



Ontario Centre of Excellence
for Child and Youth
Mental Health

Centre d'excellence de l'Ontario
en santé mentale des
enfants et des adolescents

**Bringing People and Knowledge Together to Strengthen Care.
Rassembler les gens et les connaissances pour renforcer les soins.**

Evidence In-Sight:

SELECTED EVIDENCE-BASED ANXIETY TREATMENT PROGRAMS

Date:

June 2011

The following Evidence In-Sight report involved a non-systematic search and summary of the research and grey literature. These findings are intended to inform the requesting organization, in a timely fashion, rather than providing an exhaustive search or systematic review. This report reflects the literature and evidence available at the time of writing. As new evidence emerges, knowledge on evidence-informed practices can evolve. It may be useful to re-examine and update the evidence over time and/or as new findings emerge.

Evidence In-Sight primarily presents research findings, along with consultations with experts where feasible and constructive. Since scientific research represents only one type of evidence, we encourage you to combine these findings with the expertise of practitioners and the experiences of children, youth and families to develop the best evidence-informed practices for your setting.

While this report may describe best practices or models of evidence-informed programs, Evidence In-Sight does not include direct recommendations or endorsement of a particular practice or program.

This report was researched and written to address the following question(s):

- What evidence-based programs have been shown by research to be efficacious in treating youth, aged 12-16, with anxiety disorders?

We prepared the report given the contextual information provided in our first communications (see Overview of inquiry). We are available at any time to discuss potential next steps.

We appreciate your responding to a brief satisfaction survey that the Centre will e-mail to you within two weeks. We would also like to schedule a brief phone call to assess your satisfaction with the information provided in the report. Please let us know when you would be available to schedule a 15-minute phone conversation.

Thank you for contacting Evidence In-Sight. Please do not hesitate to follow up or contact us at evidenceinsight@cheo.on.ca or by phone at 613-737-2297.

1. Overview of inquiry

A large, urban mental health agency is experiencing increased service pressure for treatment and support of children and youth with anxiety disorders. They are committed to adopting and implementing evidence-based practices in their services and would like an overview of research on whether there are particular interventions that are proven efficacious in treating youth, aged 12-16, with anxiety disorders. They are particularly interested in school refusal and social isolation, with general anxiety a secondary priority.

The agency currently provides treatment on an individual basis but it varies depending on the skills and training of the particular therapist and the needs of the client. Staff who provide services include those with Bachelors of Social Work, Masters of Social Work, or Child and Youth Workers.

2. Findings

The PracticeWise database identifies the highest quality research papers on child and youth mental health issues and scores each protocol to identify core treatment elements. By breaking down research papers into treatment components, practitioners can be aware of what common factors and elements should be included in practice, even as treatment varies from client to client. In looking at the best quality studies on anxiety in children and youth, PracticeWise has identified these core treatment components (this is not an exhaustive list, but these are the most frequently cited practices):

- exposure
- a cognitive component
- psycho-education for the child
- relaxation
- psycho-education for the parent
- maintenance and relapse prevention
- child self-reward and self-praise
- child self-monitoring

Silverman et al (2008) reviewed psychosocial treatments for phobic and anxiety disorders in youth, identified 32 studies that met methodological criteria of robustness and rigor, and drew conclusions about which treatments have the strongest evidence base. No particular treatment was determined to be well-established (authors' language), but some did qualify as probably efficacious. Individual cognitive behavioral therapy (CBT), group CBT, group CBT with parents, group CBT for social phobia, and social effectiveness training for children with social phobia met criteria for probably efficacious. Common components across these treatments involve gradual exposure (in vivo or imaginary), developing coping plans, use of cognitive self-control, relaxation, and learning self-evaluation and self-reward.

Several directories of evidence-informed practices provide information on well researched, manualized treatment approaches for adolescents with anxiety disorders. **Appendix A** includes summaries of manualized evidence-based programs for adolescents with anxiety disorders as well as programs that might be effective for younger clients.

The California Evidence-Based Clearinghouse For Child Welfare lists six evidence-based interventions for child and/or adolescent anxiety, including the level of research evidence. For a description of their scientific rating scale see **Appendix C**.

1. **The C.A.T. Project and Coping Cat**
 - Well-supported by research evidence; ages 14-17 (Coping Cat is for 7-13)
2. **Building Confidence**
 - Supported by research evidence; ages 6-11
3. **Cool Kids**
 - Promising research evidence; ages 7-17
4. **Cool Kids Outreach Program**
 - Promising research evidence; ages 7-17
5. **Social Effectiveness Therapy for Children (SET-C)**
 - Promising research evidence; ages 7-17

Cool Kids Outreach is a novel program because it takes place entirely in the home (or school) and there is no direct contact between therapist and client. The parent, with telephone support from a trained professional, either works directly with their child or in a support capacity for adolescents. Bibliotherapy such as Cool Kids Outreach does have some supporting evidence indicating that for some clients it can help mitigate problems with wait lists. However, it may not be as effective as group CBT (Rapee, 2006).

In terms of mood disorders more broadly, a number of evidence-informed programs are worth being aware of (See **Appendix B**):

1. **Coping With Depression for Adolescents (CWD-A)**
 - Well-supported by research evidence; ages 12-18
2. **Cognitive Behavioral Therapy for Adolescent Depression.** This program does not have the base of evidence that others do, but it does have a supplement for anxiety treatment.
 - Promising research evidence; ages 13-17
3. **Coping With Stress Course**
 - Promising Practices Network rates it “Proven”; ages 13-18

Finally, a different option is Solution Focused Brief Therapy (SFBT). Although it is too early to determine the strength of evidence for SFBT, it has some empirical support and is widely practiced in child and youth mental health. In Ontario, SFBT is used in at least one agency as their treatment for children and youth presenting with internalizing disorders in their brief therapy program. In this setting it is theorized that SFBT, among other brief therapies, could help reduce wait times and provide quick, targeted services to children and youth who only need several sessions of therapy rather than a longer term commitment. SFBT is summarized in **Appendix B**.

3. Next steps and other resources

Programs were sourced from:

- The California Evidence-Based Clearinghouse for Child Welfare at: <http://www.cebc4cw.org/>

- The Promising Practices Network at: <http://www.promisingpractices.net/>
- SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) at: <http://nrepp.samhsa.gov/>
- Sociometrics is private organization that sells packaged evidence-based treatment programs: <http://www.socio.com/>

Knowing what works and receiving training on an evidence-informed practice or program is not sufficient to actually achieve the outcomes that previous evaluations indicate are possible. A program that has been shown to improve mental health outcomes for children and youth but that is poorly implemented will not achieve successful outcomes (Fixsen et al, 2005). In order for a program to be evidence-informed, it needs to be applied with fidelity to the design and it needs to be implemented using supportive “drivers” related to staff competency, organizational leadership and organizational capacity. These drivers include assessing and monitoring the outcomes of your practice using evaluation or performance measurement frameworks, which are particularly important when there is insufficient evidence in the literature to guide clinical decisions. Choosing a practice is an initial step toward implementation, but the implementation drivers are essential to ensure that the program reaches appropriate clients, that outcomes are successful and that clinical staff members are successful in their work.

The Ontario Centre of Excellence for Child and Youth Mental Health has a number of resources and services available to support agencies with implementation, evaluation, knowledge mobilization, youth engagement and family engagement. For more information, visit:

<http://www.excellenceforchildandyouth.ca/what-we-do> or check out the Centre's resource hub at <http://www.excellenceforchildandyouth.ca/resource-hub>.

For general mental health information, including links to resources for families:

<http://www.ementalhealth.ca>

References

Kim, J.S. (2008). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. *Research on Social Work Practice* 18, 107-116.

Rapee R.M., Abbott M.J., Lyneham H.J. (2006). Bibliotherapy for children with anxiety disorders using written materials for parents: a randomized controlled trial. *Journal of Consulting Clinical Psychology*, 74, 436–444.

Silverman, W.K., Pina, A.A., Viswesvaran, C. (2008). Evidence-Based Psychosocial Treatments for Phobic and Anxiety Disorders in Children and Adolescents. *Journal of Clinical Child and Adolescent Psychology*, 37(1), 105-130.

The C.A.T. Program (for adolescents) or Coping Cat (for children)	
Client Profile	The C.A.T. Program is for adolescents, ages 14-17; Coping Cat is for children, ages 7-13. Presenting problem is “problematic anxiety.” It was not developed for clients with developmental delays, but has been tested in one study on this population.
Program overview	<p>The C.A.T. Program is a developmentally appropriate adaptation of Coping Cat. Coping Cat has been widely implemented worldwide, including in the Canadian context as Coping Bear and Coping Cat. It is CBT based, manualized, and is recommended for <u>groups</u> of 4-5 participants. Recommended intensity is 50 minute sessions per week, for 16 weeks. The computer-assisted version (Camp Cope-A-Lot) is for 12 sessions. All versions include homework. There is parental involvement and a family treatment session.</p> <p>The program is designed to help children and youth: recognize and understand emotional and physical reactions to anxiety; clarify thoughts and feelings in anxious situations; develop plans for effective coping; evaluate performance and give self-reinforcement. Essential components are: psychoeducation; exposure tasks; somatic management; cognitive restructuring; and problem solving.</p>
Supporting evidence	The California Evidence-Based Clearinghouse rates Coping Cat a 1 for “Well Supported by Research Evidence”. The Promising Practices Network rates Coping Cat a “promising practice.” The C.A.T. Project has not been tested separately and the evidence is only based on studies of Coping Cat.
Cost and Training	<p>Manuals and workbooks can be ordered online from Workbook Publishing or Amazon. Child workbooks are \$27 each and treatment manuals for therapists are \$24 each. Training cost will vary. Training can be obtained through DVDs and a computer based training program, or arranged through the program developer:</p> <p>Dr. Philip C. Kendall Temple University pkendall@temple.edu (215) 204-7165</p>
Staff and agency characteristics	The program is appropriate in community agencies, residential facilities, hospitals, group homes, and hospitals. Staff should be grounded in the principles of CBT, but no minimum staff qualification has been set.
Other information	<p>Promising Practices Network summary: http://www.promisingpractices.net/program.asp?programid=153</p> <p>NREPP summary: http://nrepp.samhsa.gov/ViewIntervention.aspx?id=91</p> <p>California EB Clearinghouse summary: http://www.cebc4cw.org/program/coping-cat/detailed</p>

Client Profile	Children, 6-11 years old, diagnosed with childhood anxiety disorders – social phobia, generalized anxiety disorder, separation anxiety disorder, and obsessive-compulsive disorder. Some sources say it is appropriate for ages 6-14 (example, Sociometrics, http://www.socio.com/ced09.php) but information from the program representative only states ages 6-11. The program has been tested for children with developmental delays, specifically for children on the autism spectrum.
Program overview	<p>Building Confidence is a CBT-based program for school-aged children, with <u>individual</u> child therapy and parent training and involvement. It has not been tested for group treatment. Recommended intensity is weekly 90 minute sessions, for 16 weeks. Homework is an element. Parents/caregivers are provided with psychoeducation about anxiety, independence skills, and CBT strategies to apply at home.</p> <p>The goal of Building Confidence is to enhance learning and maintenance of treatment strategies. Children and parents are taught CBT principles and techniques and integrate ways to build confidence through graduated learning and practice of age-appropriate self-independence skills. In-session exposures are extended into the home, then parents help extend in-home exposures to in the community. Essential components of Building Confidence include: assessment and self-help skill milestones; in-session and home-based exposure; psychoeducation and CBT skills for parents; partnering and collaborating with schools.</p>
Supporting evidence	The California Evidence-Based Clearinghouse rates Building Confidence a 2 for “Supported by Research Evidence.” The program has been tested through several randomized controlled trials.
Cost and Training	<p>The program is manualized (available on request from the training contact) and training is available, cost unknown. Training can be provided remotely (online) and is for 4-6 hours. No pre-implementation assessment is available, but fidelity can be assessed using an existing fidelity measure and videotaped sessions.</p> <p>Contact: Jeffrey James Wood www.semel.ucla.edu/autism/research jwood@gseis.ucla.edu</p>
Staff and agency characteristics	Building Confidence is appropriate for outpatient settings and schools. Minimum practitioner qualifications are Master’s level clinical training; experience with CBT interventions; and experience working with children and families.
Other information	<p>California EB Clearinghouse summary: http://www.cebc4cw.org/program/building-confidence/detailed</p> <p>Sociometrics overview, and materials for purchase: http://www.socio.com/ced09.php</p>

Client Profile	Children and adolescents, ages 7-17, diagnosed with any anxiety disorder or exhibiting symptoms of anxiety. There are developmentally appropriate versions for children and adolescents. There are versions for children with comorbid autism and adolescents with comorbid depression.
Program overview	<p>Cool Kids (and Cool Kids Chilled for adolescents) are CBT-based treatments. It can be run for <u>individuals</u> or <u>groups</u> of 6-8 participants. It does not have a parent/caregiver component, but there is skill instruction for parents and parents attend some of the sessions. Recommended duration is 12 weeks, with individuals having eight hour-long sessions followed by two hour-long biweekly sessions, and groups having eight two-hour long sessions followed by two two-hour long sessions. There are also parent information sessions. There is a homework component for participants, and parents practice skills in the home.</p> <p>Program goals are to reduce the symptoms and amount of life interference caused by anxiety, achieved by teaching children and their parents how to better manage the child's anxiety. Essential components include psychoeducation, cognitive restructuring, parent skills, in-vivo exposure, social skills, and improved coping strategies.</p> <p>Cool Kids is an Australian adaptation of Coping Cat, but has been implemented in Canada.</p>
Supporting evidence	The California Evidence-Based Clearinghouse rates Cool Kids a 3 for Promising Research Evidence. Studies include randomized controlled trials and pre-test/post-test control group design.
Cost and Training	<p>The program is fully manualized. Therapist manuals \$65; workbooks \$35. Purchase from: http://www.emotionalhealthclinic.com.au/index.cfm?page_id=1254</p> <p>Australian contact (program leader/creator): Ronald M. Rapee, PhD Centre for Emotional Health, Macquarie University www.emotionalhealthclinic.com.au Ron.Rapee@mq.edu.au</p> <p>The Reach Institute in the U.S. provides training in a very similar program: http://www.thereachinstitute.org/</p>
Staff and agency characteristics	Cool Kids is appropriate for community agencies, and there is a school version. There is no set minimum therapist qualification, but preferable to have a degree in clinical psychology, ideally PhD. Grounded in CBT.
Other information	<p>California EB Clearinghouse summary: http://www.cebc4cw.org/program/cool-kids/detailed</p> <p>School version: http://www.kidsmatterprimary.edu.au/programs-guide/cool-kids-school-version/</p> <p>Program creator website: http://www.emotionalhealthclinic.com.au/</p>

Cool Kids Outreach Program	
Client Profile	Children 7-12 and adolescents 13-17 (slightly different versions), diagnosed with any anxiety disorder or exhibiting symptoms of anxiety. Comorbid conditions are included, as long as anxiety is the primary problem. It is not appropriate for children with developmental delays.
Program overview	<p>Cool Kids Outreach is a version of Cool Kids and Cool Kids Chilled (see summary above). It is an <u>individual</u> treatment and is not intended for groups. Recommended intensity depends on therapist availability and individual need, but the standard is 12 weeks with phone contact during the first 10. Phone sessions are 30 minutes each. There is a homework component, and parental involvement is essential.</p> <p>Like Cool Kids it is grounded in CBT and meant to teach clear and practical skills to children and parents so they can better manage the child's anxiety. Essential components are psychoeducation, cognitive restructuring, parent skills, in-vivo exposure, social skills, and improved coping strategies. Cool Kids Outreach is unique because the primary materials are aimed at helping the parent/caregiver run the program with the child, or assist and support the young person. There is no direct contact between the therapist and the child. For children under 13 the parent/caregiver essentially becomes the therapist, whereas for adolescents the parent/caregiver is more a supporter.</p> <p>Bibliotherapy may not be as effective as group or individual treatment, but it is a promising option.</p>
Supporting evidence	The California Evidence-Based Clearinghouse rates Cool Kids Outreach Program a 3 for Promising Research Evidence. Supporting studies include randomized controlled trials and a pre-test/post-test design.
Cost and Training	Same as Cool Kids (above) Resources required are slightly different. It involves one therapist and the associated therapist manual and child and parent workbooks, and access to a telephone and/or computer are also required.
Staff and agency characteristics	Cool Kids Outreach is delivered in the home or at school. Staff characteristics are same as Cool Kids (above). Engaged parent involvement is essential.
Other information	<p>California EB Clearinghouse summary: http://www.cebc4cw.org/program/cool-kids-outreach-program/detailed</p> <p>Program creator website: http://www.emotionalhealthclinic.com.au/</p> <p>For interesting reading, see the supporting research studies on bibliotherapy, CD-ROM for anxiety disorder, and therapist-supported parent-implemented CBT at: http://www.cebc4cw.org/program/cool-kids-outreach-program/detailed</p> <p>Sociometrics sells a similar program (Helping Your Anxious Child), though it does not have as much evidence as Cool Kids Outreach: http://www.socio.com/ced08.php</p>

Social Effectiveness Therapy for Children (SET-C)	
Client Profile	Children and adolescents, ages 7-17, with social phobia. Not designed for children with developmental delays. An adaptation of SET-C has been tested for selective mutism, but the evidence is limited on extending SET-C to other anxiety disorders.
Program overview	<p>SET-C is a behavioral treatment program that combines social skills training, peer generalization sessions, and individual exposure therapy sessions. It is specifically for social phobia. The goal is to help children become more comfortable in social situations by educating them about their fears, providing social skills training, and exposing them to feared social situations.</p> <p>Recommended intensity is once per week group social skills training (60 minutes) plus peer generalization (90 minutes) after the <u>group</u> sessions, and a weekly 60 minute <u>individual</u> session. Total duration is 12 weeks (so 24 sessions in total). There are also weekly homework components, and a brief parent education component. SET-C was designed to be delivered in a group of 6 participants and 2 therapists. The peer generalization sessions require that therapists arrange to have typically developing peers available in naturalistic settings for a 90 minute activity.</p>
Supporting evidence	The California Evidence-Based Clearinghouse rates SET-C a 3 for Promising Research Evidence. It has been tested in randomized controlled trials and within-group follow-up studies (for long term outcomes).
Cost and Training	A manual and training are available, cost unknown. Contact: Deborah C. Beidel, PhD, ABPP University of Central Florida anxietyclinic.cos.ucf.edu dbeidel@mail.ucf.edu (407) 823-3254
Staff and agency characteristics	Appropriate in outpatient settings and schools. Minimum provider qualification is a Master's degree and thorough training in behavior therapy procedures such as social skills training and exposure. Agency will also need to be able to successfully recruit and use peers of the children in treatment to act as confederates in the 90-minute exposure sessions.
Other information	California EB Clearinghouse summary: http://www.cebc4cw.org/program/social-effectiveness-therapy-for-children/detailed Sociometrics summary and materials for sale: http://www.socio.com/ced05.php

Coping With Depression for Adolescents (CWD-A)	
Client Profile	Adolescents, ages 13-18 with major depression and/or dysthemia.
Program overview	CWD-A is intended for <u>groups</u> of 4-10 participants, or more participants if multiple therapists are involved. It is a CBT-based course consisting of 16 2-hour sessions delivered over eight weeks. It addresses individual problems such as: discomfort and anxiety, irrational or negative thoughts, poor social skills, and limited experiences of pleasant activities. Curriculum includes structured intervention sessions, repeated practice of skills, use of rewards and contracts, and homework assignments. Key components of the sessions are cognitive restructuring, behavioral therapy, problem solving, communication, negotiation, relaxation training, and goal setting. The parallel, optional, parent element of the program involves similar skills.
Supporting evidence	The California Evidence-Based Clearinghouse rates CWD-A a 1 for “Well Supported by Research Evidence” and the Promising Practices Network rates CWD-A a “promising practice.” It is evidence-based and the six studies included in the rating employed rigorous methodologies including randomized assignment and found significant reductions in depression symptoms for intervention youth (Promising Practices Network, 2006).
Cost and Training	Free download of manuals and workbook (multiple languages) at: http://www.kpchr.org/public/acwd/acwd.html For training, the recommended contact per the download source is: Greg Clarke, PhD Kaiser Permanente Center for Health Research greg.clarke@kpchr 503) 335-6673
Staff and agency characteristics	The CWD-A program is appropriate for community agency and outpatient clinic settings. The California Evidence-Based Clearinghouse states that the minimum provider qualification is one therapist with experience in group treatments for youth, with at least a Master’s degree in a mental health field. Therapists need to be grounded in CBT.
Other information	For a more in-depth description including outcomes, quality of research, study populations, readiness for dissemination, and replications see: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=11 or http://www.cebc4cw.org/program/coping-with-depression-for-adolescents/detailed Promising Practices Network overview at: http://www.promisingpractices.net/program.asp?programid=152 The companion parent component manual is at: http://www.kpchr.org/public/acwd/acwd.html

Cognitive Behavioral Therapy for Adolescent Depression	
Client Profile	Adolescents ages 13-17, either gender, with depressive symptoms or diagnosis of depression. The material can also be used for adolescents diagnosed with forms of anxiety, following the same CBT techniques but in line with the supplemental anxiety treatment manual.
Program overview	<p>CBT for adolescents is delivered in 12-16 weekly sessions. It is a developmentally appropriate adaptation of Beck's classic CBT model and emphasizes collaborative empiricism, the importance of socializing patients to the cognitive therapy model, and the monitoring and modification of automatic thoughts, assumptions, and beliefs.</p> <p>To adapt CBT for adolescents, more emphasis is placed on (1) the use of concrete examples to illustrate points, (2) education about the nature of psychotherapy and socialization to the treatment model, (3) active exploration autonomy and trust issues, (4) focus on cognitive distortions and affective shifts that occur during sessions, and (5) acquisition of problem-solving, affect-regulation, and social skills. To match the more concrete cognitive style of younger adolescents, therapists summarize session content frequently. Abstraction is kept to a minimum, and concrete examples linked to personal experience are used when possible. http://nrepp.samhsa.gov/ViewIntervention.aspx?id=106</p> <p>The supporting manuals are more informational than prescriptive, so it is up to the therapist to determine how to put the recommendations into practice.</p>
Supporting evidence	<p>This program is not rated by the California Evidence-Based Clearinghouse, but it is rated by the SAMHSA National Registry of Evidence-Based Programs and Practices. Several experimental and quasi-experimental studies found evidence of improved outcomes for the CBT group compared to other, comparison treatments (further information available on the comparisons upon request). The research was well conducted and assessed for fidelity.</p> <p>The manuals do not provide information on how to assess fidelity within the implementing agency.</p>
Cost and Training	<p>Manuals freely available at: http://www.starcenter.pitt.edu/DownloadManuals/54/Default.aspx</p> <p>Training and technical assistance is available from the developer, cost unknown. Contact is the Star Center, also the source for the manuals (see Other information, below)</p>
Staff and agency characteristics	<p>Appropriate for outpatient settings, but minimum practitioner characteristics are not outlined in the manuals or on the NREPP review. The manuals describe the interventions, but do not clearly describe actual implementation of the interventions. Therapists would need to already have grounding and experience in CBT, and NREPP notes that therapists would need specialized training in this modified version of CBT for adolescents in order to replicate outcomes from the randomized clinical trial.</p>
Other information	<p>For the depression manual: http://www.starcenter.pitt.edu/files/document/Cognitive_Therapy.pdf</p> <p>Anxiety supplement: http://www.starcenter.pitt.edu/files/document/ANXIETY%20SUPPL%20%28STAR%29.pdf</p>

Coping With Stress Course	
Client Profile	Adolescents, ages 13-18, at risk for depression or experiencing elevated depressive symptoms.
Program overview	<p>The Coping With Stress Course (CWS) is an adaptation of CWD-A and is intended as a prevention and early treatment program for adolescents at risk for depression or other mood disorders. It involves cognitive-restructuring techniques in which youth learn to identify and challenge negative or irrational thoughts that might contribute to developing a mood disorder. The goal is to provide “immunity” or resistance against such disorders.</p> <p>This is a <u>group</u> program, appropriate for 6-10 adolescents. Intensity is 15 45- to 60-minute sessions. It uses role-plays, cartoons, and group discussions that are oriented to the developmental level of the participants. There is an optional, separate parent component with meetings at the beginning, middle, and end.</p>
Supporting evidence	The Promising Practices Network rates CWS a Proven program. Key evaluation findings are from randomized controlled trials. It has been found effective in a variety of settings.
Cost and Training	<p>CWS therapist manuals and adolescent workbooks are freely available for download from http://www.kpchr.org/research/public/acwd/acwd.html</p> <p>Training is available and required. Therapists receive 40 hours of training that includes mock intervention sessions, role-playing, homework, and videotaped feedback.</p> <p>Contact: Gregory N. Clarke, Ph.D. Kaiser Permanente Center for Health Research (503) 335-6673 greg.clarke@kpchr.org</p>
Staff and agency characteristics	This program is appropriate for community based agencies. Minimum provider qualifications are for psychologist or counselors with at least a master’s degree, with previous experience conducting psychoeducational groups with youth.
Other information	Promising Practices Network summary at http://www.promisingpractices.net/program.asp?programid=151

Solution Focused Brief Therapy (SFBT)	
Client Profile	Adolescents with internalizing disorders.
Program overview	<p>SFBT is quite different from the other programs reviewed in this document. It does not follow a manualized sequence of sessions. It requires that therapists be flexible, collaborative, and focused on problem solving. The therapist does not look for a particular problem at the root of the client's case. Instead, the therapist works to help the client find her/his own solutions and strategies to overcome problems. It is strengths-based, and solutions are defined as changes in perceptions and interactions. The client chooses her/his goals for therapy and the therapist teaches her/him how to bring their own resources to bear on those goals. There is a homework element. Core ingredients are to develop a cooperative therapeutic alliance; set measurable changeable goals; create a solution; apply future-oriented questions; scale goal attainment to client self-evaluation; and focus on positive exceptions to the problem.</p> <p>SFBT is an <u>individual</u> program. It is intended to be effective in 3-6 sessions, and clients who need further therapy after this are transitioned into other outpatient programs. Given how brief the service is, it may be effective in addressing problems with long wait-lists.</p>
Supporting evidence	<p>SFBT has been listed a Promising Practice by the U.S. Office of Juvenile Justice's Model Programs Guide. It has not been listed by mental health evidence-based program directories. There are many studies on SFBT in a wide variety of settings for different populations.</p> <p>A meta-analysis (Kim, 2008) found that SFBT achieved more positive outcomes for children and youth with internalizing disorders compared to the control group. Note that this is the rationale behind some agencies in Ontario using SFBT as their brief therapy of choice in triage clinics for clients with internalizing disorders.</p>
Cost and Training	<p>Some materials are available for free download: http://www.sfbta.org/trainingLinks.html and http://www.solutionfocused.net/treatmentmanual.html</p> <p>Training is essential. The SFBT Association has information on training opportunities, including online training: http://www.sfbta.org/sfbt_training.html</p> <p>There are some trainers in Ontario, although their qualifications are unknown and more vetting would be necessary.</p> <p>There is no particular lead contact for SFBT, although it originally was created in one clinic in the US. A starting point would be the SFBT Association: http://www.sfbta.org/Default.aspx</p>
Staff and agency characteristics	SFBT is appropriate for community agency settings. Minimum therapist qualifications are a Master's in a counseling discipline, with personal characteristics conducive to the SFBT approach.
Other information	For an in-depth overview, see the downloadable manual at http://www.solutionfocused.net/treatmentmanual.html

Directories of evidence-based programs use different rating scales. The California Evidence-Based Clearinghouse for Child Welfare uses a scale from 1-5, and NR for Not able to be Rated.

Level 1: Well-supported by Research Evidence.

- No evidence that the practice poses a substantial risk.
- The practice has a book or manual to specify components and how to administer.
- At least two rigorous randomized controlled trials (RCTs) in different settings have found the practice to be better than an appropriate comparison practice, and the RCTs were reported in a peer-reviewed, published journal.
- In at least one RCT, positive effects were found beyond the first year after treatment.
- Valid and reliable outcome measures administered consistently.
- Overall weight of the evidence supports the practice.

Level 2: Supported by Research Evidence

- No evidence that the practice poses a substantial risk.
- The practice has a book or manual to specify components and how to administer.
- At least one rigorous RCT in a different setting has found the practice to be better than an appropriate comparison practice, and the RCT was reported in a peer-reviewed, published journal.
- In at least one RCT, the practice showed a maintained effect of at least six months past the end of treatment.
- Valid and reliable outcome measures administered consistently.
- Overall weight of the evidence supports the practice.

Level 3: Promising Research Evidence

- No evidence that the practice poses a substantial risk.
- The practice has a book or manual to specify components and how to administer.
- At least one study using some form of control (untreated group, placebo, matched wait list study) established the practice's benefit over the control, or found the practice to be as good as or better than an appropriate comparison practice. Study reported in a published peer-reviewed journal.
- Overall weight of the evidence supports the practice.

Level 4: Evidence Fails to Demonstrate Effect

- Two or more RCTs found the practice did not result in improved outcomes compared to usual care. Studies were reported in published peer-reviewed journals.
- Overall weight of the evidence does not support the benefit of the practice. Overall weight is based on the preponderance of the published peer-reviewed studies, not a systematic review or meta-analysis.

Level 5: Concerning Practice

- Overall weight of the evidence suggests the practice has a negative effect upon clients.
- There is reasonable theoretical, clinical, empirical, or legal basis suggesting that the practice constitutes a risk of harm compared to its likely benefits.

NR: Not able to be Rated: practices that are manualized, accepted in practice, and do not show risk of harm, but have not been rigorously evaluated for outcomes.