

**Session 6.03 – Common Elements of Children’s Services:
Opportunities and Research Needs**

Panelists:

Richard P. Barth
Bethany Lee
Michael A. Lindsey
Virginia C. Strand

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

Richard P. Barth: Good afternoon, I am Rick Barth, proud member of the faculty and Dean at the University of Maryland. It’s my pleasure to welcome you to this session on common elements in child welfare services. My co-presenters are Bethany Lee and Michael Lindsey, also from University of Maryland, and Ginny Strand from Fordham. And also very pleased to have Kim Becker, one of our co-authors in the audience.

So, what we’re going to do is we are going to do four separate presentations that will hopefully give you an idea about some of the work that’s going on, trying to figure out how to disassemble some of the interventions that we know have an evidence base and put them back to allow practitioners in child welfare and children’s mental health to put them back together, again in ways that we would fit the context, the service context of the population and hopefully also be effective interventions.

I usually start with my summary because I sometimes go over and then if I get cut off at the end, then you already know what I am going to say. So I am going to say that evidence based practices need to be based primarily on practice principles and common practice elements not on manualized interventions. That increasing the uptake of evidence based methods will best be achieved by increased knowledge of common practice elements and common factors. So, those are two different concepts that I will be talking about and then adopting evidence based practices to new settings populations and cultural groups will require emphasis on common factors especially. Okay.

So, one of the things I – this is a very small print I know, one of the things I think we are missing in our field is a vocabulary to talk about the range of ways that we develop, practice strategies. And what I’ve done I will show you that this is actually in a pyramid and I won’t refer you back now to the text. But basically, when I think about this as both former practitioner, as a research and as a dean, I often think that what we tend to do in our field is we start at the top, we get all kinds of specialized knowledge. Oops, I am trying to go backwards. Excuse me. And specific competencies, we learn about attachment or we learn about fetal alcohol syndrome. We learn about some very specific thing, or we work at the very bottom of the pyramid. We talk about our practice and policy framework as Erin got into today, but often we don’t well articulate what’s going on in the middle. In addition to what we have been talking about over the last few years, our manualized evidence supported treatments.

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And that’s a new piece for child welfare and children’s mental health and it’s getting a lot of buzz, but there is more to thinking about this practice framework than that. We sometimes talk about manualized programs. Lee Schorr was talking about that. Those are things that are like MST or something that has a lot of different factors or characteristics, components to it. But I am going – we’re going to be talking – I’m going to be talking mostly about common practice elements and telling you about that, and others in our panel will be also, a bit about common factors and only a small bit about practice principles. Okay.

One of the things that I am also going to be talking about is that evidence based practice doesn’t necessarily mean that you have a manualized intervention. There are other ways to think about it. For example, that you have an evidence-informed process in place where you’re actually collecting practice based evidence to inform the way that you go about your treatment and that that’s critical to the implementation of effective services and also wanting to make clear that this triangle is not around this scale.

So, specific knowledge of problems and solutions at the top of the triangle as I say, we are fascinated by topics like this. They are useful to know about, but not really sufficient for a generic child welfare worker or for the most part, any other mental health provider, there has to be more core knowledge than that.

Evidence supported programs, and this is a distinction that I am not really sure I have a very clear sense of yet, but I think may end up being useful. There are some manualized evidence supported treatments like trauma focused CBT although they have a lot of common elements in them, they are delivered in a pretty discrete way, the fidelity issues are pretty solvable, alternative family CBT, David Kolko’s intervention, the way, or Coping Cat. There are other broader interventions which I would call manualized programs that I would think of as multi-systemic therapy which you can also get fidelity measures on, but it is a much more complex program. This is what I think Lee Schorr is going to be talking about today. These complex programs for complex families with a lot of different issues, I see them as a little different from manualized evidence supported treatments although I am not going to spend a lot of time on that distinction. I’ll move forward.

So, what makes a manualized evidence supported intervention work? If we assume that the California Evidence Based Clearinghouse is correct, and we know what some of the evidence supported interventions are, what makes them correct? Is it the components that they have, some mixture of the components, the order of the components? We really don’t know. We know those things are all in trauma focused CBT. But we don’t necessarily know much more than that. The same will be true of these large programs that I mentioned like MST and MTFC. We know about in sort of multi-dimensional children foster care, there are all of these different elements. But we don’t really know, we haven’t done much de-construction of that.

We take them as a package. So, one of the things that our graduate students think about, I think all of our clinicians think about and program managers think about too, which is if

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there are all these manualized, and here I am going to focus on the evidence supported treatments rather than programs. If there are all these evidence supported treatments, how do we master those? How do we figure out which ones to take on that matches up with the population that we serve that are accessible, that are affordable and so on. And the common elements approach is an approach that has been developing over many years. Bruce Chorpita has had a major role in developing this, now at UCLA, previously in State of Hawaii and University of Hawaii, John Weisz, Kim Becker is working very hard on this. The emphasis is also on evidence-based treatments, but not necessarily as the whole. The idea is that in evidence supported treatments, you develop an evidence based intervention, you manualize it and then you teach people to fidelity to use that manualized intervention. But as I said, that has problems, problem of being overwhelming and also many of these manuals are not actually accessible to most practitioners. So that is a significant issue.

If you are trying to train people, you have to make tough choices about which things you are going to train them on. And one of the things we found is that sometimes, the population of families that you expected to come in that would have fit the intervention don’t arrive at the rate and in the place that they would. So, the common elements approach, they have identified that there are elements that are found across several manualized evidence supported treatments that clinicians often borrow strategies and techniques from known treatments. That’s how new manuals get written. I’ve written manuals and where did I get it? From other manuals. Treatment elements become units of analysis rather than the treatment manual itself in this common elements approach, so it’s the treatment elements that count. And treatment elements can be selected to match particular client characteristics. And much of what I will talk about and Bethany will be talking about is what are some of the tools for actually matching those treatment elements up into interventions and what can we do in child welfare to make that fit.

So, this slide may be a little bit older, this project keeps marching on. And Kim can fill us in if the numbers are very different. But initially, what the UCLA Group did was trained, they took a trained coders review 322 randomized control trials that had cost a fortune and had been going on for many decades and had over 30,000 youth and they ask themselves, this is Bruce Chorpita and Eric Daleiden, what strategies are common across the winning trials or the effective interventions? And they then tallied what these common practice elements and found that there were 41 practice elements that were found in at least three of the 232 winning treatment groups? All these haven’t been turned into actionable practice guides at this moment, but a substantial proportion of them have.

They have developed tools, one of them is the key tool and website, it’s called PracticeWise. It’s a subscription based resource and the website is here and you will be able to get of course with all the materials from the conference. They allow that you can use this to figure out which elements match up with what kinds of child problems with populations that have been studied of males or females by gender. So you can figure out if you have a 9-year-old depressed girl coming in, what are the practice elements that

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were in RCTs where they may – they were successful with a population that included 9-year-old depressed girls. Okay.

So that’s sort of how the thinking of it goes. The practitioner guides are available through PracticeWise. They summarize the common elements of evidence based treatments. They can guide the clinician performing the main steps of the technique. So if you were learning to do psycho education, for example, you’d go through what that process is. There is obviously also training. It’s not all self talk. But there is training for this common elements approach which is available. And when there were 29 treatment elements, and I think that’s pretty close. They included and they still include these kinds of interventions, response cost modeling, social skills timeout. So that gives you a sense of the size of what the nuggets are, and engagement as a broad category. And you will find out that one of our projects is to try to break engagement down into more specific elements and protocols. The practice guide is searchable by treatment audience purpose and objectives so that you can again get more specific indication of what the elements would be that are associated with success in a treatment group. Very importantly, there is also a clinical dashboard which is basically a monitoring tool. We heard this morning that the importance of tracking achievement of treatment goals and really looking at progress in the quality of care and whether, youth or caregivers are making progress. The dashboard can be customized, it can be used to document session activities, track client progress and do clinical supervision.

Now, some of you may be thinking, “Wait, we’ve been there before.” If you’ve been to graduate school of social work and knew about single subject designs, and we used to plot things and try to figure out what was going on. The difference here is that it’s a more sophisticated model, but also, you have elements which you can more clearly match up to the needs of children and families that you are providing services to and you can then track what happens in terms of change with those elements. In some manualized interventions, if you’ve done that session, you move on to the next session even though you are not really sure there was any benefit or any change that occurred. And this PracticeWise, the clinical dashboard function allows you to look to try to figure out how corresponding your intervention is with the changes, the improvements hopefully in client outcomes. And here is what that looks like. The top purple line or blue line is the Youth CDI score for example. The pink line is days attending school and you can see as depression goes down, days attending school goes up as you would hope it will.

You can see down in the left hand side that these are some of the interventions, for example, activity selection helping youth to pick activities that will help them overcome their depression because they activate them to go out and get rewarded by the world rather than sit back and experience reward deprivation which is associated with depression. Okay.

So, I am going to stop there in terms of talking about common elements. Bethany is going to talk about this more and so will Michael. I want to talk about another aspect of clinical work which hasn’t been as well developed in child welfare and really hasn’t been used as much, called the common factors approach. And these two pieces together, we

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have written about in a paper that’s coming out soon in research on social practice. And I think that the folks, how many of you have heard of the common factors approach, Duncan and colleagues, Wampold and so on? A few of you. The basic idea is that this, to some extent, these two directions, evidence based manualized treatments and common factors have been orthogonal. The common factors group came out of the old psychotherapy research that basically said, anybody who listens carefully and develops a good relationship and said something credible, even if it’s a faculty member or a paraprofessional or anything else can have an effect on clients. The evidence based practice literature is saying, you have to have much more specific interventions than that. It’s not primarily about the relationships – relationship is important, but it’s not primarily about that.

So, to try to put these two areas together is a big risky. But I think that there are some things that they really have in common and that are worthwhile to consider in thinking through what our interventions might look like if we’re going to try to realize the vision that Bryan Samuels gave us this morning.

So, their argument is that effective therapy rises from allegiance to a treatment model, monitoring of change and creating a strong therapeutic alliance. And the treatment model is not so important as long as it is coherent and convincing and gets people to try something different. Very important to this is feedback from clients on their level of functioning, feedback to therapists on the therapeutic alliance. So feedback is critically important. And those of you who work in child welfare know I think how little we actually get feedback from our clients. And then as I mentioned, the importance of coherent treatment approach.

So part of this also is this notion of practice based evidence and the practice based evidence, in this case, is the feedback from the clients as you are practicing about how they are experiencing the work you are doing and what kind of progress they are making. And there is some data that suggests that this systematic feedback addresses the dropout problem. There are a couple of small randomized clinical trials that indicate that people do stay in treatment longer. Both couples and individual, in this case, young adults. And also, helps with the treatment outcomes as well as adherence as a result of getting this kind of measurement feedback. A couple of the tools they use are very simple. They score them and interpret them collaboratively with the clients. And the client actually explains the meaning behind the scales, what they are marking on the scale. So this is a scale for adults. It’s not complicated. There are four things you score, looking back over the last week including today, help us understand how you can feel it.

So this is their outcome measurement. It’s not to be psychometrically tight, but to contribute to the conversation and to engage the client and expressing how they are experiencing themselves and also how they are experiencing the treatment. Are they talking about goals and topics and developing relationships in the way that they want to? There are some preliminary work that’s being done. It’s not as well developed on a children’s rating scale that is, Jacqueline Sparks has been taking the lead on, doing wrap around services. So that’s another part of this model which is that for children and young

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adults, also, working to engage them and talking about their adherence treatment and how they are experiencing the changes in their own outcome. So, arguably a common dimension of both the common elements approach and the common factors approach are these measurement feedback systems that help you to actually keep up to speed with the intervention you’re delivering and the way it’s being experienced by your clients.

And this is way too much information for one slide. But just to say that there are other people like Len Bickman at Vanderbilt who is working on this as well. I think there is always going to be a tipping point between how much data you can really collect from clients and analyze in the circumstances you are in, but to do nothing and not to collect any information about whether people are interested in coming back, whether they feel like they are getting some benefit, and what their relationship is with you, I think the evidence is now tipped to the direction that that’s not an acceptable strategy. I don’t know how this measurement feedback work is going to go, but I think it’s very critical that we find ways to incorporate it into child welfare services.

There is just one RCT with, aside from a couple that have been done on the college campus, doing college student counseling. There is just one RCT that shows that when you include these methods, you actually get better results and this is couples, a study on couples counseling that was done in Norway and reported out in *Journal of Consulting and Clinical Psychology*. So it’s still early. This work is still early. In terms of it going beyond just med analyses and other sort of studies and association of actually testing these tools in practice, but I think we will see more of this testing and I wouldn’t be surprised if we don’t find some results. We have some of these measurement feedback tools in our own work, in multi-dimensional treatment foster care and keep, where you get foster parents who we’re working with to give us feedback. So, on a daily basis, using parent daily reports. So it isn’t that unusual that we are getting this kind of, it’s not unheard of that we are getting this kind of feedback in child welfare services. But it just hasn’t been very common.

The other thing of course that we spend a lot of time talking about in your field are practice frameworks, and I don’t want to ignore those. These are ones that you are working on in your counties or states or you have helped counties or states to evaluate, safety, family focus, youth impairment systems of care, cultural responsiveness. They are at such a high level though that unless in my view, unless we really figure out what are the common elements of practice and what are some of the common ways that we can employ this common factors notion and get a measurement feedback that they really can’t guide practice effectively. And many of us have worked in agencies where everybody could quote what the practice model was or practice framework. But there was no – or they quote what the practice framework was, but there was really no good practice model.

Clarity about policy, priority is of course an essential element of effective child welfare service practice. So thank you for giving me the chance to at least quickly and broadly introduce the notion of common factors. And before that common elements, I will take a couple of questions now. And then, Dori, how am I doing on time?

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Host: You are at time for...

Richard P. Barth: Okay. So, I will take one question, and here is my chair’s priority.

Host: Any questions and observations. Okay. That’s it. And then, it’s my pleasure to introduce Michael Lindsey, our second speaker.

Michael A. Lindsey: Hi, good afternoon everyone. Hi, good excited. And also last – maybe one of the last sessions in the afternoon. So anyway, we are excited about some work that we are doing to actually take the common elements approach and apply it to some traditional things that we think about in social work practice. And one area is engagement, treatment engagement. And I want to acknowledge that our colleague’s here, Kim is in the audience as well.

So there has been a fair connection or relationship between the University of Maryland School of Social Work and PracticeWise for a few years now. One way in which this relationship has manifested is through the Common Elements Training Academy. I don’t know how many folks here have been involved in that or know folks from your institutions that may have been involved in that. For the last few summers, I think 2009 and 2010, faculty from around the country have convened at UCLA to learn about the common elements framework and the perspective with the goal of taking it back to the universities and either doing a course work around it or use it in field instructions. So, thanks to our Dean and his vision around that along with Bruce Chorpita and colleagues at PracticeWise really trying to sort of make the common elements perspective known to schools of social work around the country.

In Maryland, we had an opportunity to kind of look at, again some critical practices in social work via a Center for Medicaid and Medicaid Services waiver. Lot of states around the country are experiencing issues in terms of kids using high end mental health services. And so with those dollars, what the goal has been and is to sort of think about or implement evidence-based practices that would mitigate the extent to which kids and their families are involved in high-end mental health services. And so, with that funding we’ve been looking at, in Maryland, we had that very issue. And we’ve been looking at ways to train our staff or folks who work in high-end mental health settings or even before kids get to that setting and to try to really curb that tide of kids being involved in those services. And so, we’ve been looking at treatment engagement and will soon start to look at placement prevention as a way to curb that tie. And so, one of our goals then is to train practitioners in common elements with respect to treatment engagement and placement prevention.

These will be social work educators and field faculty. We have a current project doing in-home mental health services, which would be another outlet. And also, we have a nice relationship with a school mental health center at the University of Maryland where practitioners are in schools providing mental health services. And so, these are some of the sort of practitioners we hope to train in some of these elements. And then ultimately,

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what we want to do is to compare the implementation outcomes as well as treatment outcomes for those faculty or those practitioners who are trained in the common elements perspective and particularly these two areas of treatment engagement and placement prevention versus those who are not.

So, treatment engagement is a huge issue in child mental health services. The majority of youth in need do not actually receive treatment. And early termination is likely. The Surgeon General’s report, the New Freedom – President Freedom Commission under the Bush administration, clearly documents this. Ethnic minority children and those most in need tend to be underserved. And a nice review by [indiscernible] [0:26:10] really described what underserved means. It means that there is an identified disorder, but there is no receipt of service. Or if there is a receipt of service, it may not be scientifically supportive in terms of meeting the mental health needs of underserved families. And so that’s a huge issue.

There are significant public health implications in terms of the long-term trajectory of kids who do not receive mental health services. And we all know those issues well because we are on the front lines trying to fight them everyday.

There is an importance of engagement in child welfare services we believe. Of course, child welfare service workers regularly refer kids to mental health services. Parent training is an important initiative in child welfare. But there is not always a sense that parents are being engaged in both training, prevention or training, parent training programs or since that kids actually or families are actually being connected to services once they are referred by child welfare workers. And so, how best to engage caregivers in parent training and mental health services remains an elusive goal. There is an important study or a conceptual paper that came out in 2006 by Molly Stott, who really helped conceptualize where we are in terms of engagement. The literature can be all over the place as you will see when I sort of talk about some of our work. And so, she really laid out the importance of the fact that – when we talk about engagement, we could mean an attitudinal dimension of engagement, which gets at – to perceive relevance of services, cognitions and attitudes or beliefs about treatment as well as behavioral dimensions of engagement which is the actual attendance.

And so, individually, they both impact outcomes in terms of services, regular service participation, et cetera. But attitudinal dimensions also can be precursor to the behavioral dimensions. And so, if a person doesn’t perceive the services as being relevant, then they are not going to engage in the behavior to actually be involved positively in services. And so, this perspective is really important because it helped to sort of crystallize where we were in terms of the engagement literature and what the important dimensions of engagement were.

There have been some really important literature reviews and systematic reviews over the last six years, four in particular which helped to sort of frame our work around engagement really highlighting the important dimensions in terms of practice elements. They all talked about the dimensions of the attitudinal and behavioral perspectives of

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engagement. And so, some themes that came out of those reviews are that the outcomes and methods and terms of engagement are, they are very wily. They’re really all over the place. And so, the engagement strategies tended to have theoretical support, but not a lot of empirical support. And they may have been connected to known interventions, but the specific features of that engagement dimension of the work weren’t really sort of highlighted or we didn’t know exactly sort of what impact the engagement intervention had. So, for example, the Incredible Years is an intervention that has some elements of engagement. Or even MST, they talk about engagement as being an important feature in terms of some of those interventions, but again, the unique features of engagement haven’t always been well described.

So, that brings us to our rationale for while we thought that we would sort of tackle this issue of treatment engagement, and they really apply the common elements perspective.

The treatment engagement strategies haven’t always been clear. So, we don’t really know exactly what folks have been doing to engage and how those engagement strategies have been connected to outcomes. Again, the delineation between behavioral and attitudinal dimensions hasn’t really been well described and well featured in, in the literature. And in the engagement strategies, in terms of how they connect to outcomes, beyond initial session attendance, which is one of the engagement outcomes that has been primarily featured in a literature, but we really wanted to know beyond that how does engagement impact ongoing serve issues and how folks looked at some of these attitudinal dimensions and sort of thought about how they are related to serve issue participation and outcomes. And then a big issue is that we really don’t know how engagement is impacting child mental outcomes with child functioning. It’s really been around sort of looking at how, again, how best to engage folks in the initial session attendance, and then that’s been it.

But we really don’t know how does engagement and treatment really lead to outcomes. And so, we hope that through our study and our research that we would begin to document that and contribute to the literature in an area that really, there is just a dearth of knowledge.

So, and our baseline in terms of how we identified the initial treatment engagement practice elements, we developed the initial list of some of these engagement strategies. And we were very fortunate, again, to have reviews that sort of outline what the important engagement strategies have been in the literature, Westman Found [phonetic] [32:28] and RCTs and other levels of evidence. So we developed this initial list. Then we looked at those same reviews and used other sources to develop definitions for each of these engagement strategies. I think we ended up with an initial list of about 24-25 practice elements for engagement. Then we were fortunate to share this list with engagement experts from around the country.

These are folks that we know that readily do engagement research. They have published systematic reviews or they are involved in evidence based trials with engagement interventions. And so, we wanted to get a sense of where we hit in the target in terms of

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our initial indication of what engagement and practice elements would be. And then if we were missing, obviously, they would help us to think about some other things that we could perhaps add to our initial list, but then to help us to revise the definitions.

We also, PracticeWise quotes engagement as a practice element. And so, there were some literature and some work done with respect to PracticeWise already around engagement. But we also wanted to look at other elements that are quoted in PracticeWise that perhaps was synonymous with our list of initial practice elements. And so, what we were endeavoring to do was to create this comprehensive list to look at what our initial baseline or starting point is in terms of what strategies were already out there. So then, in terms of organizing our coding sheets, we found that there were sort of overall protocol codes, there were style codes in terms of how folks define what they did with respect to engagement, then there were the practice elements. So a protocol code would be something like brief strategic family therapy, Dr. Murray McKay’s intervention around engagement families and treatment and motivational interviewing. So those were our overall protocol codes. Then we had style codes where in the literature, folks said that we also engaged families who have to be – you have to exhibit warmth or you have to have a collaborative strategy. And so, we again identified some style codes that were prominent that we would sort of call for, and then the practice elements.

And so, basically, sort of I wish I had a coded sheet to show you, when we went through each of the articles, we were quoting for whether or not they use a protocol code, and one of these lines described here, what was the style code and then the actual practice elements.

So, in terms of how we identify potential articles, we started with the data base search, and we used the search terms, engagement, attrition, retention, and we combined that with mental health services. And then we also sort of closed our search around children’s mental health services. So, the age range was from I think 0 to 17. And that netted us an initial list of about 93 articles. And then we sort of looked at those articles to determine which ones were RCTs and I will talk about some of our inclusion criteria in a second.

We also scanned some of those articles to look to see whether or not we were actually hidden on target with some of our search words. And then if they presented words that we hadn’t really thought about that may be related to engagement, we’d sort of refine our search.

For the articles that we found, the RCTs, we did a backward search where we looked at in their reference list, how many RCTs that they cite. When we found an article, we also did a 4 search to see how many times that article was cited. And then we went back to our experts in the field to sort of give them a sense of the articles that we found and whether or not we had missed any. So, this gives you a sense of just how comprehensive we try to be in terms of the articles we identify. So that netted us about 35 RCTs that had engagement as an outcome and engagement as an intervention. So, we were looking for, again, RCTs, they had to employ some kind of engagement strategy and an outcome as a measure and had to pertain to child mental health. So the articles range from 1975 in

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terms of their years of publication to 2010. Most commonly, externalize and behavioral problems was the issue, the mental health issue, for which the family was seeking treatment.

And it primarily was in clinic settings. In terms of our coders, four members of our team actually did the coding. For each articles two persons actually coded it and then we have a supercoder which Kim Becker has trained with Bruce Chorpita, has done a lot of the training herself in terms of common elements, and so, and done a lot of the coding. So what Kim would do then is to review each article with us to handle any discrepancies with the two reviews, and then decide on a final code for each of the articles.

So, this is hot off the presses. We were able to thus far code about 27 articles, and I did 35 and here are some of the results.

There were about 62 different engagement interventions coded. And then the findings that I will talk about in a few seconds indicates that top three to four protocols, style codes and treatment engagement practice elements used. And then we have the percent of treatment engagement outcomes assessed.

So, attendance was a very common measure across the RCTs. 26 of the 27 studies had some measure of attendance, the child’s functioning or child’s mental health symptoms were in about 22% of the studies as well as 22% were on the client’s role socialization. So understanding the process of therapy and whether or not that intervening upon that would improve service participation.

So, Murray McKay in term of engagement protocol, Murray McKay’s protocol was most commonly used followed by brief strategic family therapy and motivational interviewing and I am not sure how many are familiar with any of these. I am very happy to share the literature and articles on some of those protocols. In terms of style codes, Task-oriented was the most common style code. And so, basically that would be where clients were sent a letter or a telephone call directing them to the time and the place of services, etcetera. Empathic followed by person oriented. And the least coded were collaborative expert and value too.

So in terms of the most frequently used practice elements, psycho education of services was the most frequently used followed by appointment reminders, discussion on resolution of various treatment and goal setting. In terms of the frequency of outcomes, again attendance was measured as an outcome in about 87% of the studies that we coded followed by symptoms of functioning in terms of child mental health and an ecology which was an engagement strategy that sought to improve the family’s environment. So by virtue of using services or being engagement services, their families have a better sort of family environment.

So where we are at this point in terms of just kind of reflecting upon what we’ve done is that most of the studies have, or RCTs have employed some type of an intervention to affect behavioral dimensions of engagement. We know very little about attitudinal

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dimensions. And again, attitudinal dimensions may play a very important role in terms of influencing behavior, but less is known about that.

The research has been primarily in mental health treatment services. And so, we know very little about engagement as it relates to prevention of mental health or prevention interventions in terms of mental health services or other sectors like child welfare. Also, what is known about engagement is primarily from the perspective of engaging caregivers. So the impact of engagement interventions on children for adolescents is virtually void in the literature. We don’t know much about it at all. In fact in terms of some engagement work, in terms of employing our motivational interviewing strategies, most of that literature has been done in substance abuse in terms of engaging substance abusing adolescence and treatment. But again in terms of a mental health outcome and mental health services, virtually nothing is out there in terms of engaging children and adolescents.

So for us, our next steps are to really sort of go back to our analyses and look at how engagement is really going to influence in service participation. And I think a very critical, critical, critical point for us is to really look at how engagement is influencing child mental health outcomes and child functioning. So what we should be able to do is determine the most efficacious treatment engagement elements and their relative effect size which is part of the framework that common elements has really employed in terms of the evidence based treatment in terms of child mental health. And so we are sort of using that same strategy with respect to treatment engagement. New directions or next directions in child welfare services. I think that just as we are pursuing a training implementation and evaluation agenda, with respect to child mental health, I think that this sort of an agenda around treatment engagement can also inform child welfare services and in particular programs or interventions that target parent training, etcetera.

And so, I think that there is a really critical opportunity to use its work in child welfare. I think just thinking about engagement in child welfare, some of the critical challenges at this point is sort of the different presenting circumstances might require different engagement strategies. So for example, to use a child mental health perspective to highlight this point, what might be different in terms of engaging a kid who has an externalize – or a family with a child that has externalizing behavioral problem versus a family with a child with an internalizing behavioral problem. And so, I think in child welfare, again, what we might do as per engagement, strategies may differ based on the presenting circumstances.

And then I think that we can build upon what we already know in schools of social work, in our text books, in our practice, we do a lot to stop where the client is, and we do a lot to sort of engage practitioner, I mean to engage families as practitioners. But in terms of the empirical support, I think that we have an agenda around sort of documenting the empirical support for some of the things that we do. I want to acknowledge our funding that made this work really possible as well as Dr. Bruce Chorpita and Eric Daleiden at PracticeWise who continually give us feedback and help us with thinking about next steps. And then our engagement research experts who are from the universities listed and

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have been really instrumental in helping us to thinking about things that we may be missing and walking with us along the way to give us feedback on how these things really impact their work. Thank you.

Bethany Lee: Hey good morning. So, my name is Bethany Lee and I am going to tie this together and thinking about – Rice gave you a little bit of an overview about what the common elements in this framework and approach involve. Michael talked about his application to engagement and I am going to try to build the bridge and hope to get some help from you all as well to think about how does this actually look or work within a child welfare setting. So thinking about most of this work comes from child mental health, how can we apply it and how do we start making inroads of this kind of approach within the child welfare system? So, we’ve done a lot bit of thinking about this. But you all probably have some great ideas as well. So I am hoping to talk quickly enough to not lose you, but to leave time for some of your comments and ideas as well. So that’s what we will go from, from here. So I am going to talk a little bit about the fit or the misfit of this idea and how it would work within child welfare of what parts make us really excited and think there is definitely some implications for child welfare and other pieces that make us think it’s going to be a little tricky to maneuver that. And I will leave that out.

We’ve got a couple ideas that we are already thinking about of how do we actually go about implementing this within child welfare. So I will introduce a couple of those pathways that we have come up with just in our thinking about this and talk about kind of implementing the broader framework as well as just the practice elements. So I am going to present some ideas, but certainly hope that we’ve got some time for discussion to get some of our ideas as well.

So, essentially this idea about the common elements again, they come from the child mental health literature. And we do see some parallels for child welfare and child mental health, certainly within child welfare, we’ve got interventions and those interventions have some building blocks or some pieces that we hope to see across different types of models of things. We can think of, for example, team decision making or a family group conferencing or family group decision making. There is pieces of those interventions that are the same, no matter which of those models you’re using. So, certainly, there are some building blocks in common even in interventions we use or models that we use in child welfare. Oftentimes, as child welfare workers, we don’t have the 12 or 18 weeks to work with a family or a client that is required for treatment manuals. And so, by using just those practice elements or those building blocks, that maybe fits better with some of our short-term or time-limited interactions with families. And so that might be a good fit in that regards.

And just this struggle that we’ve had as a service system that many other public systems have had as well in regards to how do we take these evidence based practices and actually go about implementing them with the complex comorbid families and systems that we work with them. So, some of the areas where maybe this isn’t quite the best fit or trying to put the square pencil in the round hole is this idea that most of these come from the child mental health world and certainly mental health is important to child welfare

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workers. We deal with the parent mental health as well as the kid mental health, but we do a lot of the things beyond just mental health too. So this isn’t just going to be comprehensive enough for all the types of things that workers need to do. Also the common elements as they are currently arranged are really organized by mental health diagnosis or problem area. And we don’t usually think about families or the kids that we serve in that same kind of framework. Certainly the DSM is important to us. But doesn’t really guide how we decide our units for example of practice or anything else. So there isn’t a perfect fit either. One of the ways that the common elements have been developed, and Rick talked about this, they had hundreds of these randomized control trials from which to build this evidence. We would love to have that in child welfare, but we certainly don’t have these numbers of really strong well rigorous developed clinical studies or research evidence from which to pull some of this.

So we are not operating from quite the same starting point that child mental health was able to do. So having said that, we have thought about where we actually are at and going with the idea of meeting the client where we’re at. Are there ways based on where we currently are to still move forward in thinking about applying this common elements idea or these practice elements and identifying them for child welfare. So the first idea is these are two approaches that I will present, first thinking about how would we identify the common practice elements of child welfare practice? So currently, Bruce Chorpita and his colleagues have done a great job helping us think about those building blocks of child mental health interventions. But what would that look like for child welfare interventions?

And so, this is sort of our first simple strategy of how to start, it’s looking at what are the child welfare programs that have the most research evidence about them and then looking at what’s common across those. So we’ve got a number of different parenting programs, some of them have quite a bit of evidence supporting them. So we can look at what are the building blocks of those parenting programs for example that are common across and those could be common elements of parenting or parent management programs, for example.

So that’s one of the starts. That’s very similar to the way that the common elements was built of looking at what’s common across how we treat depression or how we treat anxiety of what’s known of some of those manualized supported treatments. So the idea would be perhaps we could identify the relevant effective programs maybe using the California Evidence Based Clearinghouse, Rick Barth introduced that this morning if you are at the plenary of just what, that’s a helpful website to kind of catalog how much evidence is supporting different types of programs and using that same group work of looking at what earned a 1 or 2 on that scientific rating and then looking at what’s common across some of those pieces and then certainly to train and implement those elements.

So this again is a slide very similar to what Rick showed this morning of the clearinghouse scientific ratings scale looking at from the one of the effective practice where there is at least two randomized control trials done by two different PIs or in two

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different settings, all the way down to the five or six of the concerning practice or not very much evidence to support. So if you focus on that high end of the 1s and 2s where we know there is some research evidence there, we can look at those programs and then maybe start there of thinking about how do we look for common elements. There is also this piece that Rick mentioned also this morning about relevance to child welfare services. So we would want to focus on those interventions that had the most relevance again as a possible starting point. So here are some of the topics that are currently on the California Evidence Based Clearinghouse if you’re not familiar with it. And they cover quite a broad range of things, probably things that are done in every child welfare setting and some that maybe are less common or things that more of our private providers actually deliver within our child welfare populations.

And so one of the big questions is with all these different choices of starting points, where do we actually start when we are thinking about which program do we start with or which kinds of problem areas or practice areas do you want to begin with. And so a couple of our ideas is, well we can start with what’s most relevant to child welfare goals. So looking at what are the programs that support safety, what are the programs that promote permanency or well being. That’s one way to start. We can look at child welfare activities of greatest interest. So certainly there’s probably things that are more important or more relevant to individual settings to different administrators or looking at what’s more frequent in the life of what a child welfare worker actually does everyday and starting from there. So lots of different starting points are possible with this kind of approach.

So thinking about what’s of greatest interest is this, according to the California Clearinghouse, they talked with their directors and managers in California and these are the kinds of thing that they identified of, we’d really like to know more about what’s effective price in these areas. So these are some potential candidates for places to start if we are willing to identify some common practice elements.

Also, we came up with this list of just what we think child welfare workers do most frequently or what’s most common on the job description of what child welfare workers are doing of some things that could also be possible starting points of looking for some of these common practices across systems. We can see that engagement is here of family involvement, similar to what Michael Lindsey talked about. These are the projects that we are currently working on, another piece of what Michael didn’t talk about that we are just beginning is looking at placement prevention. What are the current programs in their evidence for placement prevention and can we identify some common elements of ways to promote keeping kids safely in their homes when they are at risk for placement.

And then we’ve also got a number of practices that already have a strong level of evidence, so that are rated as a 1 or 2 on that scientific rating scale. And so these could be also potential places to start of where we know that there is quite a bit of evidence backing this up and we can look at what’s common across them. So some of these maybe have less immediate relevance to large swathe of our child welfare population, but this is

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maybe where most of the evidence is at using the California Clearinghouse at least. So lots of different options as far as starting points that could be considered in this process.

So, we also have a different strategy. So, the first strategy was really looking at where is the evidence then starting from that. And this strategy says instead of starting with the evidence of actually starting with what the practices are. So, looking at these different starting points as far as programs that are most relevant or practices that are most common or things of greatest interest and then actually instead of going to the evidence of looking at from those programs, looking at common elements, so not just the programs with the most evidence or just from the research evidence, but also including other sources of evidence similar to what was discussed this morning of, from program evaluation, from the grade literature, from other places that aren’t just the RCTs that are so rare, and not so easy to conduct in most child welfare settings.

So we could then pull from all the literatures all the types of programs known for reaching each of these goals, and then looking at what are the common interventions across that and then wed that with expert feedback. So when we’ve got this list that came together of just this is what people are doing, then we take that out to various experts within the research and practice communities to say, do we think this is the list of things that really would have worked because this is what people are doing a lot of. So that’s one of the ideas. Certainly, the evidence there takes a little bit backseat, and isn’t really the driving force. Hopefully that using the consensus and the expert feedback would help to balance that out a little bit, but certainly that’s one of the concerns of that approach. If you are familiar with Ann Garland, she actually did this kind of an approach looking at problem, disruptive behaviors and how those can be dealt with, so this might be a study of interest, if that’s of interest to you of looking at all these interventions that worked with disruptive behavior disorder, what did they commonly include and those core elements that she called them then were considered here is what should be part of, kind of our best practices for dealing with disruptive behavior.

So, certainly that’s a little bit easier of a starting point, because we’re not held back by the limitations of such little evidence or so few RCTs. But it does have the draw back of, we might end up having a list of things that don’t really shake out when we actually do go to study them because not starting with the evidence. So, that’s sort of the pros and cons of these two approaches that we have thought about as far as how do we take those first steps of identifying the common practice elements. So that’s piece of this common elements approach, but another piece of this and if you were in the earlier session that Kim and I were on a panel, Kim presented this idea of the common elements as being sort of a broader framework about how we make decisions within practice. And so, this is an idea that I want to talk about too, maybe we could have the practice elements, but there is also this larger framework, either with or without practice elements of how we manage and adapt our practice or how we use our clinical decision making and improve sort of how Kim put it was sort of the floor of practice or the usual care to improve the quality of that by really thinking through with data, tracking outcomes monitoring, using the clinical dashboard of how we can do a better job with the services that we deliver. So essentially using evidence is not just evidence from the published literature or peer-

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reviewed literature, but even just from what we’re observing of our clients’ progress and using that to really inform our practice or drive the decisions we make and what we do next with a client or a family.

So these are some decision and practice support tools that are part of PracticeWise. Rick introduced a few of these. So, again they are clinical dashboard, I think he had this same slide or one very similar to that. This is one way to think about the – using the common elements approach within child welfare setting, so a worker that meets regularly with the family, could check in on various outcome measures that were relevant or important to be tracking and then having some – these are the practice elements for child mental health here on the bottom, but there is places for your own widened elements as well of things that you want to be tracking that you’ve given the families as homework assignments or other things that you want to see them during the week. Also, this idea of – when we talk about fidelity within the common elements, we are thinking less about fidelity to the specific element itself, but just to this idea of how we are managing and adapting our practice. So are we selecting the kinds of interventions that meet the client needs and are we being responsive to how the clients are, accepting those interventions or improving or not improving based on them and changing our practice as part of that?

So, this is sort of those overarching principles that we can also think about integrating whether we’ve got practice elements or child welfare or even without those practice elements of thinking about how we actually deliver practice and how we integrate data from our clients or from what we’re seeing to improve the quality of care. So, if we are trying something and we are seeing some progress, then that encourages us that we are maybe on the right track, if we are using an intervention or working with the family in a certain way that’s not making that change of really thinking about what else should I be trying or how else could I look at this problem differently. So we’ve been just using that data-driven approach, gets us closer to incorporating this common elements framework. So, essentially those are our ideas.

But I will open the floor or comments or other ideas that you might have. These are just three of the ways that we can think about infusing common elements approach in child welfare of what that might look like. So maybe starting from some of those programs that we do know that we’re using in child welfare, that do have some evidence and trying to figure out some commonalities across those, of those common building blocks, or just starting with what we’re currently doing, the common programs that are out there and then wedding some of those building blocks with experts or even just this idea of thinking about ways we can better use data at a single system design level on a very basic level as we work with clients to track the choices that we make in our own clinical decision making.

But I am open to your questions or if you’ve got other suggestions for us, we’d certainly be eager to hear your thoughts on how we can move this forward. Any ideas or questions.

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Well, I will turn this over then to Ginny Strand. She is going to talk about some of the great work that they’ve been doing with trauma. And certainly trauma is a key theme of this conference and something that Bryan Samuels talked about this morning. So maybe that will help further generate ideas about this approach.

Virginia Strand: Hi, everyone. First of all, I want to thank Rick and folks at the University of Maryland for inviting me to participate with them in this work and in this presentation and let me see if I can pull up what I wanted to focus on. Yep. Yes. There it is. There we go. Okay. First of all, let me just say that I am coming at this from a slightly different perspective. And first of all, I am only going to talk about the common elements work in reference to preparing social workers for both child welfare and mental health practice because most of what I’ve been involved with is at the graduate school level. The second thing I want to say is that I’ve had the privilege of being part of, in this work, a very large network of people at the National Child Traumatic Stress Network which, as some of you know, has about 60 centers around the country now which are now funded. And I am the Co-Director of one of those centers. It’s called the National Center for Social Work Trauma Education and Workforce Development which what Fordham is doing with Hunter. So I am part of the network and I am sort of coming from that perspective. And the reason that’s important to know is that the National Child Traumatic Stress Network began a curriculum project on developing a core curriculum for child trauma four years ago. And part of what I’m going to talk about really is, comes out of that work and is reflective of work that’s still continuing. So it’s very much based within that trauma frame.

The first thing I want to let you know about is that our core curriculum has three components which sort of go along with Rick’s – some of Rick’s early slide. But we conceptualized our curriculum as having core concepts, core treatment components which include practice elements and then core skills. And the first thing I am going to talk about is the development of the core concepts part of the curriculum which has been turned into a graduate school course, school as a social work and delivered now at a number of schools across the country. And then the second thing I am going to talk about is our approach also working with Bruce Chorpita’s lab to identify core intervention objectives and practice elements, okay. So, the critical thing about the core concepts portion of the course is really that this distills knowledge that was developed by an expert consensus panel. So that’s how initially we arrived at 12 core concepts. And the critical thing about these core concepts is that they really provide a framework for understanding the impact of trauma on children, whether you are working with children as a mental health provider, or as a child welfare practitioner.

That’s the aim of this part of the curriculum is to take those 12 core concepts which I guess are some ways, they are part of practice principles, I guess, one could almost say. And but they are relevant to child trauma. And then using a case-based and evidence and problem-based methodology, we turn this into a course for both mental health and child welfare, we have two different courses. So the one I am going to tell you about is the course that was delivered in five schools of social work, just this past year, where schools were specifically preparing MSWs for child welfare practice. Okay, so that was the

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audience. And you will see that we had some really significance in self-confidence reports which are – self reports which was very nice to see. But let me tell you a little bit more, again. First of all, I know it’s very dense, but these 12 core concepts. This is like the first, this is just a summary of a much larger elaboration of each core concept. But and the ones I wanted to bring your attention is number 5, because I will talk about that later, which is a danger in safety or core concerns in the lives of traumatized children. And what that refers to is really, one of the things that Bryan Samuels was talking about this morning, which is the impact of trauma on the brain. And the constant ways in which traumatized children are triggered in their daily experience in ways that lead them to look like they are acting unprovoked impulsively, but it really has to do with their ongoing need to ward off perceived danger, which comes from this early traumatizing experience, which has impact the brain. So you will see later how they get highlight. Just a little bit about the course of the 105 students that were in these five schools. We had an 80% response rate on the match pre-post. This is our breakdown by gender and race and ethnicity of students in the course. They really liked the case-based material. And any of you who talk from a problem-based learning approach know that this is very different way of teaching, because the whole course is organized around five cases that span 18 months to 14 years, different trauma types, different points in the child welfare system. Sometimes, the case is being seen at intake or at the point of our report. On other times, the case is being seen when the child is in foster care, and other times, the case is being seen when the child is in, when the family had been referred for preventive services. So there is a range of trauma types points in the child welfare system, race and ethnicity and age in these cases. And the students respond very positively.

What we did find that the core concepts provided a useful framework, and when there were students who were in the course who were not either in child welfare placements or maybe were not looking particularly to go into child welfare, their lack of knowledge about the child welfare system, faculty had to compensate because that was really critical to understand. So here is our gender breakdown, our race and ethnicity. And here is our, by item, how our – the self confidence increased. And we had a 9-point scale. So the mean went from 4-point something to 7-point something, which was very significant.

And one of the things it shows you is that at the beginning of the course, if you have a four – a 9-point scale, so anything under 4.5 is below the mean. And basically, you look at where they were on the different items, most of them are below the mean. And these items respond to the 12 core concepts, we turn them into the objectives for the course. So it reflects their increase in self confidence on those – around the 12 core concepts. And I will tell you the one that they had the least confidence about coming in, and we did the least well in racing, although the difference is probably the same, was their understanding of the impact of trauma on the brain and why that – understanding how triggers work, was so important for anybody working with traumatized children. And that was a low self-confidence coming in and definitely increased, but not as – it wasn’t as high as some of the others. Now, for the second part of our course, so we have this curriculum. And at our center, we’ve adapted this for social work education, throughout the National Child Traumatic Stress Network, this content is being delivered in other formats, like in in-service training.

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We also had the intention of adding to the core concepts by looking for core components which we conceptualize as common intervention objectives and common practice elements. Now, one of the things I should tell you is very important actually to our thinking is that we were developing at the national center a core curriculum of this nature because we felt that practitioners in agencies needed a core understanding of trauma before they learned specific evidence based trauma treatments. And we also felt in MSW education that students could benefit from a foundational knowledge course in trauma, before they went into whatever practice arena they were going to go into. But our goal or our intent has always been to sort of provide a foundational level about trauma. And we have not abandoned our interest in disseminating as a network evidence based trauma treatments, thinking about evidence based as a noun, particular trauma treatments. I will say that what we do in the course is very much around the idea of promoting evidence based treatment as a verb that the problem-based learning approach and actually the whole course really focused on critical thinking, case conceptualization and not how to do it, at least the core concept part of the course.

So, for the next part of the curriculum, we thought rather than just gather together a panel of experts than do another expert consensus model, why don’t we do a content analysis of evidence based trauma treatments and see what is out there in terms of what people have written about in terms of their thinking about what good trauma treatment is. So, we made the decision to go with 26 empirically based trauma treatments. And these have varying degrees of evidence. In fact, we worked in consultation with Bruce Chorpita’s lab. And one of the things he encouraged us to do was really look broadly for trauma treatments in terms of their different evidence base. So we were really looking at manuals that would have had, not just the one and two in terms of evidence, but the three and even four as well. Okay? And it was a purpose of sample in that we kind of went with people who were willing to give us their manuals, who we could identify, okay. And this was our purpose. First we had to develop a coding manual. And because we did not – and when I say we, I mean the task force at the national network that is – have been working on this whole curriculum, the task force did not want to use the PracticeWise coding book, because the feeling was that if we use that, it would not sufficiently capture some of the intervention objectives and practice elements that we felt as those in the trauma field were critical. And I have to say to Bruce Chorpita’s credit, he was quite open to us developing our coding manual, which we did.

And then his team who have a lot of experience in coding manuals, and actually, he told us when we were out there kind of doing an orientation to our manual with his team, he told us that they have now coded 1300 manuals with varying luck. And the team that was working on our 26 which was about six or eight coders, between them, they had all done hundreds of manuals. So it was a very expert group in terms of knowing how to apply a manual. So that was very encouraging. And these are all definitions of what we meant by intervention objectives and what we meant by practice elements. And we had added in the intervention objectives to the practice element piece. And he was – their team was very open to doing that. So we first developed the coding manual which was no small, project, it involved three of us reading in its entirety eight manuals, which read eight,

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three of us read, one that read eight. And then we consulted and refined and revised the codes until we ended up with a code book that had about 35 intervention objectives and about 60 practice elements. Bruce and his team had advised us not to go over 60 with the practice elements. He said that’s about all our team can handle. So we did a training on orientation with his coding team. Then over the summer, the lab analyzed the 26 manuals.

And I am going to talk a little bit about what the results are now. But I want to – I am going to put them into – it’s too hard to talk about this, but 35 intervention objectives and 60 different practice elements. So we had had grouped them into sort of nine domains. Even after – even in the developing of the coding manual. And it was very interesting for me to hear your work on engagement because that was clearly a domain that was addressed in the manuals. And there are probably two or three intervention objectives and probably more like six or eight practice elements that make up that domain. So, it would be interesting at some point to maybe compare. So anyway, so these were the nine domains that went from assessment to an emphasis on safety, engagement, attachment and strengthening relationships. When we were doing the coding, developing the manual with the eight manuals that were a sub sample of the 26, we were really struck at least in those eight with the emphasis on attachment figures in the child’s life. And we had thought that many of these manuals might isolate the child or adolescent as an individual and sort of just be focused on what you do with the child in the office. But they weren’t at all. They were really focusing on the parent and child as a dyad on, even for children who were in residential care, there was either a great focus on the care providers in the residence or institution in the case of juvenile justice. Or some of you may know Richard Kagan’s work, Real Life Heroes, on finding an alternative caregiver so that the child had someone, a permanent attachment figure and then a lot of work done with that person.

So, that was a very important domain. What we called the core interventions, and you will see this in a minute are sort of the interventions that are almost universal across the trauma treatments that really have to do with helping children and adolescents and their caregivers address this phenomenon of the trauma triggering that results in behavioral, cognitive, physiological and affective dysregulation in the child’s life and so much of the trauma treatment really focuses on those core interventions. Prior to the trauma processing, and then in there, there is a lot of attention to the social context in terms of advocacy and case planning and collaboration, but before there, it’s almost – it’s not exactly a phase oriented model. But in many of the interventions, the work around core interventions was done prior to trauma processing and then attention to post trauma growth in the consolidation followed the trauma processing, although what you see is that some of the skills that people learned in the core intervention domain were then reused in trauma processing and in the consolidation phase.

So, here is what it looked like. And this is very preliminary findings because we are still in the process of – this is a very iterative approach of going back now to all the developers with our findings and saying, this is what was in your manual when it was published five years ago, three years ago. Is this what you would still see as your core intervention objectives and core practice elements? Would you revise, would you

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change, what would you do? So you can see that – so this is just a frequency count. So 25 of the 26 manuals were doing something around engagement. 26, all were doing the core interventions. Almost all were doing what we had quoted as trauma processing and a good number we’re doing, had some focus on post-trauma growth or consolidation as well as on the initial assessment. So this is just – it begins to give you an idea of across those 26 manuals, what seems to be the common intervention objectives? Now, having said that, there are differing numbers of intervention objectives that make up each domain. Okay? So I just wanted to go over a couple; safety, core treatment and trauma processing, just so you will see that the variety and the number. This is just intervention objectives. This isn’t practice elements.

So, if a manual talked about promoting safety, which has a definition in our coding manual or building routines and rituals for, usually for predictability, security, safety, or in some ways stabilizing the child or family, then they were coded as having an intervention objective for safety. And you will see that only say 15 actually had promote safety. But when you go back, so we only come up with about 16 overall that have one of them, which was surprising to us actually, when we looked across the 26.

Core intervention, we had many more – the core interventions were spelled out in terms of the number of variables that made up that domain. So we had, what, 1, 2, 3 – 6 there. So, the domains have different numbers of intervention objectives. And that’s something else we have to look at in the analysis. Our trauma processing only had two, promoting the understanding of connection between trauma and current experience, and process, specifically processing the memories. So, I just wanted to show you the distribution. This is now the 26 practice, the manuals with the 60 practice elements. And the profile is actually very similar to the intervention objectives. Okay, where you are getting a really common emphasis on engagement, the core interventions, trauma processing and post trauma growth. Okay.

So, just one, this how this works together, hopefully in the curriculum, we will have the core concept intervention objectives that can be teased out in the cases, practice elements that can be teased out in the cases that we present. And this is just an example with, we have the core concept number five, we have the intervention objective of promote safety, and then these are the practice elements. So hopefully, as we are teaching this, students would be able to differentiate. So my time is pretty much up. So let me stop there. And I had over...

Host: We have a few more minutes. I would like to bring the panel up just to answer questions. And let me just say one other thing, that probably some of you were saying, but do these evidence based components add up to an evidence based intervention? And that’s an empirical question certainly. But just in the practical world, as an example, Los Angeles had made a decision that they would not, and they were simplified just a bit, they would not continue to reimburse that full rate, mental health service providers who weren’t providing an evidence based practice. And the mental health service providers came back and said, but even if we did provide all these evidence based practices, it wouldn’t address all the kids that we need to serve, they don’t cover the universe of

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problems that we address. Couldn’t we do something like common elements? And the county agreed, and the common elements training has been going on ferociously in Los Angeles County as a result of that. So, this is – it’s not to suggest, and there is a randomized clinical trial that has compared a common elements approach with a more detailed protocol about how you match with the evidence based treatments themselves for depression, anxiety and conduct problems with the treatment as usual approach.

And although the findings haven’t been finally published, the article that’s been written and that’s under review pretty clearly demonstrates that this approach is at least as effective as using the manuals themselves, but as you can see, considerably more flexible. So, this is on the way in many different ways to becoming a alternative, if you will, although that’s not going to be an alternative that’s going to be satisfactory to everybody because it doesn’t yet meet the full sort of gold standard strategy of being tested in multiple RCTs. Did you have a question?

Audience: [question inaudible]

Richard P. Barth: Yeah. Well I think that the most – the way that they overlap the most is that they both use evidence from – information from the client to guide the process. And so they use, in one case, a clinical dashboard and the other case, these brief measures of adherence and outcome to guide the process. The big difference is that the common factors folks don’t have strong belief that what you do in terms of techniques or the elements of practice is so critical as to the common elements approach. But Jacqueline Katz, for example, is doing work around wrap-around services. So there is a model there, but unlike some conventional wrap-around service programs, it’s not Jacqueline Katz. It’s Jacqueline...

Virginia Strand: Sparks.

Richard P. Barth: Sparks. Thank you. But unlike some wrap around programs where they are not getting a lot of feedback from clients or kids on a regular basis about adherence and also how their, they feel the outcomes are going, those pieces are added to an existing model which, in that case, is wrap around services.

So that’s sort of how I see the integration of the two. A lot of attention has been whether the meta analyses that the common factors folks rely on are as good as the RCTs and all that. I mean it starts to put that aside and find something that’s more common. That’s how I see it.

Audience: [question inaudible]

Male Speaker: Well it sounds like in that context where there is sort of pressure to use both, that might be a good way to do it. And then to understanding over time whether it really is sufficient for clinicians to be developing their own sort of intervention to go along with the common factors, or whether some of these elements, whether they are

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trauma oriented, engagement oriented elements or other common elements are needed to get the outcomes that you are trying to achieve.

Virginia Strand: But even just using that or as soon as we looked at that dashboard that had the lines going across and what you mark at the bottom, even doing that or as outcome ratings scale or session ratings scale in each session would be one of those markers that you could kind of track over time to see how am I doing and the week that that number went up was the week I tried this component. And so maybe that’s what’s being helpful for this client. So I think some of that idea could work within that framework.

Bethany Lee: So I think they often get posed and discussed as sort of alternative ways of approaching, when really it can be viewed as complementary. There is a way to think about – actually the research shows that the common factors often are more important than in terms of contributing to outcome than any particular evidence based treatment.

Male Speaker: That’s where the research gets debated.

Bethany Lee: Debated, I know. But you know – I still think it’s possible to think about them as being complementary, although often it doesn’t get discussed that way. We talk about this on a little bit more detail in the paper. I think it came out in May, research and social work practice. Rick Barth was the lead author on that.

Male Speaker: But it’s still only online. Isn’t it? Do you have a hard copy?

Bethany Lee: I think it’s available. I will put out my email address, if you want to email me, I can send it to you if don’t have access to that.

Virginia Strand: The other thing that I say and we talk about sometimes is whether this issue of abandoning, trying to disseminate evidence based practices because of the resource issues and costs, whether that can’t – isn’t sometimes worth framing is a kind of a human rights question, which is that if in fact children and families are – if one of the rights is to the best available treatment, why aren’t we doing a better of disseminating evidence based treatments. Because I think you’re right. The common elements has emerged as an alternative because it’s very expensive to – or can be to train people in a variety. Any individual evidence based treatment probably does not meet the need for more than, say, 40% of any individual practitioners’ caseload. So there are a lot of issues around disseminating just evidence based treatment. But at the same time, if we have – I mean I was very impressed I have to tell you, by reading in detail eight of these evidence based treatments because it was very clear why they would work on certain clients with certain problems because they had just been so carefully, thoughtfully detailed, designed. And a lot of them or a couple of them that we read were clearly child welfare populations too, like Real Life Heroes or Arc. So...

Male Speaker: Any other questions...