

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

Panelists:

Aleta L. Meyer
Michael de Arellano
Kimberly Becker
Dennis D. Embry
Bethany Lee

Please note: The following is a direct transcription and has not been edited.

Aleta L. Meyer: Welcome to our session today. My name is Aleta Meyer and I'm with Office of Planning, Research and Evaluation at ACF. So, a little research acting we plan it within ACF. And I have the honor of facilitating this panel and we were set up very well by the plenary, I think bringing up the issue of how did Dr. Barth said what do we do with what we have when we don't have exactly what we need. But let me in data to do evidence-based practices. And so this is a dilemma that practitioners face, that the clinicians face, you know what do we do with what we've got when we don't have what we need when we're mandated to do evidence-based practices.

And so this panel is going to begin with each of our four presenters sharing about eight minutes of their wisdom about how their work would help address that particular dilemma. And then we'll be opening it up for lots of discussions. So, I'm quite excited about that and so as you might right here we have Michael de Arrellano, it's just one -- that only has one R right there. And he will be talking, he will be presenting last and he is going to be talking about cultural adaptation, the trauma focused, trauma informed intervention and then Kimberly -- you know Bethany Lee and Kimberly Becker are going to be talking about their common elements framework and showing their own pieces of that and then Dennis, they will be going first and then I think Bethany is going to be going first and then, they didn't sit in the right order, but I thought I present them in the order right here.

And then Dennis Embry is going to be talking about work he has done on evidence-based practices kernels as well as being an everyday scientist. And so I think that you'll find all four of these approaches quite compelling for thinking about how might you know the way Dr. Schorr had those four different types of evidence and we pull them together while I think that these guys have some ideas for how that might actually roll out in some of your life applications.

So, let's start with Bethany. I mean it's 6.3.

Bethany Lee: On the family, great. Welcome. Glad to talk with you today a little bit about the common elements also just putting a little plug for at the next session we're going to have full symposium about common elements and child welfare and what we see sort of as the next steps for that of this. Intrigue zero picks your interest. There is going to be a little bit more content in the next session as well on this. But I'll just give you a

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

brief overview about the common elements of practice. I wish I could take credit for this being my idea, but much of this is really being developed by Bruce Chorpita and Kim Becker and some of their colleagues and we're just fortunate to get a partner with them at the University of Maryland on a project together that's really gotten me interested in this idea.

As one of the solutions for thinking about when there isn't evidence-based practices or it doesn't really fit with our population, how can we still move forward and feel like we're serving our clients well. So, this idea came about this is kind of Alex pointed in three simple steps. We started with this idea of we think it's really important to use evidence-based treatments and a lot of times when we think of those and certainly what we heard this morning, we heard a lot of those alphabets that acronyms about PCIT and Incredible Years and all those kind of name brand programs that are out there.

And so, as we focused on using evidence-based treatments, people began to build a lot of treatment manuals and then after few years that manual would need some updating so there will be more manuals or revised manuals or enhanced manuals and you get to a point where there is just this information overload or there is all these manuals that are well beyond what a single child welfare agency could deliver to the diverse type of clients and needs that they fed.

And so, common elements is sort of a reaction to that of how can we move forward and maybe alternative way than just relying solely on treatment manuals. Certainly there is still a place for all of those programs that are very strong and have a strong evidence base, but when that isn't the right fit or not something your agencies able to do are there other alternatives. And so, the common elements approach really comes to the idea of many of those name brand programs have some of the same pieces or building blocks that are in common across them. And so using some of those strategies or techniques from some of the known treatments that are out there that have an evidence base and seeing what's common across programs that we know are working for kids.

And so, instead of using the treatment manual to guide that, you look at the building blocks of those treatments to see what's common across that and how can we use those building blocks and developing some new or revised interventions. And so, essentially that's the idea of the common elements of finding what's common within the elements of these manualized treatments or other evidence-based practices.

So they're also by bringing it down to an element rather than a whole treatment manual, you can be a little bit more flexible or responsive to the needs of your clients. So, you can have a little bit more customization than what would be part of a manualized treatment where there is one module and then the next module et cetera. As far as how these practice elements then will identify, I'm going to focus my talk mostly on these practice elements and a little bit about how we can use those kind of those little building blocks.

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

Kim is going to talk about a couple over the other features of the common elements approach as well, so you'll hear a little bit more. But essentially as practice elements came from coding 322 plus I think they add a couple everyday randomized control trials that were done within the field of child mental health, so looking at specific disorders that you've had, what kinds of treatments were done and Treatment A was compared to Treatment B and which was the winning treatment. And then of that winning treatment, what were sort of the building blocks or the techniques that were used as part of that. So, that's what we think of and we talk about the common elements.

So, we can see in my little diagram, we have this global idea about parent training and then underneath that there is a lot of sort of name brand parent training programs some that you're probably familiar with that with there. And then underneath that we can see that there is actual building blocks of those that can sometimes be common across those programs, sometimes unique to that individual program, so trying to figure out which of those building blocks are common and commonly found in sort of the winning treatment when comparing two different groups.

So that's how they were developed and from that process of looking through all these RCTs. We found about 41 again that number is changing of these practice elements. So, from that Bruce Chorpita and his colleagues put together these really nice little practitioner guide that takes one of the practice on, this is an example of activity selection and walks through for a practitioner step by step of how would you actually do this and working with the client to help them to learn the skill. So, there is one of these for each of the practice elements and it's a quick one or two page guide for a practitioner actually use one of these building blocks that they know is found in some of these manualized treatments without using the full manualized treatment. So, it's sort of a way to deliver kind of small dose of a practice element.

So, we can see there is audience, some of these are for kids-specific; some of them for families; some just for caregivers, some goals of why you would use activity selection and then just a step by step layout that's pretty simple for a clinician to pickup to actually use. So, this is a breakdown to of you can also look at these practice elements by some specific needs or specific problems. This area, problem area was disrupted behavior and we can see this is a comparison by age group where we've got older kids, the kinds of techniques should one use with them are going to be different than if you've got younger kids are working with them.

And so, this is a little chart that shows list of the practice elements and then whether they're most commonly found or the way which they were found and working with older kids and younger kids. And so one of the things that really stands out is that we can see timeout never found to be effective for older kids, certainly if you're a parent, you've probably figured that one out already, but that's a pretty common practice element if you've got younger kids. So, this is a way that you can start to look at these practice elements and think about it's not one-sized, it's all. There really is a way to kind of customize and look at the different dimensions here.

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

There is also a tool and this is through practicewise.com which is a website that Bruce Chorpita has come up with some tools that are subscription based, but really helpful in thinking about. If I've got to use with these kinds of characteristics and these problem areas what are the practice elements that are most commonly found in interventions that treat or use with these behavior problems or mental health needs most effectively. And so, here is an example where I just put in a couple of brief details about. This is a 12-year-old girl with depression and when I go to the next screen it shows me here are the most common practice elements found within this literature that they quoted to say, here is what works for these kids.

So, some cognitive components, so like a CBT type of approach, activity scheduling, goals setting, problem solving, so right there at the clinician or the child welfare worker whoever may be working with this family has a couple of ideas for starting points at least even if there isn't a full manualized treatment that they're able to follow through with this family. So, it gives a couple little pieces of practices that could be used in that setting toward effectively with the family and I think I'm out of time, time hopefully I made it pretty close.

Aleta L. Meyer: You did great.

Bethany Lee: So, I'll turn it over to Kim who will talk a little bit more about some of the tools of this approach.

Aleta L. Meyer: Okay. And we have lots of discussion for those of you who may have arrived late, there each giving a short eight minute discussion on what how they would address the dilemma of, let me now right here, what to do with what we have when we don't have exactly what we need and we're supposed to use evidence-based practices. So, they're each addressing that and then we'll have lots of chance for discussion.

Kimberly Becker: Okay, thank you. Okay. So, my name is Kimberly Becker and I'm going to be talking to you about MAP which is managing and adapting practice. And our answer to what do you do when there is no evidence-based practice is really to address some systems issues. I want to acknowledge my colleague who cannot be here today, Bruce Chorpita, as well as many of our partners that have helped us develop and implement MAP, managing and adapting practice, MAP is a direct service model, so it's not an intervention aimed at a specific target problem. It's really a service model that has the goal of enhancing the quality of mental health services and how do we do that?

We do that by really focusing on improving the clinical decision making. The way we started MAP was really to identify and model what are the decisions that are made in -- within a child -- excuse me, within the children's mental health systems. Some of those decisions happen at the systems level. So, it might be what evidence-based practice can we train our clinicians in to reach the most, you know to bring about effective out or bring about good outcomes in the majority of the clients that we see. Some of those decisions that occur happen at the clinician level such as what EBP in particular can I use

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

with a specific client or how do I know when my client is improving and what do I do when my client is not improving.

So, we modeled all of these different decisions. Then we worked and we're still working to identify the best information that we have to guide those decisions. And we've really expanded the scope of what we mean by evidence. So, certainly there is the evidence that Bethany described that comes from the published literature in mental health services research. But we also expand the scope of evidence to refer to knowledge or information that we gain about our individual clients. So, clinicians are gathering information from their clients and in conjunction with the mental health services research, they're using all of this information to really inform their practice and bring about evidence informed practice which really provides the clinician with some local control and the ability to adapt their intervention to meet the individual uses and families needs.

So, this is actually the MAP. And you can see here the second column over those diamonds are the questions that clinicians routinely ask themselves with any given case. The rectangles to the right of those diamonds are the actions that they would take based on those questions that they're asking themselves and all of the document shapes kind of on the outer edges of this figure refer to pieces of information that inform those decisions. You'll notice that every question that a clinician asks has some piece of information that informs their decision and their follow-up action.

So, I'm going to walk you through a couple of examples and share some tools and specifically link it to how these tools might be useful when there is no evidence-based practice. Okay, so the first question is, is this a new case? And we see that the action if the answer were yes, if a clinician was just starting with a new youth in family would be to select an evidence base service using the P web's database that Bethany described. That database would pull up after the clinician entered some characteristics for the use, it would pull up some of those common practice elements that are found in effective interventions for that type of view. Thank you.

Following that there is still the question of how does the clinician implement any of those practices. How do they know which to use first, which to use second, even which ones to select out of this list that they get. So, one tool that we use is what's called the target focused decision guide. This is an example for depression, basically everything in light green is a practice element that is common to effective treatments, to many effective treatments for depressions. And they're arranged in a representative way in the literature as well with the ones in the left hand side representing practice elements that would commonly be used at the beginning of a treatment protocol such as report building and cycle education that leads to a decision making point is the client then able to proceed with the rest of treatment.

If they are, all of those light green and that gray shaded box in the middle are modules that the clinician can pick and choose based on the clients presenting problem. So, for instance, if a client is experiencing a lot of adverse events, a clinician might be wise to use problem solving to help that client solve some of these issues that they're coming up

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

against some of these situations. If a client is experiencing significant social withdrawal, the clinician might use the second one down which is activity selection and so forth. So, they're matching these different practice elements to the different presenting problems or behavioral impairment that the client is presenting with.

Then there is another decision making point in the right hand side diamond which is are the games complete, and if so, then there is some maintenance and relapse prevention, but if not, there is a loop back around to continue the same process if the client is still able to continue. Now what happens? This is a pretty straightforward case. But what happens when the client presents with something else such as maybe truancy or trauma symptoms or that there is still significant threats to their safety and there might not be a recognized EBP for that.

So, the next decision making point is, is there some interference that is preventing this client from continuing the regular course of treatment for depression. If the answer is yes, okay, hold on, because there is going to be a lot of stuff coming up on the screen, so if the answer is yes, previously you know the three colored circles pointed to you, conduct problems, anxiety or trauma related issues, the clinician actually has now more decision making points to identify what is that type of interference and to use specific modules to address these other presenting problems.

So, there is no EBP that would address all of these issues, but by using a modular approach and collecting information about the clients presenting problems, the clinician can introduce some of these different skills that will target each of these different things. Okay, so I'm just going to point to one more clinical decision that clinicians often think about and that is clinical progress. How do I know when my client is making progress and I want to show you the tool that we use. It's called the Clinical Dashboard. And this is really where the client I mean the clinician is using client level information. The Dashboard, the top of the Dashboard you can see is kind of like a dash line and almost it's like the big dipper if there is a little bit more, but that is the progress pain of the Dashboard.

And clinicians select to five different progress measures that they can collect on a regular basis. And by regular some of that, some of the measures are kind of standardized measures maybe the CBCL or the Child Depression Inventory and they collect those maybe once every three months. Other measures are more idiographic. They're behavioral and they're concrete. They can be measured on a weekly basis. So, it might be the number of times that the child attended school or the number of times that a child initiated a positive interaction with a peer. So, those are progress measures at the top.

And on the bottom of the Dashboard are a series of practice elements that the clinician can actually chart which practice elements they are using. And the goal of the Dashboard is actually to encourage sort of this integration of progress and practice so that this provides a snapshot of the client's progress, the clinician can look at the practices they're using and ask themselves you know are the practices I'm using related to client progress. If yes, the clinician is encouraged to keep going to doing what they're doing. If the

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

answer is no, they're encouraged to ask themselves some of the different questions on the MAP to determine whether the practices they are using are appropriate for the clients presenting problems and the targets that they're working on.

Okay, so that was, sorry that was really fast, but in summary, I mean we know that we can do better at building treatment programs, but programs are not enough. And MAP, the purpose of MAP is really to help build better systems and we're hoping that by building better systems and especially by using the evidence-based we can really increase evidence informed decision making which will bring about better mental health services. Okay, thank you.

Aleta L. Meyer: Great job.

Bethany Lee: Hard to deal.

Aleta L. Meyer: I know it's so.

Michael de Arrellano: Yeah, here we go. Okay, I'm normally used to using a Mac so bear with me just for a second as I figure out how to get down to the bottom here to turn this make it play. Why is that? How to view that now?

Aleta L. Meyer: You should go to slide show.

Michael de Arrellano: Okay.

Aleta L. Meyer: And then...

Michael de Arrellano: From the beginning.

Aleta L. Meyer: Yes.

Michael de Arrellano: On being an everyday scientist, I want to talk about the basic principles for influencing human behavior. Everyone in this room from the day you were born was an everyday scientist. Humans by nature attempt to control and manipulate both their physical and social universe in the name of pro-sociality and improving cooperation and reciprocity. So, we'd become extraordinarily skillful as being able to shape each others behavior and adults became proficient in historical times helping build our communities otherwise no one would be in this room. So, I'd like to make use of some of that wisdom literature in the context of more ongoing scientific literature I forgot to start that.

Some of us are engaged in creating multiple programs. I've got several things on the National Registry of Effective Programs, Policies and Practices. But I throw rocks at that, because there is a whole issue of time of history as a threat of validity. We discussed that earlier this morning that some things sort of wear out over time or they stop working so for example, we have a whole contextual variable that the rates of mental

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

and emotional and behavioral disorders in the United States have substantially increased in the last 20 years and we know some of the epidemiological causes of those things and so that causes us to have to rethink what we might do.

So, for example, here are some of the things, the effects of several things. We have changes in the genes that are happening which have been documented in the literature, the rise of obesity, rise in aggression, rise in depression rates, more severe ATOD addictions, increased schizophrenia at least in terms of some major psychotic episodes, increased autism and increased kinds of cancers. Now, oh sorry, what's causing those kinds of things, so here are some of the new ecological variables that are causing these things, fear of violence and crime.

For example, most of you if you were my age at 63 you're able to ride your bicycle anywhere you wanted to as a small child, you were not able -- no one would let their kid do that today, and that's because of the fear of crime and violence, increased use of electronic media, Omega-3 fatty acid deficiency, all of these things are interacting and these are new epidemiological variables that never figured in the original studies that were done and are on those lists.

So, now if we're going to design something new to deal with the context, one of the first things about being an everyday scientist is learning about rates of behavior and when we talk about randomized control group trials we forget about the basic observations of human behavior. So, a behavior can be stable. It can be ascending; it can be descending; it can be quite variable, but if you compute the average of any one of those things they are exactly the same. And if you did a randomized control group trial on those things you could be led to some very erroneous conclusions on what was really working. So, they can vary by intensity et cetera.

So, we need to learn to read these kinds of things as everyday scientist to be sensitive to the duration, frequency and intensity of behaviors. But also in designing something as an everyday scientist to really work in the world, we have to do our front end analysis. I get really tired of people saying we're going to do the efficacy trials and then we'll figure out if this all really work in the real world. No, you need to design it to work in the real world in the first instance otherwise it's ridiculous. So, we need to be doing our analysis of where the problems rarely occur, where they happen sometimes and where they happen often.

So, if we're working with families, yes, we need to do that at a dyadic level but families live within the context of neighborhoods and other kinds of things who're paying attention to those. So, one of the things that we pioneered many, many years ago in behavior analysis was the notion of eco behavioral assessments. So, looking at for example the rates of low rates of behavioral settings, medium rates and high rates, so you want to be able to see the curvilinear relationships, what are the antecedents, the physical antecedents that happen before behavior because sometimes the simplest thing to change is an antecedent not to have necessarily a therapist, but for example, if you want to change the way a child is attending in a classroom who has ADHD the simplest thing is not to do

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

contingency, so in consequences and all of those things, the simplest thing is to have them sit on a therapy ball and they will pay more attention and you can demonstrate that in an interrupted time series design.

So, looking at the behaviors, what increases or decreases the rates, what are the consequences, what are the things that follow negatively or positively and sometimes they maybe throw you off for example in a study that we did years ago on a leading cause of death we discovered that spanking and reprimanding high rate impulsive children increased their rate of dangerous behavior and how many people have told our families to punish children for violating the rules. Well, we just cause them to engage in more dangerous behavior as a consequence.

So, what are the rates of words, what kinds of words shape and frame or regulate behavior. So, you're all very calm right now, but if I told you there was a terrorist outside this door with a suicide bomb, you would all be in a state and I would have changed your behavior simply by using words. So, words do matter in this context. And then what are the biophysiological and epigenetic mechanisms that might be operating in this. Now, one of the fundamental units of behavioral influence or what Dr. Tony Biglan and I call evidence-based kernels. They are the smallest unit of scientifically proven behavioral influence. They are indivisible.

This is an example of one, used in a classroom to signal transitions which reduces transition time from essentially two to five minutes down to 10 seconds. If you take away the harmonica or the physical signal, it no longer works properly. So, they produce quick and easily measured change that can grow to be much larger change in time. They can be tested alone and using combination. They must have an independent experimental study one or more to show that they work. Timeout for example has 47 separate studies, all single subjects, not a single randomized trial and there are multiple versions of timeout and by the way the most important thing about timeout is not timeout. It's time in.

And they are active ingredients of evidence-based programs and they can be spread by word of mouth by modeling or by non-professionals and can address historic disparities. There are four different types antecedents reinforcement kernels and by the way not all rewards or reinforcements are created equally. There is a huge body of literature of what works and doesn't. They're physiological ones and some key everyday ingredients. I have to do this quickly. We have to count graph and do some other kinds of behaviors. And I want to introduce you to several what I call everyday scientist designs.

The first is off-on, off-on. This is an example. Many of you have heard of the good behavior game. This is the second study published in the literature showing that when the kids were not playing the game, they were out of control and very disruptive. They played the game, it went down. They return to baseline and then they did rules only. Teachers announcing rules had a little tiny effect, but using simple stop and go signals had a relatively large effect on behavior and then reintroducing the game. Now, anyone can do a reversal design if the behavior is reversible. Some behaviors like once you learn

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

to ride a bicycle unless you have a TBI, the chances are you're going to continue to remember how to do that.

There are other ones called multiple baselines which are monitor and create effective practices. So, for example, here is the one where we were teaching parents to reward safe behavior and reward the children not being impulsive and using a version of timeout called sit and watch. These are very high rate ADHD oppositional defiant children who engage in very dangerous behavior and we were able to show that that worked in a multiple baseline.

Now, the survival analysis is to show long term advantage or disadvantage of a strategy. So, survival analysis comes from the cancer literature which means time to death. So, here is an example of using something a reinforcement paradigm studied by NIDA called the prize bowl where you draw little cards for being clean and sober and doing good work. It can be used for all sorts of things we use it for violent felony offenders reentering and what that shows is if they went to normal substance abuse treatment, 90% of them, thank you, 90% of them failed and relapsed, but with the prize bowl 90% did not relapse. And I'm almost finished here. If you want to know more about evidence-based kernels, there are multiple publications. You could go to our website. We also give you instructions of how to do this to scale social marketing and other kinds of things and then behavioral vaccines are when they are used repeatedly to reduce mortality and morbidity, hand washing is an example of a behavioral vaccine. Thank you very much.

Aleta L. Meyer: Okay. That was almost like that wrap.

Michael de Arrellano: Yeah.

Aleta L. Meyer: But compelling.

Michael de Arrellano: Yes. And you can see videos about these.

Dennis Embry: So, this...

Aleta L. Meyer: Did you take microphone with you?

Michael de Arrellano: Oh right.

Bethany Lee: There is down right now.

Aleta L. Meyer: No. And there we go.

Bethany Lee: Start again.

Dennis Embry: So, the problem with going last is especially when you're following such really good talks is you know you have this pressure of being really boring. And let me just prepare you, mine is going to be much more boring, not going to have the cool slides

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

and because you know that my talk is going to be really different in that the process that we went through and adapting an evidence-based treatment was to be honest with you accidental. So, I grew up South Florida which is you know North Cuba. I'm of Cuban descent. My education was bilingual. Everyone in my class was Hispanic except for two Anglo kids. Everyone was Hispanic. I thought the rest of the world was like that except when I went to North Carolina for grad school, I learned this was not the case. And then when I went to Charleston South Carolina 16 years ago, I really realized this was not the case.

And I didn't think I were to be living in Charleston South Carolina running a clinical program and conducting clinical research, mostly focused on working with Latino populations, but that's in fact what I am doing. And part of that's because when I got there 16 years ago, I was the only Spanish speaking clinical psychologist who worked with kids in the state. That's a dubious distinction to have because I mean I was getting referrals from kids that were living two and three hours and away.

So when I got there, we really didn't have a lot of research that was – had evaluated trauma focused interventions with Latino populations. And what we do know about Latino populations is that unfortunately, it seems like they are at greater risk for experiencing victimization, especially among immigrant populations. They are at greater risk for having mental health problems as a result of trauma. And lastly, and the really unfortunate thing is that they are less likely to access services. And in the 19 years before I arrived at the National Crime Victims Research and Treatment Center, when I review the records, we had served 2 Latino families in the entire 19 years. And I imagine there were a couple more than that that needed services. And when people found out that there were some of those spoke Spanish, I was getting these referrals. But I would only get folks who had come in two or three times and then they drop out. And so we wanted to figure out what we needed to do differently to be able to provide services.

And so, the first choice point was to use a culturally derived treatment, so something more indigenous or something that is culturally based, like cuento therapy, or do we do something that is an evidence based treatment and see if we can tailor it. And so, what I picked was – TFCBT, trauma focused cognitive behavioral therapy. The research was really limited in terms of, and even today, it's relatively limited and it's a little better. And what we know works with different cultural groups, there are some preliminary evidence for evidence based treatments in general with different ethnic minority groups. And Huey and Polo did a great meta-analysis that looked at a whole series of RCTs and their evidence free use for different cultural groups. And I want to point that at the very bottom, there is a link. And you don't have to copy this, all these slides are going to be available online. But that is a link for the National Child Traumatic Stress Network. We put together a compendium of all the evidence based treatments and promising practices and what evidence there is for their use for all the ones that are trauma informed and what's the evidence for the use with different cultural groups. So just if you want some more information in general.

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

So instead of, reinventing the wheel, we decided – we just wanted to realign it a little bit, so kind of tweak it to see if we can tailor to be more appropriate, while remaining true to the treatment model. And this is – kind of goes back to the plenary, with the incredible tailors, they tailor the incredible years, but maintain the main components so that you can continue to say that it's evidence based treatment. This is a critical piece because if you like change it so much, that it no longer has those central elements, then you can no longer say that you are doing an evidence based treatment. So culturally modified TFCBT was based on our work with Latino families. It's based on our 15 years of doing treatment with this population. It is also based on the research literature and then theoretical literature because when you don't have a lot of research, you'd try to draw from wherever you can. And just the kind of the process we went through, it was kind of a community based participant research approach in that when I saw that folks weren't coming back, well, let's find out why. And so we went to schools, trusted community based organizations.

All these people who had been providing services to this community for a very long time, and asking them, what do you think we need to do differently in order to make this work. We spoke to the referral agencies that are working with this population. And importantly, we spoke to families. What do you think we need to do in order to make this work for your child or to work for you. And then we also learned through the clinical work. And so when we started to implement the treatment, we implemented it with fidelity, made sure that we are doing what Judy Cohen, Tony Mannarino and Esther Deblinger say TFCBT is. And they talk about this – TFCBT and evidence based treatments are not like a cookbook. And I have to disagree. I think they are a cookbook. But the kind of the way that I cook. So when I went to North Carolina, guess how many Cuban restaurants were there.

So, in order for me to eat Cuban food, I had to learn how to cook. And so I got cookbooks because I needed to know exactly, so what does that little bit mean, and what does it mean to have enough to cover the bottom of the pan with onions and garlic and green pepper. I needed more than that. So I got – so when it's at a quarter teaspoon, I got a little quarter teaspoon dusted off, make sure that it was a quarter teaspoon. But it wasn't the way that my *abuela* used to make it and so, once I learned how to make black beans based on the cookbook, then I tailored it so that it was more appropriate, so that it was more like what I knew black beans were supposed to taste like, which is what I think we need to do with evidence based treatments. We can take the existing model, do it the way it says, it's supposed to be done. And once you know it's working, then you can tailor it to the population that you're working with. Just and because it decreases the risk that you're going to change it so much that you can't fall back on the evidence for that intervention.

Aleta L. Meyer: And then it's no longer black beans.

Dennis Embry: Right, so no longer black beans. There is something else. It may be kind of good, but we don't know if it works. So, and then we got information from our families. We did both formal and informal assessment. We did outcomes, let's see if it's

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

working and then getting satisfaction ratings from them. And not just how – on a scale from 0 to 10, how much would you like this, because all my families love what we do because there is this issue of *respeto*. Of course what you do is wonderful because you are the great doctor coming in here, you are telling us, you are giving us this treatment. Thank you very much for doing that. So rather than, so all of our ratings were always very high in satisfaction. But then when you ask some more qualitative stuff, some fill in the blacks, what did you like most? What did you like the least? And what would you do differently to make things better? Then we started getting something useful. And so, we've continued to integrate that. We did some focus groups with clinicians, supervisors, administrators with parents. And we didn't just want to work with, I know whether this treatment worked with recent immigrant Mexican American families in Charlestown, South Carolina.

So, we really varied the locations, Los Angeles, San Diego, Houston, Laredo, Texas, Miami, New York. And then we did some pilot studies through the NCTSN in Houston, Laredo, Miami and now we're doing **one in Fort Collins** *[phonetic]* [00:36:40]. And in general, the modifications that we made for the recent immigrant Mexican American families in Charlestown, South Carolina, guess what, they really seem to be working quite well in other places. And these are – we brought in the range of traumatic events we assessed for, like so for example, we don't just assess for physical abuse, sexual abuse, domestic violence, community violence. We also assess for – when you were immigrating into this country, did you experience any events in which you feared you would be killed or injured, asking for events in country of origin. If we know that they are there in a particular country where a family is immigrating from or region that there is a lot of violence, lot of drug violence, we ask specifically about those things too.

We also assess for different cultural constructs. Gender roles, spirituality, folk beliefs, *personalismo, fatalismo, familismo*. And we don't like just say this is the Latino flavor of TFCBT. So if you are a Latino, you believe in ABC. We do 1, 2, and 3. It's really not like that. It's a tailored treatment. So we integrate it into the treatment as necessary. So for lesser acculturated families, it looks – we are integrating more modifications for more acculturated families with fewer modifications. And we integrate it throughout treatment. So for every components, we are plugging in, for example, spirituality. So spirituality will be part of the psycho education, will be part of relaxation, ethnic modulation, cognitive processing, the trauma narrative, etcetera.

So it looks like so far, we have some really positive results. We have good clinical results. We have good satisfaction ratings. One of the best things I have is, I get referrals for previous families. And these are usually court ordered families. And when they are sending other people that come talk to me, I feel like we are doing pretty good. And there is just a – this is a list of the different places that TFCBT has been used, different types of cultures and sending where we have some data on. Judy, Tony and Esther coming up in the book shortly, that will – that actually outlines some of these modifications for each one of these interventions. And here are just some resources that you can get some more information on this. And that's my email address, in case there is

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

something that you missed which is likely, because I was talking so fast. This is a day-long workshop; I just gave in 8 minutes. Thanks.

Aleta L. Meyer: Thank you.

Male Speaker: I think we're doing speed dating.

Aleta L. Meyer: Yeah. So now, I invite your questions that you have for our panel. I think we've got quite a wealth of perspective up here. Yes Mark. Yes, let's pass the mic.

Mark: This was very good. And this may not be exactly relevant. But when I was everyday practicing scientist with my cholicky infant 33 years ago. I went to the book, Dr. Sparks' book, and he said the best sleeping position for a child and he said the best sleeping position for a child was on her stomach, which I did. And I did my sort of single subject design. It wasn't very systematic. And I noticed that she didn't cry that much on her stomach as when she was on her back.

I discovered to my horror maybe 13 years later that there is now an evidence base that suggests my goodness, I was increasing her risk for sudden infant death syndrome. I wouldn't have known that just based on my single subject analysis. And the question I have is, when do you leap to some sort of comparative or randomized control trial as you are implementing these kernels or practice modules just to check whether or not the impact that you are observing is truly an impact that has some efficacy or may have some dangerous consequences that were not visible in your single subject experiment.

Dennis Embry: 1, 2, there we go. That's a really great question Mark. And I wrote a paper in 1984 called Everything Cook and Campbell Never Told You About Doing Large-Scale Research. And one of the things if we are doing single subject or even a small randomized trial, a small randomized trial would have the same basic problem because it lacks longitudinal follow-up. So I think the rule of thumb here is, first establish that you have operational control over the proximal behavior, and do that in some repeated basis. Then I think we are ready to engage soon in a randomized trial that would have some longitudinal things. I mean this is a sort of rule of thumb with a, let's say a multiple baseline or reversal study involving somewhere between 10 and 20 people that you have reliable results. You can actually run an effect size calculation on that, and that's a whopping effect size if you can do that reliably on 10 or 20 people. And you will have understood at least some of the proximal sources of variance.

Now, one of the cool things about a single subject design and the example that I gave you was very cool, if we had not been doing the single subject analysis of the behavior of parents and children, I had previously on my radio show told people it was okay. I didn't like it, but to squat your kid on the butt if they ran out into the street. Much to my horror did I learn that it actually increased the rate of street entry of impulsive kids. So the – it was a single subject analysis that actually showed that backfired. So what you are asking about is, when and how do you measure adverse effects. Well you need to measure not only the positive effects in a single subject design, but you will also need to measure the

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

backfires and then work with those, because those are likely to be things. And then I would say very soon, after 10, 20, or 30, because if you can't do even three people in an interrupted time series design and show effect, you are not ready to do on RCT. You can't make it up in the numbers. That's a problem. So then I would move quickly at least, and that's what we did and some of our things we move to, like a nine-month longitudinal thing. Now, that would have shown up something with babies potentially although the base rate of infant deaths and some other things, that might take a while to uncover some of that nature. And that in fact only show up from infant deaths reviews. Did I answer your question?

Mark: *[Indiscernible]* [00:43:44].

Dennis Embry: Yes, yes.

Aleta L. Meyer: I think the point that maybe I would make as well is about the idea of multiple sources of evidence and sometimes perhaps we honor or privilege one source of evidence over others and thinking about, even if we have a personal bias of making sure we are looking at and seeking out sources of evidence that aren't just the RCTs, or aren't just our practical wisdom, or aren't just what we're seeing in an individual client's behavior, but really thinking about how to put together the best evidence from all those. Brian is here.

Audience: Thank you. So Michael, I have a question for you. When you are talking about putting in place an evidence based practice, and you are making your adjustments, how do you track your adjustments so that eventually, it is no longer – it doesn't maintain the fidelity of the model that you are using. Do you have like a recipe like your bean recipe? Did you say, okay, well you know what, when I put pineapples in, for now, it's definitely not cold, flat beans.

Michael de Arrellano: Right. Well, so you keep the treatment fidelity to the developers say, or the necessary elements. So we do, and this gets tricky because some evidence based treatments are more flexible than others are. And when you look at TFCBT, there is pretty good flexibility. If you keep in mind what the goal of the component is that you are trying to achieve, there are lots of different ways to achieve that component. So for relaxation, it can be everything from doing controlled breathing, progressive muscle relaxation, blowing bubbles, to prayer. If a child reports that after they pray, they feel more relaxed, then that's an okay thing to use. So as long – and so it's really going to differ depending on the evidence based intervention and how flexible the intervention is. I've been very fortunate that the developers of TFCBT have worked closely with me in adapting TFCBT for Latinos and have been very supportive of it.

Dennis Embry: I would like to add something to that. I like to use the concept, I hate the phrase dose infidelity. We do not have dosing fidelity police coming to check if we properly buckle our child in a car seat everyday or buckle ourselves. And we've devised and developed robust systems that allows for some flexibility. And if a practice requires such rigid dose infidelity, it's not suitable for the real world. I mean that might be a heart

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

transplant. And there are going to be a few people who need a heart transplant. But that's not ready for distribution as a sort of widespread practice or policy. It needs to be robust. It needs to have design redundancies, alternative methodologies to achieve the same end and the degree to which it has that, it's much more likely to survive and produce durable effects.

Audience: ...more of an observation. I had gone to a seminar about evidence based practices for children who are exposed to domestic violence. And among the presence were Judy Cohen and she has talked about her research applying her model to that particular population. And she actually did adapt it somewhat by – I think she reduced the number of sessions. I don't remember the details, I don't remember why she did that. But in any event, oh, it was also in a different setting, she offered the treat. But also at that seminar was a presentation by a man from CDC – from their violence prevention division, I believe. And he was trying to develop, was working on a model, framework for considering adaptations to evidence based practice. And it was in the recognizing that so many of our interventions, particularly in child welfare which was where he was coming from necessarily have multiple components to that. We do a lot of different thing, all under one umbrella, and we call it in intervention. And he was trying to come up with a way of determining which elements similar to your common elements approach, which elements components can realistically, comfortably safely be altered without compromising the core of what your program is. And he was coming up a red light, yellow light, green light, green light saying it's okay to change it. Yellow, be careful, talk to the developer, whatever that you need to do. Red light, you don't touch that, part of it. And the thing that struck me as interesting about that was again getting back to how do you parse out those different components, how much research evaluation do you need to do to figure out which components of a multi-faceted intervention are core and which are amenable adaptation.

Michael de Arrellano: I think one of the things to look at first is, you need to know what the active ingredients are. So TFCBT for example just did a dismantling study. And they are going to have to of a number of these dismantling studies to figure out what you really need to have in order for kids to get better. And so that will help to inform that. So the ones that are critical are the ones that you need to make sure that you leave and you don't take out. I do think that at least for TFCBT, for PCIT, for another called alternatives for families, CBT which is more abuse focused, physical abuse focused, you really don't – I don't know if you need to worry about that too much, which ones to mess with – which ones do you have to keep consistent because when TFCBT has a culture adapted version too. And but when you see it, you know it's PCIT. When I do TFCBT with a family that immigrated here three months ago and is extremely traditional, their idea of mental health services is going to see curandero, a folk healer. And they think that when they first start to work with me that I am kind of weird because of the things I am presenting. You would look at my sessions and you would know I would be doing TFCBT because I stick pretty close to the model. And I think I am just arguing that you may not have to deviate so much. You may not have to toss so many things out. Still be able to stick to the evidence based treatment, but while just tailoring things in a –

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

sometimes, a substantial way, but not a way that really changes the – and that's just the critical components, but really in TFCFT, any of the components.

Audience: How do you envision building the infrastructure or training and professions development for folks to be able to do this? I know Bethany and Kim, you have thought about professional development types of issues. I mean to me, that's always the big question you have, how do you train people to do this?

Kimberly Becker: Well, as part of MAP, what we do – we have, we are actually clinicians in a number of different states, in Minnesota and in LA county, actually in particular, hoping to come to Maryland sometime soon. But we have a five-day training that we roll out, and we train clinicians and kind of the clinical decision making that MAP that I presented. And then we also trained them in the different practice elements that Bethany presented on. And then we are also training them in how to be essentially everyday scientist. How to conduct repeated assessment and how to use that information to inform their practice? But that's enough. We know that the train and pray model or – or the train and pray model doesn't really work. So what we do is we also have a six-month consultation that we do with clinicians. And we have – we have many different agencies. We have about eight clinicians per phone call, every other week, we talk with clinicians on the phone for an hour. They send in their dashboards and we talk about their cases, their conceptualization, the progress that they are doing and then also at the end of those six months, they submit their clinical materials. And that's essentially how we measure or how we assess their quality enhancement.

We don't really have fidelity to come in elements per se, because it is an individualized approach, but we look at their materials and we get a snapshot of the types of clinical decisions that they are making and are they following kind of our MAP process to improve their clinical decision making.

Audience: *[Indiscernible question] [00:53:11]*

Kimberly Becker: No, that's a great question. So the clinical dashboard actually tells us a lot. And basically, what we look for is a few different things. One is Bethany showed the data base search. And we are looking at the data base charges that the clinicians do for their different clients, and we are looking to see all the elements that they are choosing for their clients – the ones that they are actually using – the ones that they put on their dashboard. And that tell us that they are integrating some of the research literature with the practices that they are doing. We are also looking at the integration of their progress measures and kind of what they are measuring first of all. Are they using standardizing measures and some individualized measures? Are the measures that they are selecting valid and reliable as the best we can tell? Are they using multiple informants to assess client progress? And are they integrating? Is there some evidence that they are integrating the progress information to the practice?

So we would hope that when a clinician is – when a client is not showing improvement that there is some change in what the clinician is doing. And so that gives us a snapshot,

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

I mean as best we can of how the clients are – or excuse me, how the clinicians are receiving our training and implementing it.

Dennis Embry: I would endorse virtually everything you said, and I would also add a few things. In doing any kind of training, you are dealing with emotional human beings in front of you. And so you could offer a particularly powerful preventative strategy, intervention and so on. And people won't accept because of their values or experiential avoidance to introduce for example an intervention that might have two or three times the impact, may cause great emotional discomfort in people because now they feel guilt and shame for having done something that was ineffective or potentially harmful so they reject the thing – the new thing you're offering in order not to experience their emotional things. So doing a values activity out of the acceptance and commitment therapy studies has been shown to increase the adoption of innovation. Then I think it's very important that they learn to be a keen observer. We've done a multiple of studies showing that if you cannot be an observer in real time, you cannot learn to moderate your behavior within the context. So you're just doing the form, it's like driving your car. Yes I am doing all the gears, but I forgot to take the blindfold off. It doesn't work so well.

So being that keen observer, then you need to teach them in a shaping protocol. So that the shaping protocol gives them a taste of success of doing one of these interventions and it creates an early reinforcement. Then you have to do multiple exemplars for them to get generalization, but you also need to teach them how to avoid pitfalls of over generalization which can happen – they – while this works, so they are going to use that for everything. Brushing your teeth is a good thing, but brushing your teeth 100 times a day is probably not a good idea. So those are some of the other things and then one of the things that is often forgotten, this is in the paper by Stokes and Bear on the implicit technology of generalization is to create inter-locking contingencies of reinforcement. What does that mean? That means that everyone who is in a diade or triadic or quadratic behavioral influence has a stake in the change and can bid for the change. So for example in the good behavior game, we actually teach the children to beg the teacher to play the game because the principal error is that the teacher gets the implementation, but not the dose. So if you create those interlocking contingencies, then you have a more fail-safe system.

Audience: So I hope this is a clear enough question. I happened to work at a state child welfare and behavioral health agency. And this is a fantastic presentation, but I am trying to figure out how to translate it to what we do. So we have a pretty robust private provider community, but it's hard to incentivize a lot of the evidence based practices and the ones that we get, speaking to the over generalization get overused. How do we ask for or what instructions do we give to the private community to get services that are tailored to the actual individual needs of families. The presentation earlier this morning was talking about just comorbidity and a lot of different things happening together. What instructions do we put – do you have any guidance on the instructions we put out there as a stage agency? We don't have budgets for research, our sort of the clinical trials and all of that. And we also don't know, we are not necessarily the savviest when we get say RFP responses or just information back from providers. How do we sort of use the

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

kernel approach or looking at the decision trees and all of that? How can that really be implemented on a state level in a general way? Is that...

Audience: *[Indiscernible question] [00:58:32]*

Michael de Arrellano: Or at least try. One of the things that looking at where people really have implemented more evidence based treatments, you look at what those states have done is that they pay. So, California has rolled out many evidence based treatments. And so for example Los Angeles. I am in Los Angeles every two to three months because one of the seven evidence based treatments that in child welfare that were – DNH collocated with child protective services, they have to do one of seven evidence based interventions; TFCBT is one of those. And so in order to get reimbursed from this pot of money, it's not that they have to. But if they want to have to get paid, they have to do one of these seven. And so that's one of the motivating factors. I know that other states are looking – and they came at which state this was, but looking at their crime victims compensation that you got paid a higher rate if you are doing an evidence based treatment versus non-evidence based treatment. And that gets sticky. And then which evidence based treatments and then Bruce Chorpita's work which is really and you're working which is really kind of a – it's evidence based intervention and would you be counting that in LA, I think...

Kimberly Becker: They do.

Michael de Arrellano: They do?

Kimberly Becker: It's one of the seven...

Michael de Arrellano: Right. And so I think that that's one of the ways to get it done as to get people to pay. What we are doing is we have taught our folks at DSS to make as brokers of treatment to make referrals to those who are doing evidence based treatments and to ask questions what treatment you do, how long does treatment take. And to make them more educated consumers when making referrals for their children.

Dennis Embry: There are some evidence based kernels. We've actually used this in a whole statewide multiple baseline to implement an evidence based practice. Yes, you need to maybe put some money on the table to get people to do this. But the power of public hosting and what I would call prestige points are exceedingly potent and powerful. So, the more you publicize, for example, and feature people using some of these procedures and tell their stories, have case testimonials, make sure that they are recognized and have opportunities to give testimony before the appropriate legislative committee that writes the checks, making sure that they get noticed by their local state senators, state representatives, mayors and counsel, those prestige points, and then essentially to run competitions.

When we did this, for example, the State of Wyoming and the State of Wisconsin faced serious financial penalties for violating the signer things. And we instituted a reward

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

reminder, and we publicly posted every single day the results of every single county. And we made sure that the news knew about it and we created that thing so there was soft competition between the counties then to participate, because at Dane County, 55% of the, time people could buy cigarettes, and nearby Eau Claire County had only 19%, what are they doing differently? And that sort of prestige thing is a very powerful thing that you can manipulate.

Male Speaker: And now everyone gets MST. And now everyone needs it. And that's part of my worry with the pace. So we can come forward with what – we're not sort of the most nimble of agencies. So we come forward with evidence based. And then if they become outdated and people overuse them and how do we encourage the provider community to bring those ideas to us and what do we ask them so that they bring those good ideas to us?

Dennis Embry: Develop a scoreboard first off. So what would be appropriate use and reinforce that and what would be and let's device some things that would be suitable, that would be smaller scale because you are right. Not everybody needs MST, that's kind of like heart transplant surgery for a lot of families. And there is a lot of things, it quite might be that a couple – 20 minute sessions of PPP would take care of the thing. And so we need to make sure the menu is there and that they get some reasonable incentives. And they may be pressing the bar, because there are lots of financial incentives for doing MST and no particular incentives for doing anything else. So I would want to look at that.

Bethany Lee: I might also add just the – the impetus for MAP and the common elements approach really began in Hawaii where the state was under a Federal Consent Degree to provide mental health services, improved mental health services to children. And what grew out of that was almost like a grassroots movement, it was a partnership between the University of Hawaii and the Department of Health where there was a committee of professors and parents and practitioners, policymakers who really saw to look at the research literature and identify what are the most effective treatments and for what problem. And I think this is – I am bringing this up because by getting them involved in reviewing some of the research and becoming familiar with that, they really took ownership of identifying treatments for a specific problem and their use of the word menu. We developed this, it's called the blue menu. And it's essentially a guide for clinicians. It's a one pager, a click and easy guide. If clinician has a client with a certain target problem, these are the interventions, the packaged protocols that have been shown in the research literature to be effective. But this was all – this was in a top-down approach, this was really a diverse group of stakeholders who sought to enhance their practices.

Audience: So I guess, I am kind of wondering too if university or the education that we are giving, I am a social worker. And I am familiar with the common elements approach, I also do teach evidence based practice workshops or the process of evidence based practice. And so I am wondering if it requires almost like a – not a different training, but just, getting people to – or practitioners to really think in a different way and that perhaps

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

that we could implement that sort of stuff or get them to start thinking in this way at the – when they are getting their MSW or their studying at the university. So I don't know if any of you want to speak to that. But...

Bethany Lee: Yeah, I am a social worker as well. So I can speak a little bit to that. I am working at School of Social Work and teach MSW students, and I think this is certainly a discussion we are having at University of Maryland School of Social Work about do we train students in some of these manualized packages, but what happens five or 10 years down the line of, if those become obsolete, do we train them to be good, critical thinkers, to be good consumers of the evidence. Do we work on this common elements approach? And right now, we are doing a little bit of all those things and just trying to come up with an answer for that. But I know that there is other schools of social work certainly as well that are wrestling with those same issues of how do we prepare the next generation of the workforce because that's really who is going to lead the future efforts as we move forward with this.

Audience: *[Indiscernible]* [01:06:28] I am coming from a child welfare system where we work in child protective services and foster children. So we are all about family center practice. So how – as you are teaching to be a good consumer for the child welfare practitioner, how do you – do you also train about reporting out your outcomes to, let's say the court or other stakeholders that are involved with the family? How do you report out, what we can expect from the evidence based practice? How do we inform the court that these are the things that we're going to see and this is going to help us make the decision when a child might be safe to go back to a family?

Michael de Arrellano: Dennis Embry: So, as part of the dissemination process, we are not just training. So we have in the State of South Carolina, we have a dissemination program where we train clinicians and then the brokers. Brokers include folks at child protective services. But they also include the – we're just starting one in Columbia. And there were several judges there from family court. And so we have now family court judges who are making recommendations about different types of treatment, not just saying that someone has got to attend a parenting classes who has been violently abusive toward their child, and they could just either sit through a class with no outcomes and can sleep through the – as long as you show up, you pass. Now they are changing the way they are doing practice by making specific recommendations. Not just one treatment, but you can have this, this, this or this because you don't – it's going to recommend one, because that won't necessarily fit. But so we are educating our judges and folks from the state level, not just legislators, which I have a hard time with our South Carolina legislators.

Dennis Embry: There is medication.

Michael de Arrellano: Pardon...

Dennis Embry: There is medication...

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

Michael de Arrellano: There is medication, I don't think it will work. But we can talk about that later. Deep breathing for me. And but then we have a lot of directors for DHSS, for DMH that we are getting them hooked in and they are -- so we are working bottom up. So more of that grassroots, but also top down, we like the bottom up first and then go top down.

Dennis Embry: In our program that I used to run at the University of Kansas years ago, we developed a criterion reference system of change which we were doing direct-home observations. And some of that is now embodied in the Project Safe Care. There is a book that you can buy called *Reducing Child Maltreatment: A Guidebook For Parenting Services* by John Lutzker and Kathryn Bigelow for \$26, which has willy-nilly excellent measures for doing home visiting and progress monitoring. Unless you have an objective standard, then it's essentially like licking your finger and sticking it up in the air about whether or not it's safe for the kid to go back. And there are direct ways of observing parent-child interaction that every case worker should learn how to do because if they cannot see the behavioral interactions with the parent and child interacting, and they don't understand what those are and how they are working and their frequency and intensity and duration, they will make very, very bad judgments. Particularly about treatment, and just saying that the clinician signs off, is like their clinicians who are fools. I am sorry to say that, that's a clinical term.

So I would want a criterion reference system. I would also want to go back and look at my fatality and failure review and look what was it that caused the failure? What was not measured and develop that as a check help – develop that as a checklist in your particular system because there may be some things that would be appropriate to know. And that would be very, very helpful to everyone. That would also help you as a monitoring supervisor know whether or not the right things were happening because case notes are ridiculous. You cannot tell a damn thing looking at case notes. You might as well just have monkeys scribble on the pieces of paper because there is no quality – unless it's run through one of those fancy software packages, there is no way of figuring out what's happening. That's why the dashboard that you guys have is just brilliant for monitoring you guys.

Audience: I don't know if this is a coherent question. But as a researcher, in terms of taking practice elements, evidence based kernels and distributing them kind of in unitary and separable kind of little packets. I get the question in the back of my mind, what about all these combination effects? What can happen – and we know there is drug interactions when we have physical kinds of chemical treatments. And I have heard people talk about, well teaching the practitioners to be good observers, keep their eyes open, watch for unintended effects. Well part of the whole problem of that is you have to have your eyes open pretty broadly to say what should I be looking for. I mean increased risk behavior may not have occurred to somebody to be looking or even to ask about or even to learn about in an interview later on. And so there is a serendipity to the discovery process here in terms of these observations that one then relies on to understand how these combinations may or may not be working okay together when there is such an orchestra of tools available. And I am wondering – I mean I can see the potential in the

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

dashboard for gathering that evidence and bringing it back to a knowledge community and knowledge building community of the users of these systems that say, okay, let's look at the data. What things went on together that led to what? Looking at certain combinations, but it's a concern that I have in the back of my mind that this not just be considered a way to disperse things. And somebody said the train and pray method. More than that, the train and even follow up, but not have a way of looking at this issue, this kind of problem.

Bethany Lee: Thank you. That was a great question. And it's I think brought to bear that there is a common misconception about the common elements approach which is that you can just take something from a manualized protocol and throw it at that child and take something else and throw at it, and just kind of willy-nilly select practices. And that's not really the goal behind common elements. I mean our MAP framework is really intended to be complementary to manualized approaches. And when resources or other barriers to implementing manualized interventions exist, then a common elements approach can be implemented as well. And so we are interested in really not creating expert CBT clinicians or MST clinicians. But in raising the floor of kind of usual care. Now in terms of a more modular approach, there is actually some – there has been one research trial so far, looking – it's called the Child STEPs trial. And that was that Bruce Chorpita and John Weisz or co-PIs and the results have not been published yet. But this was a trial that has – that was comparing usual care to traditional manualized interventions versus modular or common elements approach to treatment of youth with destructive behaviors, anxiety and oppression.

And so I don't want to give away the findings, but there are promising results in terms of modular approach to treatment versus manualized interventions. But again, those interventions, the way they were implemented during this trial, and the way we advocate is really based on the decision making protocol that is grounded in the research literature and has specific, I guess, criteria essentially, for when you would implement certain elements. But I think your point is still well taken that we still don't know enough about kind of the mechanisms that each of these elements are addressing or – and how they are used in combination, but their effects might be.

Dennis Embry: I think that's a very good question, iatrogenic effects are a property of any human endeavor. I do note that one of the things that's very interesting about using the smaller units of change, if you promote the smallest use of change and you get change, then people are less likely to do multiple other things that could cause unfavorable interactions. So it's – and that's the kind of the principle of minimal sufficiency. So for instance, I think the PPP study is a – population level study is a very fascinating one. I was involved in the design of the experiment and its execution, in those 18 counties, none of the training for the practitioners in the intervention counties received – no one received or got training at Level 5, that's the ICU version of PPP.

80% of the delivery of the parenting support was at Levels 1, 2, and 3 which are very brief interventions. Level 1 is basically mass media. Level 2 is maybe a 15-20 minute consultation, Level 3 might be a couple of those things. And there were a few Level 4

**Session 5.16 – When the Evidence-Based Practice (EBP) Doesn't Fit:
Using Evidence To Inform Program Design in the Absence of Existing EBPs**

courses offered. And that had a 25% reduction in substantiated child maltreatment to now reform placement and child medical entries approximately. So there is hope at a – population level. So there is hope to suggest that as we promote the smallest units of change, that the possibility of iatrogenic influences might in fact decrease and that we would be more precise than in our deployment of stratagems or tools rather than, “Okay, everybody needs MST.” And the kid just had one temper tantrum in his life, probably not necessary and that might in fact be iatrogenic. It certainly is the state budget.

Aleta L. Meyer: In the principle that Dennis was just talking about, there is a book called Prescription For A Healthy America that talks about the bell curve of behavior. And then if you could move the norm for everybody just a little bit, like get everybody to be more empathic or get everybody to use less salt, then you would move the entire bell curve and make the number of people that needed the highest level of treatment a much smaller proportion. So it – what you are talking about gets at changing norms, and that might make us. So we have to do fewer triple bypass surgery.

I want to thank you all for your engaged participation and I want to thank our panels, members and I promise that I was a good – I would keep us in our time and keep us in – so thank you everybody.