*C*hoosing the Right Treatment: What Families Need to Know About Evidence-Based Practices

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Darcy Gruttadaro, J.D., Director, NAMI Child and Adolescent Action Center

Barbara J. Burns, Ph.D., Professor of Medical Psychology and Director, Services Effectiveness Research Program, Department of Psychiatry and Behavioral Sciences, School of Medicine, Duke University

Kenneth Duckworth, M.D., NAMI Medical Director, Board Certified Child & Adolescent Psychiatrist

Dana Crudo, NAMI Program Coordinator

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Acknowledgments

Methodology

In developing this guide, NAMI sought early input from a number of stakeholder groups. NAMI invited family and mental health advocacy organizations to a stakeholder meeting to provide input on the content of the guide. The organizations invited included: the Bazelon Center for Mental Health Law, The Child and Adolescent Bipolar Foundation (CABF), Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD), the Federation of Families for Children's Mental Health (FFCMH), Georgetown University National Technical Assistance Center for Children's Mental Health, Mental Health America (MHA), and the Center for Mental Health Services, Child, Adolescent, and Family Branch.

Representatives from several of these organizations reviewed a draft of the guide and were given an opportunity to provide additional input. A draft of the guide was also shared with families of children with mental health conditions from multiple states. Input from these stakeholders was incorporated into the final version of the guide. The input NAMI received was extremely useful in helping to ensure that the guide meets the information needs of families and an array of stakeholders.

Introduction

This guide is designed to inform families about evidence-based practices (EBPs) in children's mental health and to share information on an array of treatment and support options. Today, more and more people recognize the benefit of being well-educated consumers of healthcare and seek information about healthcare conditions and treatment options. This is certainly true for families raising children with mental health treatment needs and mental illnesses. Families recognize that knowledge is power and that informed parents are in the best position to advocate for the most effective treatment and supports for their child and family. Families want what works best for their child and family.

Over the past several years, the focus of mental health treatment and support for children and families has increasingly been on "evidence-based practices." Evidence-based practices are treatments that have been shown through clinical research to produce positive outcomes for children and their families. In short, the practices have been shown through research to be effective.

This focus on EBPs in children's mental health follows the release of a series of national reports calling for the broader dissemination of EBPs. These reports include those by the U.S. Surgeon General (1999), the Institute of Medicine (2001), the President's New Freedom Commission Report on Mental Health (2003), and more. Also, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Mental Health Services (CMHS) released Evidence-Based Practice Implementation Resource Kits for the adult mental health system. These tool kits included resources on six EBPs designed to help promote the implementation of these practices in the adult mental health care system. As of this writing, similar tool kits have not been released for EBP interventions for children and adolescents, although SAMHSA and CMHS are supporting the development of several including a guide for the selection and adoption of effective treatment and services for disruptive behavior disorders (conduct disorder and oppositional defiant disorder).

This guide is designed to inform families about the meaning of "evidence-based practices." It provides a brief introduction to a number of

effective mental health treatments and supports for children and their families. The guide does not include an exhaustive list of the EBPs that have been developed for children and their families. Instead, it highlights some of the interventions with strong research which may be more commonly available.

In this guide, families will find information designed to help them make more informed decisions about treatment and supports. They are encouraged to ask questions of their child's treating provider about recommended interventions. Families are also encouraged to learn more about what works for children and their families. The resource section at the end of the guide directs families to additional information about EBPs.

Although there is a growing emphasis on the use of EBPs, families must maintain their right to choose the most appropriate treatment that meets the unique needs of their child and family. Choice is necessary and highly valued by families because proposed EBP treatments may conflict with a family's beliefs, may have been tried and failed, or a family may know that a proposed treatment will not work for their child.

There is no substitute for a comprehensive evaluation and assessment to determine the individual needs of every child and family. This evaluation should include ruling out other medical conditions that may be causing challenging behaviors. This evaluation should look at all aspects of a child's life including functioning and relationships in school, with peers, and with family. An evaluation should lead to a choice of effective interventions that support a child's goals, build on strengths, and enhance problem-solving and coping skills. When a child requires mental health treatment, ideally a range of effective treatment options should be available.

One of the major goals of treatment is to get children back on track with their lives, returning them to the things they enjoy most and thrive on, such as sports, clubs, art, spending time with friends, and more.

Educated and informed families are in the best position to advocate for the most effective treatment and supports for their child. The goal is for family advocacy to lead to an improved quality of care, increased accountability, and ultimately better outcomes for children and their families.

What Are Evidence-Based Practices?

To establish an evidence-base through research, a practice is evaluated using scientific methods that measure the impact of the practice on treatment outcomes.

When the term "evidence-based practice" is used to describe a treatment or service, it means that the treatment or service has been studied, usually in an academic or community setting, and has been shown to be effective, in repeated studies of the same practice and conducted by several investigative teams.

In a typical study, participants are assigned to one of two groups. One group receives the treatment that is being studied to better understand its effectiveness, while the second group does not receive that treatment, and may instead be given usual treatment, placed on a waitlist, or given an alternative treatment. The two groups are compared to see whether the outcomes for the group receiving the treatment being studied are better than the outcomes for the group that did not receive that treatment.

The studies typically use uniform training and a treatment manual to guide providers (psychiatrists, therapists, social workers, and other health care providers) in the treatment. They also provide supervision and oversight to help ensure that providers follow the treatment protocol or procedures.

In general, those treatments qualify as an EBP that produce positive outcomes in two or more studies and preferably conducted by more than one research group. The outcomes typically measured in studies include some combination of the following:

1. Symptom Reduction and Improved Functioning
   • Improved school attendance and performance;
   • Improved family and peer relationships;
   • Decreased involvement with law enforcement and the juvenile justice system;
   • Decreased rates of substance use and abuse; and
   • Reduction in self-harm and suicide related behaviors.

2. Prevention of Deep End Service Use
   • Decreased hospital admissions, institutional care, and other types of out-of-home placement.

EBPs and Out-of-Home Placement

Historically, the mental health field has developed an over-reliance on institutional settings for children and adolescents with mental health treatment needs. Many children and adolescents were removed from their homes because treatment providers believed that children were best served in alternative settings and away from their families.

Research advances in children's mental health have shown that many children and adolescents achieve better outcomes when treatment is delivered in their homes and communities. Clearly, the best place for a child to grow up is at home and with their families, whenever possible.

A number of recent studies have shown that many children and adolescents with mental illnesses continue to receive services in restrictive institutional settings, including residential treatment centers, group homes, and detention centers. Although there may be a need for out-of-home placement in limited cases, use of institutional care is increased when intensive and effective services are not available in communities. Currently, there is an over-reliance on institutional care for mental health treatment in far too many communities. This issue has come to light as states increasingly focus policy and resources on increasing home and community-based EBPs.

Greater attention is being paid to the fact that institutional care is more costly than home and community-based services and limits the overall number of children that can be served. It is encouraging that states and communities are recognizing the need to develop a fuller array of effective home and community-based interventions for children and their families.

Cautions About EBPs

Much has been learned in the last decade about evidence-based practices in children's mental health and more remains to be done. First, the development of EBPs does not mean that these practices are widely available. There are many EBPs that are only available in a limited number of communities around the country. Many mental health providers have not been trained in EBPs and thus lack the training to provide these interventions for children and their families. Some providers also resist change in the way they practice, often believing that their clinical judgment, based on years of experience, produces the best outcomes for children. Families need to find providers that are open to change and willing to partner with them to provide the most effective and appropriate interventions.

Just because a child is receiving treatment that has not been recognized as an EBP, does not mean that the intervention will not be effective for the child. Many factors lead to successful service outcomes, and some of them can be difficult to evaluate. For example, the benefit of a strong therapeutic relationship between a provider, child, and family can be a factor leading to positive outcomes as long as the provider uses the skills necessary to change concerning behaviors. Families highly value mental health providers who respect the family's expertise about their child, and spend adequate time with the family through a thoughtful needs assessment and in developing and implementing an effective treatment plan. How these factors play into positive outcomes for the child and family can be hard to measure, but are important factors in positive change for the child.

Not all, but many EBPs have been studied in culturally and racially diverse communities. Consequently, the existing research base for some of the interventions in children's mental health does not address the effectiveness of the practices in all communities. Fortunately, more attention is being paid to the need to adapt EBPs, whenever possible, to bet-

ter meet the values, needs, and culture of children and families in diverse communities.

Co-occurring disorders are common in children and adolescents with mental illnesses. This is especially true for substance abuse disorders, attention deficit/hyperactivity disorder, conduct disorder, and opposi-tional defiant disorder. It is important for families to understand whether research supporting an EBP includes studies with children and adolescents with co-occurring disorders. If not, families may want to request several interventions which are likely to improve the outcomes for the disorders that are impacting their child.

Research gaps persist in effective treatment for a number of serious men-tal illnesses that impact the lives of children and adolescents, including bipolar disorder, early-onset schizophrenia, and eating disorders. There is limited research on child use of psychotropic medications, outside of research on the use of stimulants to treat attention deficit/hyperactivity disorder. Information about medications is included in this EBP guide, despite the limited research, which families may wish to consider when making decisions about the appropriateness of medication for their child.

The limited research that has been done on medications tends to focus on the short-term effects of medication, without examining the long-term safety and effectiveness of medications for children. Fortunately, the scientific understanding of medications continues to grow, with increased information about combining medication with other therapeu-tic interventions—often involving parents and families as co-therapists, to produce the best results. New research is being conducted so that more EBPs will be available to treat early-onset mental illnesses.

Unfortunately, there is currently not a central clearinghouse or single resource for families to access to learn more about EBPs in children's mental health and the availability of those EBPs in communities. The growing interest in EBPs led the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop NREPP, a national data-base of interventions for the prevention and treatment of mental health and substance abuse disorders. The resource section of this guide

includes the Web site address for NREPP and many other resources on EBPs that may be of interest to families.

The broader implementation of EBPs in children's mental health holds real promise for improving the quality of care provided to children and their families. It also promises to increase accountability in service delivery and to improve treatment outcomes. Families, as mental health consumers, are in a key position to advocate for the broader availability of EBPs as part of a comprehensive array of available treatment in their communities. There is great value in families continuing to learn more about effective treatment in children's mental health.

How To Talk with Providers About Treatment Choices and Evidence-Based Practices

Families are encouraged to ask questions of their child's clinician about recommended treatment. They are encouraged to bring a notebook with questions that they would like answered and to record answers to their questions. Families are also encouraged to share their values and preferences with treatment providers.

Important Questions

- Why are you recommending this treatment and what are the alternative treatments, if any?

- What is the goal of the treatment being recommended and will it help us get the outcomes that we want? (Share the outcomes you want, such as improved school attendance and performance, less child and family distress, improved behavior and relationships with family and peers, improved functioning, and others.)

- How will we know if we are reaching our treatment goals?

- How does the recommended treatment promote my child's strengths, capabilities, and interests?

- What are the risks and benefits associated with the recommended treatment?

- How does the recommended treatment work and what is involved?

- Is there research or evidence to support the use of this treatment? If so, are you following a manual that describes how it works?

- Is there research showing that the recommended treatment works for families like ours? Tell us about the research supporting the recommended treatment.

- What training and experience do you have with the recommended treatment?

- If you are not recommending an evidence or research-supported treatment, why not?

- How will our family be involved in the recommended treatment and how can we best support the treatment?

- What changes can we expect to see and how long will it take before we see these changes?

- How do we measure and monitor progress?

- What should we do if problems get worse or we do not see an improvement?

- How do we reach you after hours or in an emergency, and if we cannot reach you, will someone else from your office be available. If so, who?

- Is the recommended treatment covered by our insurance and what is the cost?

Medications
- Are there psychosocial interventions that might be tried before medication is used, or effectively used in combination with medication, which may help to lower the required medication dose?

- Does research support the use of the recommended medication for a child that is my child's age and with similar needs?

- How does medication fit within the overall treatment plan and how will we coordinate with other treatment, such as therapy, school behavior plans, and more?

- What should we be looking for in changes in behavior, changes in symptoms, and who should we contact with questions about these changes and the medication?

- What are the potential risks and benefits of the medication and other treatment options, and what are the potential side effects?

- How will our family, our child, and the treating provider monitor progress, behavior changes, symptoms, and safety concerns? (Close monitoring is critical with all medications at all times, however, it is especially important when medication is started and when dosages are changed.)

- How will we know when it is time to talk about stopping medication treatment and what steps need to be taken before the medication is stopped?

- How can we best develop a clear communication plan between our family and the treating providers (therapist and psychiatrist) to ensure open lines of communication?

- What if my child has a crisis and is hospitalized? Who can we contact in your office, especially if someone want to change medications?

What Are Current Evidence-Based Practices in Children's Mental Health?

There are a number of psychosocial interventions that have been shown to be effective for children and their families. There are also medications, often used in combination with psychosocial interventions, which are commonly prescribed for children and adolescents with mental illnesses. This guide includes a partial list of psychosocial EBPs in children's mental health that have a solid research base. The appropriateness of an evidence-based practice for a child depends on the child's age and unique needs.

The chart that follows provides families with a quick reference for evidence-based psychosocial interventions by diagnosis for children and adolescents. It also lists the medications commonly prescribed for children and adolescents with mental illness by diagnosis.

Child & Adolescent Mental Health Treatments

Diagnosis	Evidence-Based Psychosocial Interventions	*Psychopharmacology
Anxiety	• Cognitive Behavioral Therapy (CBT) — Ages 9–18 • Exposure Therapy — Ages 3–17 • Modeling Therapy — Ages 3–13	**Antidepressant medication (Selective Serotonin Reuptake Inhibitors—SSRIs); Benzodiazepines (no controlled evidence, but used in clinical practice).
Attention Deficit Hyperactivity Disorder (ADHD)	• Behavior Therapy (in home and in school) — Ages 3–12 • Parent Management Training — Ages 3–16 The combination of behavior therapy and medication is often most effective in treating ADHD.	Stimulant and non-stimulant (Strattera) medications. (FDA requires a patient medication guide alerting consumers of possible serious side effects.)
Autism	• Behavior Therapy — Ages 3–13 • Individual and family therapies that target communication skills, interaction skills, and behavior modification. — Ages 3–13	Antipsychotic medication has been shown to reduce aggression.
Bipolar Disorder	No controlled studies of psychosocial interventions for youth with bipolar disorder have been done. However behavior therapy, family education, and support benefit youth and families and improve relationships, communication, and coping skills.	Mood stabilizers (Lithium and Valproate—an anti-convulsant medication); Atypical antipsychotic medication; and other medications may be appropriate.
Conduct Disorder/Oppositional Defiant Disorder (CD/ODD)	• Parent Training (multiple EBPs for different age groups) — Ages 3–15 • Anger Coping Therapy (targets skill development in school) — Ages 9–15 • Brief Strategic Family Therapy (BSFT) — Ages 6–17 • Functional Family Therapy (FFT) — Ages 13–16 • Treatment Foster Care (TFC) — Ages 9–18 • Multisystemic Therapy (MST) — Ages 12–17 • Mentoring — Ages 12–17 • CBT — Ages 9–18	Antipsychotic medication & mood stabilizers. (CD and ODD often co-occur with other mental illnesses so other medications may be appropriate.)
Depression	• CBT — Ages 9–18 • Relaxation Therapy — Ages 11–18 • Interpersonal Therapy (IPT) — Ages 12–18 • Family Education and Support — Ages 12–18 The combination of CBT and medication is often most effective in treating major depression.	**Antidepressant medication (SSRIs)
Schizophrenia	No controlled studies of psychosocial interventions for youth with schizophrenia have been done. However behavior therapy, family education, and support benefit youth and families and improve relationships, communication, and coping skills.	Antipsychotic medication

Information in the chart is based on reviews by Burns, Chorpita, Chambless and Halloran, Hoagwood, Jensen, Weisz, and the authors of the Guide.
* Generally, there is limited research on children's medication use, but more research exists on the utilization of ADHD medication.
** The Food and Drug Administration (FDA) has issued a "black box" warning about the increased risk of suicidal thoughts and behaviors in youth being treated with antidepressant medications.

Evidence-Based Psychosocial Interventions

The psychosocial evidence-based interventions are described below in three categories. The first category includes interventions that bring together the parent and therapist, child and therapist, and/or child and teacher. The second category includes family interventions consisting of family therapy, parent training, family education and support. The third category, intensive home and community-based interventions, consists of a wide array of interventions for youth with significant functional impairment who may be at risk of out-of-home placement.

Bringing Family, Child, Provider, and/or Teacher Together
There are many types of psychosocial interventions that are currently used to treat children and adolescents with mental illnesses. A number of these approaches are behavioral and are designed to help families and school professionals better intervene to reduce troublesome behaviors and develop positive strategies to change those behaviors.

The success of psychosocial treatment often depends on the therapeutic bond formed between the provider, child, and family. The type of therapy provided often also depends on the provider's training and clinical experience. Unfortunately, not enough mental health and primary care providers are trained in psychosocial EBPs.

Research shows that the combination of psychosocial treatment and medication sometimes produces the best results for children and adolescents living with mental illnesses. In some cases, a psychosocial treatment may help to reduce the amount of medication that is required for a child. Families should talk with their child's treating provider about the appropriateness and effectiveness of combining psychosocial treatment with medication.

Psychosocial treatment often provides children and adolescents with strategies and skills to better cope with the symptoms of the illness. Many of the psychosocial EBPs rely on parent participation and recognize that parents are valuable partners in effective treatment and services.

The interventions included below have an evidence base to support their effectiveness with children and their families. Research has shown that these interventions are effective for children and adolescents with one or more of the following mental illnesses: anxiety, attention deficit/hyperactivity disorder, depression, oppositional defiant disorder, conduct disorder, trauma, and substance abuse/dependency disorders. Most of the psychosocial interventions included below have not been evaluated or specifically developed for children and adolescents with bipolar disorder and schizophrenia, an exception is limited research on family psychoeducation for children and adolescents with bipolar disorder.

Cognitive Behavioral Therapy (CBT)

Description of Intervention: CBT teaches youth how to notice, take account of, and ultimately change their thinking and behaviors that impact their feelings. In CBT, youth examine and interrupt automatic negative thoughts that they may have that make them draw negative and inappropriate conclusions about themselves and others. CBT helps a young person learn that thoughts cause feelings, which often influence behavior.

The therapy targets and works to stop negative thoughts. For example, if an adolescent did poorly on a test and is thinking, "I'm dumb and worthless"—CBT helps that young person identify how to think and act more positively to perform better on the test, rather than focusing on negative thoughts about him or herself.

CBT helps children and adolescents to improve their coping and problem-solving skills. It also encourages them to increase their involvement in enjoyable and healthy activities.

Those participating in CBT are typically given homework with the expectation that the child is working outside of the office. Family involvement in CBT includes parents reinforcing more sensible and positive thoughts and helping the child practice this new way of thinking outside of the clinician's office.

Average Length of Treatment: 12 to 16 weeks, with a 60–90 minute session each week.

Effective For: Anxiety, Depression, Oppositional Defiant Disorder, Conduct Disorder, and Trauma.

Exposure Therapy
Description of Intervention: Exposure therapy educates and teaches children and adolescents about how to manage fears and worries to reduce their distress. The child is gradually exposed to threatening situations, thoughts, or memories that make the child excessively anxious or worried.

For example, with a child that has an extreme fear of attending school, the therapist might appropriately walk with the child to school and each time get closer and closer to the school, until they eventually enter the school. The therapist gently, persistently, and gradually exposes the child to the situation that causes the extreme fear. During this time, the therapist talks with the child about his or her fear and anxiety and provides therapeutic support.

In exposure therapy, the therapist offers the child replacement strategies to reduce anxiety and fear (such as deep breathing, exercise, and talking) with the expectation that the fear will be reduced and ultimately eliminated.

Exposure therapy helps the child to cope with extreme fears and worrisome situations rather than avoiding them, helps to eliminate distressful thoughts, nightmares, problems focusing, attention, irritability, and anger.

Average Length of Treatment: 7 to 15, 90-minute sessions (depending on the severity of the symptoms).

Effective For: Anxiety Disorders, more specifically phobias.

Interpersonal Therapy (IPT)

Description of Intervention: IPT is designed for adolescents with depression. It examines relationships and transitions for adolescents, and how they affect a youth's thinking and feeling. IPT focuses on the adolescent and helps them manage major changes in their lives, such as divorce and significant loss, including the death of a loved one. In IPT, a therapist examines one or more of four areas that commonly contribute to a young person's serious distress:

•   Role transition and changes in role identity—an example may be when an adolescent is asked to leave a sport's team or becomes pregnant;
•   Role dispute and authority conflicts—an example may be when a parent insists that a young person complete homework and that person wants to do something else;
•   Grief and loss—may be related to divorce or the death of a loved one; and
•   Interpersonal conflict and peer relationships.

In IPT, the therapist helps the adolescent evaluate his or her relationships and interactions with others. This is an effective form of therapy, however, few providers are trained in IPT so it may be challenging for families to access IPT treatment for their child.

Studies show that IPT reduces depression in youth and improves social and problem-solving skills.

Average Length of Treatment: Approximately 12 weeks, with weekly face-to-face sessions and with regular telephone contact.

Effective For: Depression.

Behavior Therapy

Description of Intervention: Behavior therapy helps a child or adolescent change negative behaviors and improve behaviors in school, at home, and with peers through a reward and consequence system. In behavior therapy, goals are set for the child and small rewards are

earned for positive behavior. Children may also lose privileges or be put in time-out for a brief period for failing to meet expectations, although the primary therapeutic focus is on reinforcing positive behavior by rewarding the young person with gold stars, extra computer time, and other earned privileges.

For children with attention deficit/hyperactivity disorder, some simple behavioral interventions at home might include setting and maintaining a consistent daily schedule and routine for the child. This includes a schedule for homework, playtime, meals, and sleep. The schedule should be posted and clearly visible to help the child succeed. Everyday items that a child uses—such as clothing, a book bag, lunch, and others—are organized in a way that helps the child meet his or her goals and achieve success. At school, behavioral interventions might include developing a daily report card to provide the student with regular feed back and using a point or token system to reward positive behaviors.

Families play an essential role in developing goals for their child and in administering the reward and consequence system. In behavior therapy, the parents function as a co-therapist by carrying out the behavior management plan that is developed by the parents and therapist. The behavior therapy targets the child by helping parents and teachers apply skills that will benefit the child, including those related to communication, conflict reduction, ignoring some behaviors, and rewarding others.

There are a number of effective behavioral interventions for children and adolescents.

Average Length of Treatment: Depends on the unique needs of the child, may be ongoing.

Effective For: Attention Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder, and Autism.

Family Interventions—Family Therapy, Parent Training, and Family Education and Support

Evidence-based family interventions include family therapy, parent training, family education and support. These interventions recognize the important role of families in helping a child who is struggling with mental health disorders, substance use, and disruptive behaviors. Family-based treatments involve parents and caregivers as essential partners and recognize that they need special skills to address their child's challenging emotions and behaviors. The following are evidence-based family interventions.

Brief Strategic Family Therapy (BSFT)

Description of Intervention: BSFT focuses on improving the interactions between the family and the child. This intervention creates a positive relationship between a counselor and the whole family by looking at family strengths and conflicts in interactions between family members. This allows the counselor and family to develop and implement strategies that build on family strengths to correct problems. Therapeutic strategies include building conflict resolution skills, providing parent coaching and guidance, and improving family interactions to reduce problem behaviors.

BSFT focuses on family interactions by identifying who was involved in a conflict, when it occurred, who responded to whom, and what preceded and followed the conflict. It does not look simply at what was said, rather at the process of the interaction. BSFT can be done in a community clinic, agency setting, or in a family's home.

BSFT was developed at the Spanish Family Guidance Center in the Center for Family Studies at the University of Miami and has been tested and shown to be effective with Latino and African American youth and their families.

Average Length of Treatment: 12 to 15 sessions over 3 months, with 60–90 minute sessions.

Effective For: Oppositional Defiant Disorder, Conduct Disorder, and Substance Abuse Disorder.

Functional Family Therapy (FFT)
Description of Intervention: FFT is a family-focused therapy designed to engage families to decrease the intense negativity in their lives that may include mental illness in a child or parent, school drop out, and substance use. FFT works to motivate youth and families to change behavior. The behavior change comes through skill training in family communication, promoting positive parenting, problem-solving, and conflict management skills.

FFT helps to increase a family's capacity to use community resources such as schools, case managers, and other child-serving profession-als, to support change from multiple systems, and to prevent relapse.

FFT has been a cost-effective alternative for youth involved in the juvenile justice system. It is less costly than restrictive juvenile detention and residential treatment and produces significantly better outcomes in family interaction, reducing recidivism, and improving a young person's functioning.

Several states are engaged in statewide implementation of FFT for youth involved with the juvenile justice system, including

Washington, New York, and Michigan. FFT can be delivered in the home, as outpatient therapy in a clinic, or in a juvenile justice facility.

Average Length of Treatment: 8 to 12 one-hour sessions, with up to 30 sessions for more serious cases.

Effective For: Oppositional Defiant Disorder, Conduct Disorder, and Substance Abuse Disorder.

Parent Management Training (PMT)
Description of Intervention: PMT is designed to help parents develop effective child behavior management skills, often for children that have difficult and disruptive behaviors. In PMT, therapists work directly with parents to help them acquire effective skills to use with their child.

Parents are taught how to effectively set limits, enforce consequences, reinforce positive behaviors, and enhance behaviors at home and in school. The training programs are individualized for the unique needs of each family. Therapists maintain close telephone contact with families between sessions to help reinforce the skills they have learned, and to be informed about progress and problems that may have arisen. Children and adolescents learn new skills through PMT that help improve their behavior and relationships at home and in school.

Average Length of Intervention: 4 to 6 months, may vary with the severity of need.

Effective For: Attention Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, and Conduct Disorder.

Parent-Child Interaction Therapy (PCIT)
Description of Intervention: PCIT focuses on the child and parent. There are two phases to PCIT, one that is child-directed and one that is parent-directed. Both phases are taught in play situations. Parents are observed by a therapist and taught skills to better address their child's challenging and disruptive behaviors.

In the child-directed phase, the child leads play and parents are coached on how to respond to appropriate behavior and to ignore inappropriate behavior. Coaching is typically provided through a one-way mirror as the parent interacts with the child. The goals of the treatment include: improving the quality of the child-parent relationship, decreasing problematic behaviors, increasing positive behaviors, increasing parent skills, and reducing parent stress.

PCIT is typically used with young children between the ages of three and seven years old.

Average Length of Treatment: 12 to 20 weeks.

Effective For: Oppositional Defiant Disorder.

Family Education and Support
Description of Intervention: Family psychoeducation is an evidence-based practice in adult mental health. The Substance Abuse Mental Health Services Administration (SAMHSA) and Center for Mental Health Services (CMHS) tool kit on EBPs for adults includes resources on family psychoeducation.

Family psychoeducation programs are designed to achieve improved outcomes for people living with mental illnesses by building partnerships among consumers, families, providers, and others supporting the consumer and family. Family psychoeducation programs are often led by clinicians and can also be led by family members. These programs focus on creating an atmosphere of hope and cooperation. Through relationship building, education, collaboration, and problem solving, these programs help consumers and families to:
• Learn more about mental illnesses and effective treatment options;
• Master new and effective ways to manage the illness;
• Acquire strategies for handling crises and relapse;
• Provide social support and encouragement for each other;
• Teach caregivers to reduce stress and to take care of themselves;
• Focus on hope and the future; and
• Help families better understand how to help consumers on their road to recovery.

Research shows that family psychoeducation programs have led to improvements in functioning for adults living with mental illnesses.

In children's mental health, a limited number of studies have examined the impact of family psychoeducation on children and families. One model of family psychoeducation that has been studied is the multifamily psychoeducation groups (MFPG) program. The program is designed for families with children with mood disorders, including bipolar disorder and major depressive disorder.

The MFPG program focuses on working with families to identify the symptoms and effective treatment for mood disorders and improving problem-solving and family communication skills. The program also includes sessions with children with mood disorders that cover a number of topics (symptoms, treatment, anger management, the connection between thoughts, feelings, and actions, impulse control, and improved communication skills).

Research on MFPG is ongoing. Positive results have been reported, including increased parental knowledge about mood disorders, increased positive family and child interactions, improved parent coping skills and support, and more. The MFPG developers have received a grant from the National Institute on Mental Health (NIMH) for ongoing research to help develop an evidence base.

There are also family education and support programs developed by family organizations and taught by trained family teachers. NAMI developed the Family-to-Family education program (F2F) for caregivers of adults living with mental illnesses. This education program focuses on strengthening, supporting, and empowering caregivers to help them help their loved ones living with mental illness on their road to recovery. NAMI is working to establish an evidence-base for the Family-to-Family program through a multi-year NIMH grant awarded to the University of Maryland. NAMI is also currently developing a similar education program for parents and caregivers of children and adolescents living with mental illnesses.

Family education and support programs use experienced and trained parents of children receiving mental health services to provide support to other parents. The most common types of support include affirmation and emotional support (empathy, reassurance, and positive regard to reduce distress, shame, and blame), and informational support (about disorders, treatment options, parenting skills, coping techniques, community resources, and stress reduction). In education and support programs, families are highly valued for their expertise in understanding their child and his or her needs.

Family-driven and peer-to-peer education and support programs are receiving increased attention and it is likely that the evidence base will continue to grow for these programs.

Average Length of Program: Varies by program.

Effective For: Preliminary evidence to support use of family psychoeducation and support programs for adolescents with major depression, bipolar disorder, Tourette's syndrome, and anorexia.

Preliminary evidence also supports use of family support and education interventions for youth with a mix of disorders—with evidence showing parents and families have a greater sense of understanding and empowerment about services for their children.

Intensive Home and Community-Based Interventions

It is essential that systems of care in states and communities be developed that include a comprehensive array of services that promise to help prevent out-of-home placement for children and adolescents and provide the services and supports that families need. A national systems of care movement has gained momentum over the past decade through a grant program administered by the Center for Mental Health Services (CMHS). Through this program, CMHS provides grants to states, communities, territories, Indian tribes, and tribal organizations to improve and expand their systems of care to meet the needs of children and adolescents with serious mental health treatment needs and their families. These community systems of care programs are a helpful resource for families. The resource section of this guide includes information on how families can learn more about the services and supports available in community-based systems of care grant sites.

The following are some of the evidence-based intensive home and community-based interventions that may be available to children and their families:

Wrap-around Services and Intensive Case Management
Description of Intervention: Wrap-around is a philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes.

The values that provide the foundation for the wrap-around philosophy of care are interwoven and not mutually exclusive, but together constitute a conceptual framework. These values include:
- Voice and choice for the child and family;
- Compassion for children and families;

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- Integration of services and systems;
- Flexibility in approaches to working with families and in the funding and provision of services;
- Safety, success, and permanency in home, school, and community; and
- Care that is unconditional, individualized, strengths-based, family-centered, culturally competent, and community-based with services close to home and in natural settings.

The wrap-around process generally includes four phases.

Phase One: Engagement and Team Preparation. In phase one, the family meets with a wrap-around facilitator (person trained in wrap-around) and together they explore the family's strengths, needs, culture, and goals. They discuss what has worked in the past, and what they should expect from wrap-around. The family recommends other team members, the facilitator engages these members, and prepares for the first wrap-around meeting. [Lasts about 2–3 weeks]

Phase Two: Initial Plan Development. In phase two, the team learns about the family's strengths, needs, and goals for the future. The team decides what they will work on, how the work will be accomplished, and assigns team members responsibility for action steps. A wrap-around plan or plan of care is developed, along with a plan to manage crises that may arise. [Lasts about 1–2 weeks]

Phase Three: Plan Implementation. In phase three, ongoing team meetings are held during which the team reviews accomplishments and progress toward goals, and makes necessary adjustments. [Lasts about 9–18 months]

Phase Four: Transition. Transition is negotiated with the team once outcomes are accomplished and the team nears its goals. The family and team decide how the family will continue to get support after they have formally transitioned out of wrap-around. The team also establishes how the family will return to wrap-around, if necessary. [Ongoing]

Intensive case management is different from wrap-around services because it generally relies on a single case manager who is assigned to work with the family. The case manager works closely with a child's family and other professionals to develop an individualized comprehensive service plan for the child and family. These specially trained and qualified case managers assess and coordinate the services and supports necessary to help keep a child at home, in the community, and out of more restrictive treatment settings. Intensive case management defines the caseload size, intending less than 30 clients for any one case manager.

As with wrap-around, case managers work with a child and family in one or more of the following areas:
•   Care coordination, which is especially important when a child is receiving services from more than one agency—for example: school, a community mental health center, and others;
•   Interagency collaboration to help ensure that the child is not falling through the cracks and is receiving needed services;
•   Outreach to agencies that should be involved in the services provided to the child and family;
•   Monitoring and tracking of service use; and
•   Advocating for effective and appropriate services.

Families greatly appreciate effective wrap-around and intensive case management, because without it, the burden of care coordination falls on families who are often already overwhelmed with their child's serious mental health treatment needs.

Multisystemic Therapy (MST)
Description of Intervention: MST is short-term and intensive home-based therapy. MST therapists have small case loads (from four to six families) designed to meet the immediate needs of families. The MST team is available 24 hours a day, seven days a week to work with families.

MST recognizes parents and families as valuable resources, even when they may have serious and multiple needs of their own. MST therapists work to empower families by identifying family strengths

and natural supports that may include extended family, neighbors, the church community, school professionals, and others. MST therapists work with the family to address barriers such as: high stress, parental substance use, poor relationships within the family, and more.

The MST team uses evidence-based therapies in working with youth and their families, including behavior therapy, cognitive behavioral therapy, and others. Families take the lead in setting treatment goals and MST therapists help them to achieve those goals. MST also works with the family to develop effective strategies in the following areas:
- Setting and enforcing curfews and rules;
- Decreasing youth involvement with peers who have a negative influence;
- Promoting positive friendships and relationships;
- Improving school attendance and performance;
- Reducing substance use and the need for contact with law enforcement; and
- Relating strategies designed to meet the unique needs of the family.

Research has shown that MST is an effective alternative to incarceration for youth involved in the juvenile justice system. MST helps to reduce antisocial behavior, substance use, and contact with law enforcement. It also reduces the overall cost of services by reducing youth incarceration rates and out-of-home placements.

Average Length of Treatment: four months, with approximately 60 hours of contact with the MST team.

Effective For: Substance Abuse Disorder, Oppositional Defiant Disorder, and Conduct Disorder.

Treatment Foster Care (TFC)

Description of Intervention: TFC is a placement outside of the family home for youth with serious mental health treatment needs. Trained treatment parents work with youth in the treatment home to provide a structured and therapeutic environment while enabling the youth to live in a family setting.

Agencies that employ treatment foster parents provide them with training, regular supervision in the home, and support to help the youth in their care. They are both a treatment provider and substitute parent.

Youths are placed in TFC because of their serious treatment needs and difficult behaviors, to allow them to receive a more intensive level of treatment in the community with ongoing contact with biological families, when feasible. TFC is the least restrictive out-of-home placement, which allows a youth to receive care from a family in a home setting.

Treatment foster parents work closely with the TFC agency, the child's treatment team, and other professionals, which may include a teacher, therapist, and psychiatrist, to help develop and implement a treatment plan.

The core components of TFC include structure, support, close supervision, and monitoring.

Average Length of Treatment: Varies based on the unique needs of a youth and the progress while the youth is in care, but average length of stay is about 22 months, most often until the youth ages out of services at age 18.

Effective For: Conduct Disorder, Substance Abuse Disorder, and Oppositional Defiant Disorder.

Mentoring Programs
Description of Intervention: In mentoring programs, an adult with good child relationship skills helps children to increase their healthy activity and involvement in school and the community. A mentor works with a child or adolescent intensively, which may include up to five days a week, and over a long time—up to a year.

Mentoring relationships have a positive influence on the lives of young people, including those with mental health and substance abuse disorders. Mentoring relationships help to improve school performance and behavior, family and peer relationships, self-esteem, and to reduce antisocial behaviors. They also help to reduce youth contact with law enforcement and substance abuse. The essential elements of effective mentoring programs for youth with mental health and substance abuse disorders include training, supervision, and the use of qualified and professional mentors.

Effective For: Youth with serious mental health disorders, substance abuse disorder or at risk of developing these disorders.

Respite Care
Description of Intervention: Respite care is a type of family support that provides a family with relief from child care by bringing a caregiver into the home or placing a child in another setting for a brief period of time.

Respite care allows families with a child with serious needs, including mental illnesses, a break from the responsibilities of caring for their child. It can be a regular break for families or to allow time for a vacation. Respite is typically used in a time of family crisis, includ-

ing a medical crisis of a parent or caregiver. A trained respite care provider, which may be another parent or a professional, takes care of the child.

Respite helps to reduce the incredible stress that comes with caring for a child with serious mental health treatment needs. It also helps to prevent out-of-home placement for children and adolescents with serious mental health treatment needs.

Effective For: Families of children and adolescents with serious mental health treatment needs.

Medication Interventions

In general
There has been a steady increase in the use of psychotropic medications to treat children and adolescents with mental illnesses. Despite scientific advances in the proper diagnosis and treatment of mental illnesses in children and adolescents, much remains to be learned about the long-term safety and effectiveness of psychotropic medications for children and adolescents.

Children are in a state of rapid change and development. The diagnosis and treatment of mental illness must be approached with these changes in mind. While some changes may be short-lived and may not require treatment, others may be persistent and quite serious, and require immediate treatment, which may include medication.

Families recognize the need to approach the decision about the use of medication for their child with great caution and care. Many families first exhaust all other treatment options before agreeing to add medication to the treatment plan and only after seeing their child continue to struggle at home, in school, and with friends. As a rule of thumb, the younger the child, the less research there is available for the use of psychotropic medications.

Weighing the Risks and Benefits

Families should be fully informed of all risks and benefits associated with medications. The decision about whether to medicate a child as part of a comprehensive treatment plan should only be made after carefully weighing these factors. The balance between risks and benefits should include consideration of the seriousness of the child's symptoms and how they are affecting the child's day-to-day life and functioning.

Children and adolescents who are taking psychotropic medications must be closely monitored and frequently evaluated by qualified mental health providers. For some medications, the Food and Drug Administration (FDA) has required a "black box" warning that alerts families to rare, but serious, side effects associated with the medications. The black box warning also calls for close medical monitoring while the young person is on the medication. A black box warning is required for selective serotonin reuptake inhibitors (SSRIs), most often prescribed for depression and anxiety, because of the potential increased risk of suicidal thoughts and behaviors for adolescents and young adults using this medication. It is important to ask a physician prescribing medication about warnings associated with the medication. In addition to the rare and serious side effects noted above, most medications come with common but not life-threatening side effects, such as nausea, headaches, and decreased appetite.

At the same time, psychotropic medications can be an essential part of the treatment plan for some children and adolescents with mental illnesses. Families report that medication, often combined with therapy and other psychosocial interventions, has allowed their child to participate in school like other children, to live at home, and to develop friendships with peers.

Many psychotropic medications prescribed for children and adolescents with mental illnesses are not FDA-approved for use in children, but are routinely used off-label, a common practice among general medical physicians and psychiatrists. Off-label use means that a physician is prescribing a medication for a medical condition or age group that is not recognized on the FDA-approved labeling for that medication. This occurs largely because of limited research involving these medications and children and adolescents.
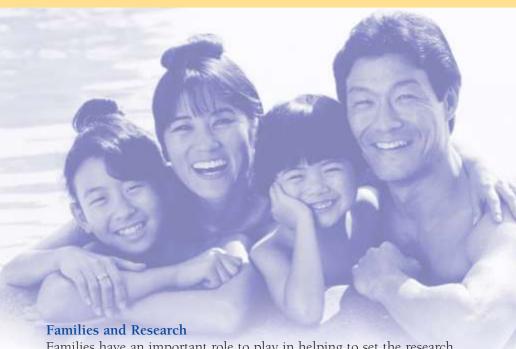
The Evidence Base for Medications

There is limited, but growing research on the use of psychotropic medications for children and adolescents. Research supporting the use of stimulants for children and adolescents with attention deficit/hyperactivity disorder (ADHD) is strong. Also, the research that has been done for many of the medications commonly prescribed for children and adolescents addresses only the short-term and not the long-term safety and effects of medication on children.

For obvious reasons, it can be difficult to involve children and adolescents in research, which has contributed to the limited studies on medication. Fortunately, the National Institutes of Health (NIH) and the FDA are developing new research approaches to provide opportunities to study the safety and effectiveness of psychotropic medications for children and adolescents. Ideally, these research approaches will examine the long-term safety and effectiveness of medications and will help families to better understand the effects of combining medication and psychosocial treatments.

In some cases, the best treatment outcomes are achieved when medication is combined with psychosocial treatments. In the case of children with ADHD, research shows that the best outcomes are seen for children with the most severe symptoms, when taking stimulant medication combined with behavior therapy. Similarly, in research involving adolescents with major depression, the best outcomes were seen in adolescents who were given an antidepressant medication (SSRI) combined with cognitive behavioral therapy (CBT).

The National Institute of Mental Health (NIMH), the federal agency responsible for funding and conducting research on mental illnesses in children and adults, has developed extremely helpful resources for families on medications and children. These resources include a recently updated family guide, titled *Your Child and Medication*, which includes the types of medication used to treat mental illnesses in children and adolescents, the dosages and side effects for the medications, a well-organized index of medications that lists the approved age for each medication, and more. The resource section of this guide includes information on how families can obtain this helpful NIMH publication.

Families and Research

Families have an important role to play in helping to set the research agenda, including studies designed to evaluate the safety and effectiveness of medications. In a truly family-driven system, families will work side-by-side with researchers in designing research studies, identifying unmet treatment needs, and in defining the outcomes that matter most to children and their families. This is true for research involving both medication and psychosocial interventions.

What About Other Promising Practices in Children's Mental Health?

Not all interventions provided to children with mental illnesses and their families have been subjected to controlled research to establish an evidence-base. There are also promising practices in children's mental health services that work well for children and their families. "Promising practices" are those interventions that have attained expert consensus on their effectiveness (for example, therapeutic recreation programs, art therapy, or psychosocial interventions for autism or bipolar disorder) and may have limited evidence supporting them. However, they lack the research necessary to qualify them as an evidence-based practice.

For promising practices, it can be extremely challenging to build an evidence base because of the small number of child researchers, the serious competition for research funding, relatively rare conditions, and the long-term commitment needed to establish evidence. These factors all combine to make progress slow in building evidence-based practices.

There are also clinical interventions routinely provided for children and their families that have little or no effect. They simply do not produce positive outcomes, yet they continue to be used because providers have used these interventions for years, believe in them, are not trained in other interventions, and may be resistant to change. To allow their child the best chance for positive treatment outcomes, families should be offered treatment, services, and supports that have been shown to be effective.

Nonetheless, there may be reasons why families consider an intervention with limited evidence for their child's treatment plan, including one or more of the following:

- An evidence-base may not be fully developed for the child's disorder and the family cannot wait. For example, this is true for psychosocial interventions for bipolar disorder. However, a wise clinician will assess and recommend strategies to manage symptoms and behaviors which include aspects of interventions demonstrated as effective for other disorders;
- An intervention has not been subjected to controlled studies, yet the family is confident that the intervention is right for their child. (The concern is that any intervention could fit here and justify the continued widespread use of interventions that have not been shown to be effective);
- The family has tried one or more evidence-based practices and they have not worked;
- The family has heard from close family and trusted friends about the benefits of an intervention with limited evidence; and
- The family's cultural values and beliefs may be in conflict with specific EBPs or may lead them to prefer a different approach.

There are also reasons for families to be cautious in agreeing to interventions that do not have an evidence-base to support them. An intervention may feel comfortable for families because it has a strong support component: however it may not benefit the child. Interventions that have not proven to be effective may in fact lead to negative outcomes—such as increased out-of-home placement, more costly services, increased disruptive behaviors, and other possibly troublesome consequences. There are also services used for children and adolescents with mental illnesses that have been shown to be harmful, such as attachment therapy, boot camps, and detention centers that use extreme punitive measures to change behaviors.

How Can Families Help Drive and Become More Involved in the Broader Dissemination of Evidence-Based Practices?

The evidence-based practice (EBP) movement has gained momentum and families have a critical role to play. Children and their families have much to gain from the emphasis on EBPs because it promises improvements in the quality of services, increased systems' accountability, increased provider accountability, and better treatment outcomes.

Knowledge is power. The more that families know about EBPs, the more they can weigh in on the movement.

The following are advocacy ideas for families to become more involved in the EBP movement:

• For starters, as families learn more about EBPs, they will know what should be available and what to ask for. By asking for EBP interventions, families create demand, which puts pressure on providers to become trained in, and experts on, evidence-based practices.
• Professional organizations representing child-serving providers also must hear from families about their efforts to help connect community providers with training in EBPs. EBPs should be incorporated into provider education and postgraduate training programs.
• Employers and insurers also must hear from families about the critical need for broader insurance coverage and benefit design in private

insurance and in the Medicaid program. Insurers rarely deny medication coverage; however, they may refuse or restrict coverage for effective psychosocial treatment, services, and supports—often essential to produce the best outcomes for children, adolescents, and their families.

- Families need better resources to stay current on EBPs (what is available and where) and research updates. There should be one central family-friendly and accessible clearinghouse on EBPs.
- Researchers should be invited to attend and present at local, state, and national family advocacy organization meetings to share their work and to strategize with families on the broader dissemination of EBPs. Researchers should look for opportunities to involve families in research design, dissemination, and implementation.
- Changing clinical practice to more broadly adopt EBPs is challenging and requires dedicated leadership. Families can work in their states and communities to find leaders in the child-serving systems that are effective-change, agents and work with them on systems' change.
- As families learn more about the services that are available and lacking in their communities, there are a number of factors to consider: is there a wide range of services, or is the system crisis-driven; are harmful practices in place, such as unlicensed residential centers or boot camps; and, is there an over-reliance on detention centers, which waste public funds with poor outcomes? Families who understand EBPs are in the best position to recommend effective alternative services.
- Advocate for research to fill the gaps. There is very little research on effective services and supports for the most serious illnesses affecting children and adolescents, including early onset bipolar disorder and schizophrenia. We know a lot about what works for ADHD, anxiety disorders, depression, oppositional defiant disorder, conduct disorder, and trauma. We need research that helps us understand how to treat these other serious illnesses.
- Schools, child welfare agencies, juvenile justice systems, and other agencies serving children and adolescents with mental illnesses should be trained and informed about EBPs.
- Medicaid funding should be available to cover the cost of EBPs for children and families that qualify for Medicaid coverage. EBP interventions are effective and should be adequately funded through the public health insurance system.

- Advocacy efforts will be strengthened when families understand the data on the number of children with mental health treatment needs being served, the systems in which those children are being served, and related data. Advocacy efforts will also benefit from families understanding how mental health services are funded in the state and local communities.
- Research on family organization programs should be supported and partnerships between family organizations and the research community should be encouraged to continue to grow the evidence base in consumer and family-driven programs. Many family organizations have developed effective support, service, and education programs for families. It is rarely feasible for family organizations to develop an evidence-base to support their programs without developing a partnership with the research community, federal agencies, or funding partners.

Families have much to contribute to the development and dissemination of effective treatment, services, and supports for children and adolescents living with mental illnesses. This guide provides information on some of the EBPs that are available. Families are encouraged to review the resources included at the end of this guide for updates and to learn more about EBPs.

The voice of family organizations must continue to be loud and clear to focus the research agenda on the most critical unmet needs in children's mental health treatment, services, and supports.

Resources on Evidence-Based Practices

In General
- American Academy of Child and Adolescent Psychiatry, *Facts for Families Series:* www.aacap.org

- American Psychological Association. *Report of the Working Group on Psychotropic Medications for Children and Adolescents: Psychopharmacological, Psychosocial, and Combined Interventions for Childhood Disorders: Evidence Base, Contextual Facts, and Future Directions.* Washington, D.C.: APA Council of

Representatives, August 2006. Available online at
www.apa.org/releases/PsychotropicMedicationsReport.pdf

- Hawaii Department of Health, Child and Adolescent Mental
Health Division, Evidence Based Services Committee:
www.hawaii.gov/health/mental-
health/camhd/library/webs/ebs/ebs-index.html

- National Child Traumatic Stress Network: www.nctsnet.org/

- Porter, G.K., and Turner, W.C. *Taking Charge: An Introductory
Guide to Choosing the Most Effective Services for the Mental,
Behavioral, and Emotional Health of Youth Within a System of Care.*
Washington, D.C.: Technical Assistance Partnership for Child
and Family Mental Health for Child and Family Mental Health,
American Institutes for research. For an online copy please visit
www.air.org/tapartnership

- Research & Training Center for Children's Mental Health Louis
de la Parte Florida Mental Health Institute, University of South
Florida: School-Based Mental Health Report (April 2006):
rtckids.fmhi.usf.edu

- Society of Clinical Child and Adolescent Psychology, Evidence-
Based Treatment for Children and Adolescents:
www.wjh.harvard.edu/%7Enock/Div53/EST/index.htm

- Substance Abuse and Mental Health Services Administration,
Center for Mental Health Services (CMHS) ~ To learn more
about the Systems of Care philosophy, resources for families
from the Child, Youth and Family Branch of CMHS, and to
learn the location of the Systems of Care grant communities
(Click on "Programs"): www.systemsofcare.samhsa.gov

- Substance Abuse and Mental Health Services Administration's
National Registry of Evidence-Based Programs and Practices
(NREPP): http://nrepp.samhsa.gov/ (There are a limited number
of interventions included in NREPP for children and adoles-
cents. The Web site is likely to be updated over time.)

- The Center for the Advancement of Children's Mental Health at Columbia University, A Caregiver's Guide to Child and Adolescent Psychiatric Inpatient Treatment Services: http://www.kidsmentalhealth.org/Traayfamilyguide.html

Psychosocial Interventions
Bringing Family, Child, Provider, and/or Teacher Together
Cognitive Behavioral Therapy
- Substance Abuse and Mental Health Services Administration: www.modelprograms.samhsa.gov (Click on "Model Programs" and then "Trauma Focused Cognitive Behavior Therapy")

- New York University Child Study Center: www.aboutourkids.org (Click on "AOK Library Articles," "Parenting," and then "Cognitive Behavior Therapy: What Is It and How Does It Work?")

- Association for Behavioral and Cognitive Therapies: www.aabt.org

Exposure Therapy
- University of Pennsylvania, Center for the Treatment and Study of Anxiety: www.med.upenn.edu/ctsa

- Substance Abuse and Mental Health Services Administration (SAMHSA): www.modelprograms.samhsa.gov (Click on "Model Programs" and then "Prolonged Exposure Therapy for Posttraumatic Stress")

Interpersonal Therapy
- Mufson, L.; Dorta, K.P.; Moreau, D.; Weissman M.M. *Interpersonal Psychotherapy for Depressed Adolescents.* 2nd ed. New York: Guildford Publications, 2004, pp. 315 (A resource for clinicians only)

Behavior Therapy
- Association for Behavioral and Cognitive Therapies: www.aabt.org.

Family Interventions—Therapy, Parent Training, Education, and Support

Brief Strategic Family Therapy
- Strengthening America's Families: www.strengtheningfamilies.org/ (Click on "Model Programs," "Program List 1999," and "Brief Strategic Family Therapy")

- Substance Abuse and Mental Health Services Administration: www.modelprograms.samhsa.gov (Click on "Model Programs" and then "Brief Strategic Family Therapy")

- University of Miami's Center for Family Studies/Spanish Family Guidance Center: www.cfs.med.miami.edu

Functional Family Therapy
- Blueprints for Violence Prevention: www.colorado.edu/cspv/blueprints (Click "Model Programs" and "Functional Family Therapy")

- Functional Family Therapy Online: www.fftinc.com/

- New York State Office of Mental Health, Information for Families on Evidence-Based Practices: www.omh.state.ny.us/omhweb/ebp/children.htm

- Strengthening America's Families: www.strengtheningfamilies.org/ (Click on "Model Programs," "1999," and "Functional Family Therapy")

- Washington State Institute for Public Policy: www.wsipp.wa.gov/

Parent Management Training
- Oregon Social Learning Center: www.oslc.org/

- Yale Child Study Center: www.yale.edu/childconductclinic

- Incredible Years: www.incredibleyears.com

Parent-Child Interaction Therapy
- University of Florida Department of Clinical and Health Psychology, Parent-Child Interaction Therapy Web site: www.pcit.org/

Family Psychoeducation
- Substance Abuse and Mental Health Services Administration, Center for Mental Health Services Family Psychoeducation Workbook for Clinical & Practical Supervisors: http://mental health.samhsa.gov/cmhs/communitysupport/toolkits/family/work book/default.asp (Includes information about Multifamily Psychoeducation Groups)

- Substance Abuse and Mental Health Services Administration, Center for Mental Health Services: www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolk-its/family/

Family Support and Education
- NAMI's Family-to-Family Education Program: www.nami.org (Click "Education Programs").

- Research & Training Center on Family Support and Children's Mental Health/Portland State University: www.rtc.pdx.edu. (*Focal Point*, Winter 2006, includes multiple articles on family support and education programs)

- New York State Office of Mental Health, Information for Families on Evidence-Based Practices, Family Education and Support Services: www.omh.state.ny.us/omhweb/ebp/children.htm

Intensive Home and Community-Based Interventions
Wrap-around/Intensive Case Management
- National Wrap-around Initiative: www.rtc.pdx.edu/nwi.

- New York State Office of Mental Health, Information for Families on Evidence-Based Practices, Intensive Case Management: www.omh.state.ny.us/omhweb/ebp/children.htm.

Multisystemic Therapy
- Blueprints for Violence Prevention: www.colorado.edu/cspv/blueprints (Click "Model Programs" and "MST")

- MST Services: www.mstservices.com

- Strengthening America's Families: www.strengtheningfamilies.org/ (Click on "Model Programs," "Program List 1999," and "Multisystemic Therapy")

- Substance Abuse and Mental Health Services Administration: www.modelprograms.samhsa.gov (Click "Model Programs")

Treatment Foster Care
- Blueprints for Violence Prevention: www.colorado.edu/cspv/blueprints (Click "Model Programs" and "MTFC")

- Multi-dimensional Treatment Foster Care: www.mtfc.com

- Strengthening America's Families: www.strengtheningfamilies.org/ (Click on "Model Programs," "Program List 1999," and "Treatment Foster Care")

- Substance Abuse and Mental Health Services Administration: www.modelprograms.samhsa.gov (Click on "Effective Programs" and "OSLC Treatment Foster Care")

Mentoring
- Big Brothers Big Sisters: www.BigBrothersBigSisters.org

- National Mentoring Center: www.nwrel.org/mentoring

Respite
- National Dissemination Center for Children with Disabilities: www.nichcy.org/index.html (Click "Our Publications," "Out of Print," and "Respite Care: A Gift of Time").

Medications
- National Institute of Mental Health. *Your Child and Medications.* To access the publication online visit: www.nimh.nih.gov (Click on "Health Information," and under "Additional Mental Health Information," click on "Children & Adolescents." The publication is listed under "Publications/Resource Materials.") You may also order a print copy of the publication by calling the NIMH information center toll-free at: 1-866-615-6464 and reference NIH Publication No 02-3020.

Family Advocacy Organizations
- Child and Adolescent Bipolar Foundation (CABF) www.bpkids.org

- Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD) www.chadd.org

- Federation of Families for Children's Mental Health (FFCMH) www.ffcmh.org

- Mental Health America (MHA) www.nmha.org

- National Alliance on Mental Illness (NAMI) www.nami.org

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Association for Children's Mental Health, *For Families: Evidence Based Practice, Beliefs, Definition, Suggestions for Families.* (available online at www.acmh-mi.org).

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Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Mental Health Services (CMHS) Evidence-Based Practice Implementation Resource Kits. (available online at mentalhealth.samh-sa.gov/cmhs/communitysupport/toolkits/)

Systems of Care

www.systemsofcare.samhsa.gov

NAMI
National Alliance on Mental Illness

2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
Ph: (703) 524-7600 • Toll Free: (800) 950-6264
Web site: www.nami.org