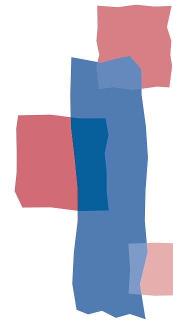

EVIDENCE-BASED PRACTICES
KIT

Knowledge Informing Transformation

Guide to EBPs

How to Use

the Evidence-Based Practices KITs

Interventions for Disruptive Behavior Disorders

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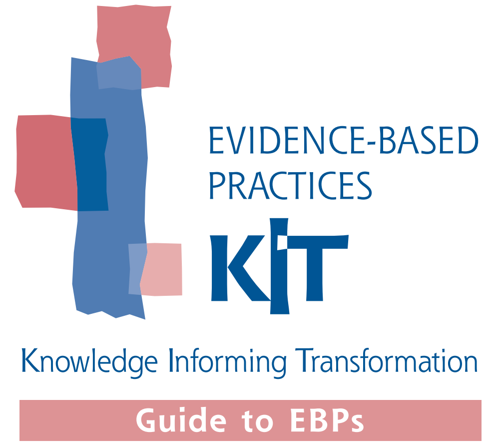

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U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

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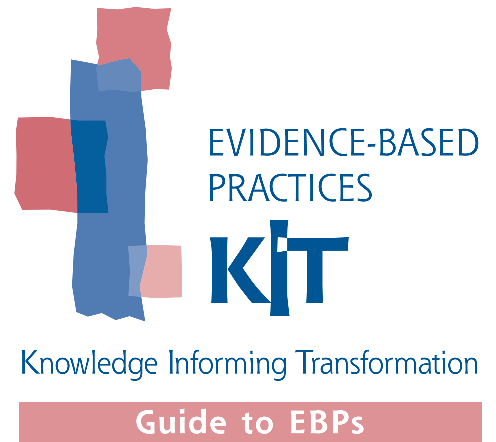


Guide to EBPs

Interventions for Disruptive Behavior Disorders

How to Use the Evidence-Based Practices KITs

The Evidence-Based Practices KITs, a product of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS), give states, communities, administrators, practitioners, consumers of mental health care, and their family members resources to implement mental health practices that work.

This KIT introduces the evidence-based practices for Interventions for Disruptive Behavior Disorders and guides readers through their implementation. *How to Use the Evidence-Based Practices KITs,* provides an overview of the KIT's contents and guidance on using the KIT.

For additional references on interventions for disruptive behavior disorders, see the booklet, *Evidence-Based and Promising Practices.*

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Interventions for Disruptive Behavior Disorders KIT, which includes six booklets:

How to Use the Evidence-Based Practices KITs

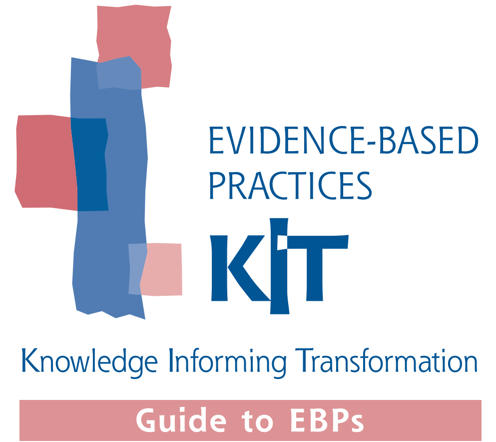
Characteristics and Needs of Children with Disruptive Behavior Disorders and Their Families

Selecting Evidence-Based Practices for Children with Disruptive Behavior Disorders to Address Unmet Needs: Factors to Consider in Decisionmaking

Implementation Considerations

Evidence-Based and Promising Practices

Medication Management



Guide to EBPs

Interventions for Disruptive Behavior Disorders

What's in *How to Use the Evidence-Based Practices KITs*

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EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Guide to EBPs

How to Use the Evidence-Based Practices KITs

Background and Purpose

Evidence-based practices (EBPs) are interventions—or treatments—whose effectiveness is supported by scientific proof. They offer hope that the lives of children and youth with disruptive behavior disorders (DBDs)—and the lives of their families—can be enhanced. By appropriately using mental health interventions shown by research to be effective, the likelihood that children and youth will have positive outcomes can be increased.

This KIT was created to help promote the use of evidence-based practices in mental health service systems—a need that was highlighted in the 1999 report *Mental Health: A Report of the Surgeon General,* which advised the country to close the gap between scientific research and clinical practice (U.S. Department of Health and Human Services).

EBPs are currently being promoted at the federal level by a series of demonstration grants through the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) and at the state level through initiatives of state and local mental health agencies. This KIT, funded by the Child, Adolescent, and Family Branch of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) is an extension of these activities.

The major goal of the Interventions for Disruptive Behavior Disorders EBP KIT is to provide a resource that will promote adopting, implementing, and disseminating EBPs in children's mental health service systems and throughout the professional field.

A major reason for the current attention to EBPs in mental health is that scientific knowledge about effective practices has grown dramatically. Professionals, communities, and families now can choose among interventions that have been proven effective in various settings and with various populations.

Scientific evidence supports adopting EBPs. These practices, however, may still not be readily available in some communities or part of the usual array of services offered by most mental health providers. Some of these practices are available at multiple sites, but are not widely disseminated throughout the nation.

Audience of Interest

The KIT is written primarily for administrators and planning groups or advisory committees in agencies and communities. Those groups and committees would include decisionmakers from various areas, including families and youth, advocates, practitioners and supervisors, and local and state agency administrators.

EBPs are used in various service sectors and in different community-based settings, so this KIT is designed to be useful to individuals and agencies in both mental health and other child-serving sectors including child welfare, juvenile justice, and education.

What Type of Information Is Available in the KIT?

Several stages are involved in implementing EBPs, including the following:

- Exploring;
- Selecting and adopting programs;
- Installing the program;
- Initially implementing the program;
- Fully operating;
- Enhancing the implementation; and
- Sustaining the implementation (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

This KIT focuses primarily on the first stage: selecting and adopting EBPs. The KIT contains information that will help agencies and communities identify EBPs that will meet the needs of families they serve. Other sections of the KIT contain general information about steps needed when implementing EBPs and information about implementing the specific EBPs included within the KIT.

The KIT includes the following booklets:

- **How to Use the Evidence-Based Practices KITs** provides an overview of the KIT's contents and guidance on how to best use the KIT.
- **Characteristics and Needs of Children with Disruptive Behavior Disorders and Their Families** provides information about the population of children and youth who might benefit from the EBPs presented in the KIT.

- **Selecting EBPs for Children with Disruptive Behavior Disorders to Address Unmet Needs: Factors to Consider in Decisionmaking** introduces readers to EBPs in general and the specific EBPs included in the KIT. It also helps direct readers to resources where they can obtain more information about EBPs. A list of the main factors to consider when selecting EBPs is provided. The comprehensive tables describe each EBP and provide important summary information, such as the following:
  - The level of evidence to support the effectiveness of the practice;
  - Whether the practice is aimed at preventing or treating disruptive behavior disorders; and
  - The demographic characteristics of children and youth who participated in the research studies that evaluated the effectiveness of the EBPs.

  The summary tables can be used to narrow the set of 18 EBPs covered in the KIT to a more manageable number of EBPs that most closely match the needs of the community for which an EBP will be selected. Two case vignettes illustrate how to use the KIT.

- **Implementation Considerations** provides a general overview of the scientific literature on implementing EBPs and lessons learned by communities when implementing and disseminating EBPs.

  Readers should scan this booklet early to become aware of the extent to which building an infrastructure for training, financing, evaluation, and management-information systems will facilitate implementing EBPs within a continuous quality improvement framework. This booklet also looks at the ways EBPs relate to culture and the cultural competency of providers.

- **Evidence-Based and Promising Practices** provides specific, indepth descriptions of the 18 EBPs found in the KIT. Each EBP has been categorized as either a *Prevention/Multilevel Practice*, which can serve as either a prevention or treatment program, or an *Intervention Practice*, which is designed to treat the symptoms of behavior disorders.

- **Medication Management** describes types of medications that have been used to treat these disorders and refers readers to available clinical guidelines. Readers should keep in mind, however, that no specific evidence-based medication algorithms (meaning systematic steps for physicians to consider in selecting medications) exist for treating disruptive behavior disorders.

The KIT for Interventions for Disruptive Behavior Disorders is organized in the same way that an advisory group might think about selecting and adopting a new practice:

- Identifying a need for an EBP;
- Considering various factors and issues that could affect decisions about implementing EBPs in a program; and
- Examining what treatments and services exist to address identified needs.

What Are Disruptive Behavior Disorders?

The topic for this KIT is disruptive behavior disorders (DBDs) which can include diagnoses of Oppositional Defiant Disorders (ODD) and Conduct Disorders (CD).

DBDs occur across the stages of child and youth development; have a significant impact on a child's functioning across many social settings (for example, home, school, community, etc.); involve multiple service sectors (for example, mental health, education, child welfare, juvenile justice, etc.); and can result in great social costs to communities when untreated (U.S. Department of Health and Human Services, 1999). DBDs are described in more detail in *Characteristics and Needs of Children with Disruptive Behavior Disorders and their Families*.

What Are Evidence-Based Practices?

EBPs are interventions for which strong scientific proof shows that certain outcomes will be achieved. This does not mean that other interventions do not work or do not produce favorable outcomes. It may be that those interventions have not yet been fully researched—that research has not been conducted at a sufficiently appropriate level for scientists to say that strong evidence exists to prove or disprove that a specific intervention is effective.

Keep two major ideas in mind when discussing EBPs. The first is the idea of scientific proof or evidence—EBPs have been researched scientifically and evidence shows that they are effective. The second is the use (the practice) of evidence-based practices—the EBPs found in this KIT are meant to be used to the benefit of children, youth, and their families. Evidence for their effectiveness is based on how, with what children, and in what contexts they are used, among other things.

It is the responsibility of the provider to inform the consumer and family member about the best intervention that can be used to address the problem and to achieve desired outcomes. The health provider and consumer may jointly decide which intervention to select after weighing information about evidence and use.

This shared decisionmaking process is an important principle identified by the Institute of Medicine (2001). The shared decisionmaking process benefits greatly from an understanding of research designs, which are examined in *Selecting EBPs for Children with Disruptive Behavior Disorders to Address Unmet Needs*. For sources of more information about EBPs, see Table 1. Several definitions for EBPs are presented in Table 2.

Table 1: Sources of Information for Identifying Evidence-Based Practices

- Effective psychosocial treatments of conduct disorder children and adolescents: 29 years, 82 studies, and 5,272 kids (Brestan and Eyberg 1989)
- Evidence-based psychosocial treatments for children and adolescents with disruptive behavior (Eyberg, Nelson, & Boggs 2008)
- *School-Based Mental Health* (Kutash, Duchnowski, & Lynn, 2006)
- Developer Interviews (National Implementation Research Network at the University of South Florida)
- *Blueprint for change: Research on child and adolescent mental health* (National Institute of Mental Health, 2001). Available from Education Resources Information Center (ERIC) (#ED462650). (**http://www.eric.ed.gov/**)
- SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP) (**http://www.nrepp.samhsa.gov/**)
- Input from Consensus Panel Meeting on Implementation Resource Kit

Table 2: Definitions of Evidence-Based Treatment and Practices in Scientific Literature

- An evidence-based practice is considered to be any practice that has been established as effective through scientific research according to a set of explicit criteria (Drake et al., 2001).
- Evidence-based treatment is the use of treatments for which there is sufficiently persuasive evidence to support their effectiveness in attaining desired outcomes (Rosen and Proctor, 2002).
- Evidence-based practice is an approach to healthcare wherein health professionals use the best evidence possible to make clinical decisions for individual patients (McKibbon, 1998).
- Evidence-based practice is the integration of best research evidence with clinical expertise and patient values (Institute of Medicine, 2001).

What Are the Evidence-Based Practices Presented in this KIT?

Tables 3 and 4 present the 18 different EBPs that are described in considerable detail within this KIT.

- Most of the EBPs have achieved a level of research evidence that is considered to be *good support*.
- The various EBPs cover a broad age and race range of children and adolescents from birth to 18 years.
- Many of the EBPs were designed to either prevent disruptive behavior disorders or treat the symptoms of disruptive behavior disorders. Several of the EBPs are multilevel and address both prevention and treatment goals.
- Most of the EBPs include family involvement.
- Many of the EBPs include cognitive-behavioral approaches or parent training.
- The EBPs are delivered in a range of community-based settings, including schools, clinics, and homes.
- All of the EBPs have training materials, and most have formal training programs.
- Many of the treatment-oriented EBPs have clinical components that can be covered financially by Medicaid or private insurance.

Table 3: Prevention/Multilevel Practices

Prevention practice	Age of youth	Race/ethnicity of children and families who participated in EBPs studies	Setting	Format	Length	Family component	Outcomes
Triple P-Positive Parenting Program	0–16	Groups of children and families in Australia who were primarily White. One study was conducted in China with 90 Chinese children.	Clinic, Home, School	Individual, Group	Varies: 1–2 sessions to 8–10 sessions	Parent training, home visits, partner support skills, mood management workbook material	■ Increase in parental confidence. ■ Decrease in child behavior problems. ■ Improvement in effective parenting styles.
Project ACHIEVE	3–14	Evaluation was carried out with groups that were approximately half white, and half diverse populations, primarily African American.	School	Group	School year	Parent training	■ Decrease in discipline problems. ■ Decrease in special education referrals and placements. ■ Increase in positive school climate. ■ Improvement in academic achievement.
Second Step	4–14	Diverse groups studied. Two studies were conducted primarily with White children. In another two studies, the population was primarily African American; in one study the proportions of White, African American, and Hispanic participants were approximately equal. In another study, the majority of participants were African American and secondarily, Hispanic. Another study included a small percentage of Asian Americans and one study was conducted in Germany.	School	Group	School year	Family Guide that includes a video-based parent training program that helps parents reinforce skills at home	■ Increase in positive social behavior and social reasoning. ■ Improvement in control of emotions. ■ Decrease in verbal and physical aggression and problem behaviors.
Promoting Alternative Thinking Strategies	5–12	Groups studied were approximately one-half White and one-quarter to one-third African American. Asian American, American Indian, and Hispanic children combined, made up the remainder of the groups.	School	Group	K–5th grade, 3 times a week for 20–30 minutes	None	■ Increase in ability to label feelings. ■ Decrease in classroom aggression. ■ Increase in self control.
First Steps to Success	5–6	The children involved in two studies were primarily White. Smaller case studies involved primarily African American and some American Indian children with minimal participation from Hispanic children.	School, Home	Individual	3–4 months	Parent training delivered in the home	■ Decrease in aggression. ■ Increase in time spent on academics. ■ Increase in positive behavior.

Table 3: Prevention/Multilevel Practices

Prevention practice	Age of youth	Race/ethnicity of children and families who participated in EBPs studies	Setting	Format	Length	Family component	Outcomes
Early Risers: Skills for Success	6–12	Evaluations included two groups of predominately White children and one group of predominately African American children.	School	Individual	School year and summer	Parent education workshops, individualized family support	■ Improvement in academic achievement. ■ Improved control of emotions. ■ Improvement of social skills.
Adolescent Transitions Program	11–18	Two studies included primarily White children. One study was primarily White and African American with very small proportions of Hispanic, Asian American, and American Indian children.	School	Individual, Group	Varies: 3–12 sessions	Family management groups, individual family therapy	■ Increase in positive parent-child interactions. ■ Improvement in behaviors at school. ■ Decrease in youth smoking.

Table 4: Treatment Practices

Prevention practice	Age of youth	Race/ethnicity of children and families who participated in EBPs studies	Setting	Format	Length	Family component	Outcomes
Incredible Years	2–12	Four studies have had primarily White participants with no description of other ethnic or racial groups. Two studies included African American, Hispanic, and other multiethnic groups in small proportions.	School, Home	Group	Less than 22 weeks	Parent training	■ Increase in parents' use of effective limit setting, nurturing, and supportive parenting. ■ Improvement in teachers' use of praise. ■ Decrease in conduct problems at home and school.
Helping the Noncompliant Child	3–8	No specification of ethnicity or race among the studied groups was available.	Clinic, Home	Individual	8–10 sessions	Parent training	■ Improvement in parenting skills. ■ Decrease in oppositional behavior.
Parent-Child Interaction Therapy	2–7	One study included approximately three-fourths White and one-fourth diverse populations (primarily African American). Support exists for a culturally sensitive adaptation for Puerto Rican and Mexican American families.	Clinic	Individual	10–16 sessions	Parent training, coaching	■ Improvement in parent-child interaction style. ■ Improvement in child behavior problems.
Parent Management Training – Oregon	4–12	Evaluated primarily on White children and parents. A culturally sensitive adaptation of PMTO for Hispanic families has been evaluated as well.	Clinic, Home	Individual	20 sessions	Parent training	■ Decrease in child's behavioral problems. ■ Increases in effective parenting.

Prevention practice	Age of youth	Race/ethnicity of children and families who participated in EBPs studies	Setting	Format	Length	Family component	Outcomes
Brief Strategic Family Therapy™	6–18	Evaluated primarily with Hispanic families. One study's sample was one-fifth African American.	Clinic, Home	Individual	12–16 sessions	Family therapy	■ Decrease in substance abuse. ■ Increase in commitment to therapy. ■ Decrease in problematic behavior. ■ Increase in family functioning. ■ Decrease in aggression.
Problem-Solving Skills: Training	6–14	Studied with groups of approximately three-fourths White and one-fourth African American children.	Clinic, Home	Individual	20 sessions	Parent training	■ Improvement in behavior. ■ Improvement in positive family functioning.
Coping Power	9–11	Groups studied were approximately half White and half African American children. One study was in the Netherlands with Dutch children.	School	Group	15–18 months	Parent training	■ Decrease in substance abuse. ■ Improvement in social skills. ■ Decrease in aggressive thoughts.
Mentoring	6–18	The major study included a group of approximately three-fourths African American children and one fourth Hispanic children.	School, Home	Individual	1 year or longer	None	■ Increase in confidence in school performance. ■ Improvement in family relationships. ■ Increase in positive behaviors.
Multisystemic Therapy	12–18	Most groups that have been evaluated have been approximately 60% African American children and 40% White children, except for two that were approximately 70% White and 30% African American. One study included an 84% multiracial group of African American and Whites. One study was conducted in Norway with Norwegian children.	School, Home	Individual	3–5 months	Family therapy, parent training	■ Decrease in arrests and re-arrests. ■ Increase in school attendance. ■ Decrease in behavior problems. ■ Decrease in substance use.
Functional Family Therapy	11–18	Groups were predominantly White families. In unpublished studies, diverse populations (primarily African American and Hispanic) made up between one fourth and one half of the group. One study was conducted in Sweden.	Clinic, Home	Individual	8–12 sessions	Family therapy	■ Decrease in out-of-home placements. ■ Decrease in re-arrest rates. ■ Improvements in family communication style. ■ Improvement in family interactions.
Multidimensional Treatment Foster Care	3–18	Studies were primarily of White children. African American, Hispanic, and American Indian children were represented in very small proportions.	School, Clinic, Home	Individual	6–9 months	Training, weekly meetings	Decrease in arrest rates. Decrease in violent activity involvement. Increase in permanent placement success.

Table 4: Treatment Practices

How to Use the Evidence-Based Practices KITs

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