



Managing and Adapting Practices: Day 2

Welcome Back!



Agenda

- Overview of Supportive Research
 - Relevance Mapping
 - Hawaii System Data
- Different Models and Applications
 - Modular Protocols
 - Child STEPs
- Working Implementation Models for CA
- A Swift Exit...



Why We Do What We Do...



Distillation and Matching Model

Mapping the Structure of the
Literature

How do we know the right level of analysis?

Winning Treatments

- To be included in the analysis, a protocol had to be tested in a RCT and must have been significantly better than a control group on a primary measure of clinical symptoms or functioning
- Resulted in 279 “winning” treatment groups

Coding Procedures

- Developed through pilot review of protocols, expert feedback and nomination
- 41 practice element codes
 - e.g., “time out,” “relaxation”
- 29 study codes in 4 domains:
 - Problem
 - Age
 - Gender
 - Ethnicity

Problem Codes

- Aggression
- Anger
- Anxiety
- Attention
- Autism
- Avoidance
- Depressed Mood
- Hyperactivity
- Justice Involved
- Oppositional/Non-compliant
- Phobia/Fears
- School Refusal/Truancy
- Shyness
- Substance Use
- Traumatic Stress
- Willful Misconduct, Delinquency

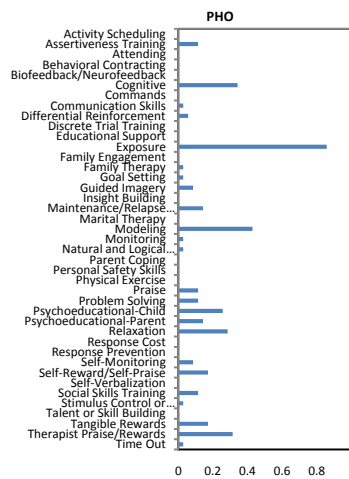
Reliability

- Protocol Codes (Kappa)
 - Median = .75, Mean = .88
- Study Codes (Kappa)
 - Median = 1.0, Mean = .93
- Evidence-Based Classification
 - Spearman R = .95

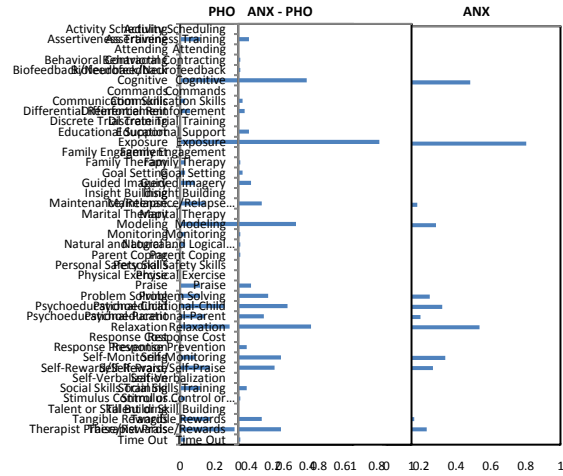
Analytics

How do we know when treatments are “alike” or “different?”

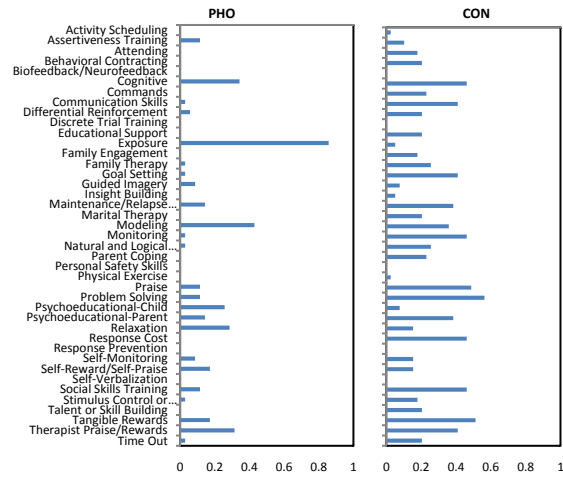
Example



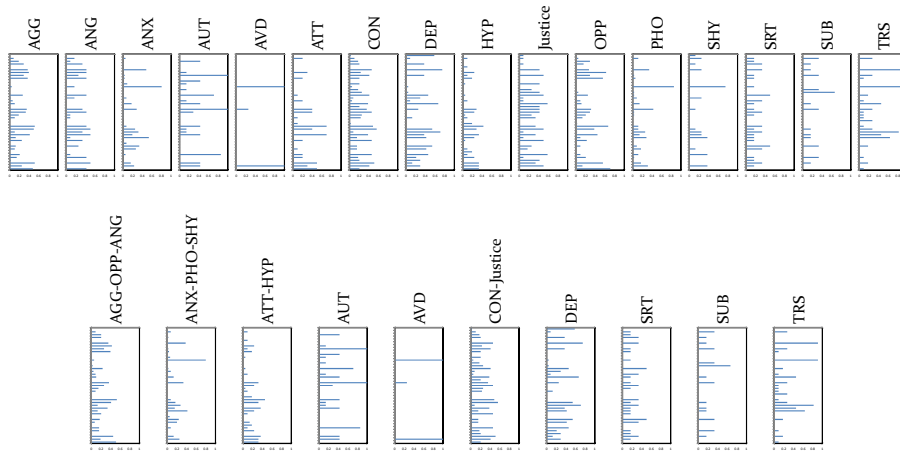
Example



Example



Problem

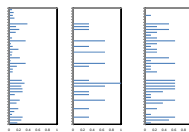


All Factors

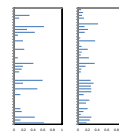
Gender



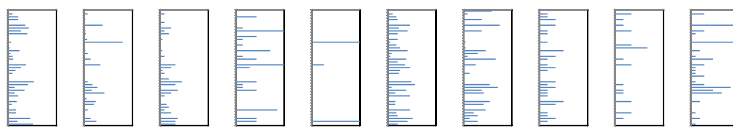
Ethnicity



Age

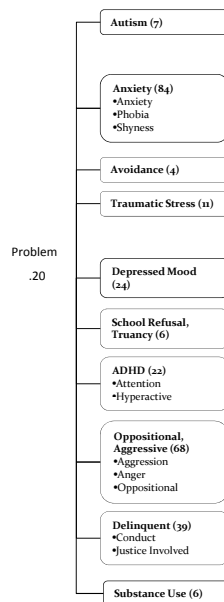


Problem

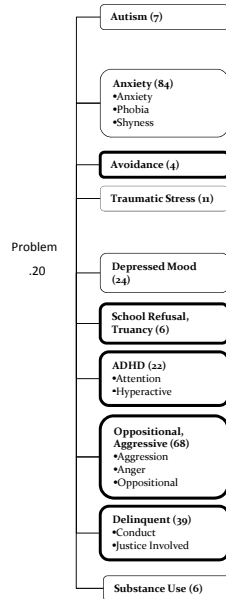


Results

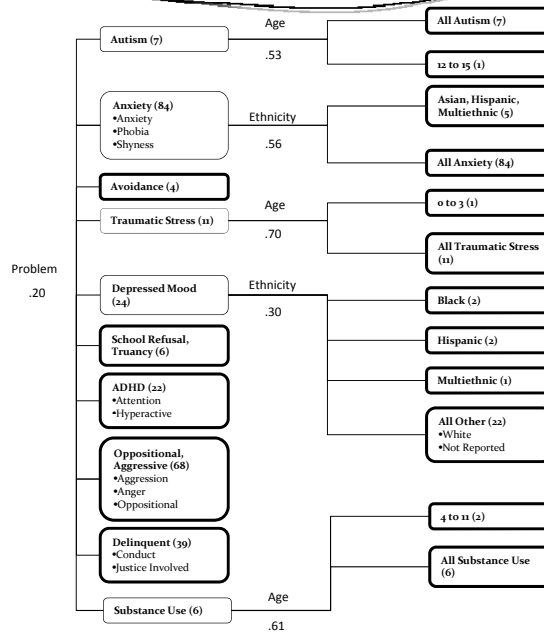
Final Tree



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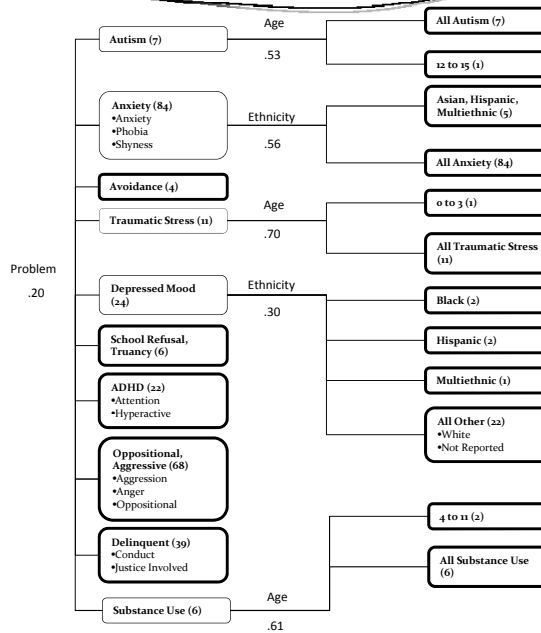
Final Tree

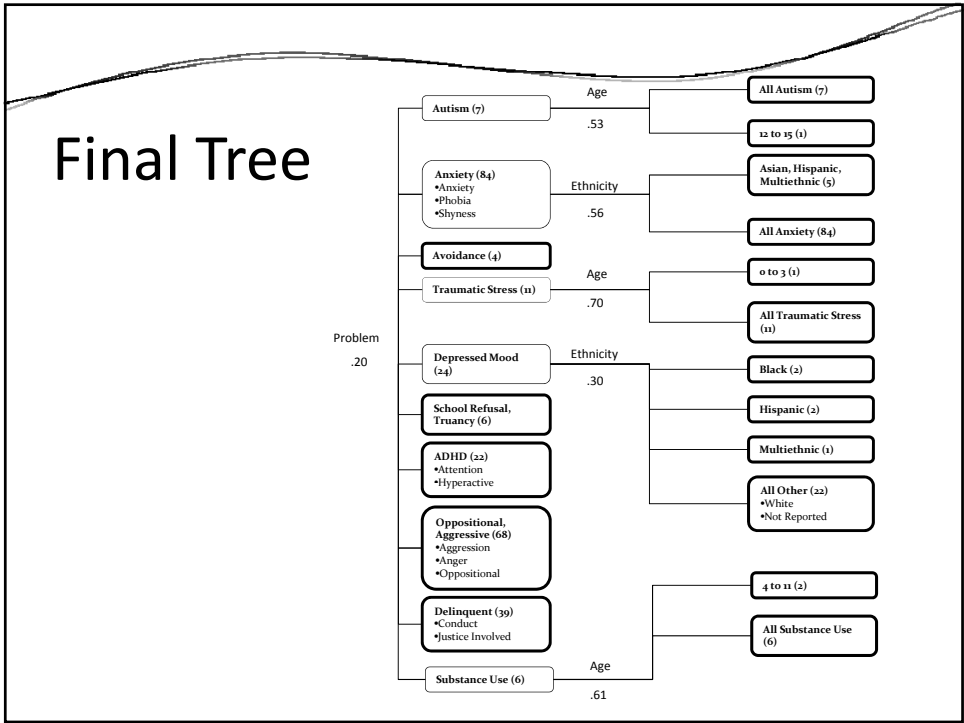
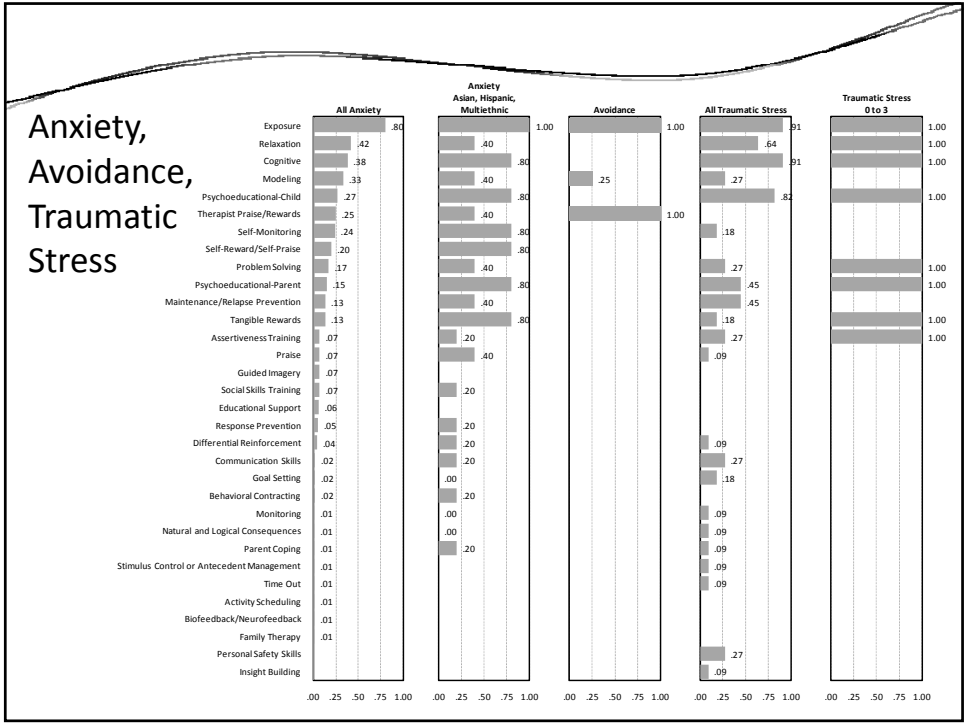


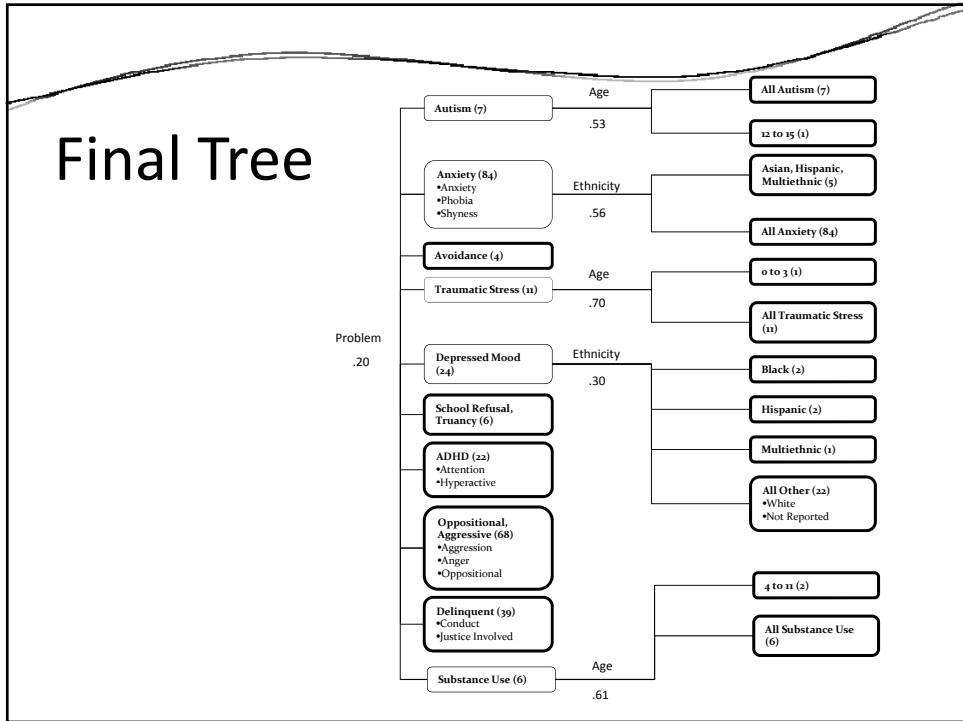
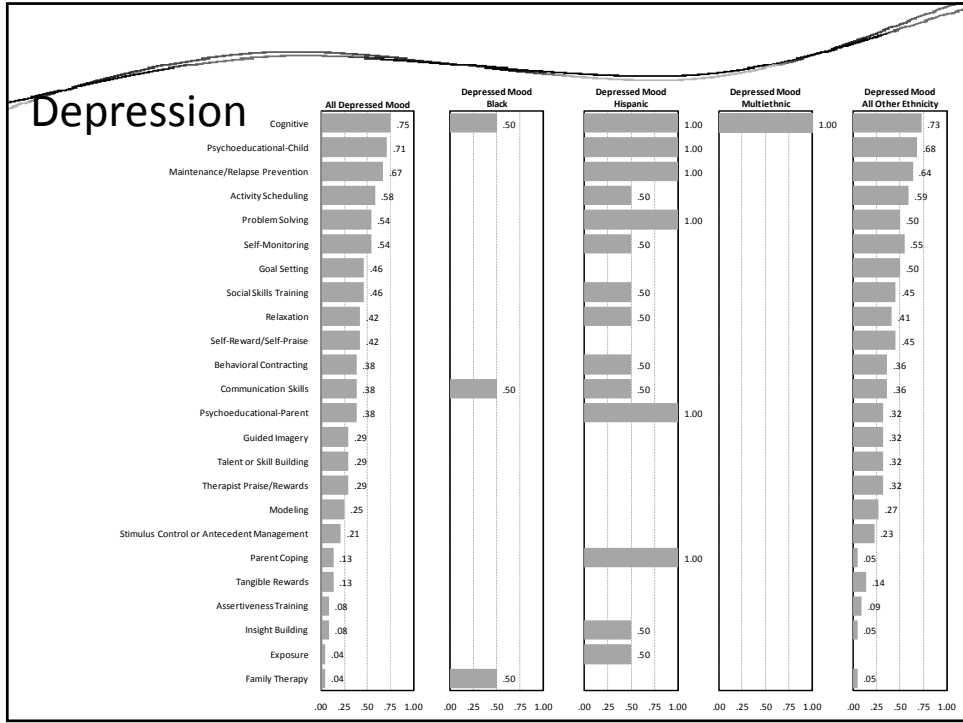
Autism

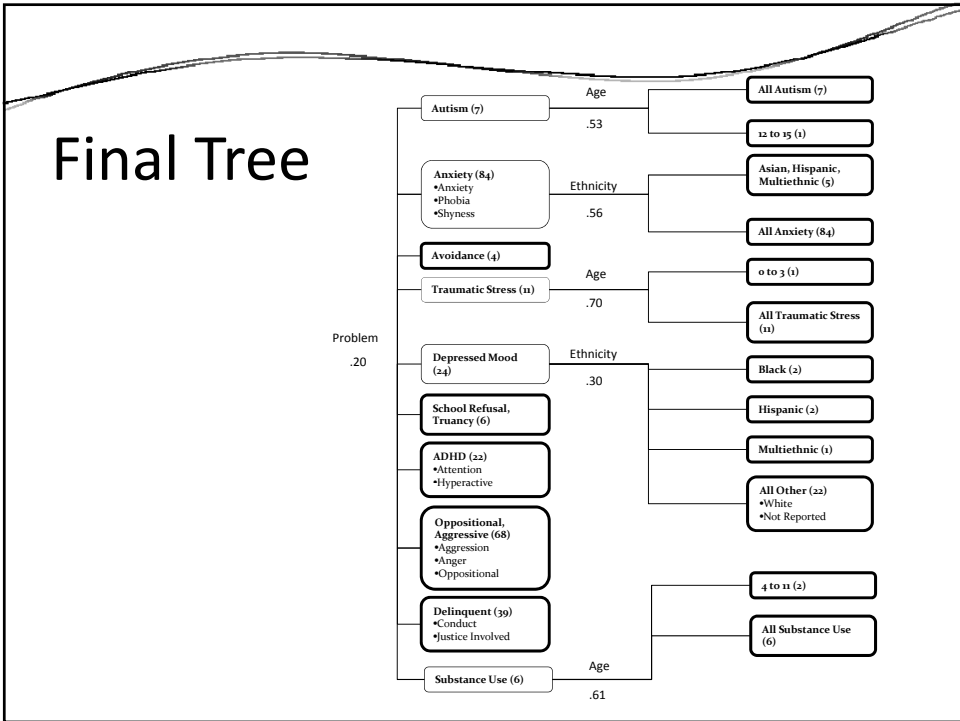
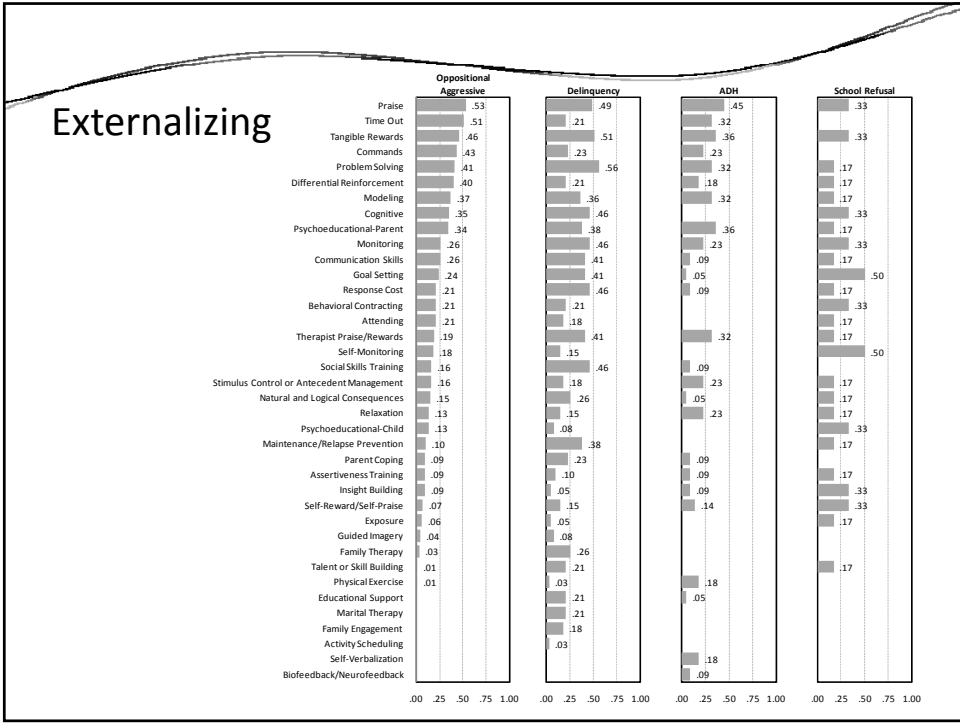


Final Tree

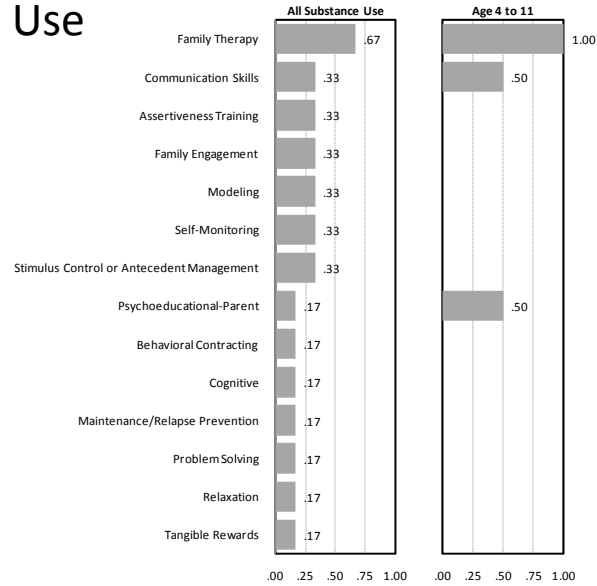








Substance Use

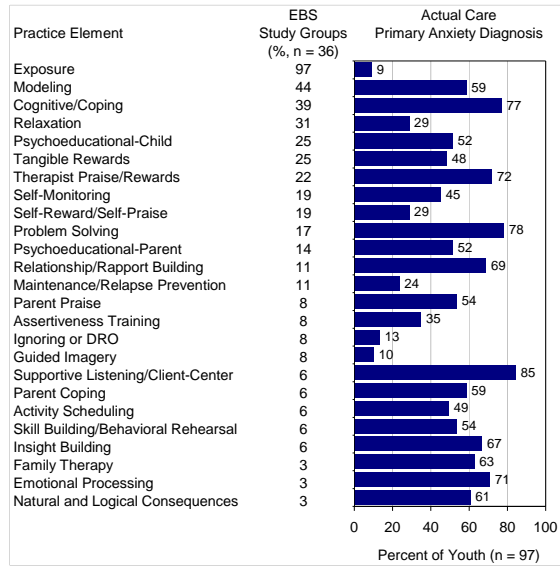


Conclusions

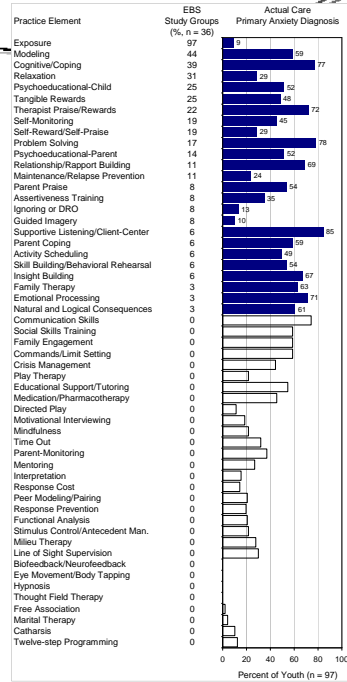
- Literature characterized mainly by problem area clusters
- Some special cases emerged within problem areas
- Creates “expected values” for service review

How Evidence Based Is Usual Care?

- Anxiety Disorders Example



What Else Happens?



Summary

- There is substantial knowledge in the literature that we are not leveraging to guide our decision making
- We need a method of extracting procedural information at multiple levels of analysis
- Products from these multiple levels of analysis can complement each other and inform system performance

Relevance Mapping

From General to System-Specific
Definitions of “Evidence Based”



Key Questions

- How are the youth in my system able to be served by evidence based practices?
- Under what assumptions?
- How can I optimize training initiatives within my system toward the goal of serving all youth better?



Procedure

- Compare every member of a service population to every study in the evidence base
- Examine different inclusion assumptions
 - Problem
 - Age
 - Gender
 - Ethnicity
- Aggregate the results



Pilot Sample (N = 712)

- 34% Disruptive; 22% ADHD; 22% Anxiety; 6% Depression
- Age 4 to 18
- 68% boys, 32% girls
- 51% multiethnic, 16% white, 14% Asian, 8% Pacific Islander




Who is covered?

Status	P	PA	PAGE
Not Covered	7.4%	11.8%	57.7%
Covered	92.6%	88.2%	42.3%


About 8,260 of the
Children Served by LA
County DMH

Can examine specific demographic characteristics of youth not covered...identify training gaps



How are they covered?

Treatment Family	P	PA	PAGE
Contingency Management	67.8%	24.6%	3.2%
Parent Management Training	67.3%	35.1%	3.7%
Parent Management Training and Problem Solving	66.7%	26.7%	3.9%
Educational Support	64.5%	26.1%	3.8%
Assertiveness Training	62.4%	10.4%	0.0%
Cognitive Behavior Therapy	61.4%	55.9%	24.6%
Relaxation	60.1%	22.9%	1.7%
Client Centered Therapy	59.0%	31.7%	9.8%
Problem Solving	51.3%	47.5%	7.0%
Social Skills	51.3%	16.4%	1.0%



Are There Ways to Optimize Practice Development?

- **Top Down:**
 - Pick treatment families or protocols that apply to largest number of youth
 - Pick non-overlapping sets to avoid redundant coverage
- **Bottom Up:**
 - Identify minimum set of practice elements to recreate protocols covering maximum number of youth



Practice Elements Example

- Problem (15 Practices)
 - *Child Psychoeducation, Cognitive, Exposure, Modeling, Praise, Problem Solving, Parent Psychoeducation, Response Cost, Tangible Rewards, Guided Imagery, Self-Reward/Self-Praise, Social Skills*
- Problem, Age (28 Practices)
 - *Activity Scheduling, Cognitive, Communication Skills, Exposure, Goal Setting, Maintenance/Relapse Prevention, Modeling, Praise, Problem Solving, Psychoeducation-Child, Psychoeducation-Parent, Relationship/Rapport Building, Relaxation, Response Cost, Self-Monitoring, Self-Reward/Self-Praise, Social Skills Training, Tangible Rewards, Therapist Praise/Rewards, Time Out ...etc.*
- Problem, Age, Gender, Ethnicity (42 Practices)



Implications

- Coverage assumptions are that system has **every** evidence based practice at its disposal
 - We can analyze actual coverage by existing EBT service array...it is of course far worse
- There is more in the evidence base than we make use of
- There must be an alternative to fill the gaps for unmet service needs



Training Prescriptions

- Can point to gaps to be filled in by MAP-type approaches or by adding specific manuals or programs (e.g., “what if” scenarios)
- Bottom Line: Need to have more balanced emphasis on system needs versus University-Based Deployment Models
- Systems need partners, not just products

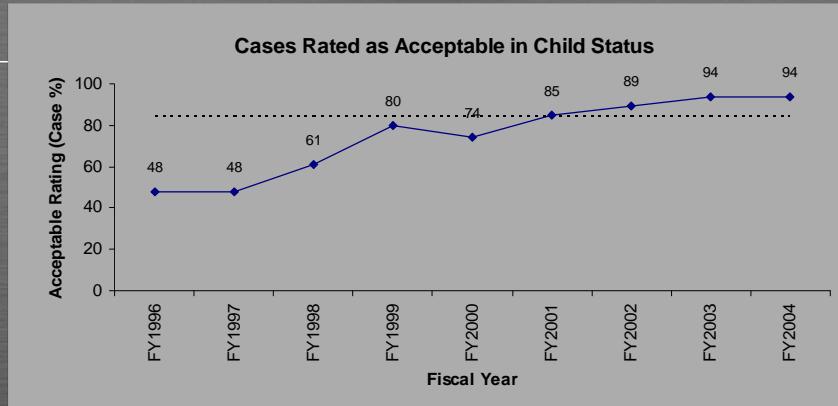


Results in Hawaii

From Daleiden, Chorpita, Arensdorf, Donkervoet, & Brogan (2006)



Quality Reviews: Child Status



Quality Dimension Examples:

Learning Progress

Personal Responsibility

Safety/Personal Well-being

Emotional/Behavioral Well-being

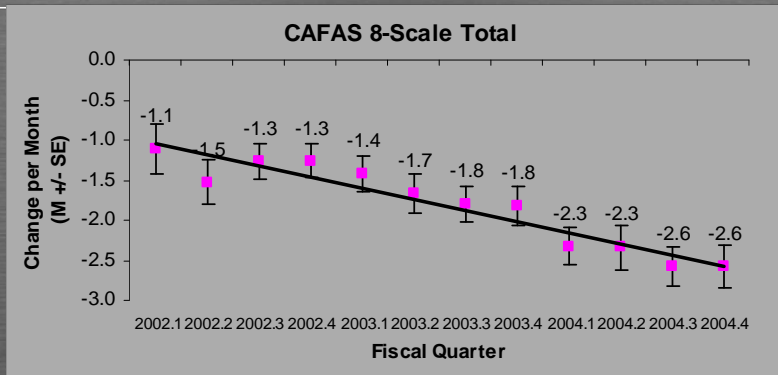
Community Home

Caregiver Functioning

Child/Family Satisfaction



Rate of Improvement?



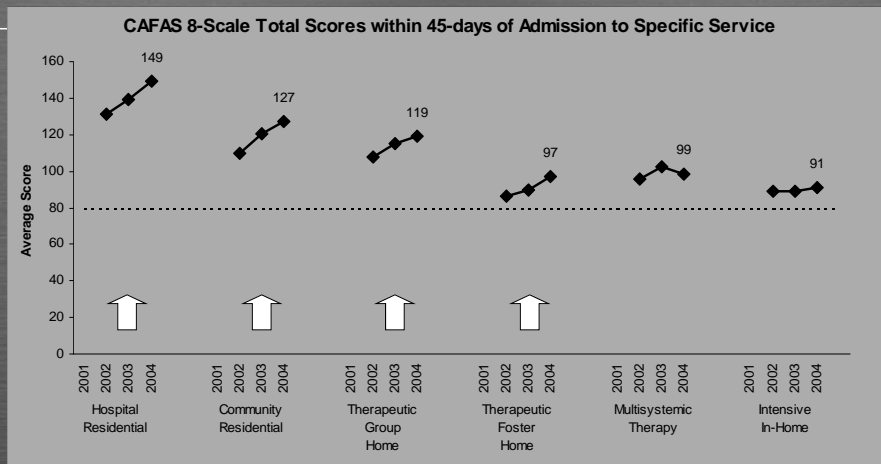
Final Effect Size for Change = .07/mo, .84/yr



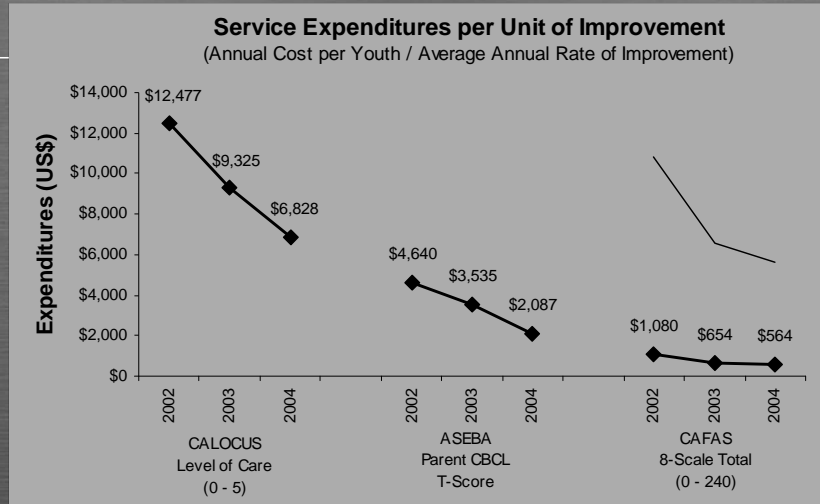
Getting Better at Getting Them Better



Greater Impairment Treated at Less Restrictive Levels of Care

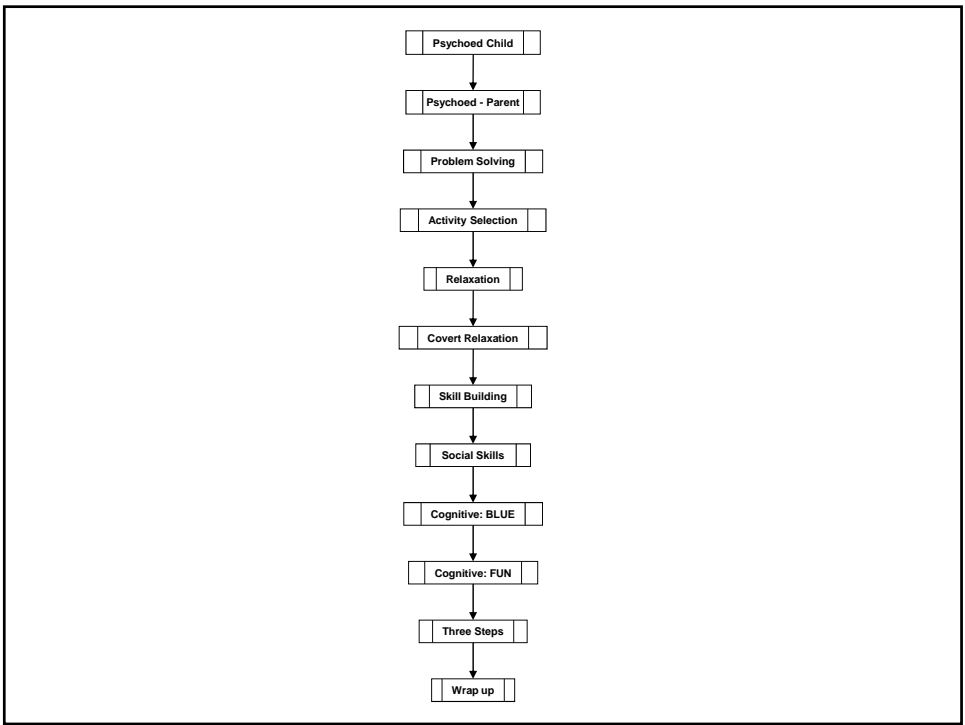
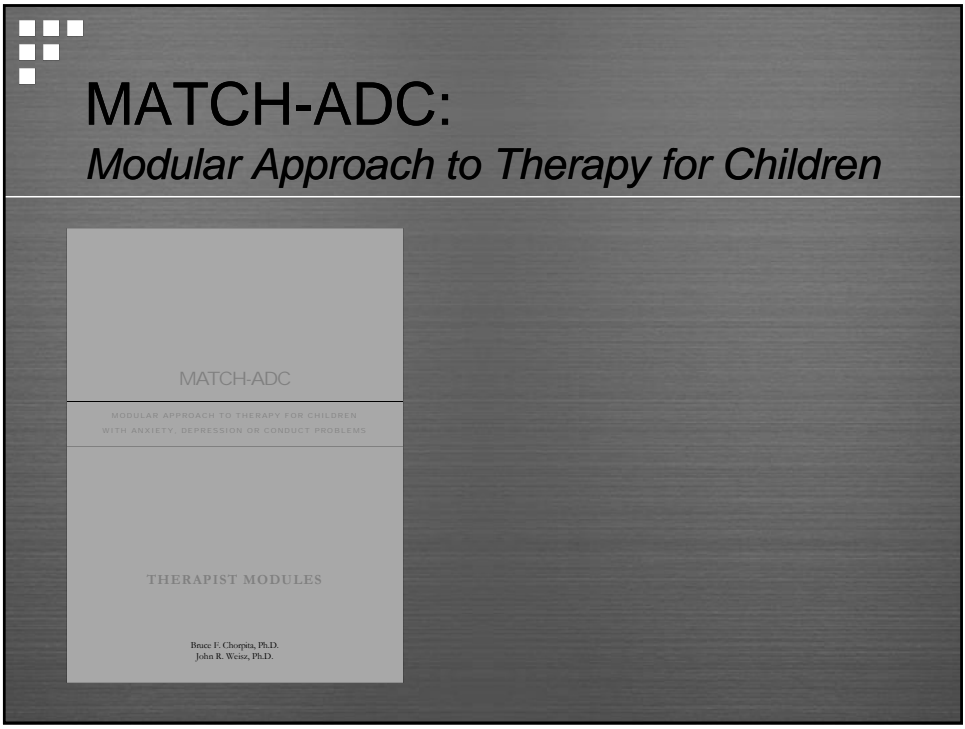


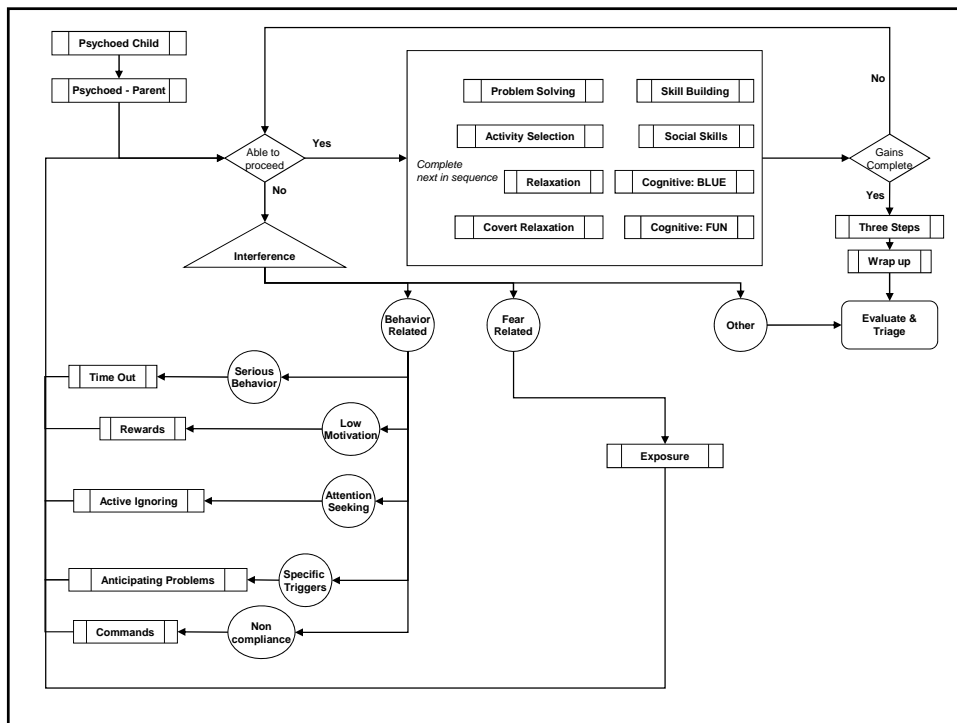
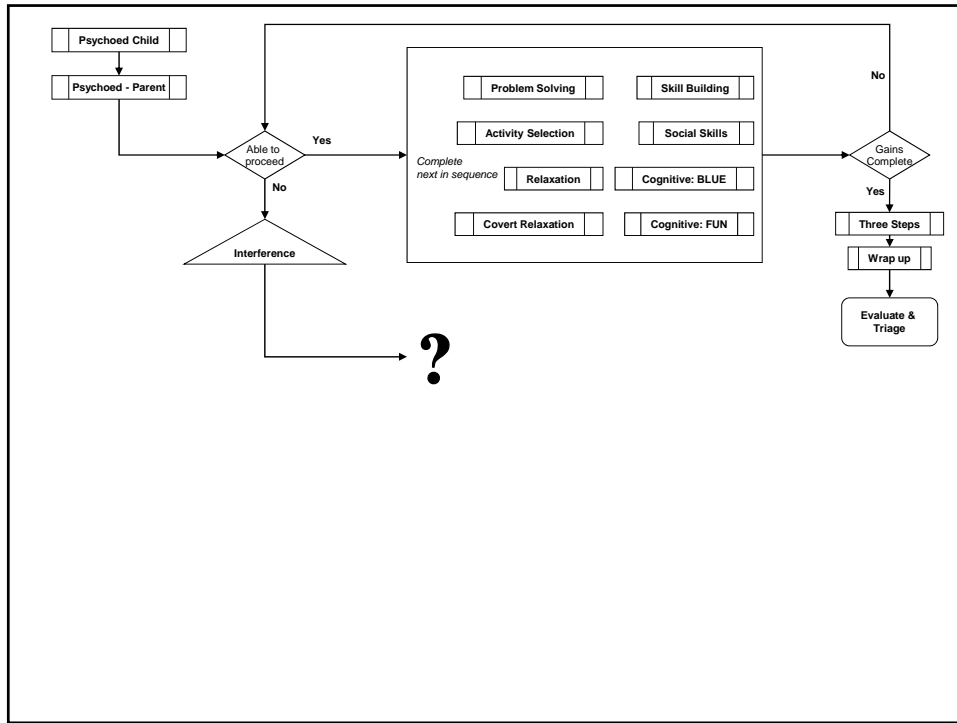
Cost per Outcome



Related Research

MODULARITY AND THE CHILD STEPS INITIATIVES





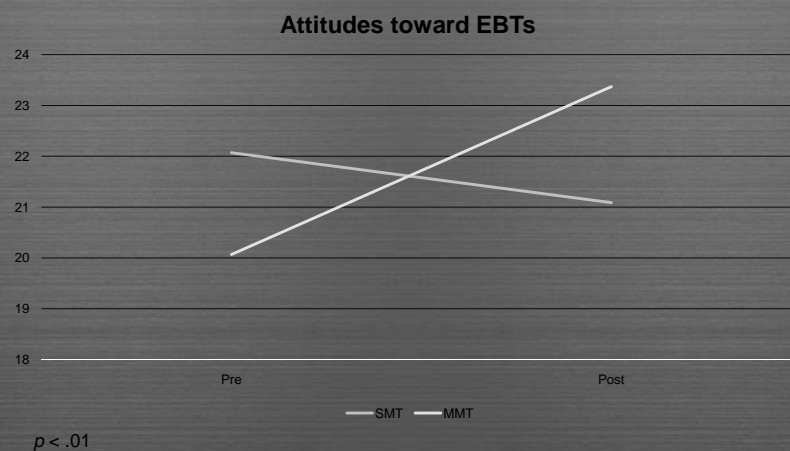


Child STEPs Treatment Project

- Youth Network on Child Mental Health
- 5-Year, multisite randomized trial
 - Boston, Honolulu
- Anxiety, Depression, Conduct Problems
- Community therapists
- Standard Manuals, MATCH, Usual Care
- N = 203 children randomized



Training Results





Preliminary Findings

- MATCH protocol at least as good as Standard Manuals in terms of efficacy



Other Efforts

- Minnesota Department of Human Services
- Hawaii Child and Adolescent Mental Health Division
- Western Australia CAMHS



One Size Does Not Fit All

	Dashboards	Protocols	Evidence Review
Hawaii CAMHD	CAMHMIS	PW Practitioner's Guide; Integral protocols (e.g., MST)	EBS Biennial Report; Blue Menu
Minnesota DHS	MS Office Version	PW Practitioner's Guide	PW EBS Website
Child STEPs	STEPS MCTP MIS	MATCH-ADC	MacArthur Phase I
UCLA	MS Office Version	MATCH-ADC Modular CBT	PW EBS Database for Students

Implementation Models

Thanks to all of you who talked
with me this year...



Working Models

- Resource Availability
- Current Training Partnerships
 - California Alliance
 - Other Agencies
- California Institute of Mental Health
- LA County (in development)



1. Resources Only

- Users can subscribe to PWEBS online
- Our protocols and dashboards are available for download
- Analogous to “buying the manual”
 - Often leads to follow up contact



2. Current Training Model

- Anxiety, Depression, Disruptive Behavior, ADHD
- 5-Day Training
- 6 Months of Consultation
 - 13 calls per call group
 - 2 call groups per training



3. CIMH Model (proposed)

- Anxiety, Depression, Disruptive Behavior, ADHD
- 5-Day Training
- 2 Booster Days
- 12 Months of Consultation
 - 24 calls per call group
 - 4 call groups per training
- Community Development Team



4. Child STEPs Phase III

- Negotiating with LA County
- Goal is to select service partners together
 - Focus on Anxiety, Depression, Disruptive Behavior, Traumatic Stress
 - Use of more structured Modular Protocol, highly sophisticated online dashboard system, five day training with 2 years of intensive coaching



Take Home Messages

- Aim 1: To derive more usable knowledge from the literature to improve usual care practices
- Aim 2: To make that knowledge convenient, accessible, sustainable, and dynamic
- Aim 3: To stay flexible in our plans for dissemination and to listen to the voices of stakeholders in the system
- Aim 4: To evaluate and adapt these models as our research tells us more



Review and Discussion

What seems promising?

What are concerns?

What are the primary current and future needs of counties and agencies in CA?



Thank you!



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<http://www.practicewise.com>