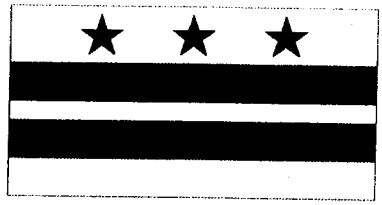
THE DISTRICT OF COLUMBIA
DEPARTMENT OF YOUTH REHABILITATION SERVICES
(DYRS)



A Closer Look at Agency Progress for the 2007 DYRS Summit

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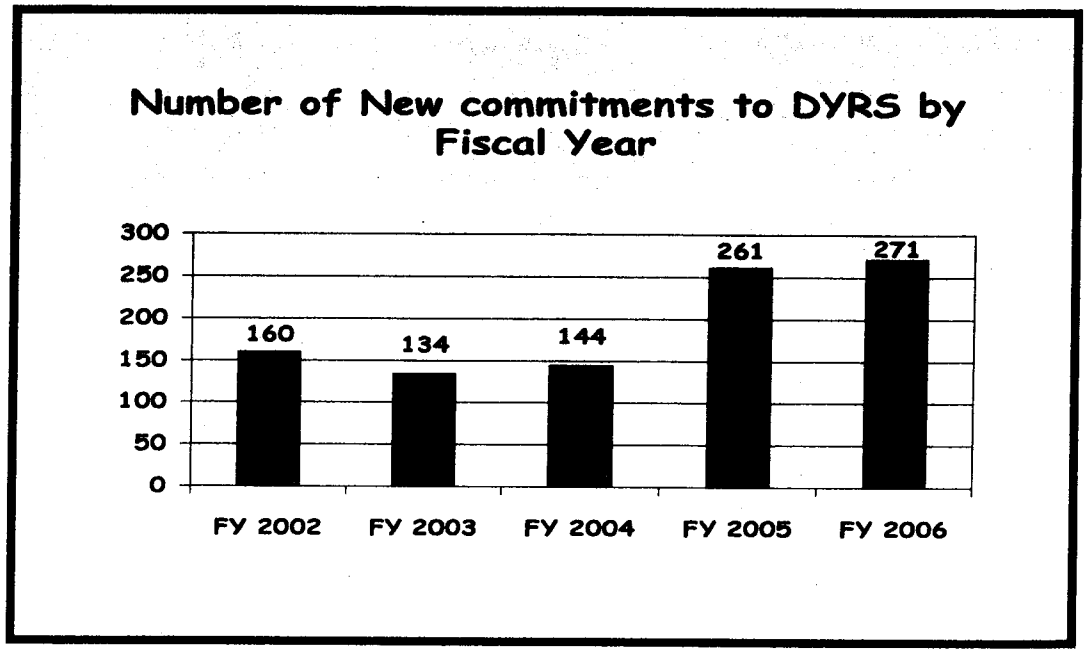
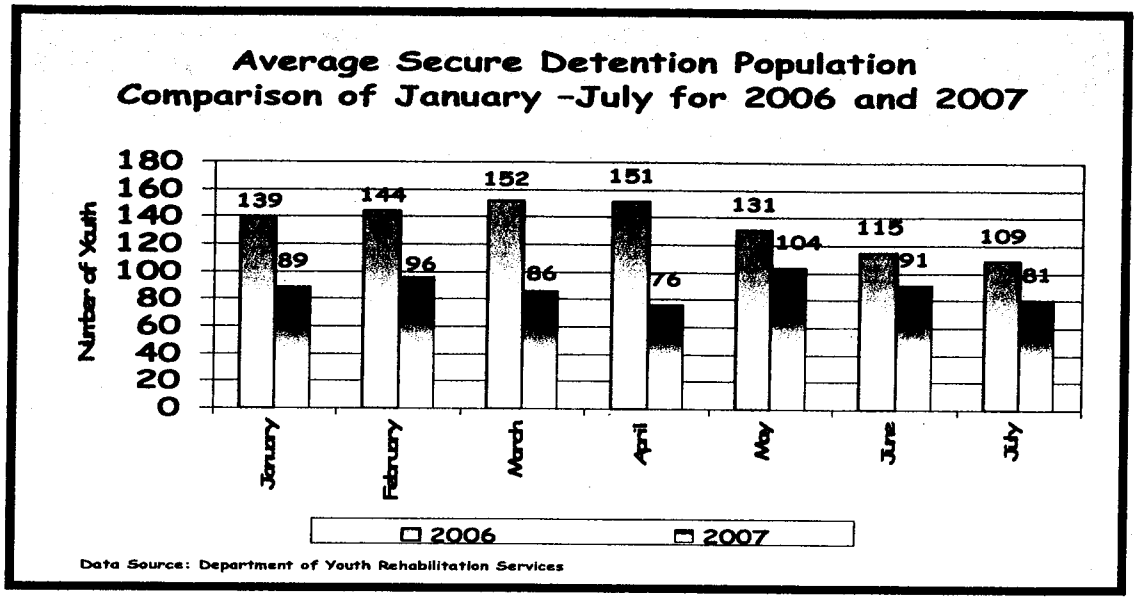
Committed Youth in DYRS

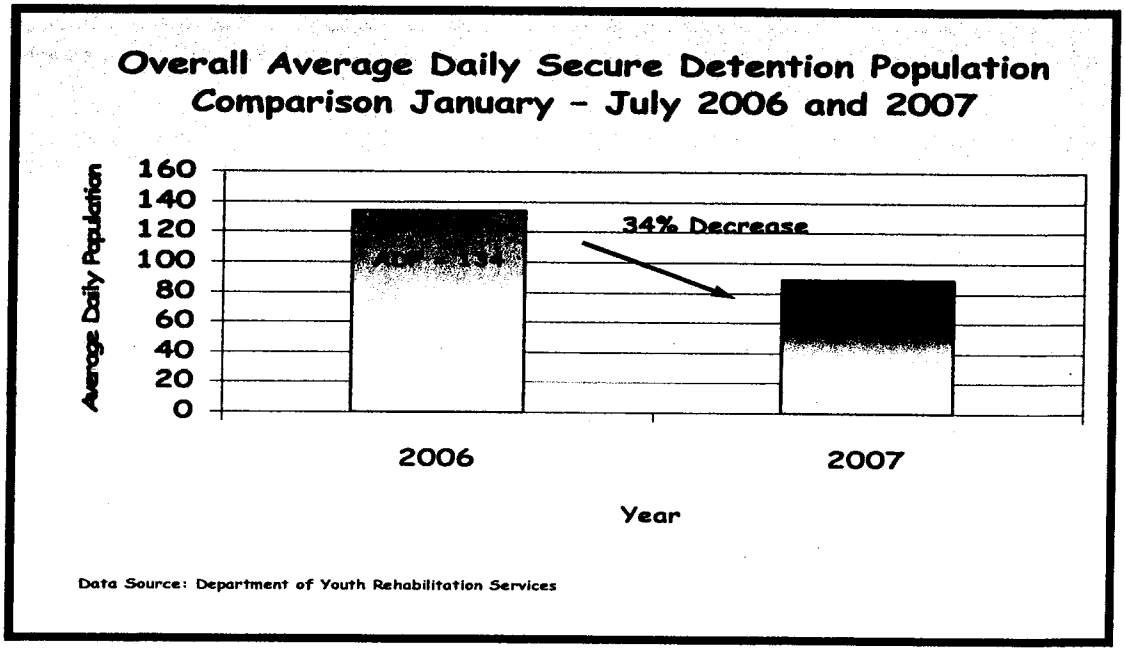


- The number of commitments to DYRS has increased by 69% over the past five years. A primary reason for this increase may be that DYRS is currently undergoing a series of reforms and has expanded its continuum of services over the past two years to create secure programming that is small, homelike, and rehabilitative which will provide community-based, family-focused interventions. Net-widening can occur with the expansion of new programs. The level of commitments has already begun to level off as we approach the end of 2007. As of the end of Aug., only 118 youth were newly committed to DYRS throughout 2007. An average of 15 youth have been committed to DYRS per month since January. If this trend continues, approximately 180 youth will be newly committed in 2007.

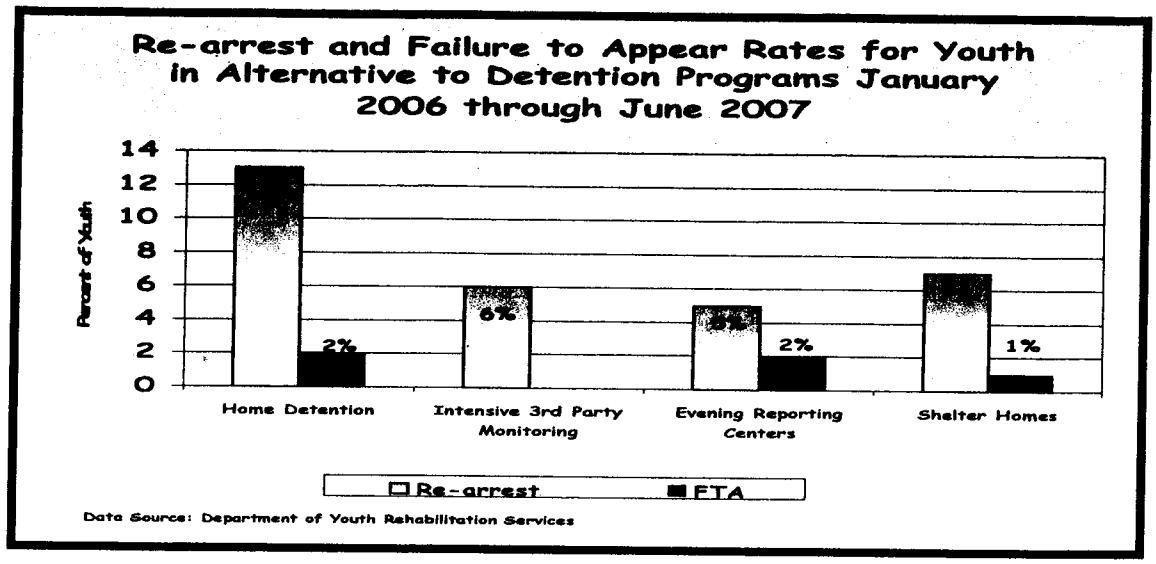
Detained Youth



- A comparison between 2006 and 2007 for the past seven months show a significant difference in the average daily secure detention population.

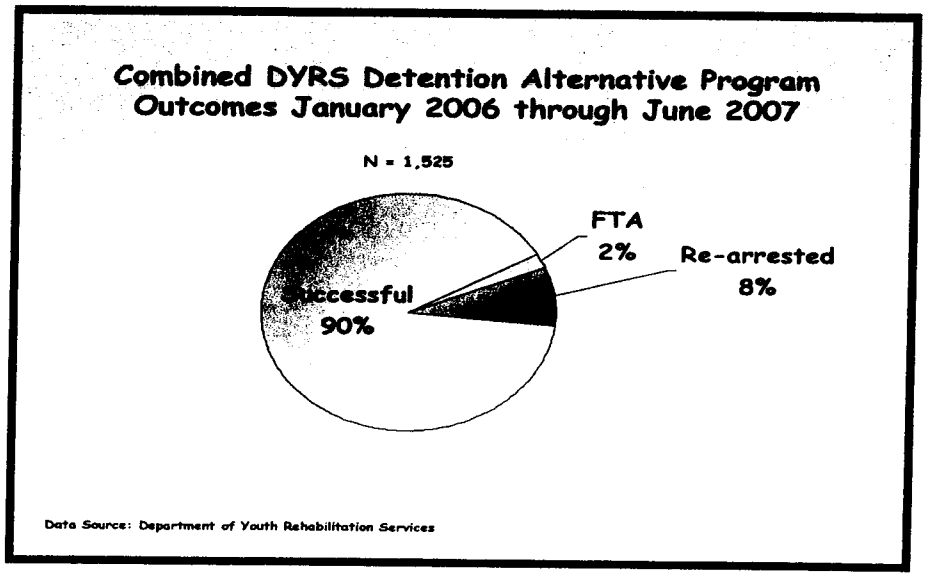


- The overall average daily population in secure detention between January through July of 2006 and January through July 2007 has decreased 34%. This reduction can be attributed to the quality of DYRS's detention alternatives and to the Juvenile Detention Alternative Initiative (JDAI).

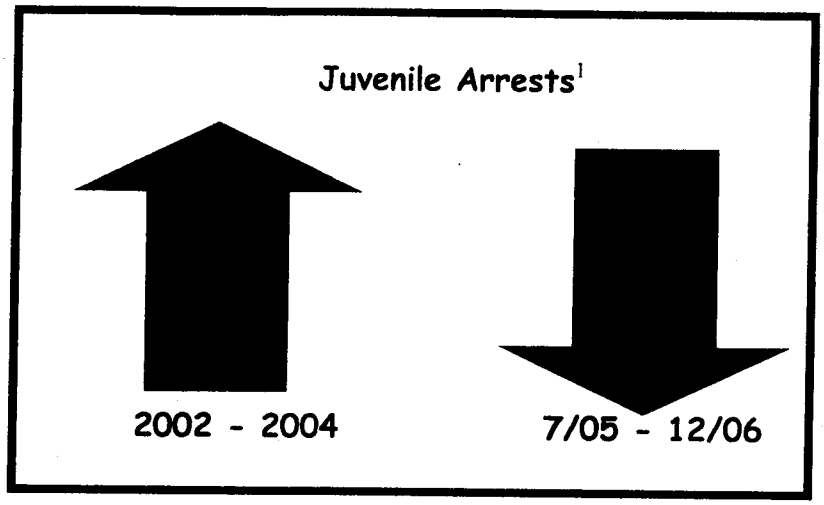


- The alternative to detention programs have shown great success in limiting recidivism among participants. Youth participating in the ARCH and Latin American Youth Center Evening Reporting Centers were least likely to be arrested while enrolled in the programs, while youth under 3rd Party Monitoring supervision were close behind. The rate of recidivism was greatest in DYRS's Home Detention program, but still, only 13% of those youth were re-arrested while participating. Rates of failing to appear in court were even lower across all alternatives to secure detention programs. Just a handful of youth participating in any DYRS alternative to secure detention program were issued a custody order for failing to appear in court.

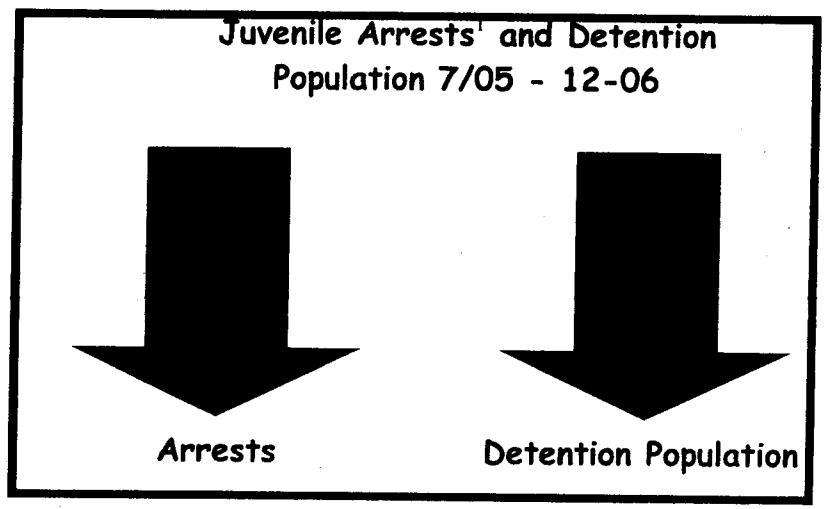
- As of June 2007, 90% of all participating youth were released successfully from a detention alternative program as shown in the chart below.



Juvenile Crime Declines After District Begins JDAI



- Serious juvenile arrests[1] were on the rise between 2002 and 2004, prior to the start of the Juvenile Detention Alternative Initiative (JDAI). Arrests of juveniles for serious offenses dropped by 15 percent after JDAI was initiated in July 2005.



- Since the start of JDAI, the number of youth securely detained on an average daily basis declined 33 percent and the rate of juvenile arrests dropped 15 percent.

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[1]Arrest offense types include robbery/carjacking, rape/sexual abuse, aggravated assault, burglary, larceny/theft, auto theft, homicide, arson, and unauthorized use of a vehicle.

Data Source: Metropolitan Police Arrest Statistics and the Department of Youth Rehabilitation Services

What is the difference among Empirically Supported Treatments (ESTs), Evidence Based Treatments (EBTs), Evidence Based Practice (EBP), Cultural Adaptations, Practice Based Evidence (PBE) and Community Defined Evidence (CDE)?

We are inundated with acronyms on a daily basis. Many are confusing. There are no more confusing acronyms than those used to describe "evidence" in our interventions and practices. This will be an attempt to clarify the terms by making important distinctions among them if they exist and provide guidance about the potential pitfalls.

Empirically Supported Treatments (ESTs) and Evidence Based Treatments (EBTs)
Refer to empirically developed specific interventions that are based upon randomized control trials (RCTs) using a control group and an experimental group to prove their validity, reliability and effectiveness (generalizability). They typically used a strict manualized approach under scientifically controlled conditions to ensure "fidelity" to the model. Examples of ESTs/EBTs are Multi-systemic Therapy (MST)), Cognitive Behavioral Therapy (CBT), Parent Child Interaction Therapy (PCIT), Multidimensional Therapeutic Foster Care (MDTFC), Functional Family Therapy (FFT) and many others that you have heard of and possibly use. These ESTs/EBTs are found on reputable lists such as:
SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), http://nrepp.samhsa.gov/;
The National Association of State Mental Health Program Directors (NASMHPD) Research Institute's Matrix of Children's Evidence-Based Interventions http://www.nri-inc.org/reports_pubs/2006/EBPChildrensMatrix2006.pdf; or
The Hawaii Department of Health Summary of Effective Interventions http://www.hawaii.gov/health/mental_health/camhd/library/pdf/ebs/ebs011.pdf

Evidence Based Practices (EBPs)
are often defined as:

- "The integration of the best research evidence with clinical expertise and patient values" (Institute of Medicine, 2000)
- "The integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences." (American Psychological Association, 2005)

Evidence Based Practices are...usually associated with specific isolated conditions rather than the types of multiple and co-morbid conditions that children and their families from diverse populations frequently experience. (Miranda et .al., 2005)

Often times, the term "evidence-based practice" (EBP) is used synonymously with the terms empirically supported treatment (EST) or evidence-based treatment (EBT). Most in the field do not make the distinction but there is a significant difference. ESTs and EBTs are empirically determined treatments based upon a western model of empiricism that use randomized control trials (RCTs). A broader and probably more accurate definition of Evidence Based Practices is: a set of practices that may, or may not include,

an EST/EBT, and other interventions or supports and services that also contribute to successful outcomes for children, youth, families and consumers. In other words, EBPs are sets of practices and not just a solitary intervention or treatment approach. Another example would the provision of legal aid services or housing and employment services to a family as part of the interventions provided that increases the likelihood of successful outcomes for the family. Some refer to this approach as the "front porch approach" because the settings are welcoming and deal with the individual's set of needs holistically.

Cultural Adaptations of Evidence-Based Practices

Are any modification to an EST/EBT that involves:

- Changes in the approach to the delivery of the service;
- The nature of the therapeutic relationship;
- Changes in the components of the intervention to accommodate cultural beliefs, attitudes and behaviors (A Whaley, Hogg Foundation, 2006)

Examples:

- University of Oklahoma Health Sciences Center-Indian Country Child Trauma Center, www.icctc.org ;
- Hogg Foundation, www.hogg.utexas.edu

Cultural adaptations must not just "tweak" the EBP but must fundamentally adapt it to reflect the cultural world view of the individual, including values, traditions, beliefs and practices and spiritual perspective. The Indian Country Child Trauma Center has done exactly that with five ESTs/EBTs.

Practice-Based Evidence (PBEs):

Practice-Based Evidence has been defined as: "A range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions. Practice Based Evidence services are accepted as effective by the local community, through community consensus, and address the therapeutic and healing needs of individuals and families from a culturally-specific framework. Practitioners of practice based evidence models draw upon cultural knowledge and traditions for treatments and are respectfully responsive to the local definitions of wellness and dysfunction. Practitioners of practice based evidence models have field-driven and expert knowledge of the cultural strengths and cultural context of the community and they consistently draw upon this knowledge throughout the full range of service provision; engagement, assessment, diagnosis, intervention and aftercare. The practice based evidence approach includes a logic-driven selection of appropriate interventions based on a range of factors, including the cultural and historical beliefs systems of the community related to healing and wellness. Practice based evidence mandates consistent and authentic adherence to family choice." (*The Road to Evidence: The Intersection of Evidence-Based Practices and Cultural Competence in Children's Mental Health,* Isaacs, Huang, Hernandez, Echo-Hawk, 2006).

A simpler definition is: Practice based evidence is a set of practices that are unique and inherent in a culture that have proven to be effective based upon community consensus (Martinez, 2007).

- They are in the community, find them. They work and they have met the community's needs for years, sometimes centuries;
- While they may not have an empirical research base, nor they may never have one, PBEs are invaluable and necessary to use to be responsive to, and respectful of, the community;
- There is no list of PBEs. Every community should document and disseminate (if culturally appropriate) effective PBEs to "build the evidence" for acceptance and inclusion in funded behavioral health care delivery models and systems.
- PBEs may or may not be generalizable or transferable, but that should not be their goal since we seek individualized care for children, youth, families and communities and what works in one community may not work in others. They do have components in common and that is what yet needs to be discovered.

Community Defined Evidence (CDE)
can be defined as a set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community (Martinez, et al., 2007). Community defined evidence (CDE) is very similar to Practice Based Evidence. It emphasizes the "bottom up" approach to determining evidence as opposed to the "top down" approach of ESTs/EBTs that evolve in the "laboratory" of academic/organizational settings and are field tested in the community. Community Defined Evidence attempts to recognize the experience, expertise, and value of existing, yet unacknowledged or undiscovered knowledge that exists in communities and has for years and sometimes centuries. The goal is to discover it, evaluate it, if that is appropriate, and acknowledge or validate it as a body of knowledge or evidence that has proven to yield positive results in communities.

Cultural Challenges Related to ESTs/EBTs:

- Most ESTs/EBTs do not include children of color in their norming and standardizing samples or they do not have large enough samples to demonstrate validity, reliability or effectiveness with children of color.
- Most youth have multiple diagnoses and most ESTs/EBTs are developed for a single diagnosis.
- Most ESTs/EBTs fail to identify the "real world" context (ecological/contextual variables, such as SES) that facilitates or reduces their effectiveness – and we know that cultural contexts are very different between and within ethnic/racial/cultural groups.
- There needs to be congruence between the child/youth and family's expectations and the outcomes designed to come from the EST/EBT.
- ESTs/EBTs must be individualized to the particular needs of the children, youth and families but that is sometimes difficult because of the need to have fidelity to the manualized approach.
- Sometimes the proprietary nature of ESTs/EBTs make them prohibitive for a community to implement.

Other Challenges and Strategies:

- Staying "in the box" by choosing ESTs/EBTs "off the shelf" without individualizing and taking the cultural and community context into consideration- Oversimplification at the cost of individualized and community driven care;
- Disconnection with SOC values and philosophy – Choices and decisions need to involve the population of focus (families/youth/community choice) - "Nothing about us, without us."
- No administrative/organizational validation of PBEs despite community validation – Need to develop administrative/policy/funder "buy-in" and create a budget to support PBEs;
- Overlooking what is already working in your community - Begin with the community knowledge, experience and expertise and not just what the "systems" provide as options (ESTs/EBTs)- Engage the community and its leaders as guides to discover the knowledge and expertise in the community;
- Under-utilizing the natural community cultural intermediaries that know, interpret and reinforce Community Defined Evidence - Create a "Front Porch."

Take Home Messages:

- An intervention (EST/EBT/EBP/CA/PBE/CDE) must:
  - Have content that is welcoming to the host culture;
  - Be relevant to the host culture and not be offensive;
  - Be validated and endorsed by the host culture;
  - Be individualized for your community.

- Systems of Care need to be individualized, family-driven, youth guided, culturally and linguistically competent and community-based;
- ESTs/EBTs are strongly emphasized but they need to be placed in context and viewed within the larger perspective, that of the host community---ESTs/EBTs cannot stand alone;
- ESTs/EBTs must be viewed within a Cultural and Linguistic Competence frame, normed, standardized, validated, replicated and individualized for a particular community and population;
- ESTs/EBTs/EBPs/CAs/PBE/CDE "All Belong," in other words, acknowledging, validating, evaluating and funding all of them allows for a full array of treatments and practices that can complement one another and improve the likelihood of successful outcomes for children, youth and families.

Resources:

- National Association of Multiethnic Behavioral Health Associations (NAMBHA) Effective Practices (www.nambha.org)
- SAMHSA Cultural and Linguistic Competence Primer, not yet published
- Resource Guide for Promoting an Evidence-Based Culture in Children's Mental Health (http://systemsofcare.samhsa.gov/ResourceGuide/index.html)
- Technical Assistance Partnership CLC Implementation Guide (http://www.tapartnership.org/cc/actiontools.asp)

- Research and Training Center, FMHI, Study 5 – Accessibility (http://rtckids.fmhi.usf.edu/research/study05.cfm)
- National Indian Child Welfare Association (www.nicwa.org)
- National Child Traumatic Stress Network (www.nctsn.org)
- Identify and share what is in your own backyard!