


Comprehensive Community Mental Health  
Services for Children and Their Families  
Program

**Results from the Year One  
APEBPS**

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An award-winning acronym:


**APEBPS: Assessment of  
Planned Evidence-Based  
Practices**

One of 5 substudies in the  
Phase V EBP Study




**Research Questions**

1. What beliefs and knowledge about EBP are held by the team members of the communities?
2. What EBP and Practice-Based Evidence interventions do the Phase V grant sites plan to use in their systems of care?
3. How do these plans change over the course of the 6-year CMHI grant cycle?



**The semi-structured phone survey**

1. Can you describe some of the thoughts that people at your site have regarding the use of Evidence-Based Practices in your community?
2. How do you decide whether a practice is evidence-based or not?
3. Does your community plan to include any evidence-based practices as part of your system-of-care service array? Which ones, details.
4. Are you planning to adapt any EBPs to meet the specific needs of your community?
5. As part of your system of care, do you use or plan to use any practices that may not be considered "evidence-based" (PBE) but seem to work well in your community or in other communities?



**Voted most-likely-to-be-implemented**

- ▶ Wraparound - 8
- ▶ Positive Behavioral Interventions and Support (PBIS) - 7
- ▶ Multisystemic Therapy (MST) - 6
- ▶ Cognitive Behavioral Therapy (CBT) - 4
- ▶ Trauma-Focused CBT - 4
- ▶ Parent-Child Interaction Therapy (PCIT) - 4
- ▶ Functional Family Therapy (FFT) - 3
- ▶ Incredible Years - 3
- ▶ Parent Management Training – Oregon (PMTO) - 3
- ▶ Dialectical Behavior Therapy (DBT) – 2
- ▶ Therapeutic Foster Care - 2



**To be adapted?**

- ▶ Multi-Systemic Therapy (MST)
- ▶ Brief Strategic Family Therapy (BSFT)
- ▶ Home-Based Crisis Intervention (HBCI)
- ▶ Parent-Child Interaction Therapy (PCIT)
- ▶ Functional Family Therapy (FFT)
- ▶ Making Parenting a Pleasure model
- ▶ Incredible Years
- ▶ Motivational Enhancement Therapy coupled with Cognitive Behavioral Therapy (MET-CBT)
- ▶ High Fidelity Wraparound



### **Motivators for adaptations**

- ▶ Culture(s) within the community
- ▶ Family needs – time, location
- ▶ Age of tx population (usually younger)
- ▶ Different and dual diagnoses
- ▶ Desire to localize protocols
- ▶ Desire to Individualize protocols
- ▶ Financial constraints



### **Thoughts about EBP: positives**

“We recognize the importance of EBP and are currently trying to find ones that are practical and functional for us. EBP allows us to improve services in a manner that has greater outcomes. Some people are enthusiastic & believe EBP is all they should offer. We are excited to have EBP in the community as it strengthens our continuum of care. EBPs should be available in every community as their availability has increased dramatically in recent years. It is extremely important to utilize limited resources to purchase services that have demonstrated their efficacy”



### **Thoughts about EBP: negatives**

“I am not convinced that effectiveness has really been demonstrated. My concern is when providers use only one model and try to fit families into that model rather than exploring which EBP would be the best fit for each particular model; I see this occurring in the use of MST. EBPs alter the way we do business and aren't necessarily culturally competent - they are too rigid. A key concern is doing what's needed, rather than simply adopting an EBP because it exists. What about the resources required to implement EBP – is this the best use of our resources? I worry that EBPs are not generalizable—it's difficult to know if EBPs used successfully with one population or in a certain region will work with other populations and regions.”



### **Thoughts about EBP: Families**

- ▶ “Family members concur that EBPs are basically a good idea, but are not sure about the local implementation and effects on their own families. The question always is, will this work for my family and my child? We are concerned that EBP protocols take away individualization. You have to consider what families need; having to stick with EBP fidelity can be confusing to families. We fear that a push for EBP will push aside other practices that work. We worry that our grassroots values will be lost to the medical model. We are aware of their importance, but we want to make sure our wishes and voices are respected. Not everything that works is evidence-based; there is at least one thing, the parent organization, which lacks evidence but is really effective.”



### **PBE**

“Also, what about PBE, and modifications to EBP? At what point does a modification make it a different practice? One size does not fit all. We look forward to using a mix of EBP & PBE. We need access to a variety of interventions including, but not limited to, EBP. We prefer this approach (PBE) to EBP.”



### **A few PBE categories**

- ▶ Culture-specific
- ▶ Geographic (i.e., rural settings)
- ▶ Spiritually based
- ▶ Wilderness, adventure, and equine
- ▶ School-based
- ▶ Consumer empowerment
- ▶ Family support
- ▶ Local responses to specific contexts



### Examples of local practices

- ▶ The Bingham Curriculum
- ▶ Prevention Access Self Empowerment and Support
- ▶ Positive Indian Parenting
- ▶ CIS: Children's Intensive Services
- ▶ The Regional Intervention Program
- ▶ CES: Comprehensive Emergency Services
- ▶ Drug-Endangered Children



### A local practice...



### The challenge:

“...while evidence-based practices, systems of care, and individualized care appear to be conceptually compatible with each other, and have something to offer each other, there seems to be relatively little integration of them in actual practice” (Freidman & Drews, 2005, p3).

- ▶ Most of these communities are trying to achieve this.



### Questions? Comments?

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