

Evidence-Based Interventions

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Evidence-based practice is an emerging perspective in health care and social services. Many social services practices and mental health treatments are based on theory, tradition or trial-and-error practice rather than scientific outcome research (Chaffin & Friedrich, 2004).

What are “evidence-based treatments”? Criteria for evidenced-based treatments differ from agency to agency. Some typical criteria are:

- * The treatment has a sound theoretical basis;
- * A substantial literature indicates the treatment’s value with abused children, their parents, and/or their families;
- * The treatment is generally accepted as appropriate;
- * There is no indication that the treatment has substantial risks of harm;
- * There is written guidance on the components of the treatment or on the treatment protocol;
- * There are randomized, controlled, experimental studies that have found the treatment is efficacious (Office of Victims of Crime, 2002).

A large body of research supports the conclusion that psychotherapeutic treatments can result in large improvements in children’s functioning (Landsverk et al.,

2006). Further, treatment effects can be lasting and continue over time. However, all treatments are not equally effective (Landsverk et al., 2006).

A number of therapeutic approaches have empirical evidence to support their effective use with maltreated children. These approaches with research support are discussed below. According to a review by the Chadwick Center for Children and Families (the Kauffman report, 2004, see block this issue for how to access this report), there are three clear “front-runners” that are the most well-supported interventions. These are Trauma-Focused Cognitive Behavioral Therapy, Abuse-Focused Cognitive Behavioral Therapy, and Parent-Child Interaction Therapy.

Trauma-focused Cognitive Behavioral Therapy (TF-CBT) and Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)

Both TF-CBT and AF-CBT use cognitive behavioral therapy and principles in structuring treatment. Both treatments normalize the emotional and behavioral reactions of young children. Both attempt to change maladaptive behaviors by providing reinforcements (behavioral techniques). They also alter distorted perceptions through thought-stopping, challenging incorrect beliefs, correcting misperceptions, and replacing beliefs that maintain dysfunction with positive thinking strategies. Stress management skills and skills for emotional regulation such as deep breathing or relaxation are taught.

The TF-CBT model is clinic-based and short-term with results expected within 12 to 16 weeks. At least eight studies have documented improvements in PTSD symptoms, depression, anxiety, behavioral problems, and feelings of shame and mistrust. When parents are involved in the treatment, the positive effects for children are enhanced. According to a review by Chaffin & Friedrich (2004), TF-CBT meets criteria as a well-

supported treatment for sexually-abused children with traumatic stress symptoms and it is a clear choice for this population.

AF-CBT is delivered in an outpatient setting to physically abusive parents and their school-aged children. Treatment is brief (12 to 18 hours). The model incorporates family systems interventions by targeting individual child and parent characteristics as well as the larger family context. AF-CBT has led to decreases in parental anger and use of force and physical discipline and it increases family cohesion and reduces family conflict.

More information is available from: The Center for Traumatic Stress in Children and Adolescents at: www.pittsburghchildtrauma.com

Parent-Child Interaction Therapy (PCIT)

PCIT was originally created for oppositional children who have negative interactions with parents and do not comply with parent requests. The treatment focuses on establishing and strengthening the positive relationship between parent and child. Through “real-time” (live) coaching, parents are taught and encouraged to become more child-sensitive and child-focused. Treatment is brief (12 to 20 sessions).

The model has been adapted for physically abusive parents with children ages 4 to 12 years. There are two categories of studies. Some studies focus on children with behavioral problems whether or not there is a maltreatment history. These studies show improvements that are maintained three to six years after treatment ends for three-fourths of those treated. A second group of studies considers only children with abuse histories. These show that PCIT is effective in decreasing subsequent abuse reports, in lowering child behavior problems, reducing parental stress, and decreasing risk for future abuse.

Since PCIT has support for effectiveness with children who have behavior problems and with maltreated children, it is considered to have great potential for children in foster care because they often show overlap between both these groups. Recent randomized efficacy trial evidence suggests that PCIT can significantly reduce rates of future physically abusive behavior among parents who have been abusive in the past (Chaffin et al, 2004).

More information is available from: Child Study Laboratory Department of Clinical and Health Psychology, University of Florida, P.O. Box 10016, Gainesville, FL 32610 Email:

pcit@php.ufl.edu Web site: <http://pcit.php.ufl.edu/>

The American Psychological Association offers a DVD (ISBN978-1-4338-0126-6, Item # 4310814) about Parent-Child Interaction Therapy (List \$99.95, APA Member/Affiliate \$69.95). order by calling (800) 374-2721 or at www.apa.org/videos

Medication Management

Medication can be an effective adjunct to other therapies. Given the high numbers of children in foster care who have mental health diagnoses, one might expect that high numbers of children in foster care take psychotropic medication. One study in Los Angeles County (Zima et al., 1999) did find that higher numbers of foster children were receiving medication when compared to a statewide sample of children ages 5 to 14 enrolled in Medicaid. The children in foster care were three times more likely to be receiving medication. The authors caution, however, that the findings were not indicative of excessive medication use because the proportions of children in foster care with diagnoses such as ADHD and major depression were higher than for children in the general population. Youth in residential care showed even higher use of medication than did children in foster care, being twice as likely to receive medication (Breland-Noble et al., 2004).

A review of the efficacy and risks of medications for maltreated children is beyond the scope of this article. Those assisting children with abuse histories should make themselves aware of the medications that have been prescribed for children who they serve and become educated about the risks and benefits of the medications.

Therapeutic Day Care and Preschools

In these facilities, children may receive social skills training, modeling, nutrition, medical referrals, and a variety of therapies. Parents might also receive parent training, social support, and child development education. Maltreated children in therapeutic preschools show improved cognitive skills, increases in social competence, and better emotional regulation (studies cited in Wiggins, Fenichel & Mann, 2007).

While research is limited, one experimental study demonstrated that maltreated children who received therapeutic day care demonstrated better functioning 12 years later with respect to drug use, delinquency, and arrest for violent crime compared to maltreated children who received regular day care (Moore, Armsden & Gogerty, 1998 cited in Wiggins et al., 2007). Studies using non-experimental designs have shown positive gains in many areas (Wiggins et al.).

Multidimensional Treatment Foster Care (MTFC)

MTFC is a clinically-effective and cost-effective alternative to residential treatment facilities that combines the treatment technologies typically associated with more restrictive settings with nurturing family environments (Landsverk et al., 2006). Highly individualized and intensive treatment plans are created with input from screening assessments. Parents or foster parents are trained and receive ongoing consultation and support. Youth are provided with structured daily feedback and a point system. A youth

therapist and family therapist work with a psychiatrist and case manager to provide integrated service. Although MTFC was once an intervention used solely for teens, it has now been adopted for younger maltreated children with serious emotional, behavioral, and developmental problems.

Cost savings can be substantial if residential placement is avoided. Savings can amount to over \$20,000 per youth to over \$87,000 per youth (studies cited by Chamberlain, Leve, & DeGarmo, 2007). Chamberlain et al. completed a two-year followup study of 81 girls with serious and chronic delinquency comparing multidimensional treatment foster care to group care. Participation in the MTFC condition resulted in better outcomes than group care at both the 12-month and the 24-month follow-ups. Youth were more effectively treated for delinquency in well-trained and well-supervised community foster homes.

An example is Oregon's Social Learning Center. Each foster parent is extensively trained in behavior modification. Families are trained to supervise closely (with less exposure to troubled peers), to offer fair and consistent limits, to give predictable consequences, and to foster a supportive relationship between the child and at least one adult.

Treatment specifically for preschool children is also available. MTFC-P combines three interventions. First, there is training, support, and consultation to foster parents. Second are services to children that decrease problem behaviors, promote attachment to caregivers, and enhance school readiness. Third is family therapy and parent training for biological and adoptive parents. With programs such as Oregon's Early Intervention

Foster Care program, highly individualized and intensive treatment plans are created based on in-depth assessments done during screening (Wiggins, et al., 2007).

MTFC-P has been evaluated in a randomized clinical trial with funding from the National Institute of Mental Health. Compared to regular foster care, MTFC-P is effective at increasing secure attachment and decreases the risk of re-entry into child welfare following a foster care placement.

More information is available from Kimberly Bronz, Ph.D., TFC Consultants, Inc. (541) 343-2388 x 206, E-mail: kimb@mtfc.com Web site: www.mtfc.com

Functional Family Therapy (FFT)

FFT is an empirically-grounded and highly successful family intervention for at-risk youth and those already involved with the juvenile justice system. It is designed for youth ages 11-18 who have demonstrated delinquency, violence, substance use, conduct problems, oppositional behaviors, disruptive behaviors, and depression. It provides 8 to 30 sessions of direct service and can be delivered in homes, schools, clinical settings or juvenile justice facilities.

More information is available from: www.fftinc.com/

Multisystemic Therapy (MST)

MST is based on social ecological and family systems theories. It provides time-limited treatment of 4 to 6 months. The major goal of this strengths-focused therapy is to empower parents with skills and resources to address the difficulties of teenagers and to empower youth to cope with family, peer, school, and neighborhood problems.

Intervention strategies are integrated into a social ecological context and include strategic

family therapy, structural family therapy, behavioral parents training, and cognitive behavioral therapies (Landsverk et al., 2006).

A meta-analysis of 7 primary outcome studies and 4 secondary studies involving a total of 708 participants (Curtis, Ronan & Borduin, 2004) found that youth and families treated with MST were functioning better and offending less than 70% of their counterparts who received alternative treatment or services. MST was found to be effective in reducing emotional and behavioral problems in individual family members, in improving parent-youth and overall family relations, in decreasing youth aggression towards peers, and in reducing youth criminality. Follow-up data suggest that the treatment effects were sustained for up to 4 years.

Attachment and Biobehavioral Catch Up

This approach was designed for young children in foster care who display relational, behavioral, and bio-behavioral dysregulation. This 10-session therapy helps foster parents engage in optimal sensitive parenting behaviors. The treatment teaches foster parents how to manage their own reactions to infant rejection while continuing to provide love and support for the maltreated infant.

More information is available from: Mary Dozier, Ph.D., University of Delaware, (302) 831-8801, Fax: (302) 831-3645, Email: mdozier@psych.udel.edu
Web site: www.cachildwelfareclearinghouse.org/program/108/detailed

Project 12-Ways/SafeCare

Although neglect is the largest reason for child welfare intervention, there is limited study of intervention models for neglect. Project 12-Ways/Safe Care is among the more widely studied and the best supported intervention, according to a review by

Chaffin & Friedrich (2004). The model uses behavioral methods and focuses on various targets in the ecology of multi-problem families. According to Chaffin & Friedrich, there are over 60 published studies, but few with randomized controls. The model is currently being tested in a large-scale field trial.

Summary

Despite the demonstrated efficacy of these interventions, there is little to indicate that their use has spread rapidly and that they are widely offered to abused children and their families (the Kauffman report, 2004). The Kauffman report suggests that reasons for slowness in adapting effective treatments is due to a professional community that has a bias against research, views therapy as more of an art than a science, and values innovation over replication.

The Kaffman report says that mental health practitioners working with abused children and their families can be categorized into one of five phases on a continuum. First is the Pre-contemplation Phase. These practitioners are unaware of the advantages of evidence-base practices and have no plan to incorporate these proven methods into their work. They are uninformed, misinformed or under informed. Practitioners in the Contemplation Phase (second phase) are aware of the evidence for best practices and are considering incorporating these therapies into their work. They must overcome lack of training and natural inertia.

The third phase is the Preparation Phase where practitioners have made the decision to learn and apply the best practice methods and concepts. They are seeking in-depth training and consultation to make changes in their practices. Those in the Action

Phase (fourth phase) are starting to apply what they have learned in an organized manner. They are offering therapy that has, at least, been influenced by best practice principles. Those who have fully integrated the best practices and are using them as intended so that clients receive full benefit of the method are in the Maintenance Phase (fifth phase). They must strive to maintain, update and sometimes work in a climate of misunderstanding of the value of their contributions by referral sources.

In short, there is a wide gap between the development of a best practice and its adoption in the general community. According to the Kauffman report (2004), there need to be incentives for practitioners to adopt proven practices (such as a connection between funding and the service), there needs to be assistance for start up costs, and there need to be models of organizations and practitioners who are successfully using these methods. Since these methods are more effective and require fewer sessions, there may even be disincentives for clinicians who are paid by the session to use the more effective methods that result in lower reimbursement and more “turn over” of clients.

It will require training, funding, peer support and effort from the therapeutic community to begin to adopt proven and effective therapeutic methods. Efficacious and compassionate healing and service require that all of us be open to change and to adopting proven therapeutic methods.

References Available Upon Request