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SCHOOL OF SOCIAL WORK

# Common Components of Evidence Base Practices

Richard P. Barth, PhD, MSW

University of Maryland School of Social Work

National Center for Evidence Based Practice in Child Welfare

Presented at EUSARF

Copenhagen, Denmark

September 4, 2014

[rbarth@ssw.umaryland.edu](mailto:rbarth@ssw.umaryland.edu)



**NATIONAL CENTER** for  
**EVIDENCE-BASED PRACTICE**  
in **CHILD WELFARE**

# An Aspiration

- An approach to balancing considerations of “treatment” effectiveness, extensiveness, and availability—ensuring, to the greatest extent, that treatments are:
  1. reliably effective (treatment works as intended),
  2. widely relevant (the available treatments cover the needs of most children and families)
  3. generally available (best practice is affordable and commonly practiced [usual care])

Adapted from Chorpita, B. F., & Daleiden, E. L. (2014). Doing more with what we know: Introduction to the special issue. *Journal of Clinical Child and Adolescent Psychology*, 43, 143-144. doi: 10.1080/15374416.2013.869751

# EBPs are Prospering

- **Incentives** to use evidence-supported interventions (a.k.a. Evidence-based practices) **are now everywhere!**
- Promise (“unproven”) practices still have some breathing room—but not much
- “Opinion-Based” treatments without a credible link to scientific support (although not rare) are getting almost no new air (Sundell et al. 2010)



# Tensions Remain Between

- **STANDARDIZED BEST PRACTICES VS. INDIVIDUALIZED PRACTICES?**
  - Are individualized approaches effective and are manualized approaches feasible?
- **GENERIC VS. NAME BRAND EBPS**
  - Do existing programs need to be replaced with model programs?
- **GOAL OF TODAY: TO FIND POINTS OF INTERSECTION BETWEEN THESE APPROACHES THAT BRING US CLOSEST TO OUR ASPIRATIONS?**

# 30 Year Scrum Continues Between...

- **Efficacy-focused strategies** (often involving manualized interventions) to increase the likelihood that entire treatments will be delivered with **fidelity**—
- **Individualization of care** via family-centered approaches that seek to optimize child and family voice and depend on therapist's general expertise to achieve results.

# A Vote for Generic (No Name) Programs From Michael Lipsey & Buddy Howell (2012)

One could certainly get the impression ... that the only programs supported by credible research findings are those that appear by name on one of the lists of evidence-based programs such as Blueprints, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) model programs guide, and the like.

In fact, the research studies conducted on all the named programs on all those lists constitute only a small portion of the total body of research investigating the effects of programs for juvenile offenders. **Most of the available research has been conducted on no-name or homegrown programs that are not on any list and, in most cases, are not so different from the programs already being used by juvenile justice agencies.**

More important, however, are the findings of the positive effects for many of these generic program types and the identification of the program characteristics associated with the most positive effects.

# Current Manualized Interventions Have Poor Coverage

- Few therapists know them
- Fewer therapists have time and circumstances to do them
- Even if they did, little more than 60% of children would benefit from them (because of individual clinical conditions that have no EBP for them)  
(Bruce Chorpita, personal communication, 2013)

# Generic vs. Brand Name?

- We know of some of the very important brand name interventions used around the world
  - *Multisystemic Therapy*
  - *Multi-Dimensional Treatment Foster Care*
  - *Trauma-Focused CBT*
  - *Parent Child Interaction Therapy*
  - *Triple P*
  - Others Identified by Clearinghouses like “*California Evidence Based Clearinghouse for CW,*” *National Repository of Evidence-Based Programs and Practices* (NREPP: US SAMHSA), and ***BluePrints*** for Healthy Youth Development

# Generic (commodity) vs. Name Brand

A generic **commodity** is a good or service where there are no special, distinguishing characteristics among individual units of the good or service. One grain of wheat, one barrel of oil, one lump of coal is indistinguishable from another of its kind (Wikipedia, [n.d.](#)).

The opposite of a commodity is a **specialty or “brand name” good or service which is differentiated because it is more effective**. (Policies that insist on the use of specialty services when a commodity would do as well, are inefficient.)

**Specialty goods and services command higher prices or greater because they are in limited supply**. Yet this limits access to clients. Generics (commodities) are cheaper because there is a much larger supply.

In our field, the pressure toward name brand specialization comes from the value of being classified as more effective, which opens many doors.

# Some Clearinghouses Only (or Largely) Include Name Brands

- NREPP (US DHHS SAMHSA)
- CEBC (does include some interventions not submitted by developers (sponsors can be from professional organizations))
- These rely heavily on developers to submit materials and answer questions about their research

# Few Clearinghouses Include Generics

- *Washington State Institute for Public Policy*
- *What Works Clearinghouse* (Institute for Educational Sciences)
  - Both rely on systematic reviews to identify and evaluate a family of interventions
  - NOT REFERENCED

# Fidelity Rules!

- In the US, at least, “fidelity” is considered the most important concept in implementation of effective programs....
- If programs work and they are repeated they should work again!
- Conversely, if they don't work again, then there was almost certainly a problem with fidelity.

# WAIT!!! But How Much Do The Specific Elements or Their Order Matter?

- Few dismantling studies are available so we are generally stuck with the order and duration of the manuals. But there is one major exception:
- TF-CBT Dismantled (Deblinger et al., 2011)

# TF-CBT Dismantling Study Design

(Deblinger et al., 2011)

- Children 4-11 years of age with a recent history of Child Sexual Abuse randomly assigned to:
  - A. 16 sessions with written trauma narrative (STANDARD TF-CBT)
  - B. 16 sessions with NO trauma narrative (STANDARD BUT NTN)
  - C. 8 sessions with written trauma narrative (BRIEF TN)
  - D. 8 sessions with NO written trauma narrative (BRIEF NTN)

# Post-Treatment Results

- **Children and parents across all treatment conditions showed significant post-treatment improvements**
- No significant post-treatment differences across conditions with respect to
  - Child reported levels of body safety skills, depression, shame, internalizing symptoms, hypervigilance, and PTSD
  - Parent depression

# Author's Conclusions

- Study replicates benefits of TF-CBT for children (4-11 years of age)
- Study documents the effectiveness of an abbreviated TF-CBT format (8 sessions)
- TF-CBT leads to trauma recovery across all conditions (with or without written trauma narratives)

# My Conclusions

- If the therapist, child, and parent had been locked into a 16 week, manualized intervention with strenuous fidelity checking, we would have wasted precious client and therapist time.
- There may be MANY other variations that would be as effective as the tightly managed standard version?

# The Big Secret is Standard Methods of Assessing Fidelity are Over-rated and Largely Infeasible



# BIG EBP Implementation Challenges for Brand Names

- For example, not a single stand alone replication of **MTFC-pre**, that I know of
- **KEEP** was developed as an easier to implement less costly version of MTFC
  - Weekly parent calls (not daily)
  - No special mental health treatment for children
  - More than one child in a home at a time
  - Works with kin (not just specially trained families)
- Yet, KEEP has not been fully sustained even in San Diego where it worked beautifully for years (during a series of implementation studies)! ([Price et al., 2009](#))

# Generic vs. Name Brand Interventions

- An effective “Generic” intervention can be defined as one that is made of elements of other evidence-based programs and is, itself, shown to have impact
  - CBT, and Cognitive Therapy for Adult Depression (CEBC)

# American Psychological Association

- The American Psychological Association, <http://effectivechildtherapy.com/content/cbt-anxiety>, Division 53, also rates therapy “families” according to effectiveness.
- A recent update on evidence-based interventions (Southam-Gerow, & Prinstein, 2014) : **explicitly argues for classifying families of interventions based on common underlying theories and common ingredients over simply classifying brand named programs.**

# From GENERICS to Common Elements

- A Risk of Generics is that there is no Fidelity Manager from the Name Brand organization to ensure that program and practice elements are in place
- **Common Elements Approaches are a Way to Implement Generic Approaches with fidelity and the greatest Attention to Being Evidence Informed**

# Beyond Generics

- One way to integrate these ideas is through the use of scientific building blocks (**elements**) from standardized interventions that are used **flexibly** but with **fidelity**!

# Overview of the Common Elements Approach

- **Premise:** Apply elements that are found across several evidence-supported interventions to flexibly meet client needs
  - An alternative or complement to using only complete, manualized-evidence supported interventions (which have poor coverage because they are often only focus on one problem)
  - These approaches can be expected to be effective and to meet basic standards of fidelity despite their flexibility

# Review of Lingo re “Building Blocks”

- **Active Ingredients:**

- An element of an intervention that is really making **the difference—nothing we say should be interpreted to mean that we know the *active ingredients***

- **Essential Components:**

- This is the CEBC language, provided by the treatment developers, as to what matters most—even though we cannot really be sure what is essential **NOT REFERENCED**

- **Common Elements:**

- Bruce Chorpita and colleagues term for **what elements are most commonly found in the winning treatment arms of studies (not sure which Chorpita article)**
- Ann Garland’s term **for what mental health professionals most often use in practice (Garland et al., 2008)**

- **Common Components:**

- Barth and Liggett-Creel (2014) term for **frequent elements in promising and effective parenting programs** (with no suggestion that we know whether these are winning or active or essential components)

- **Kernels:**

- Dennis Embry and Tony Biglan’s (2008) term **for evidence based elements, with one or more peer reviewed experimental study showing behavior change, selected as being indivisible units of effective intervention with wide generalizability**

# Ways to Identify Elements

1. Distillation and Matching Method (Chorpita et al, 2009 Lee et al., 2014)  
Through this approach, the contents of a “winning” treatment manual can be “distilled,” or separated into distinct techniques. This common elements approach lends itself to a modular approach to service delivery allowing clinicians to individualize treatment content to match a specific client’s needs.
2. Focus groups and Delphi method (Garland et al., 2008)
3. Meta-Analysis using Meta-Regression (Kaminski & Valle et al., 2008) for parenting programs; Lipsey (2014) for juvenile services
  - Meta-regression has gained popularity in social, behavioral and economic sciences. Important applications have focused on qualifying estimates of policy-relevant parameters, testing economic theories, explaining heterogeneity, and qualifying potential biases.
4. Unsystematic reviews: Broad review of the literature to find **kernels** (Embry & Biglan, 2008)

# The Common Elements Approach

## Step 1:

Emphasis on  
evidenced-based  
treatments

## Step 2:

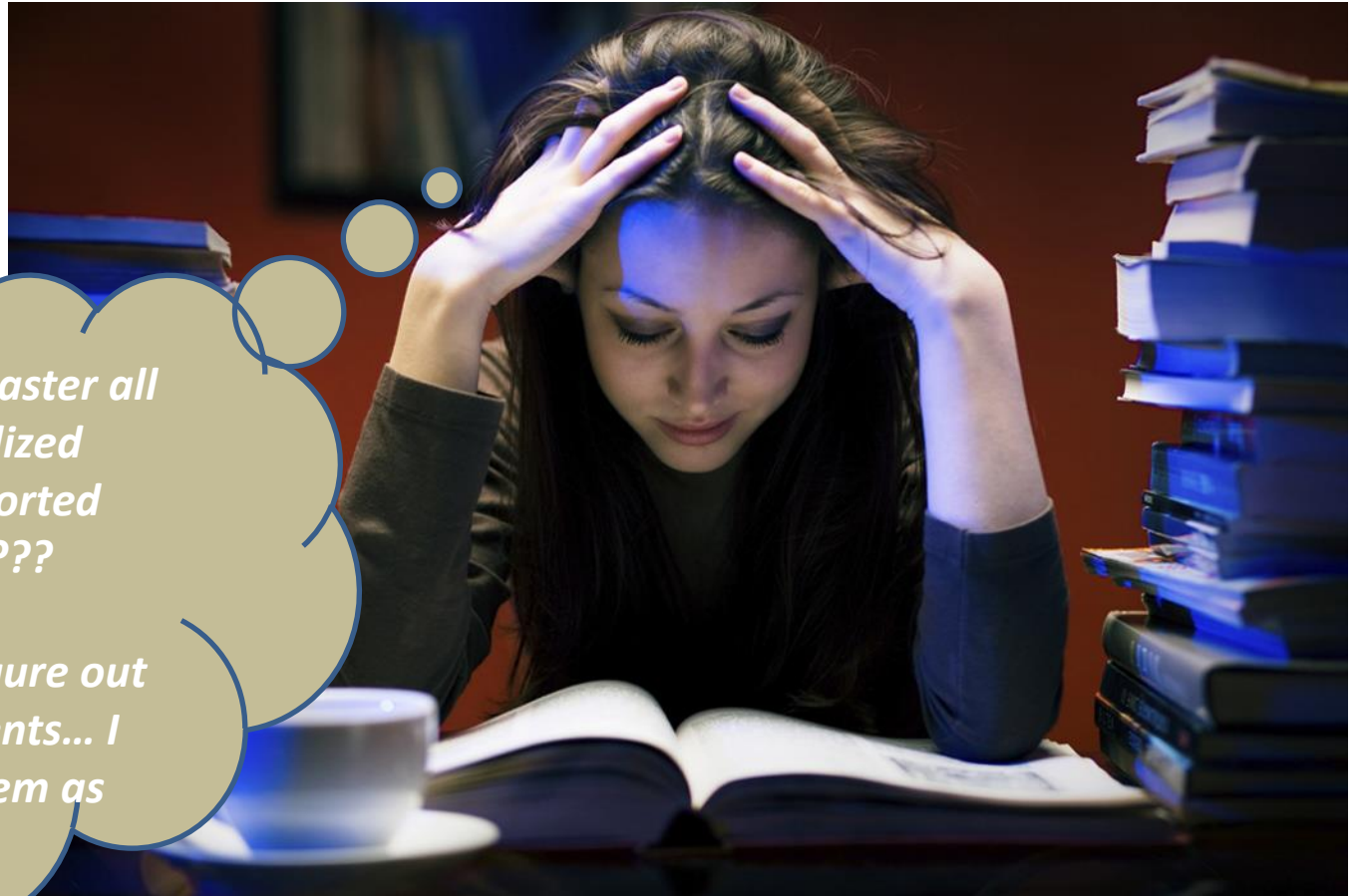
Development of  
treatment  
elements,  
compilation into  
treatment  
programs, and  
testing of treatment  
manuals

## Step 3:

Information  
overload: Too many  
treatment manuals  
to learn and  
manuals change as  
new knowledge is  
gained



# Common Elements Approach



*How will I ever master all these Manualized Evidence Supported Treatments???*

*If only I could figure out the basic elements... I could apply them as needed*

# How were the ‘Winning’ practice elements identified by Chorpita?

- ▶ Trained coders reviewed 322 RCTs for major mental health disorders for children and teens;
  - ▶ Over \$500 million invested in these research studies
  - ▶ Studies conducted over a span of 40 years
  - ▶ More than 30,000 youth cumulatively in the study samples (*Chorpita & Daleiden, 2009*)
- ▶ **Approach:** What features characterize successful treatments? What strategies are common across effective interventions?

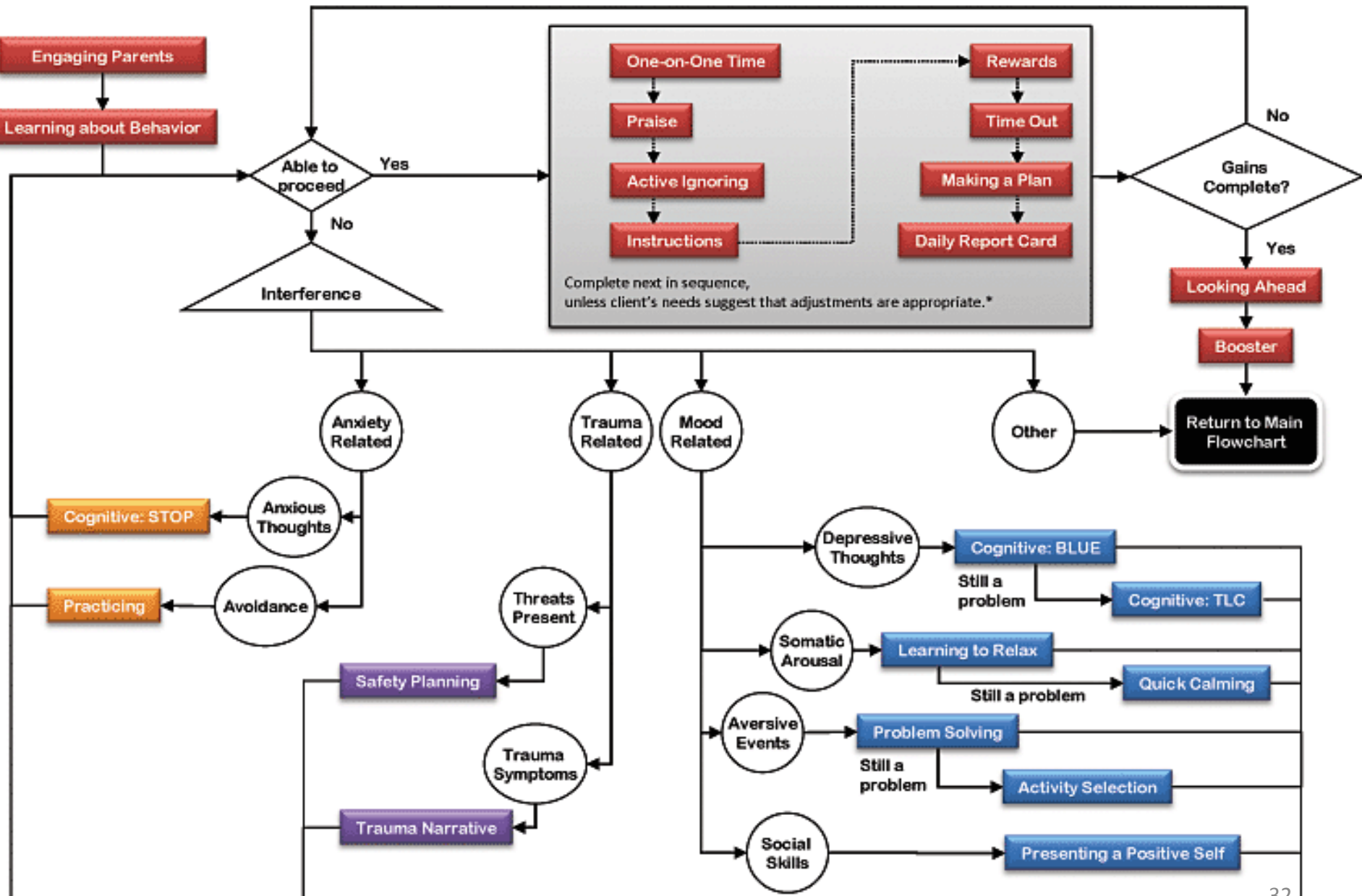
# Fidelity Strategies: Elements Are Matched By Diagnosis or Symptoms

- “Treat to the Target”
  - What elements seem to have the strongest relationship to the target symptoms?
- Given the lack of data, use “expert clinicians” to choose which elements are best related to which elements and whether the order of treatment matters

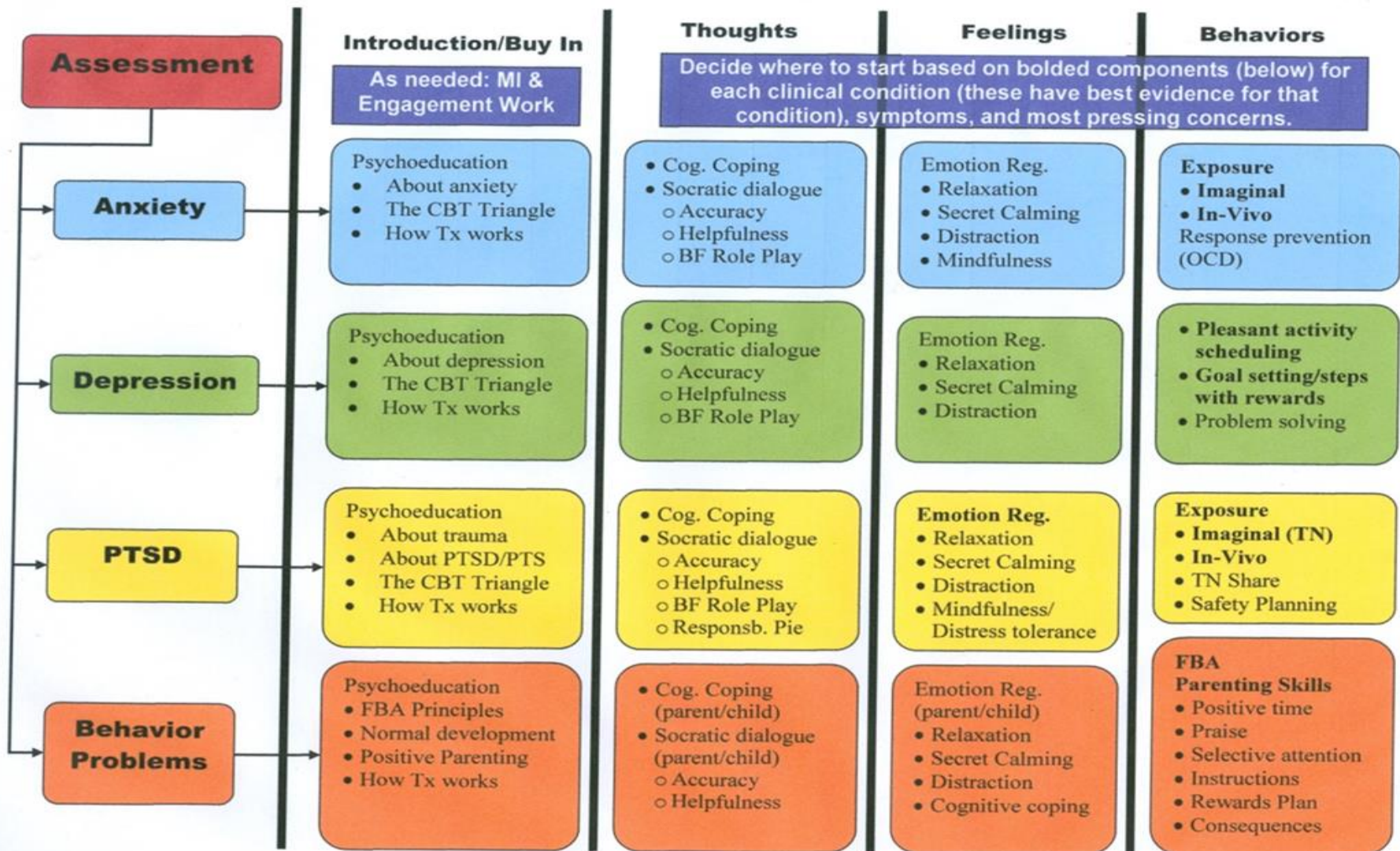
# Treatment Targets & Practice Elements

- In Hawaii, therapists record the diagnoses, treatment targets (symptom reduction), and the use of practice elements and test for their convergence.
  - **The extent to which therapists use these common elements predicts therapist reported progress** in treatment of children with a primary diagnosis of ADHD and disruptive behavior (Denneny & Mueller, 2012)
  - Usual care clinicians reported a variety of practices, only some of which were common to the evidence base for traumatic stress. **'Exposure' stood out as the most common practice element among EBTs for treating traumatic stress, but it was reported in fewer than a quarter of usual care cases** (Borntrager et al., 2013)

# Conduct Flow Chart



# Follow the CBT+ Flow Chart



# Do Generic and Common Elements Approaches Work?

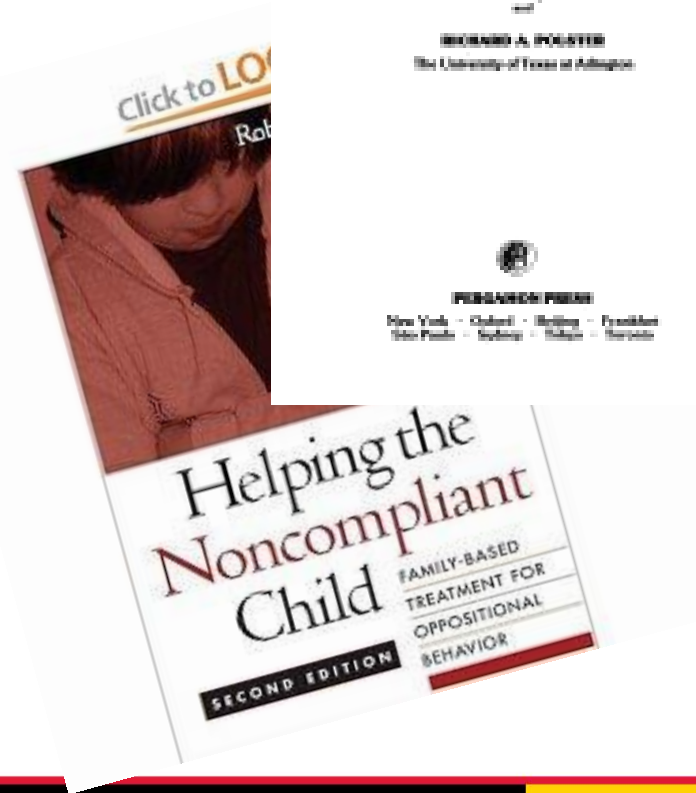
- Example One: Parent Training
- Example Two: Children's Mental Health Services

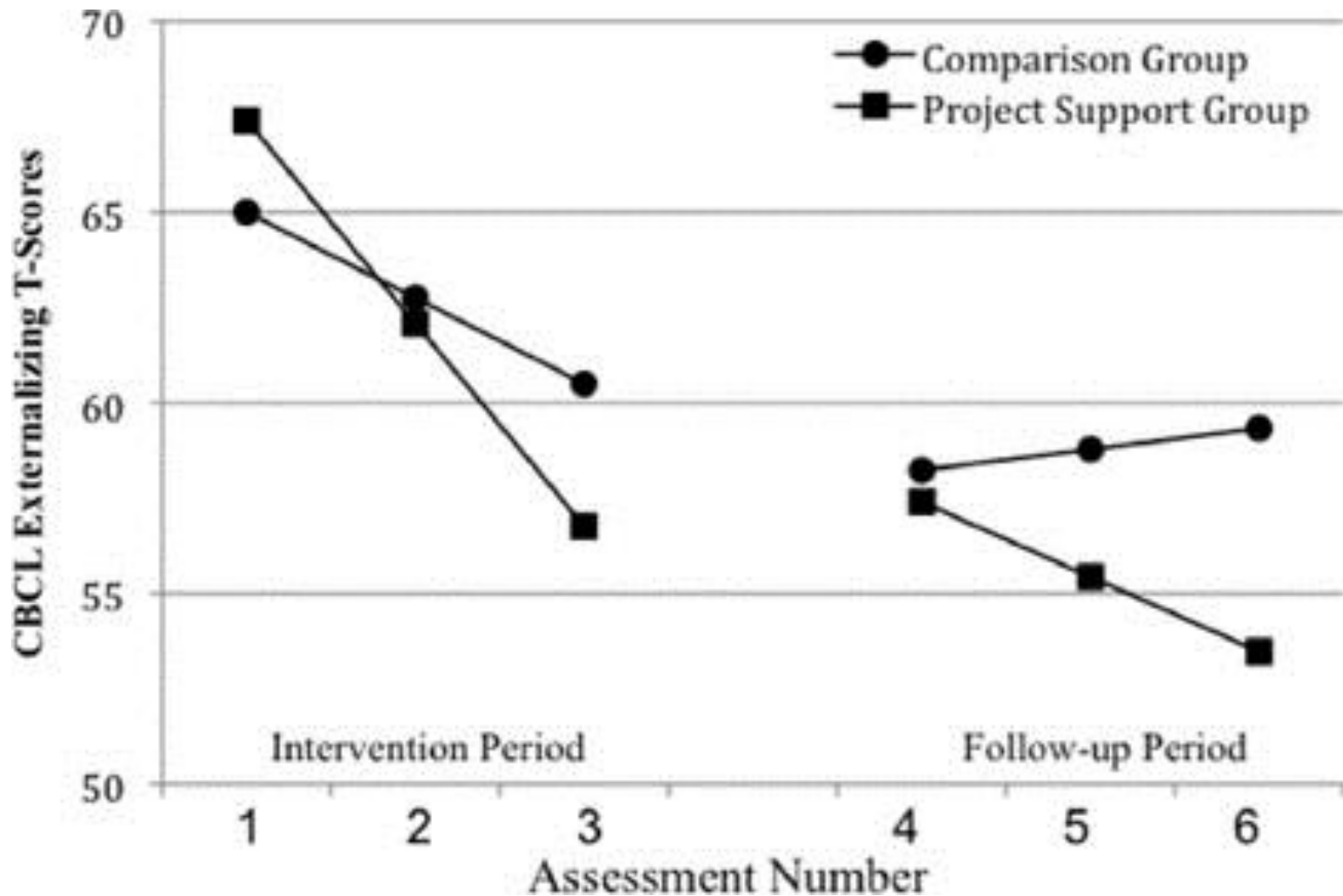
# Generic Parent Training Can Work: Reducing Conduct Problems Among Children Exposed to IPV

Jouriles and Colleagues (2009) in Texas developed a parent training intervention for mothers who had just left a DV Shelter.

Treatment based on general text books: Dangel & Polster (1988) and Forehand and McMahon (1981).

Included 12 child management skills (listening to your child, praising, reprimanding) **presented in sequence: one family at a time**. Pre-training of therapists and regular in-service supervision was provide.



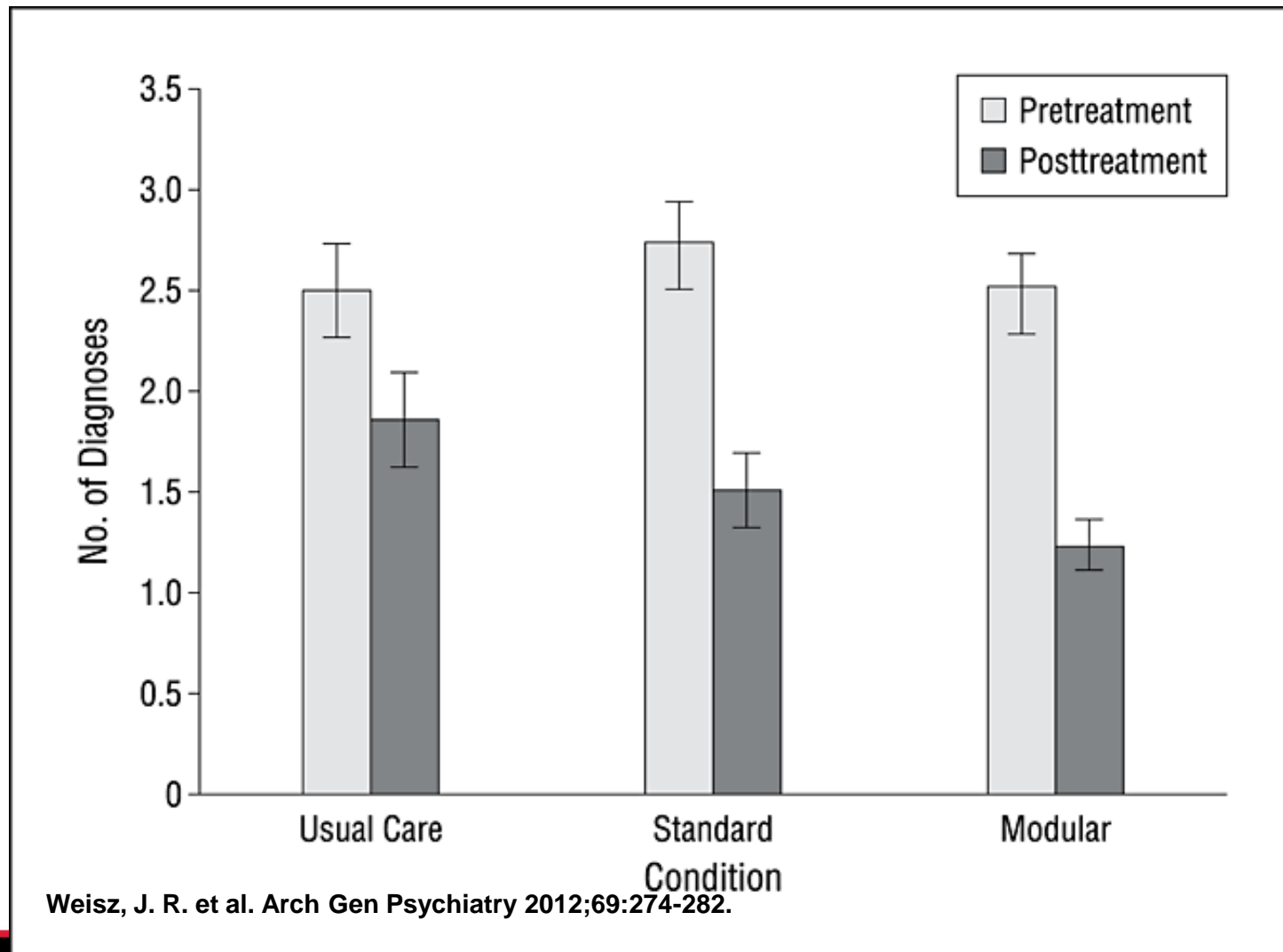


Greater improvement during parent training and continued improvement well into the normal range from “generic” parent training

# Weisz et al (2012) Summary of Results

1. Youth in modular treatment showed significantly faster improvement than youths in usual care, on overall and parent-reported behavior problem measures.
2. Modular treatment also outperformed standard (manualized) treatment, on behavior problem score.
3. Outcomes in the standard manual condition did not differ significantly from outcomes in usual care.

# Weisz et al. RCT Shows that **Modular Approach** to MH Treatment Works with Depressed, Anxious, or Conduct Disordered Children



# Common **Program Components** Matter, Too

- Lipsey has done this work regarding program context for juvenile services.
- Brunk et al (2014) have done this for MST, showing that operation of critical program structures were associated with arrests but the average therapist adherence (TAM scores) was not significantly associated with success ( $p = .15$ ).
- Program structure may be the best we have now for some problems and populations... provides some assurances of “fidelity”.

# Common Program Elements Approach

- Lipsey and Howell's SPEP (Standardized Program Evaluation Protocol) approach rates aspects of the program include the
  - type of services provided (primary and supplemental),
  - the amount of service (duration and contact hours),
  - the quality of implementation, and
  - the risk level of the youth served
- The maximum number of points available for each rated aspect of the program that is proportionate to the strength of that factor in reducing recidivism (Lipsey & Howell, 2012)

# Advantages of the Common Practice Elements Approach

- Flexibility to adapt practice to client needs or practice setting/structure;
- Practice elements derived from interventions with known effectiveness;
- Training practitioners on practice elements may be less cumbersome and was found to improve clinician's attitudes towards EBPs (Borntrager et al., 2009);

# Training in Common Elements vs Clinical Competence

- Use of common elements, with fidelity, is not competence (nor is use of a manual).
- We ultimately need to be capable of assessing the therapist's knowledge of the treatment and its use, as well as the therapist's ability to apply this knowledge in clinical practice (Fairburn & Cooper, 2011).
- ***Measurement feedback systems*** are critical to the success of common elements and generic approaches

# Divining the Future: Practice Elements (not manualized treatments) as the Unit of Analysis

A strong study found that MST therapists reported a higher proportional use of practices found in the evidence base for disruptive behavior disorders than did intensive in-home therapists (Denneny & Mueller, 2012).

Increased use of practices derived from the common elements evidence base predicted greater functional improvement in youth with a primary diagnosis of ADHD and a similar trend in youth with a primary disruptive behavior disorder (cited in Nakamura, Mueller, Higa-McMillan, Okamura, Chang, Slavin, & Shimabukuro, 2014).

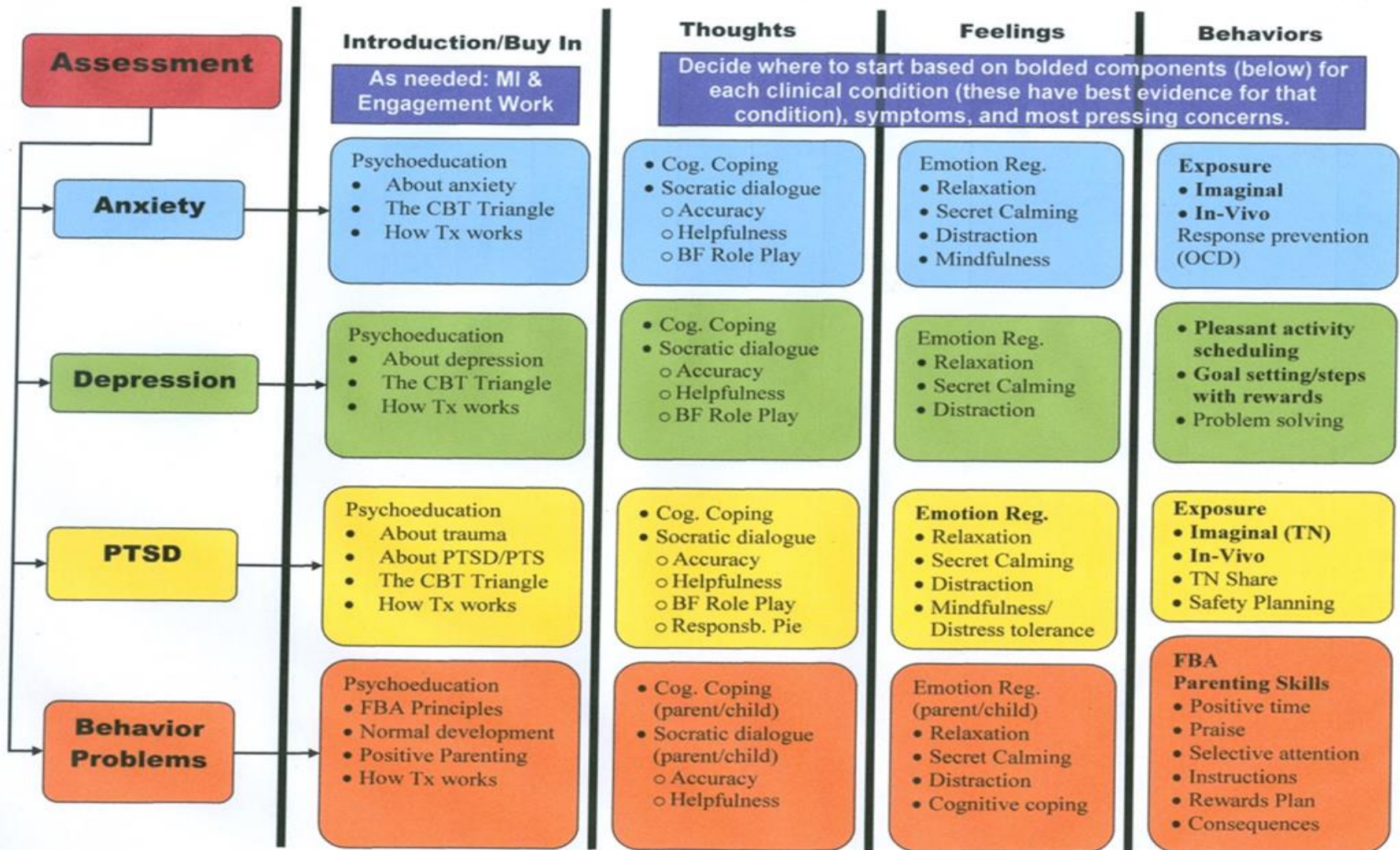
# CBT+



- Components-based therapy approach to
  - Anxiety
    - Including Traumatic Stress
  - Depression
  - Behavior Problems
- Integrating three evidence-based treatment approaches:
  - Cognitive Behavior Therapy (CBT)
  - Parent Behavior Management (Behavioral Parent Training)
  - Trauma-Focused Cognitive Behavior Therapy (TF-CBT)
- Includes “Toolkit” for measuring changes in symptoms and associating those with CBT elements



# Follow the CBT+ Flow Chart



# Efficient Measurement Feedback Systems Are Developing

- They include:
  - Clear identification of the target behaviors
  - Logical relationship between choice of treatment elements and reduction in symptoms
  - Child, Family, and Professional feedback is incorporated
  - **THEY APPEAR TO MAKE A DIFFERENCE** (Bickman, et al., 2011).

# STEPS Kid 1

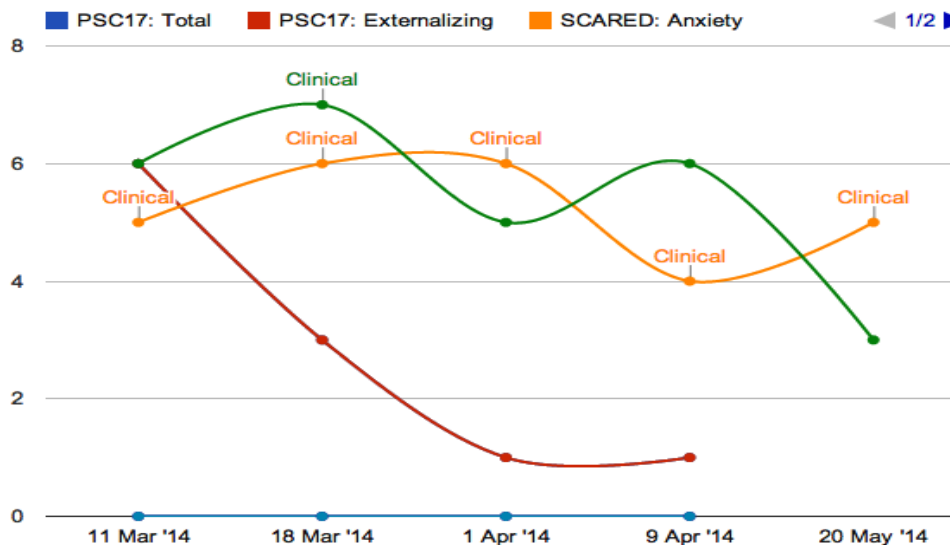
- Details
- Measures (9)
- Sessions (6)
- Analysis**

## Measures

### Filters

- SCARED
- PSC17
- All respondents
- Mom
- Self

Filter Chart



## Sessions

Content	Mar 11, 2014	Mar 18, 2014	Apr 1, 2014	Apr 9, 2014	May 15, 2014	May 20, 2014
Assessment	✓					
Psychoeducation	✓			✓		
Parenting				✓		
Relaxation		✓				
Affective Exp. & Mod.			✓			
Cognitive Coping		✓	✓	✓		

# Summary

1. Common elements are the core of name-brand interventions
2. Fidelity monitoring of practices implementation may not be as important as monitoring of program characteristics
  - a. Yet, program characteristics without proper application of common evidence-informed practice elements are unlikely to succeed
    - a. Witness the application of system of care principles to family meetings that do not seem to generate much benefit.
3. Ergo, use of common elements with strong program elements should be reinforced!

# Summary

4. Most EBPs are derivative of a few important and common intervention ideas based on CBT and Behavioral Parent Training

5. The majority of EBPs are not so special that they need a unique treatment manual, fidelity checking procedure, or clinical consultation process

- We now have plenty of generic tools, e.g., for teaching parenting for children 4-8 with conduct problems.

6. Common elements and common feedback systems are on the way to acceptance

- This combination (and informed supervision) will have more overall impact than fidelity monitoring of name brand programs

# Final Note

- I hope that I have made our challenges a little clearer—even if I have not made them easy!

**Thank you for this opportunity**



**We, together, can make the changes  
our parents and children need!**

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