Report of the Children's Evidence Based Practices Expert Panel

Submitted to DSHS-
Children's Administration,
Juvenile Rehabilitation Administration,
Mental Health Division

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Introduction

This expert panel was convened by the Mental Health Division (MHD), Children's Administration (CA) and the Juvenile Rehabilitation Administration (JRA) to review and recommend Evidence Based Practices for children and youth. The main charge of the expert panel was to create a menu of Evidence Based Practices for the three administrations to focus training and implementation activities.

The Work Group recommended, and the Assistant Secretaries endorsed, the use of a model developed in Hawaii. The premise behind the Hawaii model is to use local experts to select, review and rank practices and interventions. Using selected practices, Hawaii was able to create a menu of services that was used to guide implementation of Evidence Based Practices.

The expert panel reviewed and modified a list of clinical problems identified by youth and families receiving services from the three administrations. Then the Expert Panel conducted literature reviews of a multitude of psychosocial treatments for children and youth and adolescence and ranked them. The review was thorough, but not exhaustive, and was driven by consensus. Using the criteria developed by Hawaii, practices were ranked into 4 categories: best empirical support, good or moderate support, support as a promising practice, or as practices having known risks. The guidelines used for this ranking are listed later in this report.

It is expected that these rankings will change over time as new practices are introduced to the field, promising practices undergo more research and evaluation, and existing best practices are modified and refined. Therefore, it is the expert panel's recommendation that the menu be reviewed and revised regularly, at least once every two years.

Implementation Issues

The panel had concerns about creating a menu of practices without discussion of how, and if, the menu was to be implemented. The panel felt, in general, that it is important to consider issues of implementation and adoption while creating the menu. The expert panel highlighted the following issues as crucial components in planning for implementation and adoption of any evidence based practices with children and youth and families. The development of plans and processes to address these issues were beyond the scope of this expert panel. However, each issue is discussed in detail below and the group made recommendations where possible.

Engaging the Community

Engaging the community, both families and providers, in the development process was seen as crucial to any plan to implement EBPs. Adoption of EBPs requires a shift in the treatment culture, both from clinicians and from those receiving services. This shift has the potential to be viewed negatively without a great deal of proactive intervention. Clinicians may feel that their professional judgement and autonomy is being stripped away or questioned. Families may feel that they are being labeled, being shifted into one-size-fits-all approaches, or that they will not be able to gain access to treatments that will help them. When both clinicians and families are skeptical about adopting EBPs, any new project will fail.

However, there are interventions that can be put into place as part of an EBP implementation plan that will increase the acceptability of the project and begin to develop support for EBPs prior to adoption. Widespread education about EBPs is the first step. Education should be geared toward administrators, families, clinicians and clinical managers and should highlight the effectiveness of EBPs in treating youth and families with problems just like theirs. It should also demonstrate the individualized nature of the EBPs, and, if possible, might include a clinician or family who has successfully completed the treatment. The idea is to build local champions for the practice, and then provide support to the champion or champions to actually move the practice forward.

Assessment

Evidence Based Practices are based on research studies conducted with groups of people with similar diagnoses or problems. They are practices that have been shown to be superior to no treatment or alternative interventions for individuals with specific problems or diagnoses. A characteristic of effective interventions is that they are specifically matched to identified problems/needs. The practices lose their effectiveness, and in some cases are harmful, if they are used for persons who do not have the criterion disorder or belong to the targeted group. Clinicians must be able to accurately and reliably identify problems and make diagnoses for EBPs to have utility.

The panel recommends that a clinical assessment always be conducted prior to selecting an intervention.

Qualified Staff

The challenges of finding and retaining qualified staff are significant in the mental health field, especially in rural communities. It is even more difficult to find mental health staff who have been trained in evidence based practices. This initiative will require a major commitment to training. Not only initial training, but also ongoing training efforts to address staff turn-over, specialized training for clinicians working with minority

populations, and “refresher courses” for staff who have been conducting the practices for some time. Development of professional training in EBPs should be encouraged at both the community college and university level.

Cultural Competency

This is a critical issue throughout all mental health practices and is far beyond the scope of this expert panel. The issues related to culturally competent care are especially salient in EBPs. Some argue that EBPs have largely been studied only with white, middle-class families, and that issues of race and culture have not been factored into the development of these practices. Therefore, the argument goes, the practices are not suitable for families of different race and cultural backgrounds.

First, this argument is not true for many of the EBPs reviewed by the expert panel. Many of the practices listed by the expert panel have been studied with low income and ethnic minority groups. For a subgroup of studies, however, ethnic minorities have not been included. One recommendation would be to conduct a literature review highlighting studies where low income and ethnic minority groups were included. Implementation planning could begin with those practices that have included diverse populations and cultures in their development. There will still be some diverse populations who have not been included in any studies and the expert panel would recommend that practices be tailored to best meet the needs of these groups. Further studies could be developed to validate any modifications made to the original practices.

Furthermore, cultural considerations are very relevant to engagement and acceptability of any form of treatment including EBPs. There is substantial evidence that clients from some minority populations are less often referred for mental health services and less often follow-up with services. This speaks to the fact that mental health care is not only about the specific interventions but is also about clients’ beliefs, values and confidence. These factors may be especially salient for those obtaining mental health services via the juvenile justice or child welfare system when help seeking may not be voluntary. Significant effort should be expended to identify ways to specifically address concerns and barriers for diverse communities.

Organizational and Financial Support

Administrators, clinicians and supervisors must support the training and on-going supervision required for evidence based practices. This support may be in the form of release time, staff payment and agency wide promotion of the overall program philosophy. On-going supervision requirements alone require a substantial change of practice for many organizations.

It is important to take into account that there are costs associated with start up and ongoing monitoring and supervision requirements. A budget for training, including

travel, staff supervision, transportation and staff payment is critical to the success of the program. Staff productivity measures may decline early in the implementation phase, so providers should account for this in budget projections. Savings may not be evident for several years and the agencies providing the services may not be the direct beneficiary of the savings. Financing strategies will need to take these factors into account.

Fidelity is an important consideration in the adoption of EBPs. EBPs are standardized treatment protocols that have demonstrated improved outcomes in those clients who receive the treatment. Assessing the fidelity of the actual service delivered to the standards put forth in the model is a crucial activity in ensuring that EBPs are taking place. This will take time and resources and policies to determine at how and at what level of the system fidelity assessments will occur. This is an important topic for implementation planning

Inter and Intra-organizational change

Implementation and adoption may require crossing organizational boundaries and impacting the social ecology of the agencies and populations served. Organizational change is hard, and will require careful planning, coordination and open communication.

The expert panel offers its expertise for further planning and development related to any of the topic areas listed above.

Evidence Based Practices Menu

The guidelines and menu are listed below. The menu establishes that for all target problems and target populations there are interventions that have either the highest level of support or some evidence for effectiveness. The Expert Panel believes that the Juvenile Rehabilitation Administration, the Mental Health Division and the Children's Administration should favor empirically tested and proven interventions when purchasing services. They support these interventions because they are effective, have manuals that clearly specify the procedures to be used and can easily be learned. However, they are not recommending that the state only support "manualized", off the shelf protocols. Interventions that have not yet been fully tested, but are based on established principles of behavior change and explicitly describe the procedures in some form of a manual may also be acceptable. They recommend that the child serving divisions of DSHS undertake a coordinated and assertive effort to increase the availability of empirically supported interventions in our state.

The Expert Panel discussed the service delivery process known as "Wraparound " at some length. The panel determined that Wrap-around is a service delivery process through which any of the listed EBPs could be administered as part of a coordinated,

individualized care plan. The principles and values of Wraparound, such as services are family driven and care is individualized to the unique needs of each child and family, should be incorporated into implementation planning efforts.

The Expert Panel believes that there are circumstances where strict application of the evidence based practice protocol is the preferred approach. When the potential consequences of intervention failure are severe or accrue to innocent victims a greater priority should be placed on delivering interventions with the highest level of empirical support. For example, in most cases when the goal is to protect the community by decreasing recidivism, the proven interventions should be delivered as specified. There is ample evidence that departure from a specified protocol reduces the benefit of the interventions, which means more victimization. This same principle may apply to circumstances of child physical abuse where a child may be harmed if the intervention fails and there is an intervention specifically shown to reduce the risk of re-referral. Similarly, for the highest risk children and youth in foster care who have a history of placement disruption, the evidence based intervention demonstrated to be most effective should be initiated.

At the same time the Expert Panel does not wish to stifle innovation that may improve the array of services. There are interventions proven to work for one target problem area that appear very promising for application to other similar problems or populations. Multi-modal or combination approaches may be the best course for very complex case situations. However, given that there is a highly developed knowledge base on interventions for child psychopathology, novel applications or unproven interventions should reflect established principles and evidence.

Increasing the availability of evidence-based practices will require DSHS to take leadership, create incentives, and provide a supportive infrastructure. It has been consistently demonstrated that providers must have the proper training and ongoing supervision if the interventions are to be carried out faithfully and be effective with children and youth and families. Furthermore, research has shown that fidelity to a proven treatment model provides the greatest outcomes to children and youth and their families. The panel believes that the DSHS can and should insure that the proper training and supervision is available and that services are appropriately reimbursed. In exchange providers can be expected to deliver evidence-based practices with fidelity and accountability.

The expert panel notes that other states, when implementing evidence based practices, did not simply create a menu based on a grid. They developed a strategy and approach to mental health services that promoted the use of the common components of evidence-based interventions. This model permits therapists to flexibly apply the components based on presenting or continuing problems of children and youth. There are accountability and feedback mechanisms built in to the structure to enable therapists to assess whether children and youth are improving and to change the treatment when they are not.

The Expert Panel believes the creation of the menu is an important first step in a process. However, in order for the program menu to be meaningful it must be accompanied by a stated policy that evidence based practices are the clear preference in certain circumstances and a commitment to take actions that will increase the availability of the interventions. This would include the intent to develop a plan toward achieving the goal.

Guidelines for Ranking Mental Health Practices

The following guidelines were used in assigning practices to different levels.

Level 1: Best Support

I. At least two good between group design experiments demonstrating efficacy in one or more of the following ways:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to an already established treatment in experiments with adequate statistical power

OR

II. A large series of single case design experiments (n>9) demonstrating efficacy. These experiments must have:
   a. Used good experimental designs
   b. Compared the intervention to another treatment as in I. a.

AND

Further criteria for both I and II:

III. Experiments must be conducted with treatment manuals.
IV. Characteristics of the client samples must be clearly specified.
V. Effects must have been demonstrated by at least two different investigators or teams of investigators.

Level 2: Good Support or Moderate Support

I. Two experiments showing the treatment is (statistically significantly) superior to a waiting-list control group. *Manuals, specification of sample, and independent investigators are not required.*

OR

II. One between group design experiment with clear specification of group, use of manuals, and demonstrating efficacy by either:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to an already established treatment in experiments with adequate statistical power

OR

III. A small series of single case design experiments (n>3) with clear specification of group, use of manuals, good experimental designs, and compared the intervention to pill or psychological placebo or to another treatment.

Level 3: Promising Practice

i. The treatment has a sound theoretical basis in generally accepted psychological principles, or has been demonstrated to be effective with another target behavior.
ii. A substantial clinical-anecdotal literature exists indicating the treatment's value with the target behavior.
iii. The treatment is generally accepted in clinical practice as appropriate for use with the target behavior.
iv. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
v. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.

Level 4: Practices with Known Risks

i. At least one study or review demonstrating harmful effects of a treatment.

- **DRAFT –**

Evidence-Based Child and Adolescent Psychosocial Interventions

Problem Area	Level 1 – BEST SUPPORT	Level 2 – GOOD SUPPORT OR MODERATE SUPPORT	Level 3 – PROMISING PRACTICES	Level 4– KNOWN RISKS
Anxious or Avoidant Behaviors	Manualized Cognitive Behavior Therapy for Anxiety Disorders			
Attention and Hyperactive Disorders	Multi-Modal Approaches using Medication +Cognitive Behavioral Therapy + Parent Training + School Intervention			
Autistic Spectrum Disorders	Applied Behavior Analysis		Auditory Integration Training; Functional Communication Training	
Bipolar Disorders	Medication;		Multi-Family Group Treatment:**; Family Psychoeducation**, CFF-Cognitive Behavioral Therapy; Cognitive Behavioral Therapy-IP	
Depressive or Withdrawn Behaviors	Manualized CBT for Depression; Interpersonal Therapy (Manualized IPT-A); Medication		Dialectical Behavior Therapy	
Eating Disorders		Family Therapy (anorexia only)	Dialectical Behavior Therapy; Cognitive Behavioral Therapy; Interpersonal Therapy	Some Group Therapies
Disruptive and Oppositional Behaviors	Parent & Teacher Behavior Management (e.g. Incredible Years, Barkley curriculum, Patterson curriculum); Parent-Child Interaction Therapy	Anger Coping Therapy; Functional Family Therapy*	Multi-Systemic Treatment*; Cognitive Behavioral Therapy, Dialectic Behavioral Therapy; Multi-Dimensional Treatment Foster Care*	Group therapy without a skills focus
Self-harming Behaviors			Dialectic Behavior Therapy; Multi-Systemic Treatment	
Assaultive/aggressive Behaviors	Aggression Replacement Therapy	Multi-Systemic Treatment*	Multi-Dimensional Treatment Foster Care*	

Sexually aggressive Behaviors		Multi-Systemic Treatment; Cognitive Behavioral Therapy for Children with Sexual Behavior Problems		
Traumatic stress	Trauma-focused Cognitive Behavioral Therapy	Eye Movement Desensitization & Reprocessing; Cognitive Behavioral Therapy for Children with Sexual Behavior Problems	Trauma-Focused Integrative Eclectic Therapy; Trauma-Focused Play Therapy	
Interpersonal Relationships	Cognitive Behavioral Therapy; skills training		Dialectic Behavior Therapy; Functional Family Therapy	
Attachment Problems (0-5)		Parent-Child Interaction Therapy; Behavioral Parent Training; Family Focused, Child Centered Treatment		Coercive or Aversive therapies; Attachment Therapy
Schizophrenia and other psychotic disorders	Medication	Assertive Community Treatment for Adolescence; social skills training	**Family Psychoeducation; **Multi-Family Group Treatment	
Substance Use		Voucher-Based Contingency Management; Purdue Brief Family Therapy; Motivational Enhancement Therapy; Multi-Dimensional Treatment Foster Care***; Multi-Systemic Treatment***	Dialectic Behavior Therapy CBT**	Group Therapy
High Conflict Families		Functional Family Therapy*	Cognitive Behavioral Therapy: Intensive Family Preservation Services; Parenting Wisely	

* These practices show Level 1-Best Support for Juvenile Offenders
** Based on findings with adults only;
*** These interventions are effective if substance abuse is part of a more complex diagnostic picture

Population based Interventions

Population	Level 1 – BEST SUPPORT	Level 2 – GOOD SUPPORT OR MODERATE SUPPORT	Level 3 – PROMISING PRACTICES	Level 4– KNOWN RISKS
Juvenile Offenders	Multisystemic Therapy, Multi-Dimensional Treatment Foster Care; Functional Family Therapy; Aggression Replacement Therapy	Dialectic Behavior Therapy, Family Integrated Therapy (FIT)		Group therapy without a skills focus
At Risk for Out of Home or More Restrictive Placement	Multi-Dimensional Treatment Foster Care.	Parent-Child Interaction Therapy; Behavioral Parent Training; Family Focused, Child Centered Treatment (FTI)	Intensive Family Preservation Services	
Families at risk for child physical abuse		Abuse Focused Cognitive Behavioral Therapy. Parent-Child Interaction Therapy		
School-Aged Prevention Programs		Promoting Alternative Thinking Strategies (PATH); Project ACHIEVE; Families And Schools Together (FAST); Anger Coping-Self-Instruction Training		

Expert Panel Recommended Next Steps

The Expert Panel would like to provide technical assistance to the three DSHS administrations as they develop their implementation, and education and training plans. The experts on the panel all have experience implementing and sustaining novel and evidence based practices into community settings. There will be global overarching implementation issues, but there will also be implementation issues unique to individual providers. DSHS will need to be able to address the issues at both levels for this project to be successful.

Financing and structure are important considerations when moving a project forward and the panel feels confident that the three DSHS administrations will plan appropriately for those issues. However, there are many clinical, educational, motivational, and sustainability issues that also need to be addressed. The expert panels input would be invaluable for planning on those issues.

Fitting this body of work into a menu required the Expert Panel to make some assumptions and interpretation. The panel recommends that before these practices are implemented in the community further planning and refinement is necessary. A further caveat is that the panel did not review practices related to infancy.

In closing, we would like to thank the three assistant secretaries for the opportunity to provide input into this process. We would further warn the three assistant secretaries of the enormity of the tasks ahead. This project will require DSHS to take leadership, create incentives, and provide a supportive infrastructure. We would be willing to serve as technical consultants to the child serving divisions of DSHS as they undertake a coordinated and assertive effort to increase the availability of empirically supported interventions in our state.

Appendix 1

Problem List			
Problem Area	Practice	Expert	Articles
Anxious or Avoidant Behaviors	Manualized Cognitive Behavior Therapy (CBT) for Anxiety Disorders	• Ollendick, T.H. & King, N.J.	Empirically supported treatments for children w/phobic & anxiety disorder. Journal of Clinical Child Psychology, 27, 156-167 (1998).
		• Bandura, A.	Psychological Modeling: Conflicting Theories. Chicago, IL: Aldine-Atherton. (1971).
		• Kendall, P.C.	Treating Anxiety Disorders in Children; Journal of Consulting and Clinical Psychology, 62, 100-110(1994).
		• Barrett, P.M. et al.	Family treatment of childhood anxiety: A controlled trial; J of C&CP, 64, 333-342 (1996).
		• Barlow, D.	CBT for panic disorder; Journal of Clinical Psychiatry, 58(Suppl.2)32-37 (1997).
		• Barnett, P.M.	Evaluation of cognitive-behavioral group treatment for childhood anxiety disorders. Journal of Clinical Child Psychology, 27, 459-468. (1998).
Attention and Hyperactive Disorders	Multi-Modal Approaches using Medication + Cognitive Behavioral Therapy + Parent	• Barkley, R.A.	Defiant Children: A Clinician's Manual for Assessment & Parent Training, NY: Guilford Press (1997).

	Training + School Intervention CBT with parent, child and school involvement	• Webster-Stratton, C.	Randomized trial of two parent-training programs for families with conduct-disordered children. Journal of Consulting and Clinical Psychology, 52, 666-678 (1984).
Autistic Spectrum Disorders	Applied Behavior Analysis Auditory Integration Training; Functional Communication Training	• Rogers, S.J., et al. • Rimland, B. & Edelson, S.M. • Durand, et al.	A comparative study. Topics in Early Childhood Special Ed.11, 29-47 (1991). Brief Report: A pilot study of auditory integration training in autism. Journal of Autism & Development Disorders, 25, 61-70. (1995). Functional Communication Training to reduce challenging behavior. Journal of Applied Behavioral Analysis 24, 251-264 (1991).
Bipolar Disorders	Medication; *Multi-Family Group Treatment; CFF-Cognitive Behavioral Therapy; Cognitive Behavioral Therapy; Interpersonal Therapy;	• Dixon, L., McFarlane, WR, Lefley, H. et al. • Pateli-Siotis, I., Young, L. T., et al. • Mufson et al.	Evidence-based practices for services for families of people with psychiatric disabilities, Psychiatric Services 52:903-910, 2001. Group CBT for bipolar disorder. Journal of Affective Disorders, 65, 145-153. (2001). Efficacy of interpersonal psychotherapy for depressed adolescents. Archives of General Psychiatry, 56, 573-

			579 (1999)
Depressive or Withdrawn Behaviors	Medication Manualized CBT for Depression; Interpersonal Therapy (Manualized IPT-A); Dialectical Behavioral Therapy*	• Compton, Scott et al. • Mufson et al. • Miller, A. L., Wyman, S.E., Huppert, J.D., Glassman, S.L. & Rathus, J.H. • Rathus, J.H. & Miller, A.L.	Cognitive-Behavioral Psychotherapy for Anxiety and Depressive Disorders in Children & Adolescents: An E-B Medicine Review, J. Am. Acad. Child &Adolescent Psychiatry, 43:8, Aug. 2004. Efficacy of interpersonal psychotherapy for depressed adolescents. Archives of General Psychiatry, 56, 573-579 (1999). Analysis of behavioral skills utilized by suicidal adolescents receiving DBT. Cognitive & Behavioral Practice, 7, 183-187. (2000). Dialectical Behavior Therapy Adapted for Suicidal Adolescents. Suicide and Life-Threatening Behavior, 32, 146-157.
Eating Disorders	Family therapy (anorexia only); Dialectical Behavioral Therapy	• Eisler, I. et al. • Telch, C.F., Agras, W.S., & Linehan, M.M.	Family therapy for adolescent anorexia nervosa. Journal of Child Psychology & Psychiatry, 41(6), 727-736 (2000) Group dialectical behavior therapy for binge-eating disorder: A preliminary, uncontrolled trial. Behavior Therapy, 31. 569-582. (2000). Dialectical behavior therapy for binge eating disorder. Journal of Consulting and Clinical Psychology, 69, 1061-1065. (2001).

	CBT & IPT (bulimia only) Interpersonal Therapy (Manualized IPT-A);	• Telch, C.F., Agras, W.S.& Linehan, M.M. • Mufson et al.	A multi-center comparison of CBT & IP for bulimia nervosa. Archives of General Psychiatry, 57, 459-466 (2000). Efficacy of interpersonal psychotherapy for depressed adolescents. Archives of General Psychiatry, 56, 573-579 (1999).
Disruptive and Oppositional Behaviors	Parent &Teacher Training (e.g. Incredible Years; parent/teacher behavior management Barkley curriculum; Patterson curriculum) Parent Child Interaction Therapy; Anger Coping Therapy Functional Family Therapy Multi-Systemic Treatment	• Webster-Stratton, C. • Chaffin, Mark et al. • Lochman, et al. • Alexander, J. et al. • Henggeler, S.W. et al.	Randomized trial of two parent-training programs for families with conduct-disordered children. Journal of Consulting and Clinical Psychology, 52, 666-678 (1984). P-CIT w/Physically Abusive Parents: Efficacy for Reducing Future Abuse Reports. Journal of Consulting & Clinical Psychology 3004, vol. 72, No.3, 500-510 (2004). Cognitive-behavioral intervention w/ aggressive boys. Journal of Consulting & Clinical Psychology, 10, 426-432 (1992). Blueprints for Violence Prevention, Book Three: Functional Family therapy, Boulder, CO: Center for the Study and Prevention of Violence. (1998) MST of juvenile offenders, etc. Developmental Psychology, 22, 132-141 (1986).

	Multi-Dimensional Family Treatment DBT* CBT	• Liddle, H. A • Trupin, Eric, et al. • Kazdin, A.E., Bass, D., Siegel T. & Thomas, C.	Center for Treatment Research on Adolescent Drug Abuse, Dept. of Psychiatry & Behavioral medicine, Univ. Of Miami School of Me., Miami, FL. DBT Program for Incarcerated Female Juvenile Offenders, Child & Adolescent mental health, Vo. 7, No. 3, 121-127 (2002). Cognitive-behavioral & relationship therapy in the tx of children referred for antisocial behavior. Journal of Consulting & Clinical Psychology, 55, 522-535. (1989)
Self-harming Behaviors	DBT* MST	• Linehan, M.M., Tutek, D.A., Heard, H. L. & Armstrong, H. E. • Heneggler, S.W., et al.	Interpersonal outcome of cognitive behavioral tx for chronically suicidal borderline patients. American Journal of Psychiatry, 151, 1771-1776. (1994). MST of juvenile offenders, etc. Developmental Psychology, 22, 132-141 (1986).
Assaultive/ Aggressive Behaviors	Aggression Replacement Therapy; Multi-Systemic Therapy Multi-Dimensional Family Treatment	• Goldstein, Arnold P, et al. • Heneggler, S.W., et al. • Liddle, H. A.	Aggression Replacement Training, A Comprehensive Intervention for Aggressive Youth. Research Press, IL. (July 1998.) MST of juvenile offenders, etc. Developmental Psychology, 22, 132-141 (1986). Center for Treatment Research on Adolescent Drug Abuse, Dept. of Psychiatry & Behavioral Medicine, Univ. of Miami School of Medicine, Miami, FL.

Sexually aggressive Behaviors	MST CBT for children w/ Sexual Behavior Problems	• Borduin, C.M. & Schaeffer, C. M. • Saunders, B.E., Berliner, L. & Hanson, R.F. (Eds.)	MST of Juvenile Sexual Offenders: A Progress Report., pp. 25-42. The Haworth Press, 2001. Child Physical & Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research &Treatment Center, p.34-36 (2004).
Traumatic stress	Trauma focused CBT;	• Cohen, J.A., & Mannarino, A.P. • Cohen, J.A. & Mannarino, A.P., & Steer, R.A. • Deblinger, E. Lippman, J. & Steer, R.A. • Deblinger, E., Steer, R.A. & Lippman. • King, N.J., Tonge, B.J., Mullen, P. et al.	A treatment outcome study for sexually abused preschool children: Initial findings. Journal of the Amer. Acad. Of Child & Adol. Psychiatry, 35, 42—50. (1996). Interventions for sexually abused children: Initial treatment findings. Child Maltreatment,3,17-26 (1998). A multisite randomized controlled trail for children w/sexual abuse-related PTSD symptoms. Journal of the Amer. Acad. Of Child & Adol. Psychiatry. 43, 393-402. (2004). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. Child Maltreatment, 3, 310-321. (1996). Two-year follow-up study of cognitive-behavioral therapy for sexually abused children suggering posttraumatic stress symptoms. Child Abuse & Neglect, 23, 1371-1378. (1999) Treating sexually abused children with PTS symptoms: A

		• Mannarino, A.P., & Cohen, J.A.	randomized clinical trail. Journal of the Amer. Acad. Of Child & Adol. Psychiatry, 39, 1347-1355. (2000).
		• Stein, B.D., Jaycox, L.H., et al.	A follow-up study of factors that mediate the development of psychological symptomatology in sexually abused girls. Child Maltreatment, 1, 246-260. (1996).
		• Chemtob, C.M., et al.	A mental health intervention for school children exposed to violence: A randomized controlled trail. Journal of the Amer. Med. Assoc., 290, 603-611. (2003).
	EMDR;		Brief Treatment for Elementary School Children w/Disaster-related PTSD: A field study. Journal of Clinical Psychology, 58(1), 99-112.(2002).
Interpersonal Relationships	CBT; Skills Training	• LeSure-Lester, G.E.	An Application of Cognitive-Behavioral Principles in the Reduction of Aggression Among Abused Afr. Amer. Adol., Journal of Interpersonal Violence, 17(4), 394-402.(2002).
	FFT	• Alexander, J. et al.	Blueprints for Violence Prevention, Book Three: Functional Family Therapy, Boulder, CO: Center for the Study and Prevention of Violence. (1998)
	DBT*	• Linehan, M.M. et al.	Interpersonal Outcome of Cognitive Behavioral Treatment for Chronically Suicidal Borderline Patients. Am. Journal of Psychiatry, 151, 1771-1776. (1994)
Attachment Problems (0-5)	Parent-Child Interaction Therapy;	• Chaffin, Mark et al.	P-CIT w/ Physically Abusive Parents: Efficacy for Reducing Future Abuse Reports, Journal of Consulting & Clinical Psychology, 3004, vol. 72, No. 3, 500-510 (2004).
	Behavioral Parent Training;	• Saunders, B.D., Berliner, L. &	Child Physical and Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston,

		Hanson, R.F. (Eds.) •	SC: National Crime Victims Research and Treatment Center, pages 61-65. (2004). Saunders, B.F., Berliner, L., et al. (Eds.). Child Physical and Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research and Treatment Center, pages 66-68. (2004).
Schizophrenia and other psychotic disorders	Medication; Assertive Community Treatment for Adolescence; Social Skills Training *Psychoeducational Therapy for the Patient and the Family; *Multi-Family Group Treatment	• NAMI (web.nami.org/about/pact. htm) • Spencer, P.G., Gillespie, C.R. & Ekisa, E.G. • APA, 1997; • Rund et al., 1994 • APA, 1997	Drake, R.E., Mueser, K.T., Torrey, W.C., et al. Evidence-based tx of schizophrenia. Current Psychiatry Reports, 2, 393-397. (2000). A controlled comparison of the effects of social skills training and remedial drama on the conversational skills of chronic schizophrenic inpatients. British Journal of Psychiatry, 143, 165-239-247. (1983). Practice guideline for the tx of patients w/schizophrenia. APA, 154(Suppl. 4), 1-64 (1997). The Psychosis Project outcome and cost-effectiveness of a psychoeducational treatment programme for schizophrenic adolescents, Acta Psychiatrica Scandinavia, 89, 211-218. (1994). Practice guideline for the tx of patients w/schizophrenia. APA, 154(Suppl. 4), 1-64 (1997).
Substance Use	CBT;	• Bolvin, et al.	Long-term follow-up results of a randomized drug abuse

			prevention trial in a white middle class pop. JAMA, 273, 1106-1112 (1995).
	Purdue Brief Family Therapy;	• Trepper, Terry	McCollum, E.E. & Trepper. T.S. Family solutions for drug & alcohol abuse: Clinical & counseling approaches. N.Y.: The Haworth Press. 2001.
	MST;	• Randall, J. at al.	MST: A tx for violent, substance-abusing&substance dependent juvenile offenders. Addictive Behaviors 23, 1731-1739 (2003).
	Motivational Enhancement Therapy;	• Miller, William R.	MET meets the real work, etc. Journal of Substance Abuse Tx 23, 73-80 (2002).
	Voucher-Based Contingency Management;	• Higgins, S. et al	Dept. of Psych. (CASAA), Univ. of NM, Albuquerque, NM; http://motivaltionalinterview.org/clinical/METDrugAbuse.PDF(10/26/95)
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Population List			
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School-Aged Prevention	Promoting Alternative Thinking Strategies	• Kusche, Carol A.	Prevention Research Center, Penn. State Univ. Univ. Park, PA; www.prevention.psu.edu/PATHS/

	(PATH); Project ACHIEVE	• Knoff, Howard M.	(SAMHSA NREP) Institute for School Reform, Integrated Services & Child Mental Health & Ed. Policy, Little Rock, AR; www.projectachieve.info
	Families And Schools Together (FAST)	• McDonald, Lynn	(SAMHSA NREP) Wisconsin Center for Education Research, Univ. of Wisconsin-Madison; www.wcer.wisc.edu/fast (SAMHSA NREP)
	Anger Coping -Self-Instruction Training	• Lochman, John E.	Cognitive-Behavioral Intervention with Aggressive Boys, 3 yr. Follow-up and Preventive Efforts. Journal of Consulting and Clinical Psychology 60:426-32. (1992). (NIJ: What Works).

Appendix 2

Evidence Based Treatment Website references

University of South Florida/Louis de la Parte Florida Mental Health Institute
http://nirn.fmhi.usf.edu/

link on EBPs and cultural competency:
http://nirn.fmhi.usf.edu/resources/publications/working_paper_3b.pdf

Blueprints link:
http://www.colorado.edu/cspv/blueprints/model/overview.html

State of Virginia's Evidence Based Practices
http://coy.state.va.us/Modalities/contents.htm

Washington State Institute for Public Policy. July 2004 study on "Benefits and Costs of Prevention and Early Intervention Programs for Youth"
www.wsipp.wa.gov

DSHS Mental Health Disvisions Best Practices
http://www1.dshs.wa.gov/Mentalhealth/bestpracticesguide.shtml

Virginia Commission on Youth - Modalities Contents, the reference chart of disorders and EBPs.http://coy.state.va.us/Modalities/refchart.htm

Hawaii's mental http://www.hawaii.gov/health/mental-health/camhd/resources/index.html