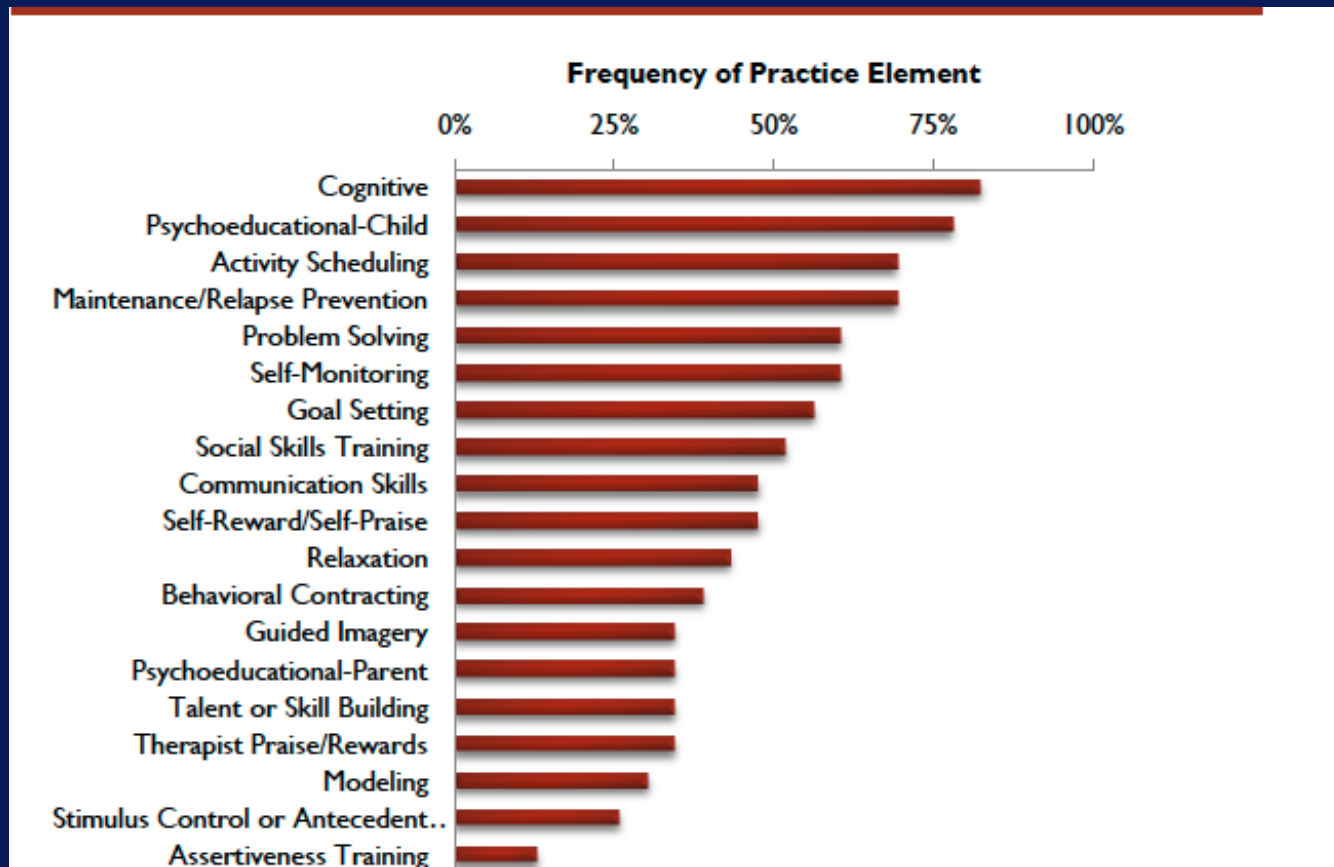
Practice Elements in Effective Treatments for Child Anxiety

(Chorpita and Daleiden, 2007)



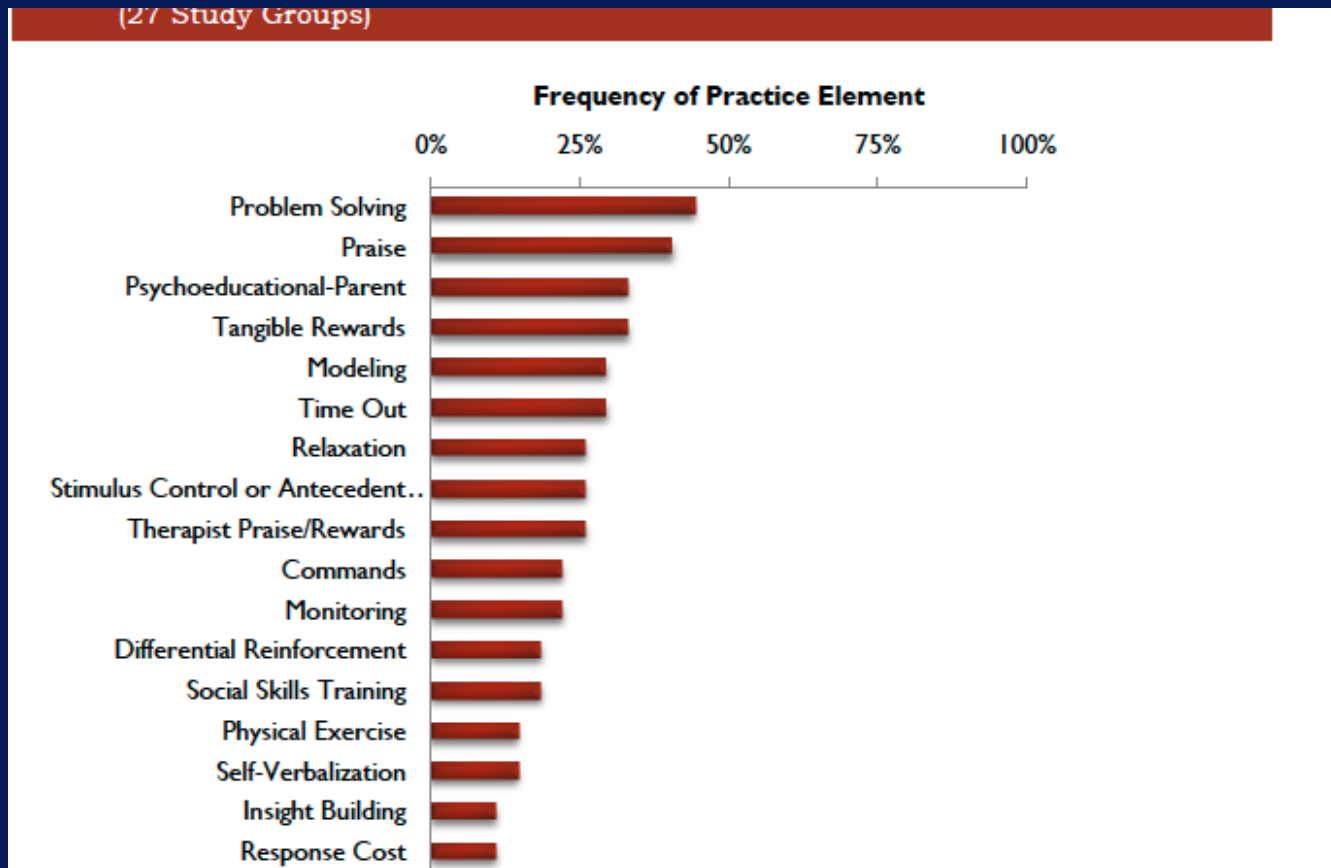
Practice Elements in Effective Treatments for Depression

(Chorpita and Daleiden, 2007)



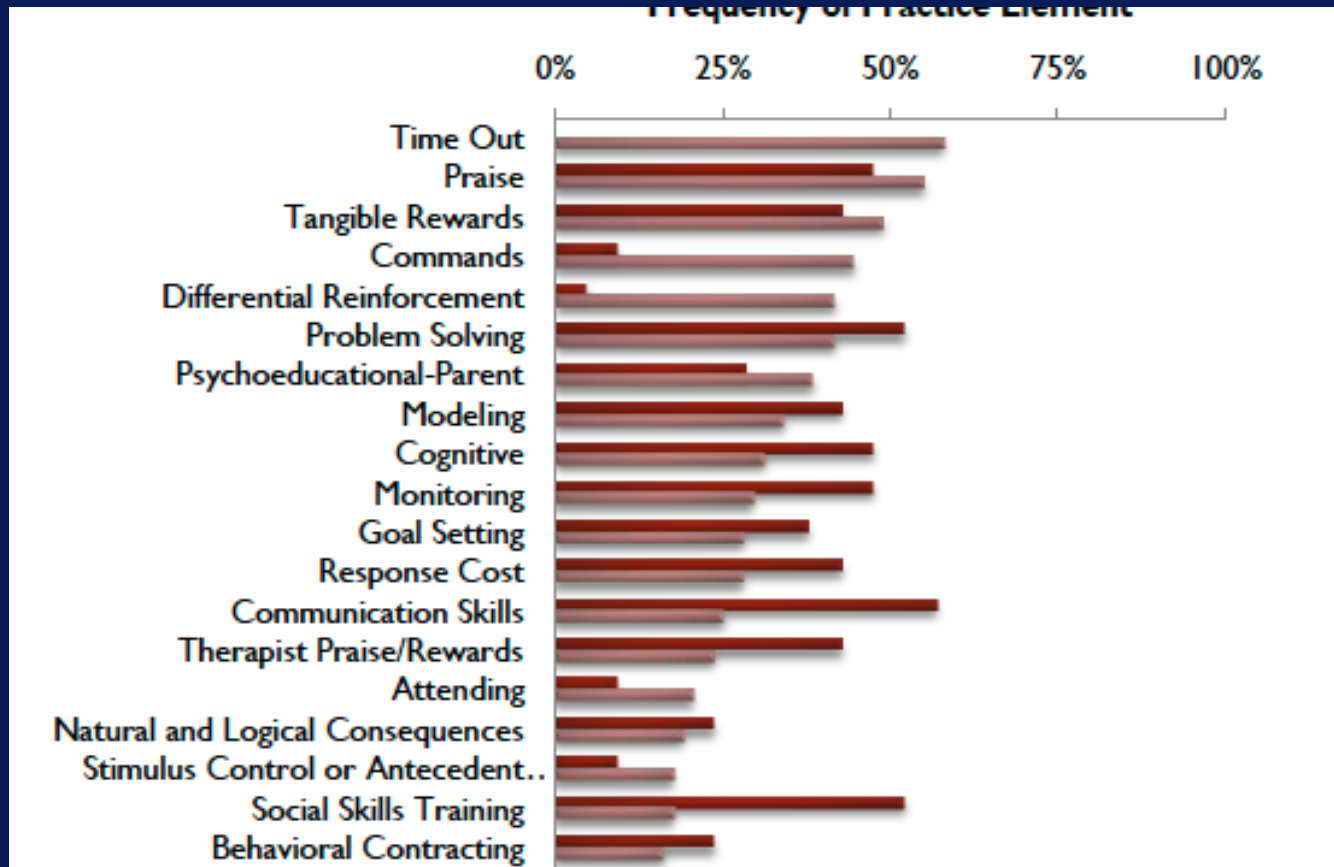
Practice Elements in Effective Treatments for ADHD

(Chorpita and Daleiden, 2007)



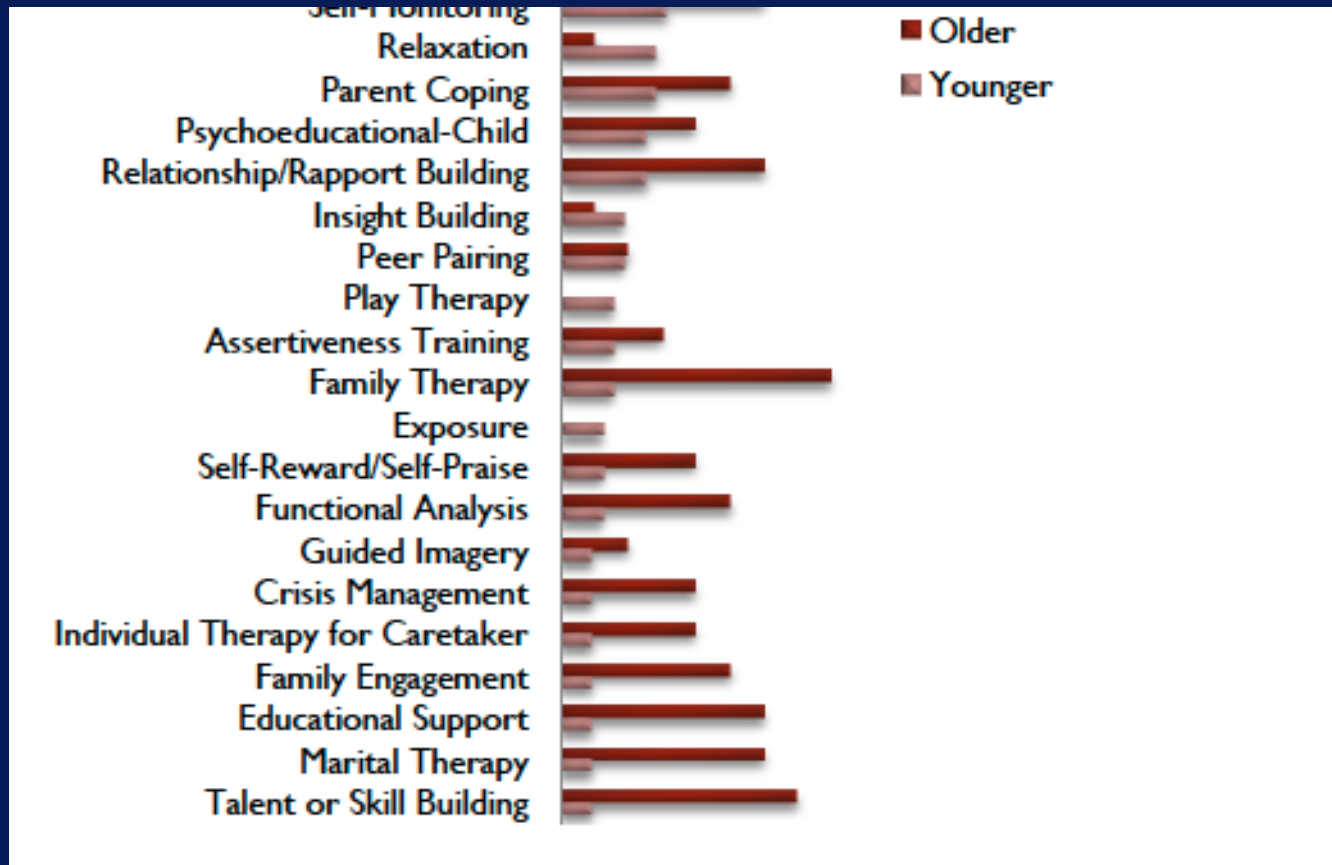
High Frequency Elements of Effective Treatments for Delinquency/Conduct Problems

(Chorpita and Daleiden, 2007)



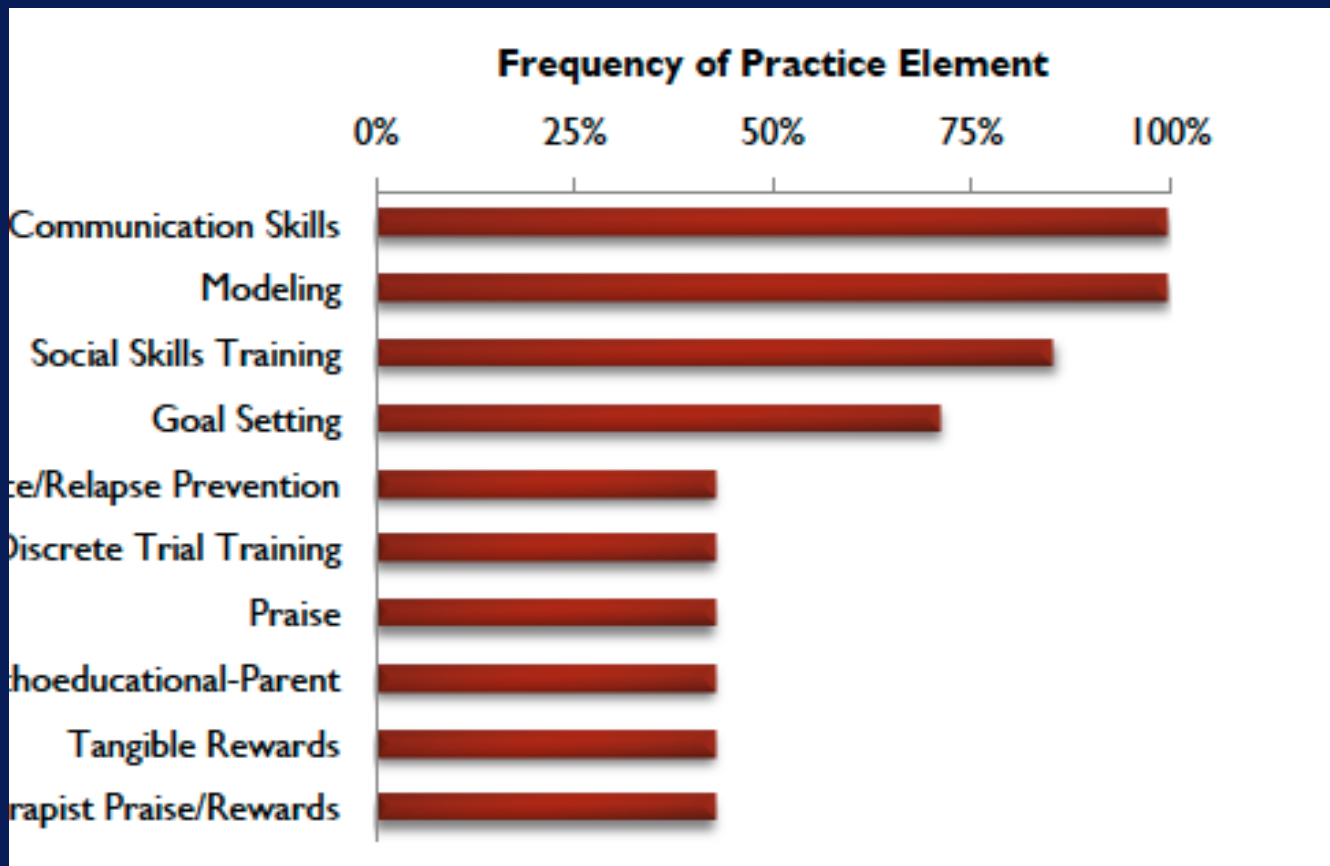
Low Frequency Elements of Effective Treatments for Delinquency/Conduct Problems

(Chorpita and Daleiden, 2007)



Practice Elements in Effective Treatments for Autism

(Chorpita and Daleiden, 2007)



Common Features of Evidence-Based Treatments for Childhood Mental Health Disorders

(Pelham & Burrows-McLean, 2005)

- Extensively studied, efficacy documented, and listed in professional association or other reputable guidelines
- Based on behavioral, cognitive-behavioral, or behavioral-family framework
- Precisely described in treatment manuals
- Focus on clearly described behaviors that are targeted for change, reducing impairments, building adaptive skills, and improving functional outcomes tied to specific therapeutic activities
- Involve parents and teachers as implementers or facilitators and use MA/BA clinicians and group treatments to reduce costs and maximize transportability
- Employ a functional analytic approach to develop, monitor, and modify intervention as necessary with each child
- Include procedures for generalization, maintenance, and relapse prevention

Components of Evidence-based Psychosocial Treatment for ADHD, ODD, and CD

(Pelham & Fabiano, 2008)

- Parent Training
- School Intervention
- Child Intervention

Parent Training-DBDs

(Pelham & Burrows-McLean, 2005)

- Behavioral approach; therapist teaches parents contingency management techniques and other parenting skills to use with the child and the parent implements the treatment
- Focus on specific target behaviors that reflect impairment in key domains of functioning (e.g., peer relationships, parenting skills and family relationships, academic and school functioning); maladaptive behaviors are targeted for reduction and adaptive skills are targeted for development
- Typical model is group-based, weekly sessions with therapist (8 to 16 sessions) initially, then contact faded
- Adherence to treatment components regularly checked, and treatment goals are continually added, deleted, or modified based on an ongoing functional analysis of behavior
- Continued support and contact as long as necessary as determined through ongoing monitoring
- Program for maintenance and relapse prevention (e.g., develop plans for dealing with backsliding/concurrent cyclic parental problems, such as maternal depression, parental substance abuse, and divorce)
- Reestablish contact for major developmental transitions (e.g., adolescence)

School Intervention-DBDs

(Pelham & Burrows-McLean, 2005)

- Behavioral approach; therapist teaches teacher contingency management techniques to use with the child, and the teacher implements the treatment
- Focus on specific target behaviors that reflect impairment in key domains of functioning (e.g., peer relationships, interactions with adults/rule following, academic progress); maladaptive behaviors are targeted for reduction and adaptive skills are targeted for development
- Consultant works with teacher — initial weekly face-to-face or phone sessions, (3 to 8 contacts) then contact faded
- Adherence to treatment components regularly checked, and treatment goals are continually added, deleted, or modified based on an ongoing functional analysis of behavior
- Continued support and contact as long as necessary as determined through ongoing monitoring
- Program for maintenance and relapse prevention (e.g., school-wide programs, inservice training all school staff, including administrators; eventually train parent to work with the teacher and monitor/modify intervention)
- Reestablish contact for major developmental transitions (e.g., move from elementary school to middle school)

Child Intervention-DBDs

(Pelham & Burrows-McLean, 2005)

- Behavioral and developmental approach – involving direct work in natural or analog settings – not clinic settings
- Focus on specific target behaviors that reflect impairment in multiple domains of functioning (e.g., peer relationships, interactions with adults, sibling relationships, academic skills, classroom and family functioning, self-esteem); maladaptive behaviors are targeted for reduction and adaptive skills (e.g., social skills, sports skills, academic skills) are targeted for development
- Often paraprofessional implemented
- Intensive treatment settings such as summer treatment programs (9 hours daily for 8 weeks), and/or school-year, after-school, and Saturday (6 hours) sessions
- Behavioral (contingent rewards and negative consequences) and cognitive behavioral (e.g., social skills training, problem solving training) integrated in the context of recreational activities
- Adherence to treatment components regularly checked, and treatment goals are continually added, deleted, or modified based on a current functional analysis of behavior
- Provided as long as necessary (e.g., 2 or 3 years after initial contact)
- Program for generalization and relapse prevention (e.g., integrate with school and parent treatments)
- Reestablish contact for major developmental transitions (e.g., move from elementary to middle school)

Components of Evidence-based Treatments for Internalizing Disorders

- Child Intervention
 - Exposure
 - Behavioral skills training
 - Cognitive skills training
- Parent Training

Common Elements of Child Intervention for Anxiety/Depression (Pelham & Burrows-McLean, 2005)

- Behavioral and cognitive-behavioral approach in which therapist works with child to reduce depression/anxiety/fears and to increase adaptive skills; can be done in office, school, and other settings
- Focus on specific target behaviors that reflect the depression/fears/anxieties that are causing impairment in key domains of functioning; maladaptive behaviors (withdrawal, depression, fears, and anxieties) are targeted for reduction, and adaptive skills (e.g., social skills, coping skills, increasing positive activities) are targeted for development
- Focus on specific cognitions that underlie the child's anxiety/fears/depression, teaching the child a new set of cognitions that will help him or her cope with anxiety and depression
- Employ modeling, shaping, prompting, and role play to teach these skills, and practice with rewards within sessions to master them; employ acronyms and charts to help child learn and remember skills
- Expose the child to the situation that produces the anxiety/fears or depression so that the child learns mastery over the anxiety or depression
- Give homework assignments that involve exposure to the target situations and practice of the coping skills acquired in the training sessions
- Can be individual or group sessions (12 to 16 sessions once or twice weekly), though group-based treatment is more effective
- Adherence to treatment components regularly checked, and treatment goals are continually added, deleted, or modified based on a current functional analysis of behavior
- Program for generalization, maintenance, and relapse prevention (e.g., integrate with parent training, develop plans with child for what to do if problem re-emerges)

Common Elements of Intervention for Parent Training-Anxiety/Depression

(Pelham & Burrows-McLean, 2005)

- Behavioral approach; therapist teaches parents contingency management techniques and other parenting skills to use with the child and the parent implements the treatment
- Focus on specific target behaviors that reflect the depression/fears/anxieties that are causing impairment in key domains of functioning; teach parents behavioral skills to reinforce what the child is learning in child sessions—that is to reduce the child's maladaptive behaviors (anxiety/fears/depression) and to reinforce the child's adaptive skills (e.g., social skills, coping skills)
- Dyadic or group-based, weekly sessions with therapist (8 to 10 sessions) initially, then contact faded
- Adherence to treatment components regularly checked, and treatment goals are continually added, deleted, or modified based on an ongoing functional analysis of behavior
- Program for generalization, maintenance and relapse prevention (e.g., parents work to reward the child for continuing his or her coping plans over time, and with the teacher when necessary to ensure that teacher backs up what child and parent are doing; plan for what parents will do if problem re-emerges)



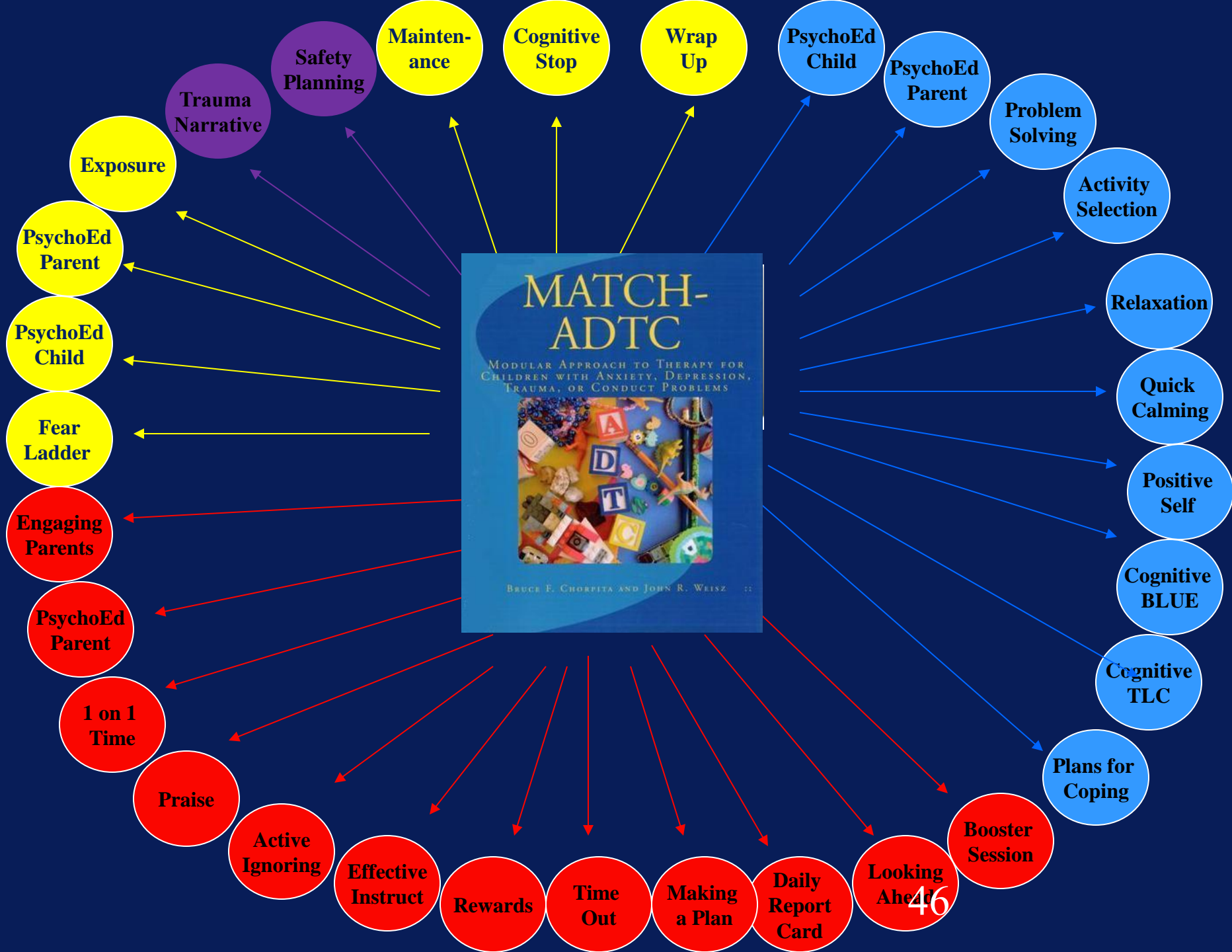
Weisz/Chorpita's ChildSTEPs Components:

- Evidence-derived procedures for multiple problems, using a modular design:

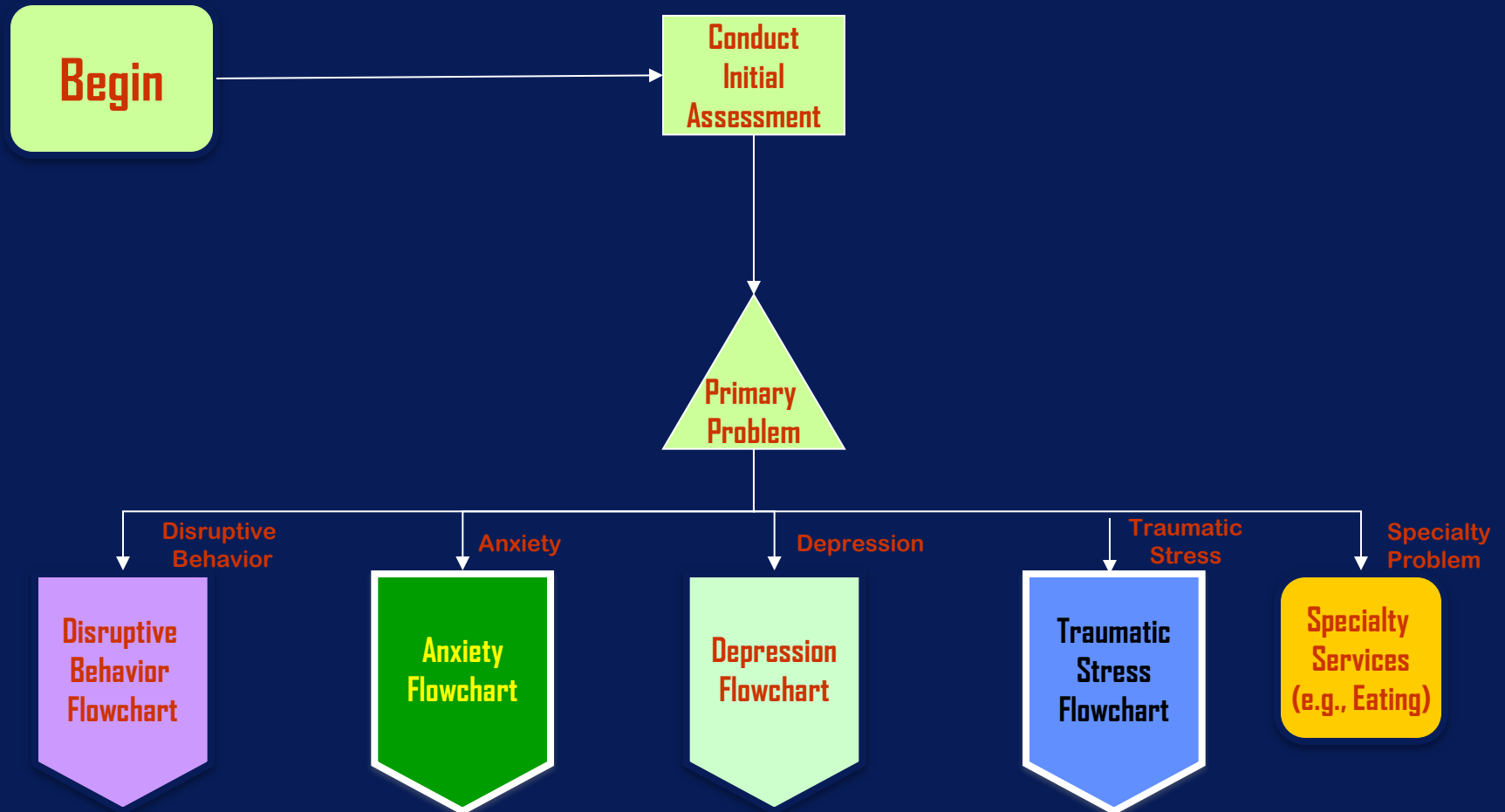
MATCH

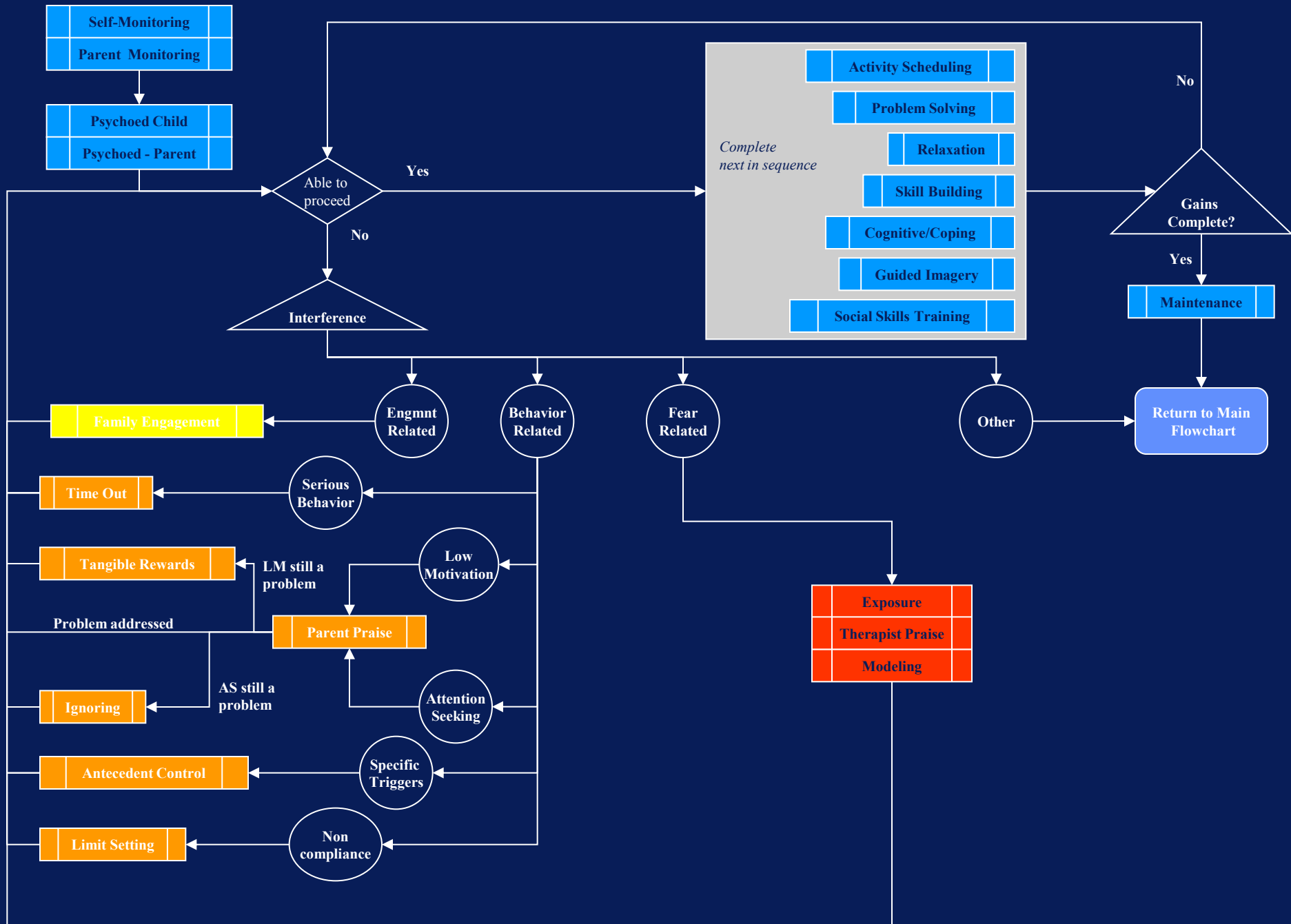
- Evidence-based clinical info system for monitoring whether treatment is working:

TRAC



CHILD STEPS[®] DECISION TREE





Components of Evidence-based Treatments for Autism

(Pelham & Burrows-McLean, 2005)

- Child Intervention
 - Discrete Trial Training
 - Structured social interactions
- Parent Training

Common Elements of Child Intervention-Autism

(Pelham & Burrows-McLean, 2005)

- Intensive behavioral approach with goal of maximizing independent functioning
- Typical model is intensive training daily for multiple hours at school and home
- Conduct functional behavioral analysis to design interventions
- Focus on specific target behaviors that reflect key domains of functioning (social interactions and communication) and behaviors that interfere with adaptive functioning (disruptive behavior)
- Social behavior:
 - ❖ Focus on social skills, social play and expressing affection.
 - ❖ Employ modeling, shaping, prompting to teach these skills
 - ❖ Normal or mildly handicapped peers may be utilized in teaching social interaction skills
- Communication skills:
 - ❖ Focus on verbal imitation, receptive language skills, expressive verbal language skills
 - ❖ Employ modeling, shaping, prompting to teach these skills
- Adherence to treatment components regularly checked, and treatment goals are continually added, deleted, or modified based on an ongoing functional analysis of behavior
- Continued intervention for as long as necessary
- Program for generalization, maintenance and relapse prevention

Common Elements of Parent Training: Autism

(Pelham & Borrows-McLean, 2005)

- Behavioral approach; therapist teaches parents contingency management techniques and other parenting skills to use with the child and the parent implements the treatment; more intensive work with parents than for most other disorders
- Reinforce what the child is learning in child sessions—that is to reduce the child's disruptive behaviors and to develop the child's adaptive skills (social behavior and communication skills)
- Dyadic or group-based, sessions with therapist (16 to 20 sessions) initially, then ongoing contact and support typically for very long periods of time
- Training involves modeling procedures with parents and child and then observing and giving feedback to parents while they implement program with child
- Adherence to treatment components regularly checked, and treatment goals are continually added, deleted, or modified based on an ongoing functional analysis of behavior
- Program for generalization, maintenance and relapse prevention (e.g., periodic respite care for parents to avoid burn out)

Mind Your eb-P' s and -Q' s in Child Mental Health

Society for Clinical Child and Adolescent Psychology (SCCAP; Division 53 of the American Psychological Association)

Special Issues of *Journal of Clinical Child and Adolescent Psychology*, 1998, 2005, 2008

Kansas and Niagara Conferences on Evidence-based Treatments (1999-ongoing)

Website (www.effectivechildtherapy.com)

Current Initiative on Dissemination of EBPs via the Web (www.effectivechildtherapy.fiu.edu)

http://www.effectivechildtherapy.com

EFFECTIVE CHILD THERAPY

Evidence-based mental health treatment for children and adolescents

Sponsored by



Welcome

The Public

Professionals & Educators

 Online Education



Find the Best
Treatments for You
and Your Family

Information for parents,
caregivers, and the
general public



Practice the Best
Treatments

Information for
practitioners, educators,
and other mental health
professionals



What is Evidence-Based Treatment?

Many treatments are available for child and adolescent mental health symptoms.

Some are backed by science (i.e., "evidence-based treatments"), and some are not.



SCCAP EBP Dissemination Initiative

<http://effectivechildtherapy.fiu.edu>

- **SCCAP developed lists of EBPs from journal reviews from experts and posted lists on its website**
- **Division decided to make dissemination of EBPs its major initiative, to use its resources for a major web-based initiative for dissemination**
- **Grant to FIU in 2010 for 3 years to develop content**
- **Co-funding obtained from FIU DoR and CCF and from The Children's Trust**

SCCAP Dissemination Initiative: Objectives

A series of internet streaming videos to provide exposure and training in a variety of EBPs for childhood and adolescent disorders.

Intent is to have information available at multiple levels of complexity such that it will be useful to multiple constituencies—parents, MH professionals, educators, primary care professionals, and students.

SCCAP Dissemination Initiative

Why internet-based accessibility?

Limitations with journal and conference dissemination

Accessibility—travel, costs

Immediate acquisition of training from experts and treatment developers

Downloadable accompanying documents

Self-paced

Generic as well as commercial modules—reducing costs for community MH centers and states/localities

Optional ongoing consultation via telephone, internet

SCCAP Dissemination Video Initiative

<http://effectivechildtherapy.fiu.edu>

Experts selected for knowledge of EBPs in field (keynote overviews) or for specific expertise in an evidence-based practice (typically, the practice developer)

Speakers brought to FIU in Miami for 1-2 days to film in front of live audience of local clinicians (subsidized by The Children's Trust) in the Speaker Series of the Center for Children and Families at FIU

Almost all of the speakers have generously donated their time and the right to include their intervention to the initiative (most are members of SCCAP) and we are grateful for their generosity

SCCAP Dissemination Initiative

<http://effectivechildtherapy.fiu.edu>

Some videos are offered for free, while others offered at a low-cost (individual, continuing ed, and group discount rates)

Series of videos :

- Parent Videos-15 min overviews of disorders and treatments for general consumers
- Keynotes- 60 minute overviews for professionals [and parents] that review what is known about EBPs for disorders
- Workshops- vary in length, how to deliver treatment with supporting downloadable information

Online Education Website

www.effectivechildtherapy.fiu.edu



Home | Parent Resources | Professional Resources | Course Catalog | About Division 53 | Contact Us



Home

Society of Clinical Child and Adolescent Psychology



Center for Children and Families

New Effective Child Therapy Online Education Website!

Welcome to the Effective Child Therapy Online Education website! ECT Online Education was developed by Division 53 of the American Psychological Association (Society for Clinical Child and Adolescent Psychology) in collaboration with the Center for Children and Families at Florida International University and The Children's Trust. On this site you will find resources for both parents and professionals about evidence-based practices that promote child and adolescent mental health. Evidence-based practices are those that have been shown to work by high-quality research studies conducted in a variety of settings.

If you are a parent or a caregiver, please check out our resources under the "Parents" tab. You will find brief videos that are interviews with

Parent Videos

Home

Parent Resources

Professional Resources

Course Catalog

About Division 53

Contact Us

Videos for Caregivers about Effective Mental Health Care for Children

Home

Society of Clinical Child and Adolescent Psychology



Parent Resources

This section of the website has videos of interviews with experts in child and adolescent psychology. In each video, the experts discuss issues that are particularly important to parents/caregivers. In addition, the experts describe the evidence-based treatment options available for children and adolescents experiencing the specific problems listed below. These videos are organized alphabetically, by disorder/problem.

To learn more about the importance of evidence-based practices, please [click here](#).

Center for Children and Families



Abuse



Dr. David Kolko defines physical abuse and reviews the impact of abuse and family conflict on children. In addition, he discusses helpful resources for families. Dr. Kolko is a Professor of Psychiatry, Psychology, and Pediatrics at the University of Pittsburgh School of Medicine. He is board certified in Child and Adolescent

Parent Videos

Overview of disorder and treatments (15 minute interview with experts)

Brief description of disorder/problem

How to decide if your child needs treatment

What to ask a treatment provider

Evidence-based treatment options

Essential components of treatment that caregivers should look for when seeking treatment

Parent Videos Available to date

Topics

Attention Deficit
Hyperactivity Disorder

Bipolar Disorder

Suicide

Depression

Divorce

Tourette's Syndrome

School Refusal Behavior

Anxiety

Pediatric Obesity

Anorexia Nervosa and
Bulimia

Physical Abuse

Adolescent Substance
Abuse

Obsessive-Compulsive
Disorder

Autism

Time-Out from Positive
Reinforcement

Medications for Anxiety
and Depression

Medications for ADHD

Mental Health
Assessment

Keynotes on State of Science of EBPs for MH Problems

Overviews of Evidence Based Practices for Youth Mental Health



Home

Society of Clinical Child and Adolescent Psychology



Center for Children and Families



EffectiveChildTherapy.com



Keynote Overview Videos & Handouts

Make a Selection

- Abuse
- Aggression
- Anxiety Disorders
- Assessment of Mental Health Problems
- Attention Deficit Hyperactivity Disorder
- Autism Spectrum Disorders
- Bipolar Spectrum Disorders
- Depression
- Learning
- Problems with Eating
- Tourette's Syndrome and Tic Disorders
- Substance Use Problems
- Suicide

Learning Objectives for Keynote Overviews

At the end of these presentations, the participant will be able to:

Topics and Speakers for Keynotes

Speaker	Title of Presentation	
David Kolko, Ph.D.	Evidence-Based Interventions for Child Physical Abuse and Family Conflict	Abuse
Anne Marie Albano, Ph.D.	Basics of Cognitive Behavior Therapy with Children and Adolescents: Social Learning Theory	Anxiety
John Piacentini, Ph.D.	Evidence-based Treatment of Obsessive Compulsive Disorder in Children and Adolescents	Anxiety
Wendy Silverman, Ph.D.	Evidence-based Approaches for Children with Anxiety Problems	Anxiety
Gabrielle Carlson, M.D.	Evidence-Based Medication Treatment of Anxiety and Depression in Young People	Anxiety/Depression
Paul Frick, Ph.D.	An Evidence-Based Approach to Assessment and Evaluation for Child Mental Health	Assessment
Tristram Smith, Ph.D.	Evidence-Based Practices for Children with Autism Spectrum Disorders	Autism
Mary Fristad, Ph.D.	Evidence-Based Practices for Bipolar Spectrum Disorders in Youth	BPSD
John Curry, Ph.D.	Evidence-based Treatment of Depression in Adolescents	Depression
Charles Cunningham, Ph.D.	Evidence-based Parenting Programs for the Treatment of Children with Externalizing Problems	ADHD
James Waxmonsky, M.D.	Evidence-based Pharmacological Approaches to Treating ADHD in Children and Adolescents	ADHD
William E. Pelham Jr., Ph.D.	Evidence-based Psychosocial and Combined Approaches to Treating ADHD in Children and Adolescents	ADHD
Daniel Le Grange, Ph.D.	Evidence-Based Treatment for Adolescents with Anorexia and Bulimia	Eating Problems

Topics and Speakers for Keynotes (cont'd)

Speaker	Title of Presentation	
David Janicke, Ph.D.	Evidence Based Psychosocial Interventions for Pediatric Obesity	Eating Problems
Christopher Lonigan, Ph.D.	Evidence-Based Instructional Strategies for Promoting the Development of Early Language and Literacy Skills for Children At-Risk	Literacy
John Lochman, Ph.D.	Evidence-based School-based Violence and Prevention Programs	Aggression
Ken Winters, Ph.D.	Evidence-Based Interventions for Adolescents with Substance Use Problems	SUD
Cheryl King, Ph.D.	Suicide Risk Assessment & Formulation in Children and Adolescents: An Evidence-Based Approach	Suicide
Douglas Woods, Ph.D.	Evidence-based Treatment of Tourette's Syndrome and Tic Disorders	Tourette's

10-15 additional keynotes planned for 2013-2014

Workshops



Home

Parent Resources

Professional Resources

Course Catalog

About Division 53

Contact Us

Workshops on Specific Evidence Based Practices



Home

Society of Clinical Child and Adolescent Psychology



Information About Online Workshops

Learning Objectives for Workshops

At the end of this presentation the participant will be able to:

1. Identify the components belonging to a specific evidence based intervention for a particular disorder, and describe the rationale for

Evidence-based practice Workshop Topics

ADHD (3)

ODD/CD (4)

Autism/PDD (3)

Anxiety (6)

Depression (3)

Bipolar (2)

Adolescent
substance abuse
(2)

Eating Disorders
(1)

•Tourette's/Tics (1)

•Divorce (2)

•Adherence to medical
regimens

•Pharmacotherapy (2)

•Suicide

•Classroom management (4)

•Early intervention

•10 to 15 others (e.g.,
Prevention/Early Intervention,
assessment) planned for
2013-2014

Workshops

Vary in

length (2-10 hours)

format of treatment: group and individual treatments

target for treatment: child-focused or parent and/teacher mediated

treatment setting: school and office/clinic based

treatment length: brief (3 sessions) to long-term treatment

Moving Evidence Based Treatments into the Community:

**What are the barriers to effective
implementation?**

**What are possible solutions to
these barriers?**

Where are the Barriers to Implementation?

- **Families**
- **Schools**
- **Mental Health Settings**
- **Primary Care**
- **Community**
- **State and National**

Barriers in Mental Health Settings

- Adequate but inappropriately used financial resources for children's MH (e.g., 80% of MH monies are wasted on treatments that are not evidence based)
- Inadequate therapist knowledge about ADHD and evidence-based psychosocial (i.e., behavioral) treatment strategies
- Lack of therapist training in nonpharmacological, evidenced-based treatment practices
- Mistaken therapist beliefs about treatment strategies (e.g., belief that play therapy is helpful)

Barriers in Mental Health Settings

- **Conceptualization of treatment as brief/time limited for disorders that are chronic**
- **Traditional, office-based, clinic-based approach to treatment with children (i.e., therapy does not take place in natural environment where impairment occurs)**
- **Lack of a focus on/incentives for identification, assessment, and treatment of functional impairment rather than DSM symptoms**

Barriers in Mental Health Settings

- **Inadequate use of peer, paraprofessional, and masters level therapists, and group treatment, all of which would reduce costs**
- **Lack of regulation and monitoring of therapists' activities (therapist uses own judgment to devise treatment plans regardless of evidence base)**

Barriers in Mental Health Settings

- **Lack of application of universal interventions (i.e., school-wide vs. child-based)**
- **Lack of attention to cultural, ethnic, and racial differences in implementation and staffing**
- **Lack of family friendly approach to services (i.e., location, hours, materials)**

Barriers and Solutions

- **Lack of financial resources for children's MH**
 - Tie local funding to use of EBTs and outcomes
 - Employ paraprofessional/MA model
- **Inadequate therapist knowledge and skills regarding EBTs**
 - Teach EBTs instead of broad approach in training programs
 - Establish as part of accreditation
 - Define absence of use as unethical
 - Establish alliances to bring other MH disciplines on board
 - Better control over CEUs
 - Tie therapist pay to use of EBTs

Barriers and Solutions

- **Conceptualization of treatment as brief/time limited for disorders that are chronic**
 - Establish a chronic care model of treatment--focus on family empowerment
 - Develop continuum of services (initial PT, booster, checkups, relapse) and integrated services (parent, child, school)
 - Emphasize outcomes rather than contact hours
 - Tie therapist pay to long-term outcomes
- **Traditional, office-based, clinic-based approach to treatment with children**
 - Close or reengineer clinics and relocate/redesign MH points of contact

Barriers and Solutions

- **Overemphasis on diagnosis rather than treatment**
 - Reduce use of structured interviews--use rating scales instead
 - Focus on functional impairment rather than symptoms
 - Change nature of intakes to focus on functional analysis rather than diagnosis
 - Require rapid movement to treatment and ongoing monitoring of response and adaptive intervention

Barriers and Solutions

- **Lack of oversight and supervision of therapists' activities**
 - Require manualized treatments
 - Require justification for exceptions
 - Develop and routinely use fidelity measures in supervision (STP example)
 - Employ written treatment consents that document therapeutic actions that deviate from EBT manuals (McFall Manifesto, APA ethics)

Final Thought

If your own child had a mental health problem, wouldn't you expect him or her to receive evidence-based treatments? Shouldn't we be doing with our patients the same thing that we expect for our own children?

Summary

- Little evidence that care as usual in the child MH system is generally effective
- Much evidence that a subset of interventions that have been done in practice, identified as evidence-based practices (EBPs) through scientific studies of their impact, represent effective interventions.
- EBPs have substantially beneficial effects on children and adolescents, compared to intervention as usual in community and school settings
- Many EBPs available for child/adolescent MH problems, lists of them are widely available, and they are accessible through many sources (e.g., www.effectivechildtherapy.com)
- More widespread use of EBPs in practice would improve MH in children and adolescents

<http://effectivechildtherapy.com>
(click on video link)

<http://effectivechildtherapy.fiu.edu>

Continued Speaker Series on Evidence-based Practices at FIU CCF ongoing

**Next Niagara in Miami Conference on
Evidence-based Practices in Child and
Adolescent Mental Health
Miami, February, 2015**

Thank you!

For more information, please go to the main website and browse for workshops on this topic or check out our additional resources.

Additional Resources

Online resources:

1. Center for Children and Families website: <http://ccf.fiu.edu>
2. Society of Clinical Child and Adolescent Psychology website: <http://effectivechildtherapy.com>

Books:

1. Chorpita, B.F. & Weisz, J.R. (2009). MATCH-ADTC: Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems. Satellite Beach, FL: PracticeWise, LLC.
2. Weisz, J., & Kazdin, A. E. (Eds.). (2010). *Evidence-based psychotherapies for children and adolescents*. Guilford Press.
3. Burrows-MacLean, L. & Pelham, W. Jr. (2005). Mental Health Interventions: Evidence-Based Approaches. In Osborn, L., Dewitt, T., First, L & Zenel, J. (Eds.) *Pediatrics*, (pp. 1940-1948). Pennsylvania: Elsevier Mosby

Peer-reviewed Journal Articles:

1. Chorpita, B. F., Becker, K. D., & Daleiden, E. L. (2007). Understanding the common elements of evidence-based practice: Misconceptions and clinical examples. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46(5), 647-652.
2. Hoagwood, K., & Johnson, J. (2003). School psychology: A public health framework I. from evidence-based practices to evidence-based policies. *Journal of School Psychology*, 41(1), 3-21.
3. Silverman, W.K. & Hinshaw, S.P. (2008). Evidence-based psychosocial treatments for children and adolescents: A 10-year updated [Special Issue]. *Journal of Clinical Child & Adolescent Psychology*, 37 (1).
4. Weisz, J. R., Ugueto, A. M., Cheron, D. M., & Herren, J. (2013). Evidence-based youth psychotherapy in the mental health ecosystem. *Journal of Clinical Child & Adolescent Psychology*, (ahead-of-print), 1-13.

