

Emotional & Behavioral Disorders in Youth™

EVIDENCE-BASED ASSESSMENTS • INTERVENTIONS FOR THE REAL WORLD

Volume 8, No. 1

Pages 1 – 24

ISSN 1531-5479

Winter 2008

Editor's Corner

Both More and Better

Mental health services have not appeared to be a high priority in Virginia during the last nine years that I have lived here. Our community mental health agencies are not well funded, school mental health services are minimal, and prevention and treatment services for children with emotional and behavioral problems almost never enter into the political discussions that are covered by the media.

Change After Virginia Tech

The political discussions changed last year after the shootings at Virginia Tech. The report that came from the governor's panel charged with reviewing the tragedy included scathing criticism of the state's mental health system. It noted long waits for care, poorly coordinated systems of care, and a myriad of other problems that have plagued the system for years. The mental health system was a target of review by this panel because the shooter at Virginia Tech had a history of mental health problems and was court ordered to receive care—care that was never delivered.

Stories of tragedies associated with children and adolescents with emotional and behavioral disorders are plentiful and have been around forever, but they have not been as visible as the shootings at Virginia Tech. A recent story in our daily newspaper reported that increasing support for mental health services

See EDITOR'S CORNER, next page

Adaptation and Implementation of Behavioral Parent Training for Latino Families: Cultural Considerations and Treatment Acceptability. 3

by Yamalis Diaz, Laura A. Knight, and Andrea Chronis-Tuscano

The Evidence-Based Treatment Dissemination Center (EBTDC): Bridging the Research-Practice Gap in New York State 9

by Michael S. North, Alissa A. Gleacher, Marleen Radigan, Lindsay Greene, Jessica Mass Levitt, Janet Chassman, and Kimberly E. Hoagwood

The First Step to Success Program for Preventing Antisocial Behavior in Young Children: Update on Past, Current, and Planned Research 17

by Hill Walker, John Seeley, Jason Small, Annemieke Golly, Herbert Severson, and Edward Feil

Calendar of Events 24

Sponsored by James Madison University's Baird Attention & Learning Disabilities Center

© 2008 Civic Research Institute. Photocopying or other reproduction without written permission is expressly prohibited and is a violation of copyright.

EDITOR'S CORNER, from page 1

is a point of near unanimous agreement between Democrats and Republicans.

Access to Care Only Part of the Problem

Two of the biggest problems that plague our mental health system—in Virginia and around the nation—are access and quality of

No Advantage of Mental Health Treatment vs. Tutoring. The first is a study by Weiss and colleagues (1999) that randomly assigned children with emotional and behavioral problems according to teacher, peer, and self-report to receive either mental health treatment or tutoring. The mental health services were provided by mental health professionals, and the amount of services and duration

was designed to evaluate the potential benefits of a well-organized system of care for children's services. Bickman (1996) contrasted the outcomes of children who received care in a well-coordinated system of services with easy access and coordination across levels of care with traditional care. In spite of the state-of-the-art system of care for the children in one condition, there were no differences in measures of mental health symptoms or social and academic functioning between the two groups of children. The investigators did not control the quality of care or adherence to best practices by providers in either of the systems. Nevertheless, there were large differences between the two systems of care evaluated in this study on ease of access, coordination of services, and the provision of care in community settings. However, if the care was only minimally effective, then issues of staffing, coordination, and ease of access are secondary to quality.

This message appears to be right on point for Virginia's plans to improve its mental health system. If quality of care is not meaningfully addressed in the improvements, it will not matter how many additional clinicians are hired or how well care is coordinated across services. As noted in the title of the article by Bickman (1996), "More is not always better."

Distinct Advantage of Research Laboratory vs. Community Care. Finally, in a third study by Weisz and colleagues (1995),

See EDITOR'S CORNER, page 23

If quality of care is not meaningfully addressed in the improvements, it will not matter how many additional clinicians are hired or how well care is coordinated across services.

care. Unfortunately, most of the discussions by advocates and politicians about the needed improvements to the system have focused only on access issues. They have argued for increases in the numbers of mental health professionals at community mental health agencies and improvements in the coordination of services. These would certainly be important changes to the system that would likely improve access; however, these changes would not improve the quality of services. The research literature includes a variety of studies documenting that care typical of the kind that is often provided in the community may be of little benefit. Three studies in particular have demonstrated this point.

of treatment were unlimited by the study. In addition, the clinicians were free to provide whatever type of services they thought would be most helpful. After two years and an extensive amount of services delivered, there were no differences in severity of symptoms, school functioning, or social functioning between those who received tutoring and those who received mental health treatment. Furthermore, the tutoring was provided by paraprofessionals at a much lower cost than were the mental health services.

No Advantage of Well-Organized vs. Traditional Health Care System. Another study that addressed this issue

REPORT ON

Emotional & Behavioral Disorders in Youth™

Editor:

Steven W. Evans, Ph.D., Director,
Alvin V. Baird Attention &
Learning Disabilities Center,
James Madison University,
Harrisonburg, VA

Assistant to the Editor:
Ashley R. Hopkins

Managing Editor:
Margaret B. Riccardi

**Publisher &
Editorial Director:**
Deborah J. Launer

The information in this publication is not intended to replace the services of a trained legal or health professional. Neither the editor, nor the contributors, nor Civic Research Institute, Inc. is engaged in rendering legal, psychological, health or other professional services. The editors, the contributors and Civic Research Institute, Inc. specifically disclaim any liability, loss or risk, personal or otherwise, which is incurred as a consequence, directly or indirectly, of the use and application of any of the contents of this publication.

Editorial Board

Marc S. Atkins, Ph.D., Department of Psychiatry, University of Illinois at Chicago, Chicago, IL

Charles E. Cunningham, Ph.D., Professor, Department of Psychiatry and Behavioral Neuroscience, McMaster University, Hamilton, Ontario, Canada

Laurie Flynn, Director, Center for Families, Communities & Health, Columbia University, New York, NY; Former Executive Director, NAMI

Steven R. Forness, Ed.D., Professor of Psychiatry (Special Education), Inpatient School Principal and Chief Educational Psychologist, UCLA Neuropsychiatric Institute, Los Angeles, CA

Kimberly Hoagwood, Ph.D., Director of Research on Child & Adolescent Services, Office of Mental Health, State of New York

Peter S. Jensen, M.D., Director, Center for the Advancement of Children's Mental Health, Columbia University, New York, NY

Mary McKay, Ph.D., Professor of Psychiatry and Community Medicine, Mt. Sinai School of Medicine, New York, NY

William E. Pelham, Jr., Ph.D., UB Distinguished Professor of Psychology, Pediatrics, and Psychiatry and Director, Center for Children and Families, State University of New York at Buffalo, Buffalo, NY

Hill Walker, Ph.D., Professor of Special Education, College of Education, University of Oregon; Founder and Co-Director, Institute on Violence and Destructive Behavior, Eugene, OR

Mark D. Weist, Ph.D., Professor and Director, Center for School Mental Health Analysis and Action, University of Maryland School of Medicine, Baltimore, MD

John Weisz, Ph.D., Professor, Department of Psychology, University of California at Los Angeles, Los Angeles, CA

Affiliations shown for identification purposes only. Opinions expressed do not necessarily reflect the positions or policies of a writer's agency or association.

Report on *Emotional & Behavioral Disorders in Youth* is published quarterly by Civic Research Institute, Inc., 4478 U.S. Route 27, P. O. Box 585, Kingston, NJ 08528. Periodicals postage pending at Kingston, NJ and at additional mailing offices. Subscriptions: \$152 per year in the United States and Canada. \$30 additional per year elsewhere. Vol. 8 No. 1, Winter 2008. Copyright © 2008 by Civic Research Institute, Inc. All rights reserved. POSTMASTER: Send address changes to Civic Research Institute, Inc., P.O. Box 585, Kingston, NJ 08528. Report on *Emotional & Behavioral Disorders in Youth* is a trademark owned by Civic Research Institute, Inc., and may not be used without express permission.

For information on subscribing or other service questions contact customer service: (609) 683-4450 or civres2@aol.com

Adaptation and Implementation of Behavioral Parent Training for Latino Families: Cultural Considerations and Treatment Acceptability

by Yamalis Diaz, Laura A. Knight, and Andrea Chronis-Tuscano*

Behavioral parent training programs have demonstrated superior efficacy in treating child attention and behavior problems. However, because most of the validated parenting programs have been developed and tested primarily with middle-class, Caucasian families (Forehand & Kotchick, 1996, 2002; Herschell et al., 2002; Wood & Baker, 1999), their cross-cultural generalizability is limited. Cultural factors affecting the utilization and effectiveness of psychosocial interventions for ethnic minorities have been an increasing focus of the treatment literature, as the field of clinical psychology strives toward achieving multicultural competency and greater service provision for underserved populations.

Findings suggest that culturally adapted psychosocial interventions may increase treatment participation and compliance among minority families and may ultimately improve treatment outcomes (Catalano et al., 1993; Gonzalez-Castro et al., 2004; Gorman & Balter, 1997). However, there is no *empirically based* framework to guide the process of cultural adaptation for psychosocial interventions. As a result, existing interventions are often modified in community service settings based on clinical intuition and general assumptions regarding relevant cultural values, issues, and the perceived needs of the target population (Vega & Lopez, 2001). This article reviews relevant research regarding cultural considerations in the adaptation and implementation of parent training interventions for Latino families.

Recent census data indicate that Latinos make up the largest minority group in the United States (Therrien & Ramirez, 2000), pointing to the need for culturally competent mental health services for this population.

*Yamalis Diaz, M.A., is a doctoral student in the Department of Psychology at the University of Maryland, College Park. Laura A. Knight, Ph.D., is a research associate with the Maryland ADHD Program in the Department of Psychology. Andrea Chronis-Tuscano, Ph.D., is an assistant professor in the Department of Psychology. Yamalis Diaz can be reached by email at ydzia@psyc.umd.edu.

This is especially the case for Latino children and adolescents, who make up 36% of the U.S. Latino population. Latino children under age five currently constitute 22% of the *total* U.S. population. These statistics underscore the immediate need to develop interventions for the growing population of Latino children and families.

Cultural Child-Rearing Values

Latinos are a heterogeneous population, with large variations in country of origin and in traditions, values, and beliefs. Although generalizations clearly won't apply to *all* Latino groups, common values, beliefs, and expectations among Latino parents of different nationalities have been identified in the literature, providing a general understanding of the context in which Latino children are reared (Harwood et al., 2002).

In general, Latino societies tend to demonstrate "collectivist" values, demonstrating an emphasis on sociocentrism and interdependency (Harwood et al., 2001;

Garcia, 1993; La Roche, 2002; Miller & Harwood, 2001) and by high levels of affiliation, cooperation, and emotional and instrumental interdependence among family members (Organista, 2007). An extended family network is viewed as an important resource among Latino families, providing social support and assistance in day-to-day functioning. Indeed, researchers have proposed that the emphasis on family loyalty, unity, and reciprocity among Latino families may protect against psychosocial problems by reducing the negative impact of environmental stressors (e.g., acculturative stress) on the family system (Bacallao & Smokowski, 2007; MacPhee et al., 1996). Finally, an interdependent, extended family structure is thought to play an important role in child socialization, providing a "changing cast of caregivers" who may be highly involved in socializing and disciplining children within Latino families (La Roche, 2002).

Respeto. Consistent with a high regard for *familismo*, Latino families share an

Latino families share an expectation for children to be highly respectful and obedient toward all adult family members, including grandparents, aunts, and uncles.

2002), compared to the more "individualistic" mainstream American culture, valuing independence, autonomy, and egocentrism. These constructs are thought to reflect cultural values at the broad societal level (Triandis, 1995), and, therefore, affect family structure and beliefs about childrearing and child behavior within cultural groups.

Familismo. Collectivist values are reflected in the high regard for *familismo* [familism] that has been noted among Latino groups (Harwood et al., 2002; La Roche, 2002; Organista, 2007). *Familismo* is evidenced by the presence of extensive social networks, made up largely of extended

expectation for children to be highly respectful and obedient toward all adult family members, including grandparents, aunts, and uncles (Calzada & Eyberg, 2002; Zayas & Solari, 1994), a value referred to as *respeto* (respect; Harwood et al., 2002; Zayas & Solari, 1994). Relatedly, children are expected to display "proper demeanor" (i.e., appropriate manners and behavior), particularly in public contexts (Gonzalez-Ramos et al., 1998; Harwood, 1992; Harwood & Miller, 1991; Harwood et al., 1996). The concepts of *bien educado* versus *malcriado* reflect this expectation

See ADAPTATION, next page

ADAPTATION, from page 3

(Organista, 2007). *Bien educado* literally translates to “well-educated,” meaning that children are expected to demonstrate behaviors indicating that they are being raised properly, versus disrespectful behavior suggesting the opposite (i.e., *malcriado*; Arcia et al., 2000; Borrego et al., 2006; Organista, 2007). As such, child behavior is viewed as a direct reflection of parenting within the Latino community.

Latino vs. Caucasian Values. Harwood and colleagues have noted significant

outlined above suggest that Latino parents may be particularly disturbed by child behavior that is perceived as disrespectful or highly inappropriate. Arcia and Fernandez (2003) found that their sample of Cuban, Dominican, and Puerto Rican mothers of children referred for treatment of attention deficit hyperactivity disorder (ADHD) were most concerned by their inability to manage their child’s behavior and by their children’s poor self-control, congruent with the values of *respeto* and *proper demeanor*. Latino parents (primarily of Mexican descent) of children diagnosed with ADHD reported

ethnic groups. These results emphasize the need for clinicians to consider not only the family’s cultural values, but also the level of acculturation of family members.

Treatment Acceptability Research

Theoretical and empirical research has linked treatment acceptability to treatment initiation, compliance, retention, and overall effectiveness, and those treatments perceived as appropriate for the target problem are more likely to be sought by consumers (Reimers et al., 1987; Witt & Elliott, 1985). Treatment acceptability reflects the degree to which a treatment approach is perceived as appropriate for addressing a given problem (Kazdin, 1980) and is largely based on Wolf’s (1978) social validity criteria. Wolf (1978) suggested that social validation of an intervention requires an assessment of the social importance of the treatment goals, the appropriateness of treatment procedures (i.e., treatment acceptability), and the significance of treatment effects (i.e., effectiveness). Any one of these factors may serve as a barrier to seeking or participating in treatment. Among Latinos, 57% of families reported that they had not sought treatment for child mental health problems because they did not believe treatment would be helpful or effective (Yeh et al., 2003).

Lau (2006) proposed that cultural adaptation efforts should be “selective” and “directed” by focusing attention on those empirically supported interventions that have demonstrated poorer engagement or treatment response among diverse families. Moreover, she specified that treatment adaptation is particularly necessary when ethnic minority clients view treatment components as “irrelevant, unhelpful, or unacceptable” (Lau, 2006; p. 299). In light of research suggesting poor engagement of ethnic and racial minority families into parent training programs (Reid et al., 2001) and concerns regarding acceptability of parenting strategies among minority parents (McCabe et al., 2005), Lau noted that parent training programs are examples of empirically supported treatments that likely warrant cultural adaptation, but the lack of research related to acceptability and treatment outcome among these families makes program adaptation difficult.

Existing Research on Adapted Parent Training Programs

Parenting programs focus on teaching parents strategies intended to modify the

See ADAPTATION, next page

Among Latinos, 57% of families reported that they had not sought treatment for child mental health problems because they did not believe treatment would be helpful or effective.

differences between Puerto Rican and Caucasian mothers with regard to these values. Whereas Puerto Rican mothers endorsed child socialization goals emphasizing “proper demeanor” (i.e., *respeto*), Caucasian mothers emphasized “self-maximization” goals (i.e., independence; Harwood et al., 1996). Moreover, Puerto Rican mothers placed importance on child behavior demonstrating *familismo*, obedience, and *respeto*. In contrast, Caucasian mothers emphasized the child’s personal control, confidence, independence, and autonomy. Further, consistent with the value of *familismo*, Puerto Rican mothers were more likely to rate proximal child behavior (i.e., staying close to mother) more positively than distal behaviors (i.e., autonomous), whereas the reverse was true among Caucasian mothers (Harwood, 1992; Harwood & Miller, 1991; Harwood et al., 1996; 2001; 2002; Miller & Harwood, 2001). Similar results have also been reported among Central American parents (Leyendecker et al., 2002).

“Normative” vs. “Defiant” Behavior.

By definition, behaviors viewed as “normative” within a culture are highly congruent with the larger societal norms, whereas “deviant” behaviors differ from those norms. Parental and societal “tolerance” for different forms of child behavior is largely determined by cultural values (Weisz et al., 1985), and this becomes particularly salient when considering definitions of “problematic” child behavior and beliefs about appropriate parental responses. The cultural values

feeling that they should be able to “handle the children” and that their peers may “blame the parents for a lack of discipline” (Perry et al., 2005, p. 316). Results suggest that parental perceptions and concern regarding child behavior is at least partly determined by culturally shaped values and beliefs regarding appropriate child behavior.

Acculturation. The degree to which parents adhere to and emphasize culturally rooted child-rearing values versus mainstream (i.e., American) values varies as a function of acculturation (Harwood et al., 2002), defined as “changes in behaviors and values made by members of one culture as the result of contact with another culture” (Burnam et al., 1987). Okagaki and Sternberg (1993) found differences between immigrant and American-born parents in values pertaining to child behavioral and developmental goals in the school setting that link cultural values and acculturation. Specifically, parents from Cambodia, Mexico, the Philippines, and Vietnam who had immigrated to the U.S. were more likely than American-born Latino and Caucasian parents to value conformity and obedience, whereas the reverse was true for autonomous behavior, with Caucasian parents being the most likely to emphasize child autonomy. Interestingly, the immigrant groups included in this study were from highly diverse, but also generally collectivist, cultures, suggesting that the values of *respeto* and conformity fall within the broad construct of collectivism for different

ADAPTATION, from page 4

antecedents and consequences of child misbehavior (Chronis et al., 2004). Skills taught in parenting programs typically address responses to negative child behavior using nonphysical punishment strategies (e.g., time out, response cost), as well as responses to prosocial child behavior (e.g., praise, tangible rewards; Miller & Prinz, 1990). Parent training programs vary in format (individual or group), age range of target child (toddler through adolescent), and target behavior (oppositional behavior, social skills), but are typically based on behavioral principles (Kazdin, 1997).

Recent research provides preliminary support for cultural adaptation of existing empirically supported parenting interventions for children with attention and behavior problems. Components of existing treatments are likely to be effective with diverse populations but may require modifications to increase their acceptability and cultural relevance to the target population (McCabe et al., 2005). Furthermore, adaptation of existing programs, rather than development of new programs, is a more economical approach that allows scientific evaluation and comparison of original versus adapted programs (McCabe et al., 2005).

The Nuestras Familias Program. The *Nuestras Familias: Andando Entre Culturas* program (Our Families: Moving Between Cultures; Martinez & Eddy, 2005) represents a culturally adapted version of Parent Management Training (PMT), an empirically validated treatment for oppositional defiant and conduct disorders (ODD; CD) in children (Brestan & Eyberg, 1998; Kazdin, 2005).

PMT is based on social learning theory, which proposes that problem behaviors in children are inadvertently developed and sustained in the home via maladaptive parent-child interactions, including parental attention to deviant behavior, reinforcement of aggressive behavior, inattention to prosocial behavior, poor monitoring, and failure to set limits (Kazdin, 1997). PMT uses didactic instruction, modeling, and role-playing techniques to teach effective parenting skills for managing child misbehavior. Based on their work with Latino families at the Oregon Social Learning Center, Martinez and Eddy (2005) adapted PMT with the assistance of community-based professionals.

Prior to empirical testing, the authors presented the adapted program to a group of Latino parents, who provided feedback

that was used to further refine the manual. The adapted program retained core PMT components (e.g., giving brief, explicit directions; consistent discipline and limit setting), which were presented in the same manner as the original program, and added sessions deemed culturally relevant to Latino families (e.g., family adjustment in the United States) and emphasizing important cultural values. The authors also adapted the presentation of traditional PMT material to be culturally sensitive (e.g., presented in Spanish). This is consistent with a hybrid model of adaptation, in which core components of established programs are

nity setting. Indeed, parents demonstrated high rates of attendance (70% completed at least 10 sessions) and reported high levels of satisfaction with the program (100% of participants rated intervention as “some-what” or “very” helpful).

Martinez and Eddy (2005) provided unique empirical data demonstrating the efficacy of a fully culturally adapted version of an empirically supported parent training program. Although commendable, they did not examine the changes *necessary* to PMT to make it acceptable to Latino parents. It is unclear whether Latino parents would have found the original program acceptable and

In contrast to Puerto Rican parents, who perceived ignoring as difficult and time-out as “cruel,” Mexican American parents noted that ignoring and time-out appeared “too mild.”

maintained, while incorporating additional components relevant to the target cultural group, thus allowing for maximization of program fidelity while enhancing *fit* (Gonzalez-Castro et al., 2004).

Treatment feasibility and effectiveness of *Nuestras Familias* was tested in a randomized, controlled trial with 73 Spanish-speaking Latino parents of “at-risk” middle-school-aged children in a community setting (Martinez & Eddy, 2005). “At-risk” was broadly defined to include factors known to influence child and adolescent behavior problems, including differential acculturation rates between parents and adolescents and level of parental monitoring of youth activities (Szapocznik & Coatsworth, 1999). The intervention group demonstrated adolescent and parent outcomes that were superior to wait-list control group outcomes.

Specifically, externalizing problems and likelihood of substance use (assessed by adolescent report of likelihood of using various substances over the course of the next year if offered by one of their best friends; Martinez & Eddy, 2005) decreased at post-intervention for adolescents in the intervention condition compared to adolescents in the control condition.

Improvements were also noted in parental use of positive practices and in general parenting effectiveness. Importantly, feasibility data supported use of this program with Spanish-speaking groups in a commu-

whether additional components influenced acceptability beyond what would be found with the original program. Thus, assessing acceptability of the original program strategies should be considered a necessary preliminary step to guide the adaptation process.

Parent-Child Interaction Therapy. Matos and colleagues (2006) adapted and examined Parent-Child Interaction Therapy (PCIT; Eyberg, 1988) for Puerto Rican parents living in Puerto Rico. PCIT is an empirically supported treatment for ODD and CD in young children that provides parents with skills to enhance the parent-child relationship and implement effective discipline in the context of dyadic play situations (Eyberg, 1988). During two phases, parent- and child-directed interaction, parents receive didactic instruction and live coaching from a therapist in the use of specific strategies (e.g., labeled [specific] praise; attending to child’s ongoing activity by providing narrative descriptions, ignoring minor misbehavior) to improve parent-child interactions and manage negative behavior. Matos et al. (2006) retained core PCIT components in their adapted version. However, rather than adding new components, Matos et al. made culturally relevant changes to the original content based on the work of Bernal and colleagues (1995). Bernal et al. recommended that specific elements or

See ADAPTATION, next page

ADAPTATION, from page 5

dimensions (e.g., language, concepts, metaphors, relevant goals, etc.) be incorporated into existing interventions in order to make them more “culturally centered.” For example, therapists used culturally relevant metaphors such as *se formo un tiri-jala* (dispute, quarrel) and *malascrianzas* (bad manners) to discuss child misbehavior (Matos et al., 2006; p. 214).

As an additional step in the adaptation process, Matos et al. (2006) conducted qualitative interviews with Puerto Rican parents who had previously completed PCIT (n = 15) and with clinical psychologists (n = 5) working with children and families in Puerto Rico to assess the “acceptability”

problems. All children (ages four to six) met criteria for ADHD (78%, n = 7) and/or ODD (89%, n = 8). Following the intervention, all families reported significant improvements in child behavior, positive parenting practices, and overall family functioning. However, qualitative interviews revealed important concerns that could influence the degree to which parents would be willing to utilize specific strategies. This further underscores the need to examine acceptability of *original* program content among ethnically and racially diverse parents as a preliminary step in the adaptation process.

The Guiando a Niños Activos (GANA) Program. In the *Guiando a Niños Activos* (Guiding Active Children) program, McCabe and colleagues (2005) outlined a

style, suggesting that time-out be framed as a “more severe punishment” and that ignoring be presented as a more “active” form of discipline (McCabe et al., 2005, p. 119).

Based on these findings, the authors incorporated relevant questions into questionnaire measures administered during the intake interviews (e.g., “Do parents believe that behavior problems simply require more strict discipline?”) and unstructured questions administered during the course of treatment to assess beliefs and attitudes that could serve as barriers to treatment acceptability (e.g., “Are family members supportive of treatment?”; McCabe et al., 2005; p. 121). Notably, most of the modifications made by the authors centered on increasing engagement and acceptability of the program and reducing barriers to participation, rather than on changing program content or methods.

These studies provide a valuable starting point, but there remains a paucity of research examining the role of Latino cultural values in the acceptability of behavioral parent training components.

Summary and Conclusions

This discussion highlights the importance of considering culturally specific child-rearing values when adapting and implementing evidence-based parent training programs with Latino families. For example, to incorporate *familismo*, program goals may be more appropriately framed in terms of improving family functioning, rather than addressing the child’s behavior in isolation. Likewise, behavioral techniques such as effective commands and discipline can be presented in terms of gaining *respeto* rather than child compliance per se. Given that extended family members are involved in socializing and disciplining children within many Latino families, it may be important to involve all of the child’s caregivers in parent training programs. Indeed, for parent training to be maximally effective, consistent application of the strategies is necessary across family members and environmental contexts. Therefore, involving extended family members may serve to enhance family “buy in” and increase treatment compliance. To this end, clinicians might consider contacting additional family members directly via telephone to discuss parenting techniques. Within sessions, parents may benefit from discussing ways to share new techniques with family members not in attendance and to manage family resistance to new techniques. Finally, it is important to be aware that Latino families may differ in acceptance of treatment strategies based on their country of origin.

In sum, parenting practices used to address negative child behavior are highly

See ADAPTATION, next page

of program procedures. Results suggested that both parents and professionals considered this an acceptable and effective treatment for child behavior problems. In particular, parents identified praise, attending, and removal of privileges as especially useful strategies. However, they reported that some child-directed interaction skills (e.g., avoiding questions and commands) and ignoring minor misbehavior were particularly difficult to implement.

Finally, a majority of parents and professionals questioned the use of the time-out procedure. It is of note that, for this study, time-out was implemented in a separate room in which the child was left alone. Parents perceived this time-out procedure as difficult to implement, “cruel” (e.g., “my kid was feeling abandoned by me”), and “emotionally demanding” for the parent (Matos et al., 2006, p. 217). While this has implications regarding treatment acceptability, time-out procedures vary across programs. For example, other PCIT researchers have used a time-out chair in a corner where parents can monitor the child, with a holding procedure to prevent escape from time-out (McNeil et al., 1994).

Matos et al. (2006) tested the adapted PCIT program in an uncontrolled pilot study with nine Puerto Rican families referred for treatment of child behavior

model for the cultural adaptation of existing interventions and made effective use of preliminary acceptability research to inform their adaptation of PCIT for Mexican American parents. To adapt PCIT, the authors first reviewed the relevant literature and collected qualitative data from professionals and parents regarding potential modifications. Next, the authors synthesized this information and proposed a list of modifications. Finally, the proposed modifications were reviewed by “experts,” including researchers whose work focuses on the adaptation of mental health treatments, Mexican American therapists who work with Mexican American families, and the creator of the PCIT program, Dr. Sheila Eyberg.

While original program components were retained in the final manual, important modifications were made to increase the cultural sensitivity of the program. The authors incorporated qualitative data regarding acceptability of individual treatment strategies into the assessment procedures and the adapted manual. In contrast to Puerto Rican parents, who perceived ignoring as difficult and time-out as “cruel” (Matos et al., 2006), Mexican American parents noted that ignoring and time-out appeared “too mild.” Mexican American parents preferred a more “firm” discipline

ADAPTATION, from page 6

influenced by culturally rooted child-rearing values and parents' degree of acculturation, which affects willingness to utilize parent training strategies originally developed for mainstream Caucasian families. The studies reviewed herein provide preliminary information regarding cultural acceptability of parenting strategies shown to be effective with other populations but also reveal the heterogeneity of Latino parents' values. The authors of these studies are commendable for adapting programs for specific populations, using theoretical frameworks and relevant empirical data, rather than relying solely on their clinical intuition.

These studies provide a valuable starting point, but there remains a paucity of research examining the role of Latino cultural values in the acceptability of behavioral parent training components. The link between treatment acceptability and treatment utilization, compliance, and retention is well-established. Further examination of specific cultural factors that influence treatment acceptability is an important preliminary step to guide adaptation efforts and ultimately improve utilization of empirically supported treatments among diverse families (Lau, 2006). Indeed, although the programs reviewed were adapted based on different theoretical models of adaptation, they collectively underscore the need to examine acceptability of original program components before adapting existing interventions. Research in this area will provide the valuable empirical data needed to inform cultural adaptation efforts aimed at improving treatment acceptability and outcomes, with the ultimate goal of reducing disparities in service utilization among Latino families.

References

- Arcia, E., & Fernandez, M.C. (2003). From awareness to acknowledgment: The development of concern among Latina mothers of children with disruptive behaviors. *Journal of Attention Disorders, 6*, 163–175.
- Arcia, E., Reyes-Blanes, M.E., & Vazquez-Montilla, E. (2000). Constructions and reconstructions: Latino parents' values for children. *Journal of Child and Family Studies, 9*, 333–350.
- Bacallao, M., & Smokowski, P. (2007). The costs of getting ahead: Mexican family system changes after immigration. *Family Relations, 56*, 52–66.
- Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology, 23*, 67–82.
- Borrego, J., Anhalt, K., Terao, S.Y., Vargas, E.C., & Urquiza, A.J. (2006). Parent-child interaction therapy with a Spanish-speaking family. *Cognitive and Behavioral Practice, 13*, 121–133.
- Brestan, E.V., & Eyberg, S.M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology, 27*, 180–189.
- Burnam, M.A., Telles, C.A., Hough, R.L., & Escobar, J.I. (1987). Measurement of acculturation in a community sample of Mexican Americans. *Hispanic Journal of Behavioral Science, 9*, 105–130.
- Calzada, E.J., & Eyberg, S.M. (2002). Self-reported parenting practices in Dominican and Puerto Rican mothers of young children. *Journal of Clinical Child and Adolescent Psychology, 31*, 354–363.
- Catalano, R.F., Hawkins, J.D., Krenz, C., Gillmore, M., Morrison, D., Wells, E. et al., (1993). Using research to guide culturally appropriate drug abuse prevention. *Journal of Consulting and Community Psychology, 61*, 804–811.
- Chronis, A.M., Chacko, A., Fabiano, G.A., Wymbs, B.T., & Pelham, W.E. (2004). Enhancements to the standard behavioral parent training paradigm for families of children with ADHD: Review and future directions. *Clinical Child and Family Psychology Review, 7*, 1–27.
- Eyberg, S. (1988). Parent-Child Interaction Therapy: Integration of traditional and behavioral concerns. *Child & Family Behavior Therapy, 10*, 33–46.
- Forehand, R., & Kotchick, B.A. (1996). Cultural diversity: A wake-up call for parent training. *Behavior Therapy, 27*, 187–206.
- Forehand, R., & Kotchick, B.A. (2002). Behavioral parent training: Current challenges and potential solutions. *Journal of Child and Family Studies, 11*, 377–384.
- Garcia, C. (1993). What do we mean by extended family? A closer look at Hispanic multigenerational families. *Journal of Cross-Cultural Gerontology, 8*, 137–146.
- Gonzalez-Castro, F., Barrera, M., & Martinez, C.R. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science, 5*, 41–45.
- Gonzalez-Ramos, G., Zayas, L.H., & Cohen, E.V. (1998). Child-rearing values of low-income, urban Puerto Rican mothers of preschool children. *Professional Psychology: Research and Practice, 29*, 377–382.
- Gorman, J.G., & Balter, L. (1997). Culturally sensitive parent education: A critical review of quantitative research. *Review of Educational Research, 67*, 339–369.
- Harwood, R.L. (1992). The influence of culturally derived values on Anglo and Puerto Rican mothers' perceptions of attachment behavior. *Child Development, 63*, 822–839.
- Harwood, R.L., Handwerker, W.P., Schoelmerich, A., & Leyendecker, B. (2001). Ethnic category labels, parental beliefs, and the contextualized individual: An exploration of the individualism-sociocentrism debate. *Parenting: Science and Practice, 1*, 217–236.
- Harwood, R.L., Leyendecker, B., Carlson, V., Asencio, M., & Miller, A. (2002). Parenting among Latino families in the U.S. In M.H. Bornstein (Ed.), *Handbook of Parenting: Vol. 4: Social Conditions and Applied Parenting* (2nd ed.) (pp. 21–46): Mahwah, NJ: Lawrence Erlbaum.
- Harwood, R.L., & Miller, J.G. (1991). Perceptions of attachment behavior: A comparison of Anglo and Puerto Rican mothers. *Merrill-Palmer Quarterly, 37*, 583–599.
- Harwood, R.L., Schoelmerich, A., Ventura-Cook, E., Schulze, P.A., & Wilson, S.P. (1996). Culture and class influences on Anglo and Puerto Rican mothers' beliefs regarding long-term socialization goals and child behavior. *Child Development, 67*, 2446–2461.
- Herschell, A.D., Calzada, E.J., Eyberg, S.M., & McNeil, C.B. (2002). Clinical issues in parent-child interaction therapy. *Cognitive and Behavioral Practice, 9*, 16–27.
- Kazdin, A.E. (1980). Acceptability of alternative treatments for deviant child behavior. *Journal of Applied Behavior Analysis, 13*, 259–273.
- Kazdin, A.E. (1997). Parent management training: Evidence, outcomes, and issues. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 1349–1357.
- Kazdin, A.E. (2005). *Parent Management Training: Treatment for Oppositional, Aggressive, and Antisocial Behavior in Children and Adolescents*. New York: Oxford University Press.
- La Roche, M.J. (2002). Psychotherapeutic considerations in treating Latinos. *Harvard Review of Psychiatry, 10*, 115–122.

See ADAPTATION, next page

ADAPTATION, from page 7

Lau, A.S. (2006). Making the Case for Selective and Directed Cultural Adaptations of Evidence-Based Treatments: Examples From Parent Training. *Clinical Psychology: Science and Practice*, 13, 295–310.

Leyendecker, B., Harwood, R., Lamb, M.E., & Schoelmerich, A. (2002). Mothers' socialization goals and evaluations of desirable and undesirable everyday situation in two diverse cultural groups. *International Journal of Behavioral Development*, 26, 248–258.

MacPhee, D., Fritz, J., & Miller-Heyl, J. (1996). Ethnic variations in personal social networks and parenting. *Child Development*, 67, 3278–3295.

Martinez, C.R., & Eddy, J.M. (2005). Effects of culturally adapted parent management training on Latino youth behavioral health outcomes. *Journal of Consulting and Clinical Psychology*, 73, 841–851.

Matos, M., Torres, R., Santiago, R., Jurado, M., & Rodriguez, I. (2006). Adaptation of parent-child interaction therapy for Puerto Rican families: A preliminary study. *Family Process*, 45, 205–222.

McCabe, K.M., Yeh, M., Garland, A.F., Lau, A.S., & Chavez, G. (2005). The GANA program: A tailoring approach to adapting parent child interaction therapy for Mexican Americans. *Education & Treatment of Children*, 28, 111–129.

McNeil, C.B., Clemens-Mowrer, L., Gurwitch, R.H., & Funderburk, B.W. (1994). Assessment of a new procedure to prevent timeout escape in preschoolers. *Child & Family Behavior Therapy*, 16, 27–35.

Miller, A.M., & Harwood, R.L. (2001). Long-term socialisation goals and the construction of infants' social networks among middle class Anglo and Puerto Rican mothers. *International Journal of Behavioral Development*, 25, 450–457.

Miller, G.E., & Prinz, R.J. (1990). Enhancement of social learning family interventions for childhood conduct disorder. *Psychological Bulletin*, 108, 291–307.

Okagaki, L., & Sternberg, R.J. (1993). Parental beliefs and children's school performance. *Child Development*, 64, 36–56.

Organista, K.C. (2007). *Solving Latino Psychosocial and Health Problems: Theory, Practice, and Populations*. Hoboken, NJ: Wiley.

Perry, C.E., Hatton, D., & Kendall, J. (2005). Latino parents' accounts of attention deficit hyperactivity disorder. *Journal of Transcultural Nursing*, 16, 312–321.

Reid, M.J., Webster-Stratton, C., & Beauchaine, T.P. (2001). Parent training in head start: A comparison of program response among African American, Asian American, Caucasian, and Hispanic mothers. *Prevention Science*, 2, 209–227.

Reimers, T.M., Wacker, D.P., & Koepl, G. (1987). Acceptability of behavioral interventions: A review of the literature. *School Psychology Review*, 16, 212–227.

Szapocznik, J., & Coatsworth, J.D. (1999). An ecodevelopmental framework for organizing the influences of drug abuse: A developmental model of risk and protection. In M.D. Glantz & C.R. Hartel (Eds.). *Drug Abuse: Origins & Interventions* (pp. 331–366). Washington, DC: American Psychological Association.

Therrien, M., & Ramirez, R.R. (2000). The Hispanic Population in the United States: March 2000. *Current Population Reports* (pp. 20–535). Washington DC: U.S. Census Bureau.

Triandis, H.C. (1995). *Individualism and Collectivism*. New York: Simon & Schuster.

Vega, W.A., & Lopez, S.R. (2001). Priority issues in Latino mental health services research. *Mental Health Services Research*, 3, 189–200.

Weisz, J.R., Suwanlert, S., & Chaiyasit, W. (1985). Child behavior problems and cultural influence. Paper presented at the biennial meeting of the International Society for the Study of Behavioral Development, Tours, France, July 1985.

Witt, J.C., & Elliot, S.N. (1985). Acceptability of classroom management strategies. In T.R. Kratochwill (Ed.). *Advances in School Psychology* (Vol. 4, pp. 251–288). Hillsdale, NJ: Lawrence Erlbaum.

Wolf, M.M. (1978). Social validity: The case for subjective measurement or how applied behavior analysis is finding its heart. *Journal of Applied Behavior Analysis*, 11, 203–214.

Wood, W.D.I., & Baker, J.A. (1999). Preferences for parent education among low socioeconomic status, culturally diverse parents. *Psychology in the Schools*, 36, 239–247.

Yeh, M., McCabe, K., Hough, R.L., Dupuis, D., & Hazen, A. (2003). Racial/ethnic differences in parental endorsement of barriers to mental health services for youth. *Mental Health Services Research*, 5, 65–77.

Zayas, L., & Solari, F. (1994). Early childhood socialization in Hispanic families: Context, culture, and practice implications. *Professional Psychology: Research and Practice*, 25, 200–206. ■

Authoritative, practical guidance for mental health professionals and educators working to meet the needs of at-risk youth ...

Advances in School-Based Mental Health Interventions

Best Practices and Program Models

Editors: Volume I—Kristin E. Robinson, Ph.D.
Volume II—Steven W. Evans, Ph.D., Mark D. Weist, Ph.D.
and Zewelanj N. Serpell, Ph.D.

“This book will pave the way for improving the effectiveness of mental health programming and the way it is delivered to children.”

—Jeffrey L. Metzner, M.D., Clinical Professor of Psychiatry, University of Colorado Health Sciences Center

Leading experts in the field bring you the latest research, practical programming ideas and intervention strategies ...

- Key components in successful school-based service delivery
 - Evidence-based clinical services
 - Funding sources and strategies
 - How to build effective, collaborative interagency relationships
 - Solutions to the barriers of misunderstanding and stigma
 - Effective family interventions
- ... and show you how “real world” programs are successfully being implemented in a broad variety of service delivery systems



SUBSCRIPTION INFORMATION
Volume I: © 2004, casebound, 552 pp.
ISBN 1-887554-41-6
Volume 2: © 2007, casebound,
approx. 590 pp. ISBN 1-887554-62-9
The series may be kept current and
expanded through additional volumes
sent to purchasers automatically on
approval.

To order, see coupon on back cover or order online at www.civresearchinstitute.com.

The Evidence-Based Treatment Dissemination Center (EBTDC): Bridging the Research-Practice Gap in New York State

by Michael S. North, Alissa A. Gleacher, Marleen Radigan, Lindsay Greene, Jessica Mass Levitt, Janet Chassman, and Kimberly E. Hoagwood*

In recent years, public recognition of the existence of scientifically validated or evidence-based treatments (EBTs) for children and adolescents with mental health problems has expanded (e.g., Chorpita, 2003; Hermann et al., 2006; Hoagwood et al., 2001). However, despite acknowledgement of these empirically based treatments, a substantial gap exists between their development and their adoption in community practice (Henderson et al., 2006; Kazdin, 2001). Several reports have documented that it can take up to 15 years for treatments that have been found to be efficacious and effective to become a part of routine clinical practice (Institute of Medicine, 2001; U.S. Department of Health and Human Services, 1999). As a consequence, few effective treatments for children and adolescents are broadly available (Bickman, 1996; Burns & Hoagwood 2004; Hoagwood & Burns, 2005; National Association of State Mental Health Program Directors [NASMHPD] Research Institute, 2005; Weissman et al., 2006; Weisz, 2004).

There are many explanations for the slow adoption of these treatments into routine practice. One reason may be the complications that arise when research-based treat-

ments are moved into the unpredictable and often chaotic world of routine practice. In the recent past, there has been an emphasis on the development of treatments in controlled (i.e., research) settings with highly trained clinicians (often doctoral students) who are supervised by the treatment developer, as opposed to the development of treatments indigenous to and developed within routine practice (e.g., Weisz et al., 1995). Weissman et al. (2006) cite a lack of commitment to EBTs in psychotherapy training programs as another cause of the research-practice gap.

Even if a commitment is made to bringing EBTs to widespread community practice, many system barriers exist for successful dissemination (Hoagwood et al., 2001;

to improve the quality of clinical care for youth and families in the system through statewide training, consultation, and support in the use of a variety of EBTs. The New York State Office of Mental Health (OMH) has contracted with Columbia University to provide expert consultation and support to front-line clinicians and supervisors.

Several factors led to the development of this training center. One of these was the creation of a service and evaluation program after the attacks of 9/11 to provide clinical services to children and adolescents who had experienced trauma related to the attacks. The Child and Adolescent Trauma Treatments and Services Consortium (CATS) was created as a state-provider partnership involving nine

It can take up to 15 years for treatments that have been found to be efficacious and effective to become a part of routine clinical practice.

Schoenwald & Hoagwood, 2001). For example, use of EBTs may require smaller caseloads, more direct forms of supervision, and continuous monitoring of symptoms and functionings. These are generally not built into the performance or accountability standards commonly in use in public clinics (Schoenwald et al., in press).

Impetus for the Evidence-Based Treatment Dissemination Center: The CATS Program

To address the disparity between research evidence and clinical practice, a growing number of U.S. states are beginning to experiment with different ways of incorporating EBTs into state-level training and dissemination initiatives. New York is one such state. In 2005, New York began a broad EBT training and dissemination program, the Evidence-Based Treatment Dissemination Center (EBTDC). The program, the first of its kind in New York State, is an initiative

community-based organizations in New York City; its primary mission was to train and support front-line clinicians in the delivery of evidence-based trauma treatments for children with moderate to severe trauma symptoms within a 15-mile radius of Ground Zero. An additional, much broader goal was to formally evaluate this EBT training initiative, not only in terms of its outcomes (i.e., whether trauma symptoms are reduced), but importantly in terms of the feasibility of its implementation processes (e.g., training clinicians, providing consultation, embedding ongoing monitoring/tracking, retaining families). Full details of this project are available in a series of papers; for more detailed information on the CATS project, see McKay et al. (2004).

The successes of the CATS project, coupled with growing interest in evidence-based treatment dissemination among community

See EVIDENCE-BASED, next page

*Michael S. North, B.A., is a research coordinator in the Division of Child & Adolescent Psychiatry at Columbia University. Alissa A. Gleacher, Ph.D., is project director and research program coordinator of the EBTDC project at the Division of Child & Adolescent Psychiatry at Columbia University. Marleen Radigan, DrPH, is associate director of the Bureau of Youth Services Research at the New York State Office of Mental Health. Lindsay Greene, B.S., is a research assistant in the Division of Child & Adolescent Psychiatry at Columbia University. Jessica Mass Levitt, Ph.D., is an assistant professor in the Division of Child & Adolescent Psychiatry at Columbia University. Janet Chassman, MBA, is the director of the EBTDC project at the New York State Office of Mental Health, Division of Children & Families. Kimberly E. Hoagwood, Ph.D., is professor in the Department of Psychiatry and director of research on Child and Adolescent Services for the Office of Mental Health in the State of New York. Michael North can be reached by email at Northm@childpsych.columbia.edu.

EVIDENCE-BASED, from page 9

practitioners, and the recognition and dedication to advancing evidence-based mental health services by the New York State OMH, led to the creation of the EBTD. This paper describes that initiative.

EBTDC Project Goals and Key Research Questions

Aside from the immediate goal of training clinicians and supervisors across the state, the broad goals of the EBTD build upon the experience of CATS and the growing scientific knowledge of EBTs and effective dissemination. To this end, we have embedded a quality improvement evalua-

The EBTDC Model

The EBTDC project model has been created to address the limitations of past treatment training models. For instance, because studies have indicated that brief trainings alone do not lead to changes in clinicians' behaviors (Bero et al., 1998; Bickman, 1999), the EBTDC uses a two-phase approach:

- An intensive three-day training workshop; and
- A full year of biweekly phone consultation with the Columbia University consultation team.

Trainings. The first day of training focuses on numerous aspects of both EBTs

of the mandatory assessment measures used in the project to determine the appropriateness of the treatment for potential clients and to monitor ongoing treatment progress throughout the course of treatment. Clinicians are asked to obtain these assessments at three points in time—intake, midpoint, and discharge (see Table 1 for descriptions of the assessments and for the schedule of assessment collection). Clinicians provide depression- or trauma-focused treatment only if the child meets the appropriateness criteria.

The subsequent two days of the training focus on the specific evidence-based treatments and are led by the respective expert treatment developers or an individual designated by them, such that one day focuses on cognitive behavioral interventions for children and adolescents with depression (Curry & Stark, 2006; for more information on cognitive behavioral interventions for children and adolescents with depression, see Stark, 1990) and the other focuses on trauma-focused cognitive behavior therapy (TF-CBT; Cohen et al., 2006; for more information, see <http://tfcbt.musc.edu/>).

Consultation Calls. The consultation piece is designed to guide clinicians in

See EVIDENCE-BASED, next page

Is it possible to train 400 people statewide in EBTs and provide high quality biweekly consultation for an entire year?

tion into the EBTD in order to examine three main aspects of this new project:

1. *Assess the feasibility of large-scale EBT dissemination.* Simply put, is it possible to train 400 people statewide in EBTs and provide high quality biweekly consultation for an entire year? It is crucial to analyze and assess the processes involved in not only implementing a widespread dissemination project, but also examining the practicality of sustaining it.
2. *Track clinician participation and progress.* A second goal of the project consists of monitoring and tracking clinician participation in the project. This includes tracking *learning* (clinician performance on a pre- and post-training knowledge test about the treatments and their application), *satisfaction* (clinician scores on a pre- and post-training satisfaction survey and attitudes toward evidence-based treatments survey), and *completion criteria* (whether participants comply with the specified criteria for completion).
3. *Identify barriers to large-scale EBT dissemination.* A final goal of the EBTD is to identify what barriers stand in the way of a large-scale dissemination of EBTs. The primary method of identifying such obstacles is clinician reports on difficulties in implementing the treatments.

and CBT, including an introduction to cognitive behavioral strategies and case conceptualization from a cognitive behavioral perspective. The remainder of the first day focuses on training clinicians in the use

Table 1: Schedule for EBTDC Clinical Assessment Measures

	Description	Intake Assessment	Midpoint Assessment	Discharge Assessment
Parent and Youth Measures				
SDQ	Brief behavioral screening questionnaire, used to give indication of symptoms and other comorbid problems that may be occurring	X	X	X
PTSD-RI*	Assessment of trauma exposure and symptoms of posttraumatic stress disorder	X	X*	X*
Clinician Measures				
CDRS-R	Measure of child depression, as rated by the clinician via interviews with both child and parent	X	X	X
CGAS	Objective measure of children's overall functioning, as assessed by the clinician	X	X	X
<small>Notes: SDQ = Strengths and Difficulties Questionnaire (Goodman, 1997); PTSD-RI = Post Traumatic Stress Disorder Reaction Index (Steinberg et al., 2004); CDRS-R = Children's Depression Rating Scale, Revised (Poznanski & Mokros, 1995); CGAS = Children's Global Assessment Scale (Shaffer et al., 1983). * The PTSD-RI was administered after intake only if the client was receiving trauma-focused CBT.</small>				

EVIDENCE-BASED, from page 10

the actual application of the treatments to the complex community cases with which they work, provide ongoing consultation and problem-solving on cases, and provide continued support and training in the use of assessment tools or specific treatment techniques (e.g., cognitive restructuring, behavioral activation).

Ninety-minute consultation calls are conducted once every two weeks, lasting for a year after the initial three-day training. Four Ph.D.-level clinical consultants divide the calls, yielding approximately 10 biweekly calls per consultant. For the first year, the number of clinicians on each call has ranged from seven to 18, with an average of approximately 12 clinicians. Although not required, supervisors of participating clinicians are strongly encouraged to attend consultation calls on a regular basis—especially when their clinicians are formally presenting cases.

Although there is some stylistic variation among consultants, consultation calls generally adhere to a consistent structure across consultants. The structure consists of the following elements:

- *Agenda setting and brief check-in* (e.g. taking attendance, setting an agenda);
- *Formal case presentations* (clinicians present their case in depth and follow a standardized case presentation form as part of their three-presentation requirement);
- *Brief case review* (a more informal “round robin,” brief discussion of how cases and treatments are going); and
- *Intervention and program issues* (consultants discuss or provide didactic instruction on an aspect of one of the treatment interventions).

Criteria for Completion. Clinicians are informed that in order to receive a certificate of completion from OMH, they must comply with the specific completion criteria required by the project (for a categorical listing of the criteria required for completion, please see Table 2). Participants who do not fulfill the completion criteria are divided into two categories:

- *Dropouts* are clinicians who notify program staff that they are withdrawing and indicate a reason, or who attend less than 50% of the calls with no explanation.

- *Non-completers* are fairly regular participators who do not meet all of the above requirements for completion.

measuring their satisfaction, knowledge of treatments, and feelings toward CBT/EBTs. See Table 3 for a complete listing

Because we want to make sure that we are able to see what is working and what is not, participants are required to complete various assessments measuring their satisfaction, knowledge of treatments, and feelings about CBT/EBTs.

Feedback and Clinician Data Measures. The EBTDC is still in its early program evaluation stages, so participant feedback and other measures are an integral part of the model. Because we want to make sure that we are able to see what is working and what is not, participants are required to complete various assessments

of clinician data measures that were used for EBTDC program evaluation.

Two-Year Cycle. Although this first iteration of the EBTDC focuses on dissemination of trauma- and depression-focused treatments for youth and adolescents, future

See EVIDENCE-BASED, next page

Table 2: Criteria for Clinician Completion and OMH Certificate of Completion

Category	Requirement
Training	Attend the three-day training and complete the 10-hour trauma-focused CBT web course
Attendance	80% or better on consultation calls
Assessments	Use of OMH-mandated assessment measures with clients
Case presentations	Three case presentations on consultation calls
Case completion	Completion of full manual treatment with at least one trauma or one depression case

Table 3: Schedule for Clinician Data Measures

Clinician Data Measure	Pre-Training	Post- Training	After One Year of Consultation
Demographic information	X		
Satisfaction with three-day training session		X	
Knowledge about CBT-trauma treatment	X	X	X
Knowledge about CBT-depression treatment	X	X	X
Beliefs survey about implementing EBTs	X	X	X
Clinician attendance on consultation calls*			X
Satisfaction with year-long EBTDC consultation			X

*Clinician consultation call attendance was tracked throughout the year.

EVIDENCE-BASED, from page 11

year planning will entail training and consultation on other EBTs, each selected for a two-year cycle. The ultimate goal is to “retool the workforce” in public mental health services for children.

participating in the first year of the EBTDC have been predominately female (82%), have been social workers (78%), have been working in outpatient settings (89.5%), and have had “some” prior CBT experience (50.2%). The majority of participants identify themselves as white (76.1%), although participants

With the proper support from the state, provider agencies, and experts in treatment development and consultation, large-scale EBT dissemination is certainly possible.

What We Have Found

Clinician Population: Who Participated? The 417 clinicians and supervisors

of various ethnic backgrounds have been involved. For a complete breakdown of demographic information, please see Table 4.

Table 4: Demographic Information for Participating Clinicians and Supervisors

Gender	Number Responding	Percent
Male	73	18.0
Female	327	82.0
Ethnicity		
Black	23	5.7
Latin	55	13.6
Asian	11	2.7
White	306	76.1
American Indian/Alaskan Native	4	1.0
Discipline		
Social work	315	78.5
Marriage, family & child counselor	56	14.0
Psychology	30	8.0
CBT experience		
None	17	4.3
Little	102	25.8
Some	199	50.2
A lot	73	18.4
Expert/Certified	5	1.3
Clinical work setting		
Outpatient	359	89.5
Inpatient psychiatric unit	6	1.5
School	21	5.2
In-home services	3	0.7
Other	12	3.0

Retention and Engagement: Did People Keep Coming Back? Overall, clinicians have had good attendance on the follow-up consultation calls. As of July 18, 2007, the overall attendance rate for participating clinicians was 83.3%. See Table 5 for complete clinician attendance statistics overall and by consultant.

Another good sign for the project is the relatively low participant dropout rate. Of the 417 mental health professionals who were trained, only 79 clinicians and 21 supervisors have discontinued participation, for an overall retention rate of 76%. The majority of those who did drop out indicated that they did so for reasons unrelated to the project itself (see Table 6).

Clinician Satisfaction: Were Clinicians Satisfied With the Training and Consultation? Clinicians indicated that they were satisfied with their participation in EBTDC, both with the training and year-long consultation. Using a five-point Likert scale (ranging from 1 = very negative to 5 = very positive), clinicians indicated that they found the trainings to be highly beneficial (see Table 7).

It is also worth noting that clinicians' attitudes toward evidence-based treatments, as measured by an internally constructed EBT beliefs survey, changed significantly from pre- to post-training. On a five-point Likert scale (1 = very negative attitude toward EBTs to 5 = very positive attitude toward EBTs), more clinicians had positive attitudes toward EBTs after the training ($M = 4.1$) than beforehand ($M = 3.9$; $p < 0.001$).

After the year-long consultation, the majority of clinicians gave positive feedback toward EBTDC. For the assessment portion of the project, 83% of participants reported that they will continue to use the assessments, 73% reported assessments were helpful in determining treatment appropriateness ($M = 4.09$ on a five-point Likert scale, with 1 = not helpful at all and 5 = very helpful), and 54.6% reported assessments were helpful in determining clinical change in their clients ($M = 3.59$). Participants indicated that they have been satisfied with the consultation calls as well; using the same five-point Likert scale, participants rated the overall quality of the consultation calls positively ($M = 3.88$). Clinicians also perceived their consultants as being particularly helpful in guiding them in the clinical application of the treatments,

See EVIDENCE-BASED, next page

EVIDENCE-BASED, from page 12

including developing and modifying case conceptualization ($M = 4.21$), using assessment data to define treatment goals and symptoms ($M = 4.09$), and constructing treatment plans ($M = 3.77$).

The Consultation Process: Effect of Consultant on Attendance and Completion Rates. Statistical analyses were conducted to see if attendance rates and completion rates differed for clinicians based on who their consultants were. Attendance rates for each of the consultants were compared for the three consultants who completed calls to date. A one-way analysis of variance (ANOVA) revealed a significant difference between these consultants with regard to their clinician percentage attendance, $F(2, 240) = 20.55$, $p < 0.001$. A post hoc Tukey test confirmed this result, demonstrating that one consultant, Consultant #2, had significantly lower clinician attendance rates than the other two, $p < 0.001$.

Differences between consultants were also found in terms of how often clinicians fulfilled the completion criteria. A one-way ANOVA determined that the clinician completion rate differed significantly between consultants, $F(2, 137) = 10.43$, $p < 0.001$. A post hoc Tukey test demonstrated that it was Consultant #1 who had a much higher rate of completion than the other two consultants, $p = 0.001$.

Despite the significant variance between consultants in clinician attendance and completion rates, this was not the case for the dropout rate. A one-way ANOVA showed there was no statistically significant difference in dropout rate among consultants, $F(2, 244) = 1.41$, $p = 0.25$.

What We Now Know About EBT Dissemination: Lessons Learned, Goals Revisited, Successes and Areas for Continued Improvement

Although the EBTDC was never intended as a research project, everyone involved learned immensely. For the Columbia University and New York State OMH staff who make up the EBTDC team, we have learned how much effort, organization, and teamwork it takes to effectively disseminate EBTs across an entire state, as well as initial lessons in what works and what does not in such an endeavor. For the clinicians who participated in the EBTDC, there was an inevitable learning curve involved with gaining knowledge of the treatments and

their application (even more so for those who came into the project with little or no prior experience with EBTs or CBT). Because of this, it is encouraging to see that the project has been generally well received by the mental health practitioners who participated. Reviewing our goals, following are some of the primary lessons from the first year of the EBTDC:

Feasibility: Is Large-Scale EBT Dissemination Achievable? The short answer to this question is “yes.” Considering that this was the first EBT dissemination project on the state level, it is highly encouraging that more than three-quarters of the participants maintained their participation

See EVIDENCE-BASED, next page

Table 5: Clinician Attendance Rates by Consultant and Overall

	Clinician Attendance (%)	Supervisor Attendance (%)
Consultant #1	88.5	60.1
Consultant #2	84.9	38.5
Consultant #3	84.1	49.1
Consultant #4	74.2	25.2
Overall	83.3	39.6

Table 6: Clinicians and Supervisors Who Dropped Out and Their Reasons

Reason for Dropout	Clinicians		Supervisors	
	N	%	N	%
Unknown	28	35.4	9	42.9
Ended employment	20	25.3	9	42.9
Time constraints	8	10.1	2	9.5
Scheduling conflict	8	10.1	0	0.0
No appropriate cases	5	6.1	0	0.0
Medical or maternity leave	4	5.1	0	0.0
Phone problems	3	3.8	0	0.0
Switching to OMH/Columbia school-based training	2	2.5	1	4.7
No longer interested		1	1.3	0
Total	79		21	

Table 7: Mean Statewide Clinician Satisfaction With Training, by Day (N = 417)

	CBT Overview Day	Depression Day	Trauma Day
	4.2	4.2	4.5
Content	4.1	4.1	4.4
Presenter	4.4	4.3	4.7
Overall	4.1	4.2	4.4

Note: Scores are based on responses on a five-point Likert scale ranging from 1 = very negative attitude toward the training to 5 = very positive attitude toward the training.

EVIDENCE-BASED, from page 13

in the program. Moreover, the most common reasons provided for those who did drop out (switching jobs/retirement, other time commitments, scheduling conflicts) were external factors, rather than concerns about the EBTD project itself. The fact that, to date, 82.7% of clinicians have fulfilled the completion criteria further

generally had very limited experience in using, administering, scoring, and interpreting assessment measures. Although clinicians understood from the beginning that all assessments were required to be conducted prior to treatment in order to determine treatment appropriateness, completing the full assessment battery has sometimes led to difficulties in engaging clients. However, encour-

disorders (e.g., externalizing) or have other characteristics preventing their eligibility for EBTD (e.g., psychotic symptoms or extreme violence).

- *Difficulty maintaining clients in treatment.* Clinicians have also reported that engaging clients in assessment after clinic intake can be problematic. Part of this difficulty may be due to the above-mentioned time burden of the assessments and clinicians' discomfort with the change in their typical clinical practice. However, there are other factors that are likely influential as well, such as motivation of the client's family in treatment and client frustration with the length of time needed for assessment before treatment. Despite this concern, the dropout rate for EBTD cases may not be higher than the rate typically found among New York State clinics. Analysis of this is underway.
- *Time burden.* Even if they been able to retain an appropriate trauma or depression case, some clinicians feel that adequately participating in the EBTD is time intensive. As mentioned above, some clinicians feel that the assessment measures take more time to administer than their typical clinic protocol. Of course, the time crunch was not due just to the assessments; clearly clinicians are asked to attend the initial three-day training, complete the 10-hour trauma treatment online course, participate in the biweekly phone calls, and set aside weekly client preparation time for each session with clients. Because clinicians were balancing their participation in EBTD with other clinical duties and clinic demands, the time contribution for EBTD was a notable difficulty for some. It is worth noting that clinicians participating from agencies that were committed to making these treatments a part of their routine clinical practice (and those from agencies that are cognizant of the time it takes clinicians to participate and garner the maximum skill from the program) did not experience the same problems with time.
- *Bureaucratic "red tape."* The ease with which clinicians participated in training was also likely affected by the level of bureaucracy at their respective agencies. There is usually a degree of difficulty involved in learning new clinical techniques; however, according

Although clinician satisfaction was surveyed and engagement tracked throughout the project, we have not yet been able to track client improvement in mental health symptoms and functioning.

suggests that they were indeed engaged in the project, despite its relatively time-intensive nature. With the proper support from the state, provider agencies, and experts in treatment development and consultation, large-scale EBT dissemination is certainly possible.

Tracking Clinician Participation and Progress. Keeping tabs on 417 clinicians and supervisors—their attendance, case presentations, learning, and evaluation—is somewhat daunting, but it has nevertheless been accomplished. For each of the 35 consultation call groups, the consultant was given a template on which to take attendance, log notes on specific cases, and make note of when each clinician made a formal presentation and/or completed a case. Attendance was taken on every phone call by the consultant and then logged into the larger data system. A database was created for further analysis of attendance data, as well as pre- and post-training attitudes toward EBTD, satisfaction, and learning data. The ability to keep track of so much information has proven to be necessary in order to evaluate the project to the fullest extent possible.

Barriers to Large-Scale EBT Dissemination. As mentioned above, a final goal of the EBTD is to identify the barriers to the large-scale dissemination of evidence-based practices. The following is a list of such difficulties reported by clinicians:

- *Problems using assessments.* Despite the relevance of the assessments to the treatments, clinicians have reported that the assessments often either took too much time or were too difficult to interpret. This is unsurprising, because the group

agingly enough, over time, clinicians have expressed less frustration with the assessments, after gaining experience in using them. Moreover, while some of the assessment measures have caused difficulty, others have been more well received, specifically self-report and informant-report measures that could be administered in the waiting room and scored and interpreted easily (e.g., via the computer with an automatic score report generated). On yet another positive note, many clinicians stated at the end of the year that the training and use of these assessment measures made an indelible impression, and they reported that they now consider the assessment process and the information gained a critical aspect of the treatment process and critical to their ability to successfully treat a case.

- *Difficulty in finding appropriate clients.* Many clinicians indicated that finding clients who fit in with the treatment criteria has been problematic. This has been caused by a number of reasons. For example, some clinicians work for agencies that simply did not treat many children or focused on the treatment of other problems (e.g., ADHD). Others have found that although they see many traumatized and depressed children on a regular basis, often these problems are not the primary diagnoses. Another difficulty that has been raised by clinicians is that even if they encounter a substantive number of depression and trauma cases, too often the cases fit exclusionary criteria for the project, such as comorbidity with other

See EVIDENCE-BASED, next page

EVIDENCE-BASED, from page 14

to participant feedback, the level of commitment by mid-level administrators and/or supervisors varied greatly among agencies. Naturally, clinicians who worked at agencies where there was not a great deal of investment in the project faced greater difficulty in their learning. For other clinicians, it was problematic to balance the particular demands of their agency (e.g., productivity quotas) with learning new techniques.

Another (Unexpected) Lesson. Another important lesson we learned (albeit somewhat unexpectedly) is that despite our best efforts to standardize the consultation process, not all consultation is created equal—that is, who the consultant was made a significant impact on the attendance rate of clinicians in the project. From this, it is apparent that consultant style may be important in the engagement of clinicians. However, at this point we do not know exactly what style may maximize clinician motivation.

Areas for Improvement and Future Directions

A number of issues are currently being considered for future EBTDC training efforts. These include:

Tracking Clinical Outcome. Year one of the EBTDC has tracked clinician satisfaction, attendance, etc., but has not tracked clinical outcome. Clearly, the core goal of a large-scale EBT dissemination effort is to help those individuals using clinical services get better. However, although clinician satisfaction was surveyed and engagement tracked throughout the project, we have not yet been able to track client improvement in mental health symptoms and functioning in this iteration of the EBTDC program. This is due to a number of reasons. The need to meet time constraints of participating agencies (including meeting project deadlines agreed upon by OMH and Columbia University), clinician burden, and complex IRB issues all precluded assessment at the client level in the first year. However, in future years of the EBTDC, it is hoped that some information on clinical progress will be tracked. That way, it will be more feasible to further evaluate the impact of the EBTDC on client functioning and clinical improvement.

How Long Is “Just Right” for the Duration of Consultation Calls? The decision was made by the EBTDC design

committee to have follow-up consultation calls for a year after the initial three-day training. However, we do not know if this was the ideal length of time. In fact, there is at least anecdotal evidence to the contrary—attendance records indicate that there was a noticeable drop-off in attendance beginning around the six-month period, and, similarly, the majority of dropouts occurred after roughly six months. Consequently, next year’s EBTDC will not only keep track of the exact time that clinicians drop out, but will also measure clinician satisfaction at the six-, nine- and 12-month periods of consultation.

model, it would be unrealistic to think that once clinicians participate in the initial training and get on the phone once every two weeks that they will automatically be masters of the treatments in which they were trained. Rather, it is up to their supervisors to facilitate this process, making sure that clinicians are using the proper techniques, and answering any issues that might come up. Given the great importance of supervision, in the second year of the EBTDC, there will be a monthly call with supervisors and EBTDC consultants to help supervisors get more involved in the dissemination

The significant difference between consultants in clinician attendance and completion rate suggests that clinician retention and engagement truly depends on the individual qualities of the consultant.

What Makes for a Good EBT Dissemination Consultant or Consultation Call? We do not know what explicitly makes for a good EBT dissemination consultant or consultation call. The ability of each consultant to engage clinicians under his/her watch is crucial in a large-scale dissemination effort. The significant difference between consultants in clinician attendance and completion rate suggests that clinician retention and engagement truly depends on the individual qualities of the consultant. While at this point we do not know what exactly has caused this main effect of consultant on clinician attendance, future iterations of the EBTDC will seek to know what makes for a quality consultation. In fact, an EBTDC consultant manual is already in the works in an attempt to further systematize the consultation process and the material covered in the calls.

Supervisor Participation. Supervisor participation is important but has not been a requirement in year one. During the first year of the EBTDC, supervisors have been encouraged to participate in consultation calls but have not received any specific consultation on supervision practices in CBT. Perhaps not surprisingly, the participation of clinicians’ immediate supervisors has ranged from nonexistent to extremely heavy. Supervision is important in any kind of clinical psychology setting, but it is even more imperative on a large scale such as this. As optimistic as we are about the EBTDC

process. Moreover, we believe that the participation of supervisors is not only crucial for initial learning but will also prove to be extremely important in terms of sustaining the use of these treatments in OMH-licensed clinics in the long term.

Future Modifications. Based on what we initially planned and what we learned—as well as participant feedback—the following are changes planned for future iterations of EBTDC:

- *Modify assessment battery:* The next year of the EBTDC is incorporating clinicians’ suggestions and using fewer clinician-interpretive measures.
- *Extend EBTDC training to incorporate other mental health disorders:* Clinicians have expressed a keen interest in extending the EBTDC to treat other disorders, especially oppositional defiant disorder (ODD) and other disruptive behavior disorders. While year two will still include depression- and trauma-focused CBT, plans are already underway to incorporate other interventions in future EBTDC installments.
- *Shorten consultation calls and make them more individualized:* Although consultants have done their best to give personal attention to each clinician on consultation calls, some clinicians have felt that they could benefit from

See EVIDENCE-BASED, next page

EVIDENCE-BASED, from page 15

more individual consultation. However, it has been found that clinicians expressing this concern generally have been participating in calls with more than 10 clinicians. To try to resolve this issue, we are imposing a limit of

Clinicians and supervisors alike have reported that one of the biggest barriers in providing the treatments is either too little or too much involvement from the families.

seven clinicians and supervisors on each consultation call for the second year of the EBTDC.

- *More consultation on engagement and working with difficult parents:* Clinicians and supervisors alike have reported that one of the biggest barriers in providing the treatments is either too little or too much involvement from the families. This is a crucial issue not just in the EBTDC, but in mental health treatment in general. To do more investigation on this matter, an offshoot project involving EBTDC, client engagement, and family empowerment is planned for September of this year.

Although the EBTDC remains an ever-evolving project, it is noteworthy that New York State has undertaken this kind of intensive effort to bridge the gap between research and practice. To the best of our knowledge, this is one of only a handful of state-level initiatives to train front-line clinicians on specific empirically validated therapies for children (Bruns & Hoagwood, in press; Bruns et al., in press). With year two already underway, and nearly 400 additional clinicians and supervisors signed up for upcoming trainings, we believe that this model holds promise for redirecting clinical practice toward more evidence-based methods and for providing a useful guidepost for other initiatives disseminating systemic evidence-based practices.

References

- Bero L.A., Grilli R., Grimshaw J., Harvey, E., Oxman, A., & Thomson, M. (1998). Closing the gap between research and practice: An overview of systematic reviews of interventions to promote the implementation of research findings. *British Medical Journal*, 317, 465–468.
- Bickman, L. (1996). A continuum of care: More is not always better. *American Psychologist*, 51, 689–701.
- Bickman, L. (1999). Practice makes perfect and other myths about mental health services. *American Psychologist*, 54(11), 958–973.
- Bruns, E., & Hoagwood, K. (in press). State implementation of evidence-based practice for youth, part I: State responses to the state of the evidence. *Journal of the American Academy of Child and Adolescent Psychiatry*.
- Bruns, E., Hoagwood, K., Rivard, J., Wotring, J., & Marsenich, L. (in press). State implementation of evidence-based practice for youth, part II: Recommendations for research and policy. *Journal of the American Academy of Child and Adolescent Psychiatry*.
- Burns, B.J., & Hoagwood, K. (2004). Evidence-based practice, part I: Research update. *Child and Adolescent Psychiatric Clinics of North America*, 13(4), xi–xiii.
- Chorpita, B.F. (2003). The frontier of evidence-based practice. In A.E. Kazdin and J.R. Weisz (Eds.), *Evidence-Based Psychotherapies for Children and Adolescents* (pp. 42–59). New York: Oxford.
- Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents*. New York: Guilford.
- Curry, J., & Stark, K.D. (2006). Cognitive behavioral interventions for children and adolescents with depression. Unpublished manuscript.
- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, 38, 581–586.
- Henderson, J.L., MacKay, S., & Peterson-Badali, M. (2006). Closing the research-practice gap: Factors affecting adoption and implementation of a children's mental health program. *Journal of Clinical Child and Adolescent Psychology*, 35(1), 2–12.
- Hermann, R.C., Chan, J.A., Zazzali, J.L., & Lerner, D. (2006). Aligning measurement-based quality improvement with implementation of evidence-based practices. *Administration and Policy in Mental Health and Mental Health Services Research*, 33, 636–645.
- Hoagwood, K.E., & Burns, B.J. (2005). Evidence-based practice, part II: Effecting change. *Child and Adolescent Psychiatric Clinics of North America*, 14(2), xv–xvii.
- Hoagwood, K.E., Burns, B.J., Kiser, L., Ringeisen, H., & Schoenwald, S.K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–1189.
- Institute of Medicine (2001). *Crossing the quality chasm: A new health care system for the 21st century*. Washington, DC: National Academy Press.
- Kazdin, A.E. (2001). Bridging the enormous gaps of theory with therapy research and practice. *Journal of Clinical Child Psychology*, 30(1), 59–66.
- McKay, M.M., Hibbert, R., Hoagwood, K., Rodriguez, J., Murray, L., Legerski, J., & Fernandez, D. (2004). Integrating evidence-based engagement interventions into "real world" child mental health settings. *Brief Treatment and Crisis Intervention*, 4(2), 177–186.
- National Association of State Mental Health Program Directors (NASMHPD) Research Institute (2005). *Results of a Survey of State Directors of Adult and Child Mental Health Services on Implementation of Evidence-Based Practices*. Alexandria, VA: NASHMPD.
- Poznanski, E.O., & Mokros, H.B. (1995). *Administration Booklet: Children's Depression Rating Scale, Revised (CDRS-R)*. Los Angeles, CA: Western Psychological Services.
- Schoenwald, S.K., & Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of interventions: What matters when? *Psychiatric Services*, 52(9), 1190–1197.
- Schoenwald, S., Chapman, J.E., Kelleher, K., Hoagwood, K., Landsverk, J., Stevens, J., Glisson, C. (in press). A survey of the infrastructure of children's mental health services: Implications for implementation of EBTs. *Administration and Policy in Mental Health and Mental Health Services Research*.
- Shaffer, D., Gould, M.S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A Children's Global Assessment Scale (CGAS). *Archives of General Psychiatry*, 40, 1228–1231.
- Steinberg, A.M., Brymer, M.J., Decker, K.B., & Pynoos, R.S. (2004). The University of California at Los Angeles Post-traumatic Stress Disorder Reaction Index. *Current Psychiatry Reports*, 6, 96–100.
- U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- Weissman, M.M., Verdelli, H., Gameroff, M.J., Bledsoe, S.E., Betts, K., Mufson, L., Fitterling, H., & Wickramaratne, P. (2006). National survey of psychotherapy training in psychiatry, psychology, and social work. *Archives of General Psychiatry*, 63(8), 925–934.
- Weisz, J.R. (2004). *Psychotherapy for Children and Adolescents: Evidence-Based Treatments and Case Examples*. Cambridge: Cambridge University Press.
- Weisz, J.R., Donenberg, G.R., Han, S.S., & Kauneckis, D. (1995). Child and adolescent psychotherapy outcomes in experiments versus clinics: Why the disparity? *Journal of Abnormal Child Psychology*, 23(1), 83. ■

The First Step to Success Program for Preventing Antisocial Behavior in Young Children: Update on Past, Current, and Planned Research

by Hill Walker, John Seeley, Jason Small, Annemieke Golly, Herbert Severson, and Edward Feil*

The First Step to Success early intervention program is a selected, early intervention for achieving secondary prevention goals and outcomes (Walker et al., 1997; 1998). The First Step program was designed to assist behaviorally at-risk students in achieving a successful beginning to their school careers. The program has three modular components—universal screening, school intervention, and parent training—and is applied individually to one behaviorally at-risk child at a time in K-3 classroom settings. First Step utilizes parents, teachers, and peers as supportive social agents in the intervention process and connects families and schools together in a partnership that builds a foundation for fostering school success and reducing mental health problems.

This article provides an overview of the First Step program, discusses the development and trial testing of the intervention, and describes a statewide, scaled-up application of the First Step program. It reviews results from ongoing First Step research and describes additional planned research on the program. An appendix lists all publications to date on First Step, along with a series of research reviews in which it has been recommended as a best or preferred practice.

Overview of the First Step Program

The First Step program has been described previously in several venues (see Epstein & Walker, 2002; Golly et al., 1998; Walker

*Hill Walker, Ph.D., is a professor in the College of Education at the University of Oregon, a research scientist at the Oregon Research Institute, and the lead author of the First Step program. John Seeley, Ph.D., is a research scientist at the Oregon Research Institute. Jason Small, B.A., is a research analyst at the Oregon Research Institute. Annemieke Golly, Ph.D., is a coauthor of the First Step program and serves as the lead trainer of First Step teachers and behavioral coaches at the Oregon Research Institute. Herbert Severson, Ph.D., and Edward Feil, Ph.D., are coauthors of the First Step program and research scientists at the Oregon Research Institute. Professor Walker can be reached by email at hwalker@uoregon.edu.

et al., 1998). As noted, First Step to Success contains three, interrelated modular components:

- A screening and early identification procedure that provides four different options for use by adopters in identifying First Step target participants;
- A school intervention component that teaches an adaptive behavior pattern for fostering school success; and
- A parent component, called HomeBase, that teaches parents how to develop and strengthen their child's school success skills (e.g., cooperation, accepting limits, sharing, doing one's work, and so forth).

lowing successful completion of program day 10, the regular teacher assumes full control of the program and operates it on a daily basis until program day 30 when it is completed. The three First Step modular components are described below.

Screening. The First Step screening procedures are universal in nature and are designed to insure that every child is given an equal chance to be identified for the intervention. Classrooms of students in grades K-3 are screened for the presence of emerging patterns of antisocial behavior. Four screening options are provided, ranging from less expensive (teacher nominations) to more expensive (a three-stage, multiple-gating process). For example, the simpler procedure

On program day six, the coach begins transferring operation of the First Step program over to the teacher and provides supervision, support, and technical assistance as needed.

First Step is a highly manualized intervention that comes in a kit containing both consumable materials (forms, stickers) and nonconsumable materials (behavioral coach's guidebook, parent handbook) that can be used in repeated applications. The First Step program is set up and operated initially in regular K-3 classrooms by a behavioral coach (school psychologist, counselor, mental health specialist, early interventionist, behavior disorders specialist) who invests 50 to 60 hours of professional time during an approximately two- to three-month implementation period.

The coach secures parental permission to implement First Step, recruits the classroom teacher's participation, and operates the program for brief periods in the classroom during two daily sessions (20 minutes each) for the first five program days. On program day six, the coach begins transferring operation of the First Step program over to the teacher and provides supervision, support, and technical assistance as needed. Fol-

lowing successful completion of program day 10, the regular teacher assumes full control of the program and operates it on a daily basis until program day 30 when it is completed. The three First Step modular components are described below.

requires that the regular classroom teacher simply nominate and rank order students who show the externalizing, behavioral indicators of aggressive or disruptive behavior. The most complex and accurate of the screening options uses the Systematic Screening for Behavior Disorders three-stage, multiple-gating procedure (Walker & Severson, 1990) to accomplish universal screening of all children in a regular classroom in order to identify qualifying target students.

School Intervention. The First Step school intervention component is designed to teach target participants an adaptive pattern of behavior that will facilitate their academic success and improve peer relations. A group-dependent contingency procedure is used in the school intervention to enlist peer support for the target child's attempts at changing his or her behavior. In this procedure, the First Step child earns points and praise for such things as

See *THE FIRST STEP*, next page

THE FIRST STEP, from page 17

following classroom rules, responding to teacher requests, instructions, and commands, cooperating with others, and doing appropriate academic work. If 80% or more of the available points are earned for a given session, the target student earns a group activity privilege at school (e.g., extra recess time, classroom games) shared with the entire class. If the reinforcement criterion is met in both daily sessions, then the student also earns a home reward or privilege prearranged with parents and caregivers.

Home Intervention. The home intervention component of the First Step program, called HomeBase, enlists parents and caregivers as cooperating social agents in the

home, the target child displays the skills at school, and teachers monitor, recognize, support, and praise the child's display of the skills at school. The behavioral coach conducts six home visits, one per week, during this program phase, during which parents are instructed in how to teach the HomeBase school success skills at home. One skill is covered per visit with reviews of previously taught skills provided as needed.

Although not a formal part of the program procedures, it is highly recommended that behavioral coaches continue to monitor the child's progress after program termination, to consider implementing maintenance procedures as necessary, and to stay in contact with the parents and

Although not a formal part of the program procedures, it is highly recommended that behavioral coaches continue to monitor the child's progress after program termination.

intervention process. Their main role is to support the school intervention and to work with the First Step coach in teaching their children school success skills at home. We find that approximately two-thirds to three-fourths of First Step parents actively participate in this portion of the intervention while the remainder often agree to it but don't follow through.

Over approximately a six-week period, beginning on program day 10 of the school intervention, parents are taught how to teach their child essential school success skills at home using such methods as modeling, role plays, discussion, question-answer, and coaching. These skills include:

- Communication and sharing;
- Cooperation;
- Limits setting;
- Problem solving;
- Friendship making; and
- Self-confidence.

Parents are provided with a HomeBase program manual and a box of games and activities targeted to each of the six HomeBase skills. Parents and teachers, under the coach's supervision, work cooperatively in developing the target child's skills repertoire; that is, parents teach these skills at

participating teacher(s) until at least the end of the school year in which First Step is implemented. It may be necessary to reinstitute part of the First Step program in the form of "booster shots" in order to sustain previously achieved behavior changes.

Development and Trial Testing of the First Step Intervention

The First Step program was developed through a four-year grant to the senior author from the U.S. Office of Special Education Programs. This grant supported a collaborative development effort involving the Institute on Violence and Destructive Behavior (IVDB) at the University of Oregon, the Oregon Social Learning Center, the Eugene 4J School District, and the Oregon Research Institute. Each of these affiliating agencies made unique contributions to the First Step program's development and final form. Year one of the project was focused on planning, program design, creating a context for implementing the intervention, and recruitment; years two and three involved implementation and trial testing of the intervention; year four activities were concentrated on packaging, dissemination, and staff training efforts associated with adoption of the First Step program by school districts.

Two Cohorts Recruited. In the original trial testing of the First Step program reported in Walker et al. (1998), two cohorts of 24 and 22 kindergartners and their families, teachers, and peers were recruited from Eugene school district 4J across two school years. These kindergartners were randomly assigned to the First Step intervention using a waitlist-control group design; that is, half of cohort 1 participants were assigned to receive the First Step program during year one while half served as waitlist controls who, in turn, received the intervention following program completion by those who received it first. This procedure was repeated exactly for cohort 2 participants during the next school year.

Five Assessment Measures Used.

Five measures were used to assess program outcomes in the Walker et al. (1998) study. They included four teacher report measures and one behavioral observation measure. The teacher report measures consisted of the adaptive and maladaptive teacher rating scales from the Systematic Screening for Behavior Disorders (SSBD) procedure developed by Walker and Severson (1990), the aggression and social withdrawal subscales of the Achenbach Child Behavior Checklist (Achenbach, 1991), and in vivo recordings of academic engaged time (AET) within the regular classroom settings where the First Step program was implemented. The teacher report measures are validated and nationally normed frequency-based rating scales of child behavior that provide teacher estimates of occurrence. The academic engaged time measure uses a stopwatch duration recording procedure. These five measures were completed on a pre/post basis for each target child in cohorts 1 and 2 who participated in the intervention.

Table 1 presents outcome data on the study measures for cohorts 1 and 2. Analyses of covariance were conducted for each of these measures, in which baseline scores on them were used as covariates. Mean differences were statistically significant on four of the five dependent measures favoring the First Step participants. The social withdrawal subscale of the Achenbach Behavior Checklist was not sensitive to the First Step intervention.

A series of studies using largely single-subject methodology has replicated and extended First Step applications to rural and

See THE FIRST STEP, next page

THE FIRST STEP, from page 18

urban school settings and to more diverse populations of behaviorally at-risk students. These studies are reported in Beard and Sugai (2004); Golly et al. (1998; 2000); Overton et al. (2002); and Walker et al. (2005). Their outcomes show considerable correspondence across multiple investigators. Ongoing research, described below, has used randomized control trials with much larger samples to investigate First Step outcomes with more diverse student populations within large urban and suburban school settings.

The Oregon First Step Replication Initiative

The First Step program was the focus of a state legislature funded program evaluation conducted by the Oregon Human Services Research Institute (HSRI) of Salem, Oregon, and reported in the spring of 2001. During the 1999–2001 biennium, the Oregon State Legislature appropriated approximately \$500,000 to begin making the First Step program available statewide for all schools and districts interested in adopting it. This scaled-up First Step application was the focus of the HSRI evaluation,

and its results were published in Walker et al. (2005). The legislatively appropriated funds supported the cost of First Step program materials, staff training in the implementation of First Step, provision of technical assistance, and independent evaluation of the program's effects and outcomes. This effort, known as the Oregon First Step Replication Initiative, is the first example of the program's being scaled up and applied on a widespread basis in the "real world" conditions of regular classroom settings and schools absent careful supervision and

See THE FIRST STEP, next page

Table 1: Raw Score Intervention and Follow-Up Results: Evaluation Time Points' Means and Standard Deviations by Cohort

Measures		1993–1994 Cohort 1					
Teacher Ratings	Normal Range	Kindergarten		1st Grade (N = 21)	2nd Grade (N = 18)	3rd Grade (N = 17)	4th Grade (N = 10)
		Pre- (N = 24)	Post- (N = 23)				
ESP Adaptive ^a	(35.9)	21.96 (4.57)	28.83 (6.25)	25.43 (4.70)	26.72 (5.66)	30.60 (5.60)	29.43 (8.36)
ESP Maladaptive ^b	(13.5)	32.58 (7.61)	22.26 (8.86)	23.48 (6.50)	23.83 (9.37)	19.40 (5.58)	18.14 (12.50)
CBC Aggression ^c	(7.0)	20.33 (11.10)	11.04 (8.31)	14.19 (10.06)	14.55 (11.79)	8.60 (7.22)	7.00 (11.25)
CBC Withdrawn ^d	(0–1)	7.04 (4.87)	4.50 (4.41)	4.62 (4.05)	6.11 (4.08)	4.90 (3.07)	5.29 (4.89)
AET Observations ^e	(75.19%)	(N = 24) 62.54% (16.35)	(N = 24) 79.83% (22.16)	(N = 20) 90.65% (10.62)	(N = 17) 83.67% (14.02)	(N = 17) 78.68% (12.90)	(N = 10) 90.40% (5.52)
		1994–1995 Cohort 2					
Teacher Ratings	Normal Range	Kindergarten		1st Grade (N = 15)	2nd Grade (N = 12)	3rd Grade (N = 8)	4th Grade
		Pre- (N = 22)	Post- (N = 22)				
ESP Adaptive ^a	(35.9)	21.73 (5.26)	26.68 (4.86)	26.47 (5.78)	28.33 (3.05)	29.63 (9.12)	—
ESP Maladaptive ^b	(13.5)	31.45 (6.97)	26.27 (8.04)	23.67 (6.95)	21.33 (7.50)	23.00 (10.11)	—
CBC Aggression ^c	(7.0)	24.82 (10.41)	16.77 (10.56)	17.27 (9.17)	16.00 (7.00)	16.88 (12.33)	—
CBC Withdrawn ^d	(0–1)	4.00 (3.49)	2.64 (3.40)	1.20 (1.90)	0.33 (0.58)	2.88 (4.73)	—
AET Observations ^e	(75.19%)	(N = 22) 59.64% (14.41)	(N = 22) 90.77% (6.71)	(N = 13) 81.85% (10.31)	(N = 12) 89.85% (9.63)	(N = 8) 75.00% (20.25)	—

^a ESP Adaptive — Early Screening Project, Adaptive Behavior Rating Scale.
^b ESP Maladaptive — Early Screening Project, Maladaptive Behavior Rating Scale.
^c CBC Aggression — Child Behavior Checklist, Aggression Subscale.
^d CBC Withdrawn — Child Behavior Checklist, Withdrawn Subscale.
^e AET Observations — Academic Engaged Time.

THE FIRST STEP, from page 19

monitoring of the implementation process by the program's developers.

During a 15-month implementation program, the First Step program was applied to more than 200 K-3 student participants within school districts located in 22 of Oregon's 36 counties. Pre- and post-change scores for target participants (N = 181) for whom useable data were obtained are displayed in Table 2. In order to provide

magnitude, when the First Step program is scaled up and applied under far less than controlled conditions, as a positive sign. However, without an untreated or usual care control group, these results cannot be attributed to the First Step implementation.

Two additional outcomes of this initiative were that both parents and teachers, via consumer satisfaction survey responses, reported that they saw collateral positive effects on the classroom and the family, respectively, as a part of their involvement;

This is the first example of the program's being scaled up and applied on a widespread basis in the "real world" conditions of regular classroom settings absent supervision by the program's developers.

for replication of the results from Walker et al. (1998), the HSRI evaluators used the identical dependent measures.

Table 2 results show substantial changes in the desired directions for each of the dependent measures favoring the First Step participants. All of the pre/post changes for the target participants were statistically significant at $p < 0.001$ and closely replicated those obtained by Walker et al. (1998).

The overall results of this program evaluation were largely positive. The findings of the HSRI evaluators replicated the level and direction of the First Step program's impact as indicated by the close correspondence between results for the HSRI sample (N = 181) and the Walker et al. (1998) sample cohorts 1 and 2 (Ns = 24 & 22). We regard achieving intervention effects of this

and that study results suggested that the First Step program may be most effective with at-risk children having severe behavioral problems in the classroom.

The HSRI evaluators' observations of the First Step program's implementation fidelity indicated that the quality of First Step implementation varied substantially. They found, as expected, that the key steps in the model's implementation were followed closely in some cases and that, at other times, there was significant deviation from the intervention protocols and guidelines contained in the First Step program manuals. HSRI evaluators concluded that the First Step program usually produced consistent changes in child behavior, even when there was relatively poor implementation fidelity.

Ongoing and Planned First Step Research

Four-Year APS Study. Over the past several years, the authors have been involved in two large-scale investigations of First Step funded by the National Institute of Education Sciences. The first of these investigations is a four-year (2004–2008) efficacy trial of the First Step program that is being conducted within the Albuquerque Public Schools (APS). APS is the 17th largest U.S. school district and serves a multicultural client population that has a low socioeconomic status (SES) index. APS is a highly diverse school district, with 67% students of color (50% are from Latino ethnic backgrounds). Problems with drug and alcohol abuse are relatively common in the APS catchment area.

Year one of this study was devoted to recruiting, gearing up, and planning tasks; years two and three to First Step implementation; and year four to maintenance procedures and follow-up assessments. A total of 200 target student participants in grades one to three are participating in this investigation. The participants are divided into two cohorts, with 101 students receiving the First Step intervention and 99 serving as untreated, usual care controls.

Students were randomly assigned to either First Step or control conditions following universal screening and teacher recruitment procedures that identified one student per classroom who met eligibility criteria. Randomization occurred at the classroom level with one participating student (experimental or control) per classroom. A total of 34 APS schools participated in the study. Extensive assessments of implementation fidelity, including adherence to implementation protocols for both teachers and parents, were recorded.

Selected students were behaviorally at risk, with higher than normal levels of externalizing behavior problems (aggression, disruption, oppositional). Twenty-eight percent of First Step students and 21% of control students were female. Sixty-one percent of control students and 66% of First Step students were eligible for free and reduced lunch.

Results of this research will be published in forthcoming manuscripts. Pre/post assessments of the combined cohorts 1 and 2 samples across behavioral (teacher-parent Likert ratings, direct observations) and academic (oral reading fluency, letter-word

Table 2: Mean Scores Across Four Measures for HSRI Participants

Measure and Group	Pre-Intervention		Post-Intervention		N	p value
	M	SD	M	SD		
Adaptive — Experimental	21.38	4.42	27.90	5.50	181	0.001
Aggression — Experimental	25.41	9.27	16.04	9.62	123	0.001
Maladaptive — Experimental	32.33	6.57	23.10	7.38	123	0.001
AET — Experimental	64.05	20.90	86.66	12.80	128	0.001

See THE FIRST STEP, next page

THE FIRST STEP, from page 20

recognition, SSRS academic competence subscale) measures for the APS study show effect sizes favoring First Step participants generally in the moderate (academic measures) to robust (social-behavioral measures) range. Currently, we are recording one-year follow-up data on cohort 1 and 2 participants and also evaluating the efficacy of a "transition roadmap" procedure to facilitate the sustainability of First Step achieved gains across school years.

IES Goal 4 Effectiveness Study. In collaboration with Mary Wagner and her associates at Stanford Research Institute (SRI), the authors are collaborating on an Institute of Education Sciences (IES) Goal 4 effectiveness study of the First Step program, in which it is being scaled up and implemented in urban-suburban school districts within five sites across the country (i.e., California, Florida, Illinois, Oregon, and West Virginia). This investigation runs from 2006 to 2011, with the first two years devoted to First Step implementation (two sites in year one and three sites in year two) and the remaining three years focused on sustainability, maintenance, and follow-up issues. The diversity of sites in this investigation, in terms of student population, economic conditions, and size of district, should extend the range of the First Step program's applicability substantially. We are using the same measures in this effectiveness study as those in the APS Goal 3 efficacy study. Year one results for the first two implementation sites (California and Illinois) closely replicate those for our APS study, although they are not quite as robust in their magnitude.

Concluding Remarks

The First Step to Success program appears to have acceptable social validity, as indicated by feedback from consumers across multiple studies (although some teachers see it as too demanding of their time and effort). The relative contributions of the home and school components of First Step to an overall

- Develop an online training regimen so that behavioral coaches do not have to rely upon direct, in vivo training sessions, as is now the case, in order to acquire First Step implementation skills.

In addition, we plan to revise the First Step program to incorporate our experiential and research findings to date. An

It is possible that a substantial treatment effect can be achieved from the school-only part of the program. This would be an important finding because some schools are reluctant to provide services to parents via home visitations.

treatment effect is a question that has not been addressed and needs investigation. It is possible that a substantial treatment effect can be achieved from the school-only part of the program. If so, this would be an important finding to document because some schools are reluctant to provide services to parents via home visitations.

The long-term impact of the First Step program is unknown; however, our ongoing IES Goal 3 and 4 studies will allow this question to be studied across school years. Our current plans are to solicit funding in order to:

- Investigate the efficacy of the preschool version of First Step;
- Adapt the HomeBase component of First Step so that it will accommodate severely at-risk children requiring tertiary-level interventions; and

important part of this revision process will focus on utilizing the excellent work of Rob Horner and his associates in investigating factors associated with at-risk students who are weak and non-responders to the First Step implementation process (see Carter & Horner, 2007; in press). Finally, there are some needed program adaptations for working effectively with more diverse student and family populations that will be addressed in the revision process.

Since the First Step program's development and publication in 1997, there have been several evaluations that demonstrate its efficacy for primary grade children. Our ongoing randomized trials will further elucidate the validity and effectiveness of the program in this regard. We welcome research on First Step by other investigators.

Appendix: First Step to Success Publications

Books

- Walker, H.M., Golly, A.G., Kavanagh, K., Stiller, B., Severson, H.H., & Feil, E.G. (2002). *First Step to Success: Helping Young Children Overcome Antisocial Behavior—Preschool Edition*. Longmont, CO: Sopris West.
- Walker, H.M., Stiller, B., Golly, A., Kavanagh, K., Severson, H., & Feil, E. (1997). *First Step to Success: Helping Young Children Overcome Antisocial Behavior* (an early intervention pro-

gram for grades K-3). Longmont, CO: Sopris West.

Journal Articles

- Beard, K.Y., & Sugai, G. (2004). First Step to Success: An early intervention for elementary children at risk for antisocial behavior. *Behavioral Disorders, 29(4)*, 396–409.
- Diken, I.H., & Rutherford, R.B. (2005). First Step to Success early intervention program: A study of

effectiveness with Native-American children. *Education and Treatment of Children, 28(4)*, 444–465.

- Golly, A.M., Sprague, J., Walker, H.M., Beard, K., & Gorham, G. (2000). The First Step to Success program: An analysis of outcomes with identical twins across multiple baselines. *Behavioral Disorders, 25(3)*, 170–182.
- Golly, A.M., Stiller, B., & Walker, H.M. (1998). First Step to Success:

See THE FIRST STEP, next page

THE FIRST STEP, from page 21

Replication and social validation of an early intervention program. *Journal of Emotional and Behavioral Disorders*, 6(4), 243–250.

- Overton, S., McKenzie, L., & King, K. (2002). Replication of the First Step to Success model: A multiple-case study of implementation effectiveness. *Behavioral Disorders*, 28(1), 40–56.
- Walker, H.M. (1998). First steps to prevent antisocial behavior. *Teaching Exceptional Children*, 30(4) (Special issue on discipline), 16–19.
- Walker, H.M. (2002). The First Step to Success program: Preventing destructive social outcomes at the point of school entry. In P.S. Jensen (Ed.), *Report on Emotional & Behavioral Disorders in Youth*, 3(1), 3–6, 22–23.
- Walker, H.M., Golly, A.M., McLane, J.Z., & Kimmich, M. (2005). The Oregon first step to success replication initiative: Statewide results of an evaluation of the program's impact. *Journal of Emotional and Behavioral Disorders*, 13, 163–172.
- Walker, H.M., Kavanagh, K., Stiller, B., Golly, A., Severson, H.H., & Feil, E.G. (1998). First Step to Success: An early intervention approach for preventing school antisocial behavior. *Journal of Emotional and Behavioral Disorders*, 6(2), 66–80.
- Walker, H.M., Stiller, B., & Golly, A. (1998). First Step to Success: A collaborative home-school intervention for preventing antisocial behavior at the point of school entry. *Young Exceptional Children*, 1(2), 2–6.
- Walker, H.M., Stiller, B., Severson, H.H., & Golly, A. (1998). First Step to Success: Intervening at the point of school entry to prevent antisocial behavior patterns. *Psychology in the Schools*, 35(3), 259–269.

Book Chapters

- Epstein, M.H., & Walker, H.M. (2002). Special education: Best practices and First Step to Success. In B.J. Burns & K. Hoagwood (Eds.), *Community Treatment for Youth: Evidence-Based Interventions for*

Severe Emotional and Behavioral Disorders (pp. 179–197). New York: Oxford University Press.

- Walker, H.M., Sprague, J.R., Perkins-Rowe, K.A., Beard-Jordan, K.Y., Seibert, B.M., Golly, A.M., Severson, H.H., & Feil, E.G. (2005). The First Step to Success program: Achieving secondary prevention outcomes for behaviorally at-risk children through early intervention. In M.H. Epstein, K. Kutash, & A.J. Duchnowski (Eds.), *Outcomes for Children and Youth with Emotional and Behavioral Disorders and Their Families: Programs and Evaluation Best Practices* (2nd ed.) (pp. 501–523). Austin, TX: PRO-ED.

Programs in Which First Step Is a Recommended Program

Reviews of effective early intervention programs for addressing antisocial behavior and risk factors for destructive outcomes in which First Step to Success is a recommended program are:

- **Preventing Mental Disorders in School-Age Children: A Review of the Effectiveness of Prevention Programs.** Mark T. Greenberg, Ph.D., Director, Prevention Research Center for the Promotion of Human Development, College of Health and Human Development, Pennsylvania State University, University Park, PA 16802; phone: (814) 863-0112; fax: (814) 865-2530; website: <http://www.psu.edu/dept/prevention>.
- **Effective Interventions for Children Having Conduct Disorders in the 0 to 8 Age Range.** Carolyn H. Webster-Stratton, Ph.D., Professor & Director, Parenting Research Clinic; Professor, Family and Child Nursing; Box 354801, 305 University District Bldg., School of Nursing, University of Washington, Seattle, WA; phone: (206) 543-6010; fax: (206) 543-6040; email: cws@u.washington.edu.
- **Effective Programs and Strategies to Create Safe Schools.** Paul Kingery, Ph.D., Director, Hamilton Fish National Institute on School and Community Violence—National Office, 2121 K Street, NW, Suite 200, Washington, DC 20037-1830; phone: (202) 496-2201; fax: (202) 496-6244; email: kingery@gwu.edu; website: www.hamfish.org.

- **Compilation of Early Violence Prevention Programs and Resources.** American Psychological Association. Julia M. Silva, Ph.D., APA Public Interest Directorate, 750 First Street, NE, Washington, DC 20002-4242; phone: (202) 336-5817; fax: (202) 336-5723; email: publicinterest@apa.org; website: www.apa.org/pi.

- **Programs and Interventions to Make Schools Safer.** Video Series on Safe Schools, National Education Association, 1201 16th Street, NW, Washington, DC 20036; phone: (202) 833-4000.

- **Preventing Delinquency Through Early Interventions: Prenatal to Age Ten.** Ray Mathis, Children's Delinquency Reduction Committee; Executive Director, Citizens Crime Commission, Affiliate of the Portland Metropolitan Chamber of Commerce, 21 NW Second Ave., Portland, OR 97209-3999; phone: (503) 228-9736; fax: (503) 228-5126; email: ccc@pdxchamber.org.

- **School-Based Aggression Prevention Programs for Young Children: Current Status and Implications for Violence Prevention.** Stephen Leff et al. (2001). *School Psychology Review*, 30(3), 344–362.

- **Communities That Care Prevention Strategies Guide.** The guide is an integral part of the Communities That Care prevention-planning system developed by Dr. J. David Hawkins and Dr. Richard F. Catalano of the University of Washington. The overall purpose of the system is to help communities facilitate positive futures for their youth. In press, Channing-Bete Co.; One Community Place, South Deerfield, MA 01373-0200; phone: (413) 665-7611; fax: (413) 665-2671; website: www.channing-bete.com.

- **Comprehensive Evidence-Based Social-Emotional Curricula for Young Children: An Analysis of Efficacious Adoption Potential.** Gail E. Joseph and Phil S. Strain, Positive Early Learning Experiences Center, University of Colorado at Denver.

- **Model Programs Guide.** Office of Juvenile Justice and Delinquency Prevention (OJJDP). website: www.dsgonline.com/mpg2.5/TitleV_MPG_Table_Ind_Rec.asp?id+611.

See THE FIRST STEP, next page

THE FIRST STEP, from page 22

References

- Achenbach, T. (1991). *The Child Behavior Checklist: Manual for the Teacher's Report Form*. Burlington, VT: Department of Psychiatry, University of Vermont.
- Carter, D.R., & Horner, R.H. (2007). Adding functional behavioral assessment to First Step to Success: A case study. *Journal of Positive Behavior Interventions* 9(4), 229–238.
- Carter, D.R., & Horner, R.H. (in press). Adding function-based behavioral support to First Step to Success: Integrating individualized and manualized practices. *Journal of Positive Behavior Interventions*.
- Epstein, M.H., & Walker, H.M. (Eds.) (2002). Special education: Best Practices and First Step to Success. In B.J. Burns & K. Hoagwood (Eds.).

Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders. New York: Oxford.

- Golly, A., Sprague, J., Walker, H.M., Beard, K., & Gorham, G. (2000). The First Step to Success program: An analysis of outcomes with identical twins across multiple baselines. *Behavioral Disorders*, 25(3), 170–182.
- Golly, A., Stiller, B., & Walker, H. M. (1998). First Step to Success: Replication and social validation of an early intervention program for achieving secondary prevention goals. *Journal of Emotional and Behavioral Disorders*, 6(4), 243–250.
- Overton, S., McKenzie, L., King, K., & Osbourne, J. (2002). Replication of the First Step to Success model: A multiple-case study of implementation effectiveness. *Behavioral Disorders*. *Behavioral Disorders*, 28(1), 40–56.

Walker, H.M., Golly, A., McLane, J., & Kimmich, M. (2005). The Oregon First Step Replication Initiative: Statewide results of an evaluation of the program's impact. *Journal of Emotional and Behavioral Disorders*, 13(3), 131–141.

Walker, H.M., Kavanagh, K., Stiller, B., Golly, A., Severson, H.H., & Feil, E.G. (1998). First Step to Success: An early intervention approach for preventing school antisocial behavior. *Journal of Emotional and Behavioral Disorders*, 6(2), 66–80.

Walker, H.M., & Severson (1990). *Systematic Screening for Behavior Disorders*. Longmont, CO: Sopris West.

Walker, H.M., Stiller, B., Golly, A., Kavanagh, K., Severson, H.H., & Feil, E. (1997). *First Step to Success: Helping Young Children Overcome Antisocial Behavior*. Longmont, CO: Sopris West. ■

EDITOR'S CORNER, from page 2

the investigators compared the results of studies that evaluated the psychiatric and functioning outcomes of children receiving treatment in community practices to children who received treatment in research laboratories as part of treatment outcome studies. The average effect of the treatment provided in the community was of very little to no benefit for the children. This was in stark contrast to the medium to large effects found for children who received treatment in the research laboratories. There are many questions and potential limitations to comparing the two sets of outcomes; however, the near zero benefits of community care are concerning and raise questions pertaining to quality of care.

Training in Evidence-Based Practices Needed

The findings of these three studies are not surprising when you consider the lack of training in evidence-based practices in many of our graduate programs that train mental health practitioners (Shernoff et al., 2003) and the absence of accountability for quality in our mental health systems. Many mental health clinicians can be well regarded and successful in their careers if their clients do not complain, they get along with colleagues, and they meet expectations for billable hours. But these same “successful” clinicians may do nothing of any

meaningful value during their treatment sessions.

Of course, there are many clinicians who take great pride in the quality of their services

require that advocates and politicians recognize that making something bigger does not necessarily make something better.

Many clinicians may believe that they are providing evidence-based practices, but due to confusion about the meaning of the term “evidence-based,” their services may actually miss the mark.

and pursue knowledge and training in best practices, but this is often above and beyond what is expected by many current accountability standards. Further, many clinicians may believe that they are providing evidence-based practices, but due to confusion about the meaning of the term “evidence-based,” their services may actually miss the mark (see Van Eck et al., 2007).

Certainly, access to care and well-coordinated systems of care are important; however, addressing these problems without improving quality of care is of little to no benefit for children who need services. Quality issues are difficult to address but are critically important. The article by North and colleagues in this issue of *EBD* describes work being conducted in New York to address this problem. I hope similar efforts come out of the recent priority for mental health care in Virginia. This will

References

- Bickman, L., (1996). A continuum of care: More is not always better. *American Psychologist*, 51, 689–701.
- Shernoff, E.S., Kratochwill, T.R., & Stoiber, K.C. (2003). Training in evidence-based interventions (EBIs): What are school psychology programs teaching? *Journal of School Psychology*, 41, 467–483.
- Van Eck, K., Evans, S.W., & Ulmer, L. (2007). From evidence-based to best practices: What does it mean? *Report on Emotional and Behavioral Disorders in Youth*, 7, 35–40.
- Weiss, B., Catron, T., Harris, V., & Phung, T.M. (1999). The effectiveness of traditional child psychotherapy. *Journal of Consulting and Clinical Psychology*, 67, 82–94.
- Weisz, J.R., Donenberg, G.R., Han, S.S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology*, 63, 688–701.

—Steven W. Evans ■

SUBSCRIPTION INFORMATION

Report on Emotional & Behavioral Disorders in Youth is published quarterly. A basic one-year subscription is \$159 plus postage and handling. Non-exempt New Jersey and New York residents please add appropriate sales tax.

TO ORDER

Complete the information below and mail to:

Civic Research Institute
P.O. Box 585
Kingston, NJ 08528 or
online at: www.civicsresearchinstitute.com

- Enter my one-year subscription to **Report on Emotional & Behavioral Disorders in Youth** at \$159 plus \$14.95 postage and handling.
- Enter my one-year subscription to **Juvenile Justice Update** at \$159 plus \$14.95 postage and handling.
- Enter my order for **Attention Deficit Hyperactivity Disorder: State of the Science; Best Practices**, edited by Peter S. Jensen and James R. Cooper, at \$125 plus \$10.95 shipping and handling.
- Enter my order for **Advances in School-Based Mental Health Interventions, Volumes I and II**, edited by Kristin E. Robinson (Vol. I) and Steven B. Evans, Mark D. Weist, and Zewelangi N. Serpell (Vol. II) at \$220 plus \$17.95 postage and handling. volumes I and II are also available separately for \$125 plus \$10.95 shipping and handling per volume.

Name _____

Agency _____

Address _____

City _____

State _____ Zip Code _____

Phone Number _____

Purchase Order # _____

Missing or damaged issues?

Call Customer Service at 609-683-4450.

Reprints: Parties wishing to copy, reprint, distribute or adapt any material appearing in *Emotional & Behavioral Disorders in Youth* must obtain written permission through the Copyright Clearance Center (CCC). Visit www.copyright.com and enter *Emotional & Behavioral Disorders in Youth* in the "Find Title" field. You may also fax your request to 1-978-646-8700 or contact CCC at 1-978-646-2600 with your permission request from 8:00 to 5:30 eastern time.



Calendar of Events, May – July 2008

May

- 22-25 APS 20th Annual Convention.** Chicago, IL. Sponsor: Association for Psychological Science. Information: Association for Psychological Science, 1010 Vermont Avenue, NW 11th Floor, Washington, DC 20005-4918; phone: (202) 783-2077; fax: (202) 783-2083; website: <http://www.psychologicalscience.org/convention>

June

- 13-16 2008 NAMI Convention.** Orlando, FL. Sponsor: National Alliance on Mental Illness. Information: National Alliance on Mental Illness, Colonial Place Three, 2107 Wilson Boulevard., Suite 300, Arlington, VA 22201-3042; phone: (703) 524-7600; fax: (703) 524-9094; website: <http://www.nami.org/template.cfm?section=convention>
- 25-28 2008 National School-Based Health Care Convention.** Los Angeles, CA. Sponsor: National Assembly on School-Based Health Care. Information: National Assembly on School-Based Health Care website: http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.2708163/k.9443/Convention_Intro.htm
- 28-June 1 American School Counselor Association Annual Meeting.** Atlanta, GA. Sponsor: American School Counselor Association. Information: American School Counselor Association, 1101 King Street, Suite 625, Alexandria, VA 22314; phone: (703) 683-ASCA and (800) 306-4722; fax: (703) 683-1619; website: <http://www.schoolcounselor.org/content.asp?pl=325&sl=129&contentid=182>

July

- 13-15 ASHA Health Care 2008 and Business Institute.** St. Louis, MO. Sponsor: American Speech-Language-Hearing Association. Information: American Speech-Language-Hearing Association, 10801 Rockville Pike Rockville, MD 20852; email: actioncenter@asha.org; website: <http://www.asha.org/about/events/hcare-conf/HC2008.htm>

REPORT ON

Emotional & Behavioral Disorders in Youth™

Civic Research Institute, Inc.
4478 Route 27 P.O. Box 585
Kingston, NJ 08528