



# **nami** *Beginnings*

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A Publication Dedicated to the Young Minds of America from the NAMI Child & Adolescent Action Center



## **An Update on Evidence-based Practices in Children's Mental Health**

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NAMI is a grassroots, family and consumer, self-help, support, education, and advocacy organization dedicated to improving the lives of children and adults living with severe mental illnesses. Severe mental illnesses are biologically based brain disorders that can profoundly disrupt a person's ability to think, feel, and relate to their environment and others.

NAMI web site: [www.nami.org](http://www.nami.org)  
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# Capitol Hill Watch

## Year End Wrap-up

by **Darcy Gruttadaro, J.D.**, Director, NAMI Child & Adolescent Action Center

**C**ongress has adjourned for the year – unfortunately without passing critically important legislation that would help address the crisis in our nation's children's mental health system. Your help is needed to convince your Congressional Representatives to move this legislation early in 2004, despite the fact that it is a presidential election year, which is likely to distract many lawmakers.

Now is the time – while Congress is adjourned and most members are in their home districts – to schedule a visit with your Congressional Representatives. It is extraordinarily beneficial to our efforts when NAMI members and friends visit their Representatives in their district offices and sit face-to-face to share their concerns. These visits put a face on the issues and make them more real for lawmakers.

Here are suggestions of what you may wish to share with your Congressional members:

- Ask Your Congressional Representatives to help end the tragic practice of forcing families to give up legal custody of their child to secure mental health services by supporting *The Keeping Families Together Act* (S. 1704/H.R. 3243);
- Ask Your Congressional Representatives to help improve the academic achievement and educational outcomes of students with mental illnesses by supporting the Senate Bill to Reauthorize IDEA and opposing the House Bill (Support S. 1248/Oppose H.R. 1350);
- Ask Your Congressional Representatives to help end the crisis in

the shortage of child and adolescent mental health providers that serves as a significant barrier to families accessing mental health services by supporting *The Health Care Crisis Relief Act* (S. 1223/H.R. 1359);

- Ask your Congressional Representatives to help expand health insurance coverage for children with serious mental illnesses so families are not forced to give up custody or to face financial devastation by supporting *The Family Opportunity Act* (S. 622/H.R. 1811); and
- Ask your Congressional Representatives to oppose legislation that threatens to interfere with open communication between schools and families by opposing *The Child Medication Safety Act* (S. 1390/H.R. 1170).

To learn more about all of the legislation included in Capitol Hill Watch and to review proposed talking points for this legislation, please visit the policy section of the NAMI web site at [www.nami.org/policy.htm](http://www.nami.org/policy.htm). Also, all members of Congress can be reached by calling the Capitol Switchboard toll free at 1-800-839-5276 or at 202-224-3121 or through the policy section of the NAMI web site, by clicking on "Write to Congress."

You can review the text of any of the legislation included in Capitol Hill Watch and learn which of the Congressional members have co-sponsored legislation by visiting [thomas.loc.gov](http://thomas.loc.gov). For a list of co-sponsors, click on the "Link to the Bill Summary & Status File" and then click on "Co-sponsors." 

# Evidence-based Practices in Child and Adolescent Mental Health: Its Meaning, Application, and Limitations

By **Kimberly Hoagwood, Ph.D.**, Professor of Clinical Psychology at Columbia University and Director of Research on Child and Adolescent Services at the Office of Mental Health, State of New York

**T**he term “evidence-based practices” (EBP) has become widely popularized in local, state and national policy discussions on service quality.

At least 26 federal Web sites use this term to refer to their practices. A Medline search of articles dated from 1995 to 2002 found more than 5,400 citations that included the term “evidence-based medicine,” “evidence-based treatment” or “evidence-based practice.” Between 1900 and 1995 there were only 70 such citations. In general, “EBP” has become a useful shorthand to refer to a body of scientific knowledge about clinical treatments, preventive programs or service practices. The term is used to differentiate research-based, generally structured and manualized practices that have been examined using randomized trial designs, from less rigorous or well-tested practices.

EBP has captured the public imagination in part because it provides what appears to be treatment based on a body of work whose application in real-world clinical practice is presumed to lead to improvements in children’s emotional or behavioral functioning. Because the state of mental health service delivery has been widely criticized as being fragmented, ineffective and insufficient (Bickman, 1006; Stroul & Friedman, 1986; Weisz et al., 1995), in the minds of policymakers the hope for improvements in service delivery and practices is now largely linked to the delivery of EBPs. This idea makes sense.

The research base on the risks for mental disorders or conditions, on the efficacy and effectiveness of mental health treatments and preventive strategies for youth and on the effectiveness of specific service models has expanded enormously in the past decade. During this period, there has been a doubling of research studies on child and adolescent mental health at the National Institute of Mental Health (NIMH) and a tripling of funds for research on these issues (Blueprint for Change, NIMH, 2001). Yet research-based practices have rarely found their way into routine clinical practice.

In the remainder of this article, I will describe the major types of practices that are deemed to constitute

construction of EBPs, including recommendations for the development of EBPs within routine practice and the creation of empirically driven practices that routinely apply empirical inquiry to the delivery of standard care.

## Current Categories of EBPs

Operational criteria for establishing EBPs have been proposed by the Division of Clinical Psychology of the American Psychological Association (1998) and applied to studies of specific psychosocial treatments for childhood disorders. A similar process has been developed for evaluating the evidence for pharmacological treatments (Jensen et al., 1999); preventive programs (Greenberg et al., 2001); and

*“... There has been a doubling of research studies on child and adolescent mental health at the National Institute of Mental Health (NIMH) ...”*

EBPs for children and adolescents. Then I will describe some of the reasons why research knowledge on evidence-based practice has not reached its intended audience—children and adolescents with mental health needs, families and providers. Three major reasons for this are limitations to the definition of EBP itself, limitations in understanding how to *implement* the EBPs and failure to link family-driven research-based practices to the delivery of EBPs. Finally, I make recommendations for a 180-degree revolution in the

school-based mental health services (Rones & Hoagwood, 2000).

Effective psychosocial, pharmacological or service programs are deployed in different ways. For example, in pharmaceutical medicine, evidence-based approaches have been built into the regulatory standards developed by the Food and Drug Administration (FDA) to review scientific evidence and identify effective medications. The strength of the evidence for pharmacological treatments is regulated by the FDA, and an indus-

try for their distribution has grown up around this. In contrast, psychosocial treatments, services and preventive interventions do not have regulatory backing, and their distribution depends largely upon the resourcefulness of individuals who developed the treatments or services (Hoagwood et al., 2001).

**Outpatient Treatments**

The bulk of the evidence for evidence-based practices comes from numerous studies of specific psychosocial or behavioral treatments for youth with specific emotional or behavioral problems. More than 1,500 clinical trials have been conducted examining a range of outpatient treatment models (Kazdin, 2003). For outpatient treatments for anxiety, depression and disruptive behavior problems, an analysis of experimental child psychotherapy intervention trials points to a consistent beneficial effect of treatment over no treatment (Kazdin et al., 1990; Weisz et al., 1987, 1995). These beneficial effects are comparable to those found in adult psychotherapy (e.g., Smith & Glass, 1977). The evidence suggests that psychosocial interventions for children can reduce symptoms associated with childhood mental disorders when conducted in research-based settings. However, the impact of these therapies within clinical practice settings (e.g., in a clinician’s office rather than a research setting) is only now being studied (Weisz & Weersing, 1999).

**Community-based Services**

Studies on community-based service models for children with multiple co-occurring disorders have examined a range of service modalities, including intensive case management, treatment foster care and home-based services. Studies of intensive case management have shown that children with case managers require fewer restrictive services, such as psychiatric hospitalizations, than do children without these services (Burns et al., 1996; Evans et al., 1996). A series of studies have tested the impact of therapeutic foster care services for children with multiple co-

morbid mental disorders and have found decreases in aggressive behavior and increases in positive adjustment at the conclusion of placement (Chamberlain & Reid, 1991, 1998).

Several home-based service models have been developed for children with serious emotional disturbances, the most notable of which is Multisystemic Therapy (MST). The primary goal of MST is to develop independent skills among parents and youth with behavioral problems to cope with family, peer, school and neighborhood problems through brief (three to four

months) and intense (sometimes daily) treatment (Schoenwald et al., 2000). Treatment strategies integrate empirically based treatment approaches (e.g., behavioral parent training, cognitive behavior therapies, functional family therapy) to address youth problems across different environments—home, school, community and others. MST has been used as a treatment approach for youth with mental disorders in the juvenile justice system. Eight randomized trials of MST have demonstrated consistent results in lowering rates of youth re-offending and out-of-home placements (Henggeler et al., 1993), reducing the rates of psychiatric hospitalization and improving youth and family functioning. MST researchers suggest that adequate supervision, therapist training and institutional MST program support are key to successful MST outcomes for youth with mental disorders (Schoenwald et al., 2000).

**School-based Preventive or Treatment Programs**

The school system provides the only form of either early intervention or treatment for many children with mental health needs (Burns et al., 1995). School-based research on interventions for children with emotional or behavior problems has been recently reviewed,

covering a 15-year period. Among these studies, a range of individual, classroom-wide or targeted interventions were identified as effective for youth with mental health needs (Rones & Hoagwood, 2000). They include targeted classroom-based contingency management for children diagnosed with attention deficit/hyperactivity disorder (ADHD) (Pelham et al., 1998). Contingency management approaches have been shown to reduce aggression when used for the entire classroom. The Good Behavior Game—a classroom-based behavior management

*“Eight randomized trials of MST have demonstrated consistent results in lowering rates of youth re-offending and out-of-home placements”*

strategy for first-grade students—demonstrated long-term benefits many years later in reducing disruptive behaviors in middle school (Dolan et al., 1993; Kellam et al., 1994). Behavioral consultation to help teachers accommodate difficult students has been found to reduce the number of special education referrals and placements, as well as to improve teacher reports of students’ behavior problems (Fuchs et al., 1990).

**Psychopharmacology**

Clinical psychotropic medication trials are needed for many childhood mental disorders. Despite the widespread use of psychotropic medications with children, surprisingly few randomized controlled studies have been conducted (Weisz & Jensen, 1999).

Weisz and Jensen (1999) recently reviewed evidence on the efficacy of child pharmacotherapy utilizing criteria established for the International Psychopharmacology Algorithm Project. In addition, the National Institute of Mental Health (NIMH) recently commissioned six scientific reviews of published research on the safety and efficacy of psychotropic medications for children (JAACAP, 1999). The reviews were recently undertaken to better understand the safety and effectiveness of these med-

ications. These reviews identified several psychotropic medications that are effective for both childhood externalizing and internalizing disorders. Most prominent among the medications are psychostimulants for children with ADHD. The relatively new selective serotonin reuptake inhibitors (SSRIs) are beginning to show positive effects for adolescents with depression (Emslie et al., 1997). Among children with anxiety disorders, one multisite controlled trial of SSRIs found fluvoxamine to be superior to placebo (the absence of active medication) in treating children diagnosed with social phobia, separation anxiety or generalized anxiety disorder (Vitiello et al., 1999). Several pharmacologic agents have been shown to be effective in the treatment of children and adolescents diagnosed with obsessive-compulsive disorder (OCD). These agents include the SSRIs and tricyclic antidepressants (Emslie et al., 1999; Geller et al., 1999). There is also support for the use of antipsychotic medications for early-onset schizophrenia. However, information on the long-term effectiveness and safety of antipsychotic medications for youth is not known (Weisz & Jensen, 1999).

**Some Reasons Why EBPs Are Not Used**

***No Consensus on Definition of Evidence-based Practice***

There is currently no national consensus on how to define the term “evidence-based,” nor is there consensus on when the evidence base is ready to use in community settings. The varying definitions used by professional associations and the scientific community make it difficult for policymakers or practitioners to decide which practices to adopt in any given circumstance. Foundations and federal agencies are currently attempting to standardize the definition. The Substance Abuse Mental Health Services Administration (SAMHSA) is looking to create agreed-upon criteria for EBPs and a national registry of research-based practices that can be updated to provide assistance to the field on the quality and strength of research on mental health practices.

**NAMI NORTH CAROLINA: Attention Deficit Hyperactivity Disorder – AD(H)D Fact Sheet**

**Symptoms/characteristics:**

- Rapid movement/hyperactivity, can be aggressive
- Arouse early in AM
- Love of novelty, forbidden
- Problem w/disinhibition or attention or both
- Hypersensitive senses – fluorescent lights, fabric on skin, high pitched voice
- Very sensitive in emotional, cognitive, kinesthetic domains – “driven-ness, frantic starts, endless running”
- Three subtypes per DSM-IV: hyperactive/impulsive, inattentive, combination

**Brain biology:**

- Right prefrontal cortex and basal ganglia – smaller
- Lacking enough dopamine (helps us focus)
- 60% have co-morbid disorders
- All helped by medication (stimulants); 2/3's need behavior therapy

**Treatment:** Most studies point favorably to use of medication (stimulants) along with psychosocial treatments - behavioral strategies such as reward system and time out; also parent training where parent learns child management skills.

**Classroom applications:**

- Respond best to immediate rewards and consequences
- Visual learners
- Find out what they love – “emotional side of learning”
- Break goals down into many smaller goals
- Encouragement – stars, small frequently-changing rewards
- Use checklists
- A specific, organized “place” for all activities
- Need escape, time out place, punching bags

- Do best in classroom with well-defined rules, posted schedules, reduced stimulation (not near windows, doors) but do not isolate. (Without guidance, will be lost in thoughts)
- Self-monitoring system – terrific! Like # of times out of seat, in seat.
- Smaller assignments, less on homework – break into manageable parts
- Reporter style homework for older students (Who, what, where...)

**Advice for parents/care givers**

- Follow a specific schedule for all activities- from waking up to doing homework to bedtime.
- Keep rules and consequences simple, easy to understand.
- Keep directions clear and brief. Ask child to repeat directions back to you.
- Reward appropriate behavior.
- Closely supervise child and observe with friends. Child may need help with learning appropriate social behavior.
- Focus on effort and reward small accomplishments.
- Follow a well-balanced diet and encourage regular exercise routine.
- Use “reminder” language to overcome short-term memory problems.
- Keep language positive. (Instead of saying “Pay attention,” say “I will continue when I know you are with me.”)
- From George Lynn, enter into a coaching/consultant type relationship. Ask child why he does certain things, how he is feeling. Observe and learn from him what his challenges are.

***Books for children, teachers and parents are also included on the fact sheet, along with recommended Internet websites that address ADHD.***

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- A new initiative from the MacArthur Foundation, the Youth Mental Health Initiative, is extending the reach of evidence-based practices by reviewing the evidence for therapies targeted at the most common childhood mental disorders and testing two alternative methods of delivering evidence-based practices in community-based mental health clinics. A parallel project will investigate the organizational, system and payment issues that influence the ability of providers and clinics to adopt new practices. The findings from these two projects are likely to answer significant questions about the readiness of research-based treatments for integration into community practices and the readiness of community practices for adoption of new clinical strategies.

**Lack of Attention to Family-driven Practices**

Treatments that are inaccessible to the youth and families who may benefit from them are essentially useless. However, a series of important studies have found that successful efforts can be made to enhance a family's service engagement and decrease rates of families terminating treatment early. A range of studies have been undertaken to understand the barriers to engaging families in mental health services and increasing minority family involvement (McKay et al., 1996; Santisteban et al., 1996; Szapocznik et al., 1988).

Among the values that have become intrinsic to interest in community-based services have been those that stipulate that parents, guardians or consumers must be integrally involved in treatment planning and delivery if the quality of care for children is to improve. The federal government, through SAMHSA, has supported the development of an infrastructure within state mental health agencies to support consumer involvement in service planning, and most states have consumer offices to strengthen this involvement. Numerous family advocacy organizations support the needs of families with children who have emotional or behavioral problems more generally and those with specific psychiatric disorders. Simultaneously, sev-

eral major initiatives in primary care to reform health care services nationally have empowered consumers to make decisions about their own health care. These initiatives within both general health care and mental health care are leading to innovations in source delivery, such as providing families with vouchers to function as case managers for their child's care. The movement away from office-based practice and toward empowerment of consumers and families is likely to increase significantly over the next decade.

**Toward a 180-Degree Revolution**

***Clinic and Community Intervention Development and Deployment Models***

The time lag between creation of an EBP and its acceptance into routine clinical or service practice is estimated to be 20 years (IOM, 2002). To accelerate the pace of development of EBPs and their deployment into routine

*“The time lag between creation of an EBP and its acceptance into routine clinical or service practice is estimated to be 20 years”*

practice, new models for the creation of the next generation of EBPs have been proposed. Building on the Deployment Focused Model of Weisz (2003), Hoagwood, Burns and Weisz developed the Clinic-Community Intervention Model to extend deployment by attending to context variables such as characteristics of the practice setting (e.g., practitioner behaviors, organizational variables, community characteristics) and involvement of families and community from piloting, manualization and dissemination that are essential to the ultimate acceptability of new services. These models are proposed as a way of ensuring strong scientifically based practices and accelerating the adoption of research-based approaches into practice.

If the goal of creating and deploying EBPs is to enhance the application of research findings to practice, then from the outset, research models should

incorporate the perspectives of families, providers and other stakeholders into the design of new treatments, preventive strategies and services (Jensen, Hoagwood & Trickett, 1999). Only by doing so can the following issues be addressed:

- the relevance of the service or treatment intervention to youth and families
- the cost-effectiveness of the intervention
- the extent to which it reflects the values and traditions of families and community leaders to be addressed

These issues are ultimately essential for any evidence base to be of any practical utility.

***Creating a Context for Constant Empirical Inquiry in Routine Practice***  
Current approaches to the implementation of EBPs within state and local service systems are largely character-

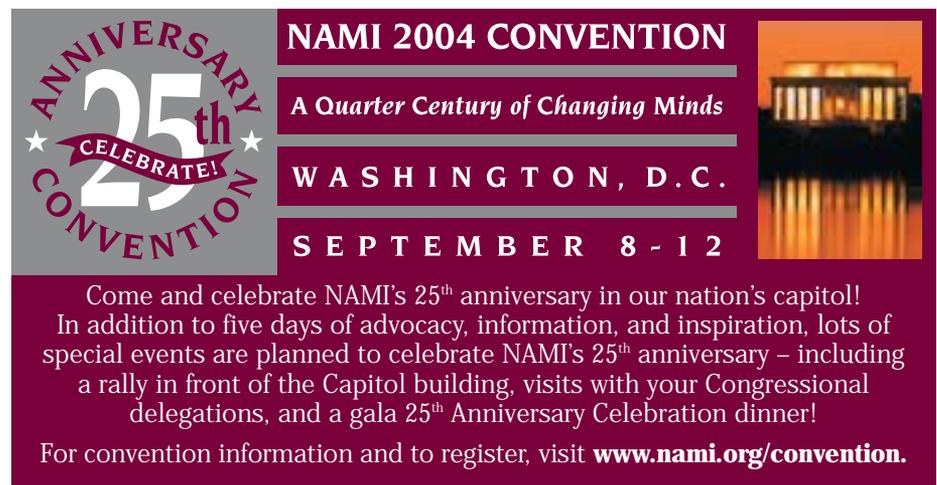
ized as unidirectional: research-based models to be taken off the shelf, put into place within routine practice settings and institutionalized there. An alternative approach would be to encourage routine practice settings to become the seat of empirical inquiry—to become empirically driven centers

for both delivering and examining practices and their link to outcomes. Such normalization of research-based approaches to practice would demystify the scientific enterprise and create services that could be constantly re-evaluated, refined and improved. This kind of revolution in thinking could lead to the creation of service clinics that construct locally relevant evidence. This approach could be used to create a context for empiricism within routine service settings, leading ultimately to improvements in the quality of mental health services.

**Conclusion**

Significant state and national policy initiatives are currently focused on more closely aligning science and practice.

These initiatives present unique opportunities for linking scientific developments on effective clinical care for youth with mental disorders to organizational system and policy reform. The availability of a growing research base on effective clinical treatments and practices offers an opportunity to tap into a reservoir of scientifically based strategies and to test their applicability within locally based services. However, limitations to the evidence base as well as limitations to the connectedness of EBPs to issues of real-world implementation suggest that new models for crossing the boundaries between research and practice are sorely needed. Creating family-driven, empirically based, high-quality services will require commitment to constant inquiry and obstinate questioning. 



**ANNIVERSARY**  
**25<sup>th</sup>**  
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For convention information and to register, visit [www.nami.org/convention](http://www.nami.org/convention).

# Multisystemic Therapy: An Evidence-based Practice for Serious Clinical Problems in Adolescents

Scott W. Henggeler, Ph.D. Family Services Research Center, Medical University of South Carolina

**M**ultisystemic therapy (MST) is a family- and community-based treatment that has achieved favorable long-term outcomes: reduced out-of-home placement and increased school attendance and cost savings for youth presenting with serious clinical problems (e.g., violence, substance abuse, serious mental health treatment needs) and their families. In light of those favorable results, MST programs have been developed and are currently operating in more than 30 states and 8 nations. Yet, only about 1 percent of eligible youth—adolescents presenting with serious antisocial behavior at high risk of out-of-home placement—receive this evidence-based treatment annually. This article provides a brief overview of the key features of the MST model, summarizes outcomes of evaluation studies for several clinical populations and discusses current efforts to disseminate the MST model.

## The Foundation of MST's Clinical Success

Several critical components of MST account for its clinical success (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Henggeler, Schoenwald, Rowland, & Cunningham, 2002). These components are logical, make common sense and are research based. Nevertheless, the components conflict with the majority of mental health and substance abuse services provided to youth and their families.

## Provide Services in the Natural Environments of Youth and Families

With a home-based model of service delivery, MST aims to change identified problems where they occur—at home, in school, and in other community locations. Characteristics of the home-based model include low caseloads (four to six families per MST therapist); treatment provision in home, school, and other community locations; time-limited treatment (four to five months); and 24/7 availability of therapists. The home-based service delivery model, along with the MST program philosophy discussed below, provides several significant advantages over traditional outpatient and inpatient approaches to delivering mental health services:

- Barriers to service access are largely removed, which decreases the rate of families dropping out of services and missing appointments.
- MST significantly enhances families' involvement and alliance to treatment and services.
- Data related to assessing the effectiveness of treatment and services are more accurate and realistic, which allows for the design of more effective treatment interventions.
- Information pertaining to treatment progress and outcomes is more valid, which supports the fine-tuning of service interventions.
- Clinical changes are made directly in the family's living environment, where problems may arise.

## Address the Known Risk Factors for Serious Clinical Problems

MST takes advantage of decades of research documenting that antisocial behavior in youth and other problems are linked with individual characteristics of youth, family relations, peer relations, school performance and social support. Consequently, interventions used in MST are specifically designed to address those factors in the youth's environment that contribute to identified problems and to promote youth and family strengths that enhance resiliency. For example, as association with deviant peers is a powerful predictor of adolescent antisocial behavior, a major thrust of MST is to help caregivers disengage their children from deviant peer groups while at the same time promoting their involvement in prosocial peer activities, including afterschool sports and clubs, church youth groups and community service organizations.

## Parents and Caregivers Are Key to Obtaining Desired Youth Outcomes

In the MST model, parents and caregivers are viewed as absolutely critical to obtaining favorable long-term outcomes for their children. Thus, treatment goals are set primarily by the parents, and the therapists and parents collaborate in the design of service interventions to meet these goals. In this regard, MST often extends great effort to help parents build their capacity to monitor and discipline their children effectively, while providing supportive emotional contexts for them as

well. Parental barriers to obtaining favorable outcomes (e.g., parental drug use or a parent living with a mental disorder) must be addressed before parents can develop the skills and social resources needed for effective parenting. To maintain treatment gains, MST devotes considerable energies to helping parents identify and build indigenous support systems. Emphasis is placed on developing informal networks composed of friends, family, neighbors, church, and others, rather than on formal supports such as those received from state agencies. Formal supports are used primarily when indigenous supports have been exhausted or when service need is very high.

**Accountability of MST Providers and Ongoing Quality Assurance**

MST programs assume accountability for engaging families in the treatment process and for attaining positive outcomes. Such accountability plays a critical role in the high treatment completion rates and favorable outcomes obtained in MST programs. Moreover, as much as possible, incentives are provided to program staff who meet performance criteria. If providers are to be held accountable for outcomes, however, they must have the clinical, supervisory and organizational resources to accomplish treatment objectives. Hence, training, supervision and ongoing consultation are essential aspects of quality control in MST programs. Our research has clearly shown that favorable long-term outcomes for youth are linked with high therapist adherence to the MST treatment protocol, whereas poor outcomes are linked with low adherence. Hence, MST strives to surround clinicians with the resources needed to help families attain their desired outcomes.

**Use of Evidence-Based Intervention Techniques**

MST incorporates evidence-based treatment interventions insofar as they exist. MST programs include cognitive behavioral approaches, behavior therapies, behavioral parent training, prag-

matic family therapies and certain pharmacological interventions (medications) that have a reasonable evidence base. These evidence-based techniques are delivered in a considerably different context than usual. For example, consistent with the view that caregivers are key to long-term outcomes, an MST cognitive behavioral intervention would ideally be delivered by the caregiver in consultation with the therapist. The therapist would also be accountable for removing barriers to service access and engaging the family in services.

**Outcomes from Clinical Trials**

Federal entities such as the Office of the Surgeon General (DHHS, 1999; U.S. Public Health Service, 2001), National Institute on Drug Abuse (1999) and Center for Substance Abuse Prevention (2001) have identified MST as either demonstrating or showing considerable promise in the treatment of youth criminal behavior, substance abuse and emotional disturbance (including youth with mental disorders). These conclusions are based on the findings from eight published outcome studies (seven randomized, one quasi-experimental) with youth presenting serious clinical problems and their families. These studies included approximately 800 families, and, as dis-

cussed below, approximately 4,000 additional families will have participated in MST research by 2004.

The following summary of juvenile justice, substance abuse and mental health outcomes is based on the three randomized trials with chronic and violent juvenile offenders (Borduin et al., 1995; Henggeler et al., 1997; Henggeler, Melton & Smith, 1992), one with juvenile offenders with substance abuse (Henggeler, Pickrel & Brondino, 1999), one with youths presenting with psychiatric crises (i.e.,

suicidal, homicidal, or psychotic) (Henggeler, Rowland et al., 1999), one with families with abuse and neglect issues (Brunk, Henggeler, & Whelan, 1987), one with juvenile sexual offenders (Borduin, Henggeler, Blaske & Stein, 1990) and one with inner-city delinquents (Henggeler et al., 1986). These projects were conducted in Memphis, TN, at several sites in South Carolina and in Columbia, MO.

Across studies, consistent clinical- and service-level outcomes have emerged. At the clinical level, in comparison with control groups, MST demonstrated the following favorable outcomes:

- improved family relations and functioning
- increased school attendance
- decreased adolescent psychiatric symptoms and suicide attempts
- decreased adolescent substance use
- decreased long-term rates of re-arrest ranging between 25 and 70 percent

At the service level and in comparison with control groups, MST has achieved the following favorable outcomes:

- 97 percent and 98 percent rates of treatment completion in recent studies
- decreased long-term rates of days in

*“MST programs assume accountability for engaging families in the treatment process and for attaining positive outcomes.”*

out-of-home placement ranging from 47 to 64 percent

- higher consumer satisfaction
- considerable cost savings; for example, the Washington State Institute on Public Policy concluded that MST produced more than \$60,000 in savings per youth (Aos, Phipps, Barnoski & Lieb, 1999)

Approximately 15 major MST studies are currently in progress, with the hope that findings will (a) further improve MST outcomes for youth presenting

with serious antisocial behavior; (b) extend the effectiveness of the MST model to other serious clinical populations, such as juvenile sex offenders, youth with serious mental health needs, maltreating families and adolescents with poorly controlled juvenile diabetes; and (c) inform the effective transport of MST to real-world clinical settings.

### MST Dissemination Efforts

Demand for MST increased considerably following the publication of the short-term, long-term and cost-effectiveness findings for violent juvenile offenders described above. Numerous state and county juvenile justice and mental health authorities, state legislators and executives of large service provider organizations contacted our research group with the hope of establishing MST programs in their communities. To meet that demand, MST experts essentially duplicate at remote sites the clinical training, supervision and fidelity monitoring procedures used in the successful randomized trials of MST. In addition, considerable attention is devoted to aspects of the provider organization and community resources that can affect the outcomes of the MST program.

Licensed MST programs are currently operating in more than 30 states and 8 nations. Statewide MST initiatives are operating in Connecticut, Hawaii, Ohio, South Carolina and Colorado, and nationwide MST initiatives are under way in Norway and Denmark. Program development, training and quality assurance are provided by MST services, which has the exclusive license for the transport of MST technology and intellectual property through the Medical University of South Carolina. For states, nations and organizations that have large MST initiatives, MST services has helped develop the internal capacity to provide virtually all aspects of MST program development and quality assurance. To learn more, please visit our web site at [www.mstservices.com](http://www.mstservices.com).

Consistent with the research empha-

sis of the MST model, MST programs are currently being transported only for youth presenting with serious antisocial behavior. Adaptations for MST to treat juvenile sex offenders, youth presenting with serious mental health needs and maltreated children are undergoing further refinement and validation. These adaptations will not be available for dissemination to community settings until we have full confidence that the corresponding treatment protocols will be reasonably effective.

### Implications for Advocacy

From the perspective of supporting evidence-based services, the most important implication for advocacy pertains to the issue of outcome accountability. Favorable outcomes for youth and families will be enhanced when provider organizations are held accountable for achieving pragmatic goals set by youth consumers and their families. In the case of adolescents presenting with serious antisocial behavior, these outcome goals pertain primarily to preventing residential placements of youth, preventing re-arrests and promoting school and vocational success—in sum, youth should be “at home, in school and out of trouble.”

Currently, provider organizations have little incentive to use evidence-based practices to achieve such goals because (a) these organizations can benefit substantially from funding structures that provide much greater support for out-of-home placements than for intensive home and community-based services and (b) funders rarely hold providers accountable for the clinical success of their programs. Policies that reward treatment providers differently on the basis of outcomes (e.g., performance contracts) rather than simply for hours of service could play a major role in improving the quality of services provided to children and their families. Consumer advocacy is likely the most effective strategy for influencing such policy. 

# RESPONSIBILITY

By Anthony Scibilia

I forgot it.

At the bottom of the Nile

Or it was eaten by a crocodile.

I forgot it

In space

I had to leave quickly

From that scary place.

I forgot it

In the Sun yesterday

It was so hot

I had to run away.

And every time I give my excuse

I tell you it really is the truth

My teacher says “zero”

Unless I have some proof.

*Editor's Note:* Anthony, who is 15 years old and in 9<sup>th</sup> grade, lives in Beaver, PA with his parents and four siblings.

# Ask the Doctor:

## Obsessive-Compulsive Disorder in Children

Suzanne Vogel-Scibilia, M.D., Psychiatrist in Beaver, PA and NAMI National Board member

**O**bsessive-compulsive disorder (OCD) often first presents with anxiety symptoms similar to normal childhood fears, which progress to the point that the child's life is consumed by intrusive thoughts and corresponding behaviors designed to combat the anxiety. Children and adolescents diagnosed with OCD may develop abnormally intense fears of aggression, contamination, disorderliness, sexuality, or illness. They may engage in checking, washing, questioning, counting, throwing away, or hoarding to a degree that may make completion of everyday life tasks almost impossible.

Often young people will deny the presence of these thoughts, but the family will see ritualistic behaviors or evidence of anxiety as the manifestation of the illness. Other children will become consumed by describing the symptoms and attempting to have the family participate in the rituals. Dressing, bedtime, washing, or checking rituals are often associated with this illness, but some children also have a propensity to throw away objects they feel are slightly damaged, question parents ritualistically about the health of family members, or read and reread homework assignments. They may develop fears involving sexuality, especially around homosexual or sexually transmitted illness themes. When the onset of symptoms occurs gradually, children and their families may not realize how much the symptoms have altered family life until treatment begins to ameliorate the symptoms.

The age of onset of OCD for those who become ill in childhood is approximately 7 to 9 years, and onset is often associated with a precipitating event. Children as young as 3 or 4 may manifest classic obsessive-compulsive symptoms. There are increased rates of OCD symptoms in young people with

Tourette's syndrome, eating disorders, depression, panic disorder, or chronic hair pulling (known as trichotillomania). The number of people identified with OCD in the National Institute of Health Epidemiologic Catchment Area Study (a study designed to collect data on the prevalence of mental illnesses) may be artificially low because of the tendency of children to hide their symptoms and under-report the degree of illness.

Obsessive-compulsive symptoms are thought to involve at least three neurotransmitter systems in the brain, but there is no clear consensus yet about the exact nature of the dysfunction. Because of the success of medication that addresses problems with serotonin levels in the brain, many theories focus on dysfunction involving that system, but OCD cannot be explained by serotonin dysregulation alone. Dopamine and, to lesser degree, norepinephrine systems also appear to be involved. Recent positron emission tomographic (PET—a process for imaging the brain) studies have provided the most convincing data showing that areas of the brain are involved in OCD.

A child or adolescent with OCD may describe the obsessional thoughts as being separate from his or her own cognition, with the result that clinicians may mistake the thoughts for hallucinations or delusions. Ruling out childhood schizophrenia or psychotic mood disorders is an important step in diagnosing OCD. The child may describe the anxiety as involving sensations of physical illness such as headaches, nausea, abdominal discomfort, or dizziness, which may lead to consultations with multiple medical specialists. Although a thorough diagnostic psychiatric and medical work up is important, focusing on the treatment—including cognitive-behavioral psychotherapy, family education, and psychopharmacology—early

in the course of the illness helps to prevent negative consequences for the child and should not be delayed. These negative consequences might include adverse experiences in school and in social development.

There is a tremendous need for further research into what therapeutic modality or combination of treatments will provide the best acute relief and maintenance care for children and adolescents with OCD. Psychosocial treatments for obsessive-compulsive symptoms are often not successful, but cognitive-behavioral therapy has shown promise. Behavioral strategies, such as therapy that pairs exposure to the anxiety and prevention of the compulsive ritual, have been found to be even more helpful than cognitive interventions such as thought stopping and distraction interventions. Spending large amounts of time reassuring the person diagnosed with OCD, trying to reason away the fears or completing the rituals yourself at the child's request are not helpful and may increase the symptoms.

Treatment with medication is also very helpful, with strong data suggesting that selective serotonin reuptake inhibitor (SSRI) antidepressants are efficacious in adults and children for both the acute phase of OCD and maintenance of stabilization. Another medication, Anafranil, which is a tricyclic antidepressant, has had good success but requires blood-level and electrocardiographic monitoring. Further medication strategies being investigated include the use of anti-anxiety medications from the benzodiazepine class, mood stabilizer augmentation or atypical antipsychotic medications for people with severe treatment-resistant illness. Many clinicians believe that the first line of treatment should be cognitive-behavioral therapy, with or without an antidepressant. 

# NAMI North Carolina's Young Family Program

by Linda Swann, Director, Young Families Program, NAMI NC

**N**AMI North Carolina revamped its Young Families Program six years ago. The first thing we did was ask parents and other caregivers of children with mental illness what they wanted us to do. We needed to identify the biggest challenge they faced everyday as they cared for their children and adolescents. The overwhelming response was, "We need teachers and other school personnel to understand that mental illnesses are no-fault brain disorders. Our children just need the appropriate accommodations and interventions in order to experience success at school."

What began as a basic two-hour overview of mental illness in children and adolescents has morphed into a more in-depth presentation that focuses largely on how students with neurobiological brain disorders present in the classroom, and at home. Our goal is to share how teachers and other child-serving agency personnel can respond more effectively. We share personal anecdotes about our own children. We feel that makes the presentation more real. We talk a lot about problems with executive functioning, with handling stress, and memory deficits.

We begin our presentation with background on the latest in brain research. We want the attendees to understand that these are indeed "no-fault" brain disorders. A favorite is the quote from Steven Hyman, former Director of NIMH: "Nobody is to blame. This is not a mental weakness. These are diseases just like any other neurobiological disorders. They just happen to affect complex behaviors."

An overview of the diagnosis process, especially why it is so difficult, follows and includes benefits of early intervention. We share the major warning signs of mental illness in children and adolescents, from increased irritability to aggressive behavior to poor concentration. More importantly, we



Linda Swann and Phyllis Kennedy (center) with workshop attendees.

take the major disorders – attention deficit/hyperactivity disorder (ADHD), bipolar, depression, anxiety, obsessive-compulsive disorder (OCD) – and reframe the behaviors from the point of view of the child with the disorder. For example, a child with anxiety may repeatedly ask for approval ("Am I doing it right?"); whereas a child experiencing mania may be aggressive, goofy, or distractible.

Next we cover treatment options. Here we also focus on cognitive behavioral therapy, the System of Care model, and the use of medications. We include the classes of medications and the behaviors that are actually improved by medication. After showing a video ("A Different Journey" from NAMI New Mexico is our favorite), we discuss the problems of stigma and a family's need for support and understanding. We believe we have succeeded in our efforts if teachers and other professionals leave our workshop with more empathy for children with mental illness.

"What school personnel can do" is our next big topic. We provide school professionals with some very basic suggestions like "Be aware that behaviors that are unusual or interfere with learning may be symptoms of a brain disorder" and "Remind parents they are not to blame." Our favorite ideas also

include placing the focus on a child's strengths and needs, not on pathology. We also focus on the fact that "front-end interventions are best." Dealing with executive functioning challenges and with stress-related issues takes a big chunk of our time. Professionals need to understand that these children may need extra help in organization and planning. A proactive response would be to break an assignment down into manageable parts and check the child's work early on, before the student has made a lot of mistakes or has become frustrated. We remind our audience that when a child is very emotional, his or her thinking is impaired. Our suggestion is to let the child calm down before processing what has happened.

We summarize the following basic points at the end of our school based education program:

- Mental illnesses are no-fault brain disorders;
- Getting the right diagnosis is difficult but treatment works;
- Early recognition of symptoms is vital;
- Families need support; and
- Interventions work!

We have expanded our list of Power-Point presentations to include an early intervention approach geared to child-care providers. Our audience includes

*continued on page 14*

# NAMI Affiliate Expands Support and Education Initiatives Focused on the Needs of Families of Young Children and Adolescents

by Sharon A. Miller, Director of Education and Outreach, NAMI Southwestern Pennsylvania

**N**AMI Southwestern Pennsylvania has consistently explored the needs of families and stakeholders through outreach to “folks who have been there.” Our affiliate convenes focus groups throughout our 10 county region. We also participate in multiple stakeholder collaboratives. NAMI members have a seat on several oversight and advisory boards including those that monitor access and quality of treatment and related supports for individuals of all ages. The input we receive becomes the framework for our strategic planning process. All of our child and adolescent focused initiatives incorporate the participation of parents, and at times the children themselves, that are directly impacted by mental illnesses or serious emotional disorders.

## Hopes and Challenges Film and Discussion Workshops

“Hopes and Challenges” is an education program tailor-made for specific audiences comprised of either, school based professionals, mental health treatment providers, casemanagers, other child serving professionals, community organizations and other stakeholders. NAMI Southwestern Pennsylvania, in collaboration with Western Psychiatric Institute and Clinic of the University of Pittsburgh Medical Center, produced the film *“Hopes and Challenges: Children and Families Discuss Mental Illness.”* This film offers candid portrayals of local children diagnosed with a mental illness and introduces viewers to members of their family. The children and their family members discuss the fears



NAMI SW PA's Children and Families' Outreach Picnic and Arts 'n Crafts Event—*“Nurturing Your Child's Mental Health”*

and frustrations associated with the first diagnosis while sharing personal coping skills and feelings of encouragement and hope. Mental health professionals stress the need for early intervention, securing needed supports and the effectiveness of treatment. This film, which has been sold throughout the country, Canada and Australia, has also become the focal point of our workshop presentations. Our workshop panel participants include family members, a child psychiatrist and NAMI Southwestern Pennsylvania staff who expand upon the issues presented in the film.

After a presentation to 75 social workers and counselors of the

Pittsburgh Public Schools, the Coordinator of Student Services writes:

*“...The title of the film and workshop authentically describes the hopes and challenges experienced as faced by the children (students) and their families as they live through the peaks and valleys associated with their mental illness. Our staff came away from the workshop with a greater respect, understanding, and appreciation for the struggles (challenges), devoted love and support (hope) shown by the families that participated. The medical professionals reinforced that treatment works... NAMI is an organization that I will suggest to both teachers and families.”*

Workshop evaluations have indicated that the film and discussion event provide seldom heard but much needed information. One comment frequently heard from participants is the need for written resource materials tailor-made for the film. NAMI Southwestern Pennsylvania has heeded the message and we have developed a companion educational booklet. The “Hopes and Challenges” booklet includes sections on the development and early phases of a mental illness, the diagnostic assessment, information guides for parents and teachers, and the varied emotional reactions among family members. The film and companion booklet offers caregivers, teachers, and providers a true picture of how mental illness may affect families of children and adolescents, but more importantly, it suggests “next steps” for addressing the challenges that may lie ahead. The “Hopes and Challenges” education program can be readily

replicated by affiliates throughout the country. The educational package is available for purchase and includes the film (in VHS format), film transcript, and the educational booklet.

**Family Partner Program-Meeting Unmet Needs**

Parents and caregivers of children and teens with mental illness have indicated, especially in the rural communities of southwestern Pennsylvania, that ongoing advocacy and support for families is an unmet need. Families share that they need much more help than mental health professionals or support group participation alone can offer in their attempts to navigate the complex mental health and education systems.

NAMI Southwestern Pennsylvania has responded with a new and exciting initiative—the Family Partner Program. The Family Partner program, funded through the support of the Staunton Farms Foundation and based upon a model from NAMI New Hampshire, provides one-on-one assistance to parents and caregivers in acquiring the necessary information and skills they need to become “full partners” in obtaining mental health, education, and related support services for their child.

First and foremost, the Family Partners are family members “who have been there” and are able to offer empathetic support and practical information to parents who may feel overwhelmed, isolated and alone. They “walk along side” parents, navigating these complex systems of care. The Family Partners foster the empowerment skills necessary for parents to more effectively advocate for their child. Through our collaboration with



*Youth sharing in Arts 'n Crafts*

other education and advocacy organizations, the Family Partners are trained in federal and state special education law, dispute resolution, transition services for children, mental health treatment and related support services and the policies and procedures of a myriad of financial systems (Medicaid, private insurance and the related insurance regulations, Social Security and others).

Parents and caregivers can access the services of the Family Partners through self-referral and through the recommendation of NAMI affiliates, mental health and other child serving professionals.

**Ensuring Continuous Quality Improvement in Child and Adolescent Services**

CART (Consumer & Action Response Team) of Allegheny County, a project of NAMI Southwestern Pennsylvania, is a consumer and family satisfaction process. Consumers and families of adults and youth, receiving publically funded mental health and substance abuse services, are interviewed about both their satisfaction and dissatisfaction with these services.

Consumers and families have long advocated for their inclusion in the evaluation of mental health services.

Consumer satisfaction has been emphasized as a key indicator of service quality with the initiation of managed care for Medicaid recipients. This quality improvement initiation includes a structured process for service providers to respond to consumer and family dissatisfaction with the service system. It also provides a process for dialogue between service recipients, providers and funders. Aggregate reports related to questions concerning service access, respect, choice, involvement in treatment planning, and information about medication side effects, peer support and consumer rights -- provide a mechanism for looking at system trends and areas of overall improvement.

In 2002, CART completed 2,666 interviews, 298 of which addressed a range of children’s services including inpatient, residential and community-based services.

In the CART interviews, parents stressed the value of treatment related education and the value of knowledge of their child’s rights within the service system. Some examples of dissatisfaction included difficulty with timely service access, high staff turnover and insufficient psychiatric time. Parents report an increase in information about services and provider choices and receiving more information about family support groups over the previous year. CART will continue to look for creative ways to work with families, consumers, providers and funders to help ensure continued quality improvements.

*To learn more about NAMI Southwestern Pennsylvania initiatives, contact us by phone at 1-888-264-7972, or email at [info@namispwa.org](mailto:info@namispwa.org), or visit our website at [www.namispwa.org](http://www.namispwa.org).*

*continued from page 12*

**S T A T E N E W S**

professionals in social services, the court system, juvenile justice, school nurses, and other professionals working in children’s systems of care. We have always included parents and foster parents as part of the audience. As a matter of fact, some of our best experi-

ences (when attendees really get it) have occurred with a variety of child-serving agency personnel. It’s a great example of collaboration among agencies and an opportunity for folks to network.

We have educated over 4,000 teachers and other child-serving professionals over the past 5 years. Our audiences

are largely grateful for the information and resources that we share. We firmly believe that most professionals who serve children want to know how to relate better to them. They just haven’t had the opportunity to hear our message. We leave attendees with plenty of resources and handouts including our quarterly newsletter, “Insights” and

# Tony and His Mental Illness

by Emily Scibilia

**H**e sprints into the room, a look of sheer terror on his face as his fingers claw through the many objects shielding his path to the door. Heart pumping and jaw locked, Tony realizes that the enemy will soon be on him and he has no chance to flee from the peril of disobedience. Hearing the footsteps behind him thumping closer and closer, he leaps to the floor wailing out with remorse and self-pity.

Finally, they are standing over him, Tony screams and jolts around on the floor trying to find the nearest object to protect himself. Nothing however is around him but the legs of his adversaries. He grabs a hold and strikes as hard as he possibly can hoping to make a break-away escape to the door once the enemy is distracted. His attempt is successful and Tony makes a frenzied dash to the kitchen grabbing a knife like a knight unsheathing his sword before charging into battle. At this point I, studying at the kitchen table, can not bear the noise anymore and scream at the top of my lungs, "Mom! Dad! Tony's got a knife again. Make him leave so I can do my physics homework!"

You see, Tony is not some grown man on the run from his captors trying to save himself from physical abuse and torture. Instead he is my fourteen-year-old brother denied a Nintendo game before his homework is finished. Both of my parents mobilize and corral Tony until his chest stops heaving and he comes to his senses. Placing the knife back into its holder, he slowly



*Emily and Tony Scibilia*

sulks out of the room and stumbles upstairs to sleep it off. This is what my family affectionately calls a "Tony Meltdown."

Sometimes I become extremely agitated with my parent's differential punishment for Tony's actions compared to his four siblings. I cause a slight commotion in the car while driving to school and have my television removed for two weeks, while Tony has a nuclear holocaust one evening and is sent upstairs to rest and contemplate his actions. However my family has come to realize that Tony has both attention deficit disorder and bipolar disorder. His life seems to be like a rollercoaster with constantly changing dips and bends. He struggles daily to fit in with his classmates and has severe learning disabilities that set him apart

from his peers. These disorders cause him much pain when dealing with everyday tasks and many times even the small punishments received from my parents seem overwhelming to him. Whenever Tony is grounded or sent to his room, we realize that his illness may seem like an inconvenience to us, but in reality it causes him much more emotional turmoil and suffering.

Sometimes these "Tony Meltdowns" also occur at our local mall or in other public places. Many people look at Tony and automatically judge him as spoiled or infantile. These onlookers do not understand Tony's condition and their intolerance causes severe stress and frustration for my whole family. Above all else, I wish that some-day mental health awareness will be common knowledge in our society. So when Tony has another one of these tantrums, he would be our main focus not the intrusive bystanders who tell my family he needs to learn obedience. When Tony is doing well, I find him to be humorous, witty, affectionate, and kind. He is friendly to everyone and is not judgmental or rude. In the future, I hope that these close minded people will see the true side of Tony's personality, instead of judging him because of his illness. 

**Editor's note:** Emily, who is 16 years old and in 11<sup>th</sup> grade, lives in Beaver, Pennsylvania with her parents and four siblings. Her mom, Suzanne Vogel-Scibilia, M.D., is a psychiatrist and a member of the NAMI National Board of Directors.

also a copy of "Teachers and Parents as Allies." Teachers especially appreciate having their own copy of the PowerPoint slides, a list of helpful websites, books, and videos.

You may want to know how we get invited to speak. We have a brochure that describes the basic presentation. We have display tables at conferences

across the state so we can pass out information and let folks know we are here. However, the majority of the time when we are invited to give our presentation, it is because a motivated parent or caregiver goes to the principal or someone in authority and lets them know that we are a resource. There is no stopping these young parents. Their

resourcefulness and energy never ceases to amaze us! For more information on NAMI North Carolina's PowerPoint presentation, contact Linda Swann, Director of NAMI North Carolina's Young Families Program by phone at 919-788-0801 or by e-mail at [lswann@naminc.org](mailto:lswann@naminc.org). 

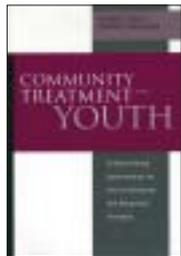
## Community Treatment for Youth

Evidence-Based Interventions for Severe Emotional and Behavioral Disorders

by Barbara J. Burns, Kimberly Hoagwood

List Price: \$32.95 Soft cover: 390 pages (2002);

Publisher: Oxford University Press



Barbara Burns and Kimberly Hoagwood have developed an excellent resource for advocates and policy makers interested in the evidence base that currently exists for children in need of mental health treatment and services. The book is designed to bring together, in one volume, current information about evidence-based interventions for youth with mental

health needs.

One thing is clear from this book—there are many effective treatment and intervention approaches for children with mental illnesses. Many of these can be delivered in the child's home and community. More importantly, many incorporate families as partners in the service delivery process. Among the treatment models or approaches featured in the book, are—The Wraparound Approach, Multisystemic Therapy, Treatment Foster Care, Family Support and Education, Psychosocial treatment, Special Education: Best Practices and more.

Toward the end of the book, the conclusion and accompanying commentary provide a rich discussion on next steps – the policy implications related to implementing evidence-based treatment and how we can best bring what we learn in science into our communities.

Just a word of caution—some sections of the book are a bit technical and use professional jargon, so it may not be for everyone. Despite that fact, the editors—Barbara Burns and Kimberly Hoagwood—true leaders and experts in the field, do a fine job of educating us about the growing evidence base for children's mental health treatment and services.

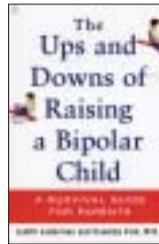
## The Ups and Downs of Raising

a Bipolar Child: A Survival Guide for Parents

by Judith Lederman, Candida Fink, M.D.

List Price: \$14.00 Paperback: 294 pages (November 2003)

Publisher: Fireside



In *The Ups and Downs of Raising a Bipolar Child*—author Judith Lederman immediately grabs the reader's attention by sharing the story of her 5-year-old son's threat to kill himself in a very public place. She then moves on to his first hospitalization at age 8 and his diagnosis of bipolar disorder. Co-author, child psychiatrist Candida Fink—helps guide the discussion on bipolar disorder—explaining early on in the book how it is diagnosed and often not diagnosed in children who actually suffer from the disorder.

The book, divided neatly into four parts, is an invaluable resource for parents who are coping with the reality of raising a child with bipolar disorder. The four sections of the book—*Your Bipolar Child*, *Your Child in the World*, *Family Matters*, and *Money Matters*—provide detailed practical advice and valuable guidance for parents and families. The book includes several useful chapters within the four sections; one chapter titled *Day Care, Schools, and Camps*—covers the topic for the entire range of ages from kindergarten to high school. Extra attention is paid to special education services and the book arms parents with helpful information to use in Individualized Education Program (IEP) meetings.

The *Family Matters* section includes a chapter dedicated to sibling issues. The chapter includes a helpful discussion on the incredibly difficult challenge many parents face in raising a child with bipolar disorder, while also attending to the diverse needs of the child's siblings.

The *Ups and Downs of Raising a Bipolar Child* is truly a survival guide and a must have for parents raising a child with this illness. Judith Lederman effectively incorporates anecdotal stories from several families that have lived experiences quite similar to her own.

**Editor's note:** A special thanks to our reviewer, CW Tillman, a parent, advocate and NAMI's Managing Editor for Web Content.

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The Nation's Voice on Mental Illness

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