Practice Patterns in the Hawaii System of Care: Have Evidence-Based Services Become Usual Care?

Eric L. Daleiden & Bruce F. Chorpita
Web: http://www.hawaii.gov/health/mental-health/camhd/index.html

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Practice Development Approaches

1. Implement structured empirically supported programs
2. Make usual care look more like evidence-based protocols

Goal

Bring together evidence-based ideals with the need for individualized, comprehensive, and family-friendly services for youth

Interventions and Elements

1. Interventions are multifaceted services with many techniques and strategies
2. Each technique or strategy can be identified as a **practice element**
3. These elements are view as building blocks of interventions

Identifying Common Elements of Evidence-Based Practices

1. "Meta-Analysis" of treatment studies (CAMHD 2002, 2004)
2. Informal intervention content review
3. Generate common element codes through consensus (CAMHD 2003)
4. "Meta-Analysis" of treatment protocols
5. Create practice profiles (CAMHD 2004; Chorpita, Daleiden, & Weisz, 2003)

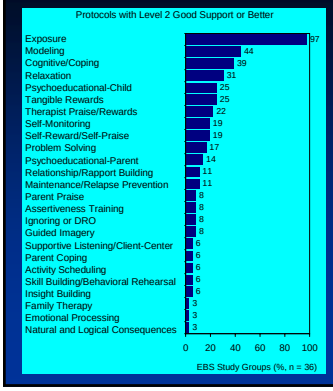
Each Study Group Has…

1. Identified context (e.g., problem area)
2. Identified intervention protocol (e.g., set of practices)
3. An EBS Level assign by committee:
   - Level 1 Best Support
   - Level 2 Good Support
   - Level 3 Moderate Support
   - Level 4 Minimal Support
   - Level 5 Known Risks

Aggregating the Literature

1. Hawaii has focused on problem-based organization to EBS
2. This is not necessary
3. Source of ongoing debate

EBS Protocols for Anxiety and Avoidance



	Average Protocol
N of Practices	4 - 5
Ave. Weight per EBS Practice	51%

Evaluation of EBS

1. How is our measurement?
2. Do the services fit our problems?
3. How evidence-based is actual care?

How is Our Measurement?

1. Literature Codes
2. Youth Problems
   - Diagnoses
   - Treatment Targets
3. Therapeutic Practices

EBS Literature Codes

1. Compare each judge to grand mean
   - No judges emerged as outliers
2. Intraclass correlation for each code
   - Initial Analysis ICC's > .65
   - Problematic codes reviewed by team
3. Intraclass correlation for each protocol
   - Two problems MST and RET
   - Solution: MST include core elements only
     RET discard as undefined

How Do We Measure Problems & Practices?

1. Clinical Diagnosis
2. Monthly Treatment and Progress Summary

90-Day Diagnostic Stability

Problem Area	κ	Interpretation
Anxiety and Avoidant	.54	Fair
Attention and Hyperactivity	.49	Fair
Bipolar Disorder	.31	Poor
Depressed and Withdrawn	.42	Fair
Disruptive Behavior	.32	Poor
Psychotic/Schizophrenic	.61	Good
Substance-Related	.65	Good

Monthly Treatment & Progress Summary: MTPS Target Stability

Interpretation	N	%
Excellent	11	17%
Good	32	50%
Fair	9	14%
Poor	9	14%
Insufficient Data	3	5%

MTPS Practice Stability

Interpretation	N	%
Excellent	15	11%
Good	40	55%
Fair	11	15%
Poor	4	5%
Insufficient Data	3	4%

MTPS Validity: Convergent Targets & Diagnoses

	Diagnostic Group	
	Anxiety & Avoidant	Attention & Hyperactivity
More Likely Targets	Anxiety	Attention Problems
	Shyness	Hyperactivity
	Traumatic Stress	Learning Disorder/ Underachievement
	Personal Hygiene	

MTPS Validity: Convergent Targets & Diagnoses

	Diagnostic Group	
	Depressed & Withdrawn	Disruptive Behavior
More Likely Targets	Depressed Mood	Anger
	Suicidality	Aggression
	Positive Family Functioning	Oppositional/ Non-Compliant
	School Attendance/ Truancy	Willful Misconduct/ Delinquency
		Substance Use

Do the services fit our problems?

1. Diagnoses

33% had pure diagnosis with EBS

89% had primary diagnosis with EBS

70% had EBS for all diagnoses

Do the services fit our problems?

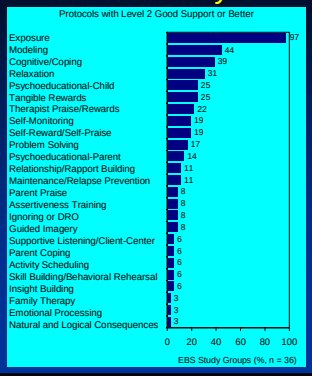
2. Treatment Targets

90% had EBS for one or more targets

3% had EBS for all targets

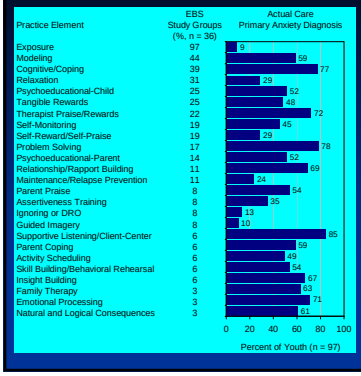
∴ 97% had one or more targets with with no EBS

How evidence-based is actual care? Anxiety and Avoidance



	Average Protocol
N of Practices	4 - 5
Ave. Weight per EBS Practice	51%

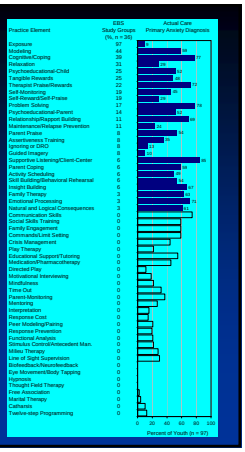
How evidence-based is actual care?



	Average Case
N of Practices	12
Ave. Weight per EBS Practice	18%

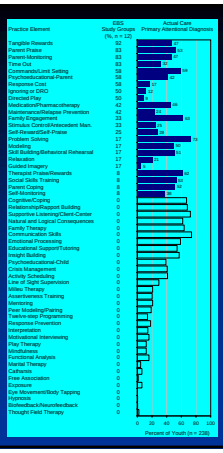
Primary Anxiety or Avoidant Disorders

	Average Protocol	Average Case
Total N of Practices	4 – 5	20
N of EBS Practices	4 – 5	12
Ave. Weight per Practice	51%	9%



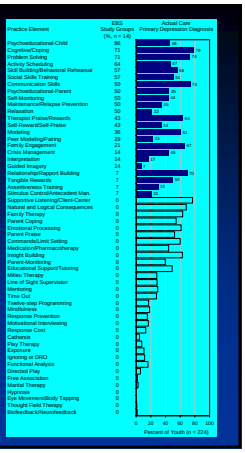
Primary Attention or Hyperactivity Disorders

	Average Protocol	Average Case
Total N of Practices	9	19
N of EBS Practices	9	8 – 9
Ave. Weight per Practice	66%	18%



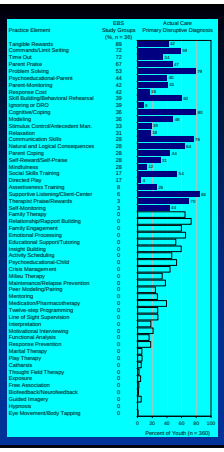
Primary Depressed or Withdrawn Disorders

	Average Protocol	Average Case
Total N of Practices	9	20
N of EBS Practices	9	10
Ave. Weight per Practice	54%	22%



Primary Disruptive Behavior Disorders

	Average Protocol	Average Case
Total N of Practices	8	19
N of EBS Practices	8	11
Ave. Weight per Practice	48%	20%



Take Home Messages

How is our measurement?

Diagnoses are mediocre

Monthly Treatment and Progress Summary

- Generally good monthly stability
- Similar to diagnosis in 90-day stability

Support for validity of targets with diagnosis

Validity of practice elements unknown

Take Home Messages

Do services fit our problems?

EBS identified for the primary problems of the vast majority of CAMHD youth

Many youth have additional problem targeted for treatment without EBS identified yet

Problems still needing EBS:

adjustment disorder with mixed disturbances, reactive attachment disorder, learning/communication/academic disorders, intermittent explosive/impulse disorders

Take Home Messages

How evidence-based is actual care?

Typically both empirically supported and unsupported practices used in actual care

Actual care is generally less focused than empirically supported protocols

Actual care incorporates less frequently supported practices