Missouri Institute of Mental Health
4633 World Parkway Circle
St. Louis, MO 63134
314-516.8419(phone)
314-516-8428 (fax)
WWW.MIMHTRAINING.COM

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Evidence-Based Practice in a Children's System of Care

with Patsy Carter, PhD

Summary

In this presentation, Dr. Carter explains Evidence-Based Practices and how they apply to providing services and supports to children and families. She discusses how to select a practice, and how to apply it. Likewise, she explains when not to rely exclusively on Evidence-Based Practices. This is a frank, open conversation regarding the often challenging world of finding the right treatment strategies for the children you serve.

Presenter

Patsy Carter, PhD, received her Bachelor's Degree in Psychology from the University of Missouri-Columbia, and her Master's and Doctorate Degrees from the University of Mississippi. She has worked her entire career dealing with children's and adolescents' issues in the mental health field. She has worked for the Tennessee Department of Mental Health as a Treatment Coordinator and Custodial Designee. She then came to Missouri and completed her internship at Western Missouri Mental Health Center. She has also worked at the Hearnes Youth Center and the Mid-Missouri Mental Health Center. She has worked in St. Louis at the Great Rivers Mental Health Services; and she is currently the Clinical Director of Children, Youth and Families for the Missouri Department of Mental Health, where she focuses on developing policies and standards to promote quality care in meeting the needs of children and youth with emotional, behavioral, developmental or substance abuse disorders.

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References

Dialectical Behavior Therapy
http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=72

Nurse Family Partnership
http://www.nursefamilypartnership.org/content/index.cfm?fuseaction=showContent&contentID=2&navID=2

http://www.nrepp.samhsa.gov/about-evidence.htm

www.findingevidence.com

Multisystemic Therapy
http://www.colorado.edu/cspv/blueprints/model/programs/MST.html

Glossary

Cognitive Behavior Therapy - a group of psychotherapies that emphasize the role of thinking in feelings and actions; examples include Dialectical Behavior Therapy, Rational Emotive Behavior Therapy, Cognitive Therapy and Rational Behavior Therapy

Dialectical Behavior Therapy - a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes

Evidence-Based Practice - a practice or treatment approach that is standardized, includes manuals or guidelines, has been studied in controlled research designs using a variety of research teams, and produces outcomes that matter to its recipient

Multisystemic Therapy - an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems.

Nurse-Family Partnership - an evidence-based, nurse home visiting program designed to improve the health, well-being and self-sufficiency of low-income, first-time parents and their children

System of Care - a collaborative effort bringing together all the people that are significantly involved in a child's life

Therapeutic Foster Homes - A foster home in which the foster parents have received special training to care for a wide variety of children and adolescents, usually those with significant emotional or behavioral problems. Parents in therapeutic foster homes are more closely supervised and assisted more than parents in regular foster homes.

Transcript

T: Thom Pancella **PC: Patsy Carter**

Thom Pancella: Hello. Welcome to the MIMHTraining presentation on Evidence-Based Practices in a Children's System of Care. I'm Thom Pancella with the Missouri Institute of Mental Health. With me today is Dr. Patsy Carter from the Missouri Department of Mental Health. Dr. Carter received her Bachelor's Degree in Psychology from the University of Missouri-Columbia, and her Master's and Doctorate Degrees from the University of Mississippi. She has worked her entire career dealing with children's and adolescents' issues in the mental health field. She has worked for the Tennessee Department of Mental Health as a Treatment Coordinator and Custodial Designee. She then came to Missouri and completed her internship at Western Missouri Mental Health Center. She has also worked at the Hearnes Youth Center and the Mid-Missouri Mental Health Center. She has worked in St. Louis at the Great Rivers Mental Health Services; and she is currently the Clinical Director of Children, Youth and Families for the Missouri Department of Mental Health, where she focuses on developing policies and standards to promote quality care in meeting the needs of children and youth with emotional, behavioral, developmental or substance abuse disorders. Dr. Carter, thanks for joining us today.

Patsy Carter: Thank you for having me.

TP: Why don't we start with a little bit of history, and give us a little bit of background and history in mental health treatment related to children.

PC: Well, in the public mental health system, we try to work in what we call a System of Care, and a System of Care basically is a collaborative effort bringing together all the people that are significantly involved in a child's life. For example, school personnel that are working with the child, mental health providers, neighbors, if they're actively involved in a child, Children's Division, juvenile courts, etc., and working collaboratively, because children often are functioning in multiple different areas of a life—school, at home, in the community, they may be involved with juvenile justice, maybe involved with child welfare, so we need to

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bring all the resources of these different agencies to bear in supporting and treating the child and the family who has the needs.

We have been working in this and have brought together both local, state and federal resources in Missouri to create specific System of Care sites that work together on developing effective policies and practices, and then also create family support teams that actually work intimately with the child in providing intensive services and supports.

TP: So in building the treatment now, we're hearing a lot about Evidence-Based Practices, and that's been coming up a lot in the last few years. What exactly are Evidence-Based Practices?

PC: Well, Evidence-Based Practices basically means that there has been good research that has been done that supports the use of that particular practice with children and adolescents. And when I talk about research—there's different levels of research that can be used. The ideal is often randomized controlled studies. Sometimes that's a little hard to achieve, but we try to use the best quality research that we have.

And Evidence-Based Practices also have support from many different researchers, not just one. We'd like to see that it's been replicated in the research that's been done.

They'll also talk about Evidence-Based Practices as being manualized. Now some people kind of talk about that being kind of a "cookbook" approach—and there's some truth to that—but there's still a very strong clinical approach that needs to be taken in applying any Evidence-Based Practice. What it means to be manualized is basically that we know that there are very core components in that Evidence-Based Practice that make a difference in achieving positive outcomes for the child and family.

And that's the third piece to this, is that we really are looking at positive outcomes

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in different areas of a child's life.

So to be in Evidence-Based Practice, you need significant training in that area that is very targeted; you need to be—to make sure that you are true to the practice, or what we call having fidelity in applying the practice, and then are focused on very targeted or specific outcomes for that child and family.

TP: Do you use the same Evidence-Based Practices with adults and children?

PC: That's a good question. The answer is kind of yes and no. I think we've learned through history that taking adult interventions or adult programs and applying them to children just really doesn't work. Now we may have very similar—you might hear of a practice that is sharing the name, such as Cognitive Behavior Therapy, or Dialectical Behavior Therapy—but you really have to adapt it to meet the needs of children and families, because of the developmental issues. People need to be very familiar with the developmental phases going through infancy, toddlers, childhood and adolescence. And so you have to adapt the practice.

Many practices are designed specifically for children, and there are certainly Evidence-Based Practices that are designed for adults that have not yet been researched and proven effective for children.
So there are some commonalities, but even with those, you need to make sure that you're applying it in a very developmentally-appropriate manner.

TP: Well let's go into some specifics then. What are some of the Evidence-Based Practices for children?

PC: Well there is just a multitude of Evidence-Based Practices out there, and luckily it's growing as we're spending more time doing research and looking at the needs of communities and what the children and families need.
Some of the ones most often talked about in the children's world is Cognitive Behavior Therapy; there's Multisystemic Therapy, some folks may have heard

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of that; there's also kind of broader service packages such as Therapeutic Foster Homes—and really that's kind of a place for treatment, but there's also specialized training of the families that are providing the services and supports.

We also have a full continuum—services—when we talk about Evidence-Based Practices, it doesn't just mean that a child is getting a specific therapy service—we have Evidence-Based Practices that are also available, from prevention on forward. So there are good Evidence-Based Practices being developed that can be applied in schools that can be used to help promote health social and emotional development, and enhance protective factors for children and hope to reduce the risk factors for developing behavioral, emotional or substance abuse problems in the future.

The other thing to consider—I mean, there's a number of Evidence-Based Practices—really too many to mention—but really, they can be applied in a number of different settings, too. For example, I probably would know more about services designed to treat such issues as emotional or behavioral or psychiatric problems, substance abuse—but there are Evidence-Based Practices in the child welfare field, in working with children who have been in the welfare system or the child abuse/neglect system; there are Evidence-Based Practices that can be applied in school settings to enhance school performance or behavioral functioning in schools; and there are Evidence-Based Practices that can be applied in the juvenile justice setting, and hopefully to decrease delinquency and recidivism in the future.

As I mentioned early on, because children function in so many different domains, we've tried to provide all of our services and supports in kind of that collaborative manner, with all the systems that are involved in a child—there's a great deal of overlap then, too, in the types of services that a child may need. So the important thing to remember when picking an Evidence-Based Practice, because there's so many, is to pick the targeted population for what the research focused on. For example, if it was focusing on kids in an urban area, from the age of eight to fourteen, then applying that Evidence-Based Practice in a rural area for children three to five—it wouldn't really be considered an Evidence-Based Practice, because it

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hadn't been proven with that particular targeted population.
The other area where we talk about kind of target, is targeted outcomes—in knowing what it is you're trying to achieve for that child. So, for example, if you're trying to relieve feelings of depression or feelings of anxiety, you might pick one particular type of Evidence-Based Practice that has shown to be effective in that area. But if you're looking at decreasing delinquency or the probability of recidivism in the future, you're not gonna choose the same Evidence-Based

Practice that's gonna focus on depression or anxiety; you're gonna wanna pick an Evidence-Based Practice that has shown to decrease recidivism, perhaps improve community functioning, improve family communications.
So you pick an Evidence-Based Practice by the targeted population that it was researched and proven to be effective, and for the specific targeted outcomes that you want to achieve. If you go outside of that, then you're really not applying an Evidence-Based Practice.

TP: Earlier, you mentioned the different developmental stages that kids go through. Is there an early limit—how old does a child have to be to get a diagnosis that would actually benefit from Evidence-Based Practices?

PC: You know, there's a lot of folks who think you have to be a certain age before you can have any type of emotional problem or behavioral problem. But that's really not true; we know, unfortunately, that some children from a very young age—and I'm talking about infants to toddlers—have experienced some types of traumas—whether it's abuse or perhaps even prenatal trauma—that is going to impact their emotional and behavioral functioning. So there are Evidence-Based Practices that can focus very early on for specific problem areas, or, as I mentioned before, there's Evidence-Based Practices in the area of prevention, or even kind of kids who are at risk. So you can be—there's Evidence-Based Practices out there focusing on very young children. Now most of those are gonna have a very strong family component. An example of a very early one is the Nurse-Family Partnership, which is designed to be used for low income families, and really helping them with parenting skills, and promoting social and emotional development

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and the bond and the communication and the interactions between a child and their parents. And then it can go all the way up to looking at adolescent issues. So it's—there's really no bottom age limit or top age limit—I mean, as others have spoken, it goes through the entire life span. The key then, again, though is to remember to pick the targeted population and the targeted outcomes that you want to achieve and apply it to the right population of kids.

TP: So if this information pool has been growing steadily for years, why isn't it more widely accessible?

PC: Well, that's a good question, because to many people it seems very easy—you just pick an Evidence-Based Practice and start applying it. Well, for the clinician themselves there are issues where they have to go and become trained, and it's not just a one-shot training; we know that just doing one-shot training isn't very effective, that you need kind of ongoing supervision or consultation—and that's key particularly in sustaining that fidelity to the practice. And I want to emphasize that component of the fidelity, because people may start off—and we all have the natural habit of kind of adding our own spin to something or thinking, "Oh, I'm going to change this a little bit."

But, really for an Evidence-Based Practice to continue its effectiveness, it has to be applied as it was researched, as it was developed and researched. So, it takes time on the clinician's part; it takes money on the clinician's part to get that early training.

The other issue is the availability of the training—that sometimes, different Evidence-Based Practices aren't maybe available in the midwest areas, so you're having to look to the east coast or the west coast to bring that up.

But those are some of the factors that clinicians have to face. We have to remember that these Evidence-Based Practices are not being applied in isolation; that private practice—practitioners may be using them; they may be being applied in an agency. And some of them are not very traditional—not necessarily office-based,

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sitting in an office—some of them are. But some are more hands-on, a little bit out in the community—Multi-Systemic Therapy is one, where a lot of the work happens with the families, in the home, in the community, maybe even in the school setting. So the agency or the environment that it's being applied may have to make changes to how they think about doing or implementing different type of therapy services and supports.

Then there's the whole issue of how do we fund these Evidence-Based Practices? Whether it's through public dollars, such as through the Department of Mental Health, whether it's public dollars through Medicaid, public dollars through Child Welfare or the Children's Division or juvenile courts or in the schools—that we have to be able to restructure some of our financing pieces to be able to fit kind of the Evidence-Based Practice—some aren't going to easily lend themselves to like an hourly rate.

We also have to make sure again that the people who are applying these have had the appropriate training and are being true. So there come in this monitoring piece that has to be assured perhaps for the payer source.
Another component of any Evidence-Based Practice being accepted and applied is really its acceptability to the recipient of the service. It's very important that those children, families, other participants understand what and Evidence-Based Practice is.

So there are lots of different components, and you can kind of think about it from the training component—of becoming a practitioner of an Evidence-Based Practice; there's the financing component of it that we have to look at; and then there's kind of that fidelity and monitoring and assuring the quality to it.
Another issue is that there may be some areas where Evidence-Based Practices have not yet been developed and we still need to be doing research, and I think we can talk a little bit about that in the next few minutes.

TP: Yeah, that kind of feeds into another question, and that would be, is there a reason to NOT to use an Evidence-Based Practice or a practice that isn't evi

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dence-based?

PC: Well, as I had just mentioned, there are some areas, for a certain population of kids, or for a certain targeted outcome, that Evidence-Based Practices have not yet been developed. So, you're going to have to look at something that still can be used to meet that child and family's needs. We can also think about this though as a continuum, and some of my peers talk about it as having kind of a portfolio approach to Evidence-Based Practices. And what that means is that there may be actually a continuum of evidence that we need to be looking at; there are many websites out—available—the internet and other resources that give you lists of different types of practices. And they're even kind of rated on a scale or on a continuum where they're considered and Evidence-Based Practice, or an Effective Practice, a Model Practice, or a Promising Practice. And that just means that perhaps the research hasn't fully been completed, or hasn't had the strength that we yet want to see, or that we know that it's only applied to a very small population; so there's kind of this continuum of evidence that we want to be looking at, and making sure that we have a variety of different services to meet a variety of different populations' needs, and filling in the gaps where there is not yet enough evidence.

Another feature that we always have to consider when we're picking an Evidence-Based Practice is to think about the recipients needs again, in that it may feel uncomfortable; it may be something that—the Evidence-Based Practice that's out there may be something that they're not willing to engage in. And so you might have to look at some other types of interventions or supports that help the recipient feel more comfortable—the consumer feel more comfortable and more engaged in the treatment, and therefore looking towards more positive outcomes. So it's still very much a developing field, and needs to remain that way. I hope, if we were having this interview even two years from now, Thom, that there would be new Evidence-Based Practices that are hitting the websites and are available for training and for practitioners to implement. It's a dynamic field. And, hopefully, we're gonna continue to improve the science and improve the evidence so that we have a wider continuum of services and supports to offer consumers.

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TP: Well you've given quite a list of some of the things that have to be considered. Are there other issues that are keeping us from moving forward?

PC: Well, I think that there's still a lot of fear or stigma about mental health issues that often keep people from a—moving forward or attaining services and supports, particularly with children. Again, people don't think—some people don't think that children can have mental health concerns, whether it's in the area of substance abuse or psychiatric and emotional—and we stigmatize people who do come forward. We put them off. And particularly children and adolescents, you know, they can be kind of a tough crowd, even being a little bit different, you know? A child who has asthma, or a child who has diabetes—even obesity is a big issue in this country—often are kind of teased or ostracized by their peers. So if you have a child who has a significant developmental delay or an emotional problem, a behavioral problem—maybe they've experienced a lot of trauma in their life—the kids may view them as different, and therefore ostracized. So they don't want to be engaged in therapies, or they don't want to be seen as different. And the adults do it, too—that we do not recognize mental illnesses the same way that we recognize physical or medical illnesses. And so I think that stigma and that fear is often a barrier to people reaching out to get assistance in getting the supports and services they need. It also therefore may impact the resources that are brought to bear on an issue—if we don't have the parity with physical health issues, we may not get the research that needs to be done and the funding to support that; the dollars for the services and supports to be available for the children and families.

So there are a number of barriers, and we all need to be having dialogues about these kind of things. Hopefully in schools or family settings, the kids, the parents can talk about these issues, and recognize that mental health issues, social and emotional development is as critical as physical development—in having good physical health it's important to have good mental health. And I just don't think we talk about it enough. So I think that stigma, that lack of dialogue, also acts as a barrier to us sometimes, in getting the appropriate services out there.

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TP: Anything else people can do?

PC: I just think that dialogue and learning more about it—I think that the science is advancing in this field, and—I have a psychiatrist friend and co-worker of mine has often said, you know, the things that we thought of as mental illnesses 50, 60 years ago, are no longer deemed as mental illnesses, because we know what causes them. They actually have a very physiological cause. It may be through an infection of some sort. Our mental hospitals used to often serve folks who had syphilis, because of the manifestation of symptoms; so it was thought of as a mental illness. I think as the research grows, we know that many, many of these mental health disorders have a very significant biological basis very similar to other physical disorders.

So I think constantly having that dialogue and creating that parity with physical health issues, and integrating physical and mental health, so that we have children and families who are growing up physically healthy and socially and emotionally healthy.

TP: I'd like you to talk directly to the practitioner, if you could. If you could say—somebody comes and says, "Is this another fad? Are we going through another series of changes? Am I doing everything wrong again? What are you telling me? Here you are, a representative of the bureaucracy." What would you tell the practitioners?

PC: Boy, that's a really good question, Thom. I do know that there are a lot of fears from practitioners out there for a variety of reasons. One, change is always threatening to people, and I can understand that; I don't like having to go through changes. If I had to move my house, I'm going through a great deal of stress. But I think it's important that people recognize that we're not diminishing the clinical expertise in application of Evidence-Based Practices. I also don't think that it is a fad. I think we're gonna be shaping ourselves more and more towards specific outcomes, and showing that our interventions, whether it's prevention, early identification—is meaningful and has an impact. And so I think, more than a fad,

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it's really a trend that we're gonna be seeing. Like I mentioned, I hope it's not the same Evidence-Based Practices—that we'll either have a broader continuum, we'll know more—there's a lot of discussion—we didn't touch on the fact of having to adapt existing Evidence-Based Practices—and when we talk about adapting and changing an Evidence-Based Practice—that may sound kind of contradictory, because we just talked about fidelity and the need to apply the model as it was researched—but we also know that there may be things that we can change so that it has a broader applicability, or to a different targeted population, or targeted outcome. But it has to be done in a very thoughtful and planned way, and the research again has to support that.

That, paired with other types of services and supports that maybe have not yet reached the Evidence-Based Practice I think helps us a lot.
But I think if practitioners recognize this just gives them more powerful tools; and what we all want to do is make a difference in children and families' lives. And if this can be more effective—there's still core competencies that require clinical expertise; that relationship is still a very important component—that therapeutic relationship—so I don't think people should be fearful of this minimizing their clinical expertise, but embrace it as a way to show that it is a very legitimate intervention, and that we can make a difference in people's lives.

TP: Thank you, Dr. Carter.

PC: Thank you.

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4633 World Parkway Circle
St. Louis, MO 63134
314-516.8419(phone)
314-516-8428 (fax)
WWW.MIMHTRAINING.COM