Large scale implementation of evidencebased programs in Norway

Integrating research, policy and practice

Réttur til verndar, virkni og velferðar

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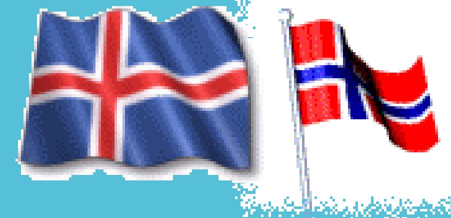
Norwegian Center for Child Behavioral Development



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What influenced the implementation of EBPs in Norway?

- Lack of services and competency in Child Welfare and Child Psychiatric Services concerning children and youth with serious behavior problems
- Much media attention to the deficiencies within the child welfare systems and the lack of professional personnel within some of the institutions
- The fact that youth were being institutionalized, for longer periods of time, far away from their homes and returning home not to their original environment where little changes had been made

- Great budgetary deficits in Child Welfare because of the amount of out-of-home placements

- By the Childlaw - family based help and support should be tried before the children are placed out of home

Large scale implementation MST and PMTO

- 1997: Conference on Serious Behavior Problems
- 1998: A committee appointed by the Norwegian Research Council recommended that *empirically supported family and community treatment programs* should be implemented and evaluated in randomized controlled trials.
- 1998 a national initiative was launched by the Norwegian government in order to increase and improve services, competence and research in relation to children and youth with conduct problems,
- 1999: All 19 county health directors accepted an invitation from two ministries to initiate the nationwide implementation of the Oregon Model of Parent Management Training (PMTO) and Multisystemic Therapy (MST).

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Facilitators at the National Level

- A genuine interest and commitment at the political and administrative level – consistent funding from The Ministry of Children and Eqality and the Ministry of Social and Health

- Determination and support to establish a national implementation and research center
  - National implementation teams for children and youth
  - Research group

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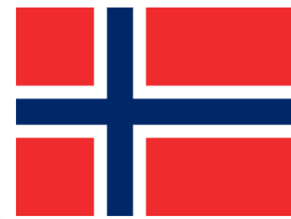

Mandate

To strengthen competence in the specialist treatment services for young children and youth with conduct problems through the nationwide implementation of Evidenced based programs

Research
RCT

To make the evidence-based knowledge and principles available in various settings and arenas in municipality-based services for children and youth

Three organizational levels

Municipality (431)

County (19)

Region (5 – 4)

Our implementation goal

To make a continuum of evidence based public efforts to

- prevent
- reduce
- and stop

the development of behavioral problems in order to hinder antisocial careers among the child and youth population

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PMTO
Parent Management
Training

PALS
School-wide PBS
model

TIBIR
Early intervention
For Children at
Risk

PMTO for Minority
Families and Children

Functional
Family Therapy
FFT

Integration of
Contingency
Management
for Drug-abuse
treatment

MST
Multisystemic
Therapy

Multidimensional
Treatment Foster
Care (MTFC)

Multiple evidence-based model programs 2014

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Research on clinical effectiveness and sustainability

- The effectiveness of PMTO compared to regular services were demonstrated in a RCT (Ogden & Amlund-Hagen, 2008) and the sustainability of clinical outcomes was demonstrated in a follow up study one year after termination of treatment (Amlund-Hagen, Ogden & Bjørnebekk, 2011).
- The effectiveness of MST compared to regular services were demonstrated in a RCT (Ogden & Halliday-Boykins, 2004) and the follow up study indicated that the outcomes were sustained and for some measures even improved two years after intake (Ogden & Amlund-Hagen, 2006),
- An RCT on the effectiveness of FFT in Norway has been started. Results are expected to be available in 2017.

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Establishing a continuum of interventions: PMTO and adapted short term preventive interventions by local services (training, supervision and monitoring of fidelity)

Intervention components	Training of practitioners	Target for intervention	Research
PMTO (full scale)	20 days training combined with supervision over 18 months 20 – 30 sessions with family	**Parents**	**RCT pre-post and follow up study published**
Brief Parent Training	9 days training over 6 months followed by 6 months supervision 4 – 6 sessions with family	**Parents**	**RCT (in print)**
Social Skills Training	6 days training and supervision over 6 months 8 – 10 sessions with the child	**Children**	**RCT**
PMTO group intervention for minority families	Certified PMTO therapists and 5 days training of bi-lingual link workers 20 sessions with group	**Mothers**	**RC T wait list control (in print)**
PMTO group intervention	2 days training of certified PMTO Therapists 12 sessions with group	**Parents**	**RCT wait-list control**
Teacher Consultation	4 days consultation training for PMTO therapists and Brief Parent Trainers 6 – 8 sessions with staff	**Staff in schools and Kindergarten**	**Planned RCT**
Assessment tool	3 days training	**Selected Staff**	**Validation**

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Establishing a continuum of evidenced based interventions for families with youth showing serious behavior problems (training, supervision and monitoring of fidelity)

Intervention components	Training of practitioners and QA	Target for intervention	Research
MST (Multisystemic Therapy) 24 teams	5 days training combined with weekly supervision and weekly consultation, 4 2-day "boosters" every year	Parents and youth	RCT pre-post and follow up study published
FFT (Functional Family Therapy) 5 teams	12 days training over 12 months plus weekly supervision 3 1-day boosters every year	Parents and youth	RCT started 2013
MTFC A (Multidimentional Treatment Foster Care- Adolescents) 2 team	4 days training and weekly supervision and consultation and a certification process 4 1-day boosters every year	Parents and youth	RCT planned when more teams are implemented
MultifunC 5 Institutions, one in each region	Training in MST, MI (motivational interviewing), ART (Aggression retaining training) Weekly supervision Boosters	Parents and youth	**Quasi experimental design (ongoing)**

Functional Family Therapy (FFT)

- An evidence-based model for treating youth-at-risk and their families. Target population same as MST + those with less severe problems.
- FFT-treatment has three distinct phases:

1. **Engagement and Motivation**
   - Family therapeutic techniques are used to reduce blame and negativity and increase hope and a relational focus in the family
2. **Behavior Change**
   - Developing within-family skills that eliminate the problem behavior:
   - e.g. communication, conflict management, problem solving /negotiation, parenting skills and contracting
3. **Generalization**
   - Focus on the sustaining the change, generalizing change to other systems, preventing relapse and linking family to (in-)formal support Team of 3 therapist, 8-12 sessions, 6-10 families

Multisystemic Therapy (MST)

- Community-based, familybased treatment
- Focus is on “Empowering” caregivers (parents) to solve current and future problems
- MST “client” is the entire ecology of the youth - family, peers, school, neighborhood
- Highly structured clinical supervision and quality assurance processes
- Team:1 supervisor, 3 therapists (4-6 fam) Duration 3-5 months
- 24/7 accesibility for the family

Multidimensional Treatment Foster Care (MTFC)

- Youth are placed individually in foster homes
- Treatment in a family setting and focusing on the youth *and* the family

Intensive support and treatment in a setting that closely mirrors normative life

- Intensive parent management training is provided weekly to biological parents (or other aftercare resource)
- Youth attend public schools
- Team of supervisor/individual-family therapists/skillstrainer (6-8 families pr team) Duration 9-12 months
- 24/7 accesibility for fosterparents and family

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The MultifunC-project was sponsored by the Ministry of Children and Equality in Norway, The National Board of Institutional Care (SiS) and Centre for Evaluation of Social Services (IMS) in Sweden.

1. Review of the research on residential treatment of antisocial behaviour in juveniles (2001-2002).

2. **Development of a residential treatment program based on the research (2003-2004).**

3. Implementing the treatment program – **MultifunC** - in Norway (five units) and in Sweden (two units) (2005-2007). Later also in Denmark. (8 youths pr institution) 9-12 months

Evidence Based Practices (EBP)

- Based on theory and resent research knowledge
- Defined target group – whom or what (with a specific problem) intervention is designed for
- For whom does it not work (criteria's for exclusion)
- Pre defined components, treatment plans
- Documented – manuals
- Training program for practitioners (theory and skill training)
- Systems for quality control- feedback to follow the method
- Showed effect in (two) Randomized control studies (RCT)

FFT, MST and MTFC are programs for the most marginalized youth in relation to social inclusion

- targets youth ages 12-17 years old who exhibit chronic or serious antisocial behavior, such as:
  - delinquency
  - school dropout (or push out)
  - violent behavior
  - drug use
  - incarceration

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Co-morbidity

- **More the rule than the exception**
- 65% - 90% also have a ADHD-diagnosis
- Substance-abuse
- Anxiety
- Depression

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YLS: Risk domains

- Prior and current offences/dispositions
- Family circumstances/parenting practices
- Education/Employment
- Peer relations
- Substance abuse
- Leisure/recreation
- Personality/behaviour
- Attitudes/orientation

- **WHAT DOES RESEARCH TELL US?**

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Delinquency is a Complex Behavior

Common findings of more than 50 years of research:
delinquency & drug use is determined by multiple risk factors :

- **Individual**
- **Family**
- **Peer group**
- **School**
- **Community**

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Risk- and protective factors

- The research is clear about the main influence factors for behavioral problems
- Behavior problems have multifactorial causes and multiple causal mechanisms
- The causal mechanisms are not the same for all youngsters with behavioral problems

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Research on Delinquency and Drug Use

Family Level

- Poor parental supervision
- Inconsistent or lack of discipline
- High levels of conflict
- Poor affective relations between youth, parents, and siblings
- Single parents
- Parents with substance abuse and mental health problems

Research on Delinquency and Drug Use (Cont.)

School Level

- Academic difficulties, low grades
- Behavioral problems at school, truancy, suspensions
- Negative attitude toward school
- Attending a school that does not flex to youth needs

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Research on Delinquency and Drug Use (Cont.)

Peer Level

- Association with drug-using and/or delinquent peers
- Poor relationship with peers, peer rejection
- Association with antisocial peers is the most powerful direct predictor of delinquent behavior!

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Research on Delinquency and Drug Use (Cont.)

Community Level

- Availability of weapons and drugs
- High environmental and psychosocial stress (violence)
- Neighborhood transience – neighbors move in and out

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Research on Delinquency and Drug Use (Cont.)

Youth Level

- genetic predisposition to mental illness
- difficult temperament
- ADHD, impulsivity
- Low performance level
- poor social skills
- Positive attitude toward delinquency and substance use
- Lack of guilt for their violations
- Negative affect

Peer culture and the risk of negative side effects of group treatment

- In residential settings an unintended consequence might be that the group might contribute to the development and maintenance of antisocial behaviour, and then to negative side effects of the treatment (Dodge, Dishion and Lansford, 2006).

- **The risk of negative influence from antisocial peers implies that the period of time used in residential setting should be as short as possibly, and should be linked to community services and aftercare.**

Protective Factors for normal and healthy development

- Association with prosocial peers
- Engagement in prosocial activities
- Positive relations with caregivers
- Supportive family environment
- Natural support network
- Commitment to schooling
- Conventional attitudes, respect for others
- Problem-solving and social skills

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- Key Program Treatment Components target the risk factors in the youths environment

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- Family interventions
- to improve parenting skills and communication skills family/youth

reduce conflict, build postive relationships, enhance, monitoring and supervision

- Individual interventions
  - to increase prosocial attitudes & skills; reduce other individually-based problems for parents & youth

Substance Abuse interventions

  - Reduce SA, reduce the personal and interpersonal supports for SA behavior, enhance alternatives to SA behavior

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- School interventions
  - to Improve school behavior, attendance, and performance
- Community interventions
  - to improve family connections and develop support network of extended family, neighbors and friends to help caregivers achieve and maintain changes. Address community risk factors, enhance involvement and satisfaction in prosocial activities.
- Peer interventions
  - to decrease association with negative peers; increase association with prosocial peers and involvement in prosocial activities

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Common treatment principles:

- All methods focus on establishing an environment that supports a positive development for the youth.
- This can be done in different ways in the various EBP methods, but with a common theoretical understaning on:
  - Behavioral psychology and positive reinforcement
  - Contingency management of negative behavior
  - Positive and supportive parenting practices

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Common treatment principles:

- All methods focus on tailoring the interventions to each family by:
  - focusing on engagement and motivation
  - systematic and structured analysis of the problem behavior
  - systematic assessment of all relevant risk and protective factors
  - ongoing evaluation of treatment progress

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Contingency Management for Substance Abuse (CM)

- Interventions are based on a functional analysis of the antecedents and consequences of drug use
- Urine analyses are incorporated to provide a monetary reward for

  clean urine screens
- To support long term change once the urine screens and treatment are complete, monetary incentives are awarded for other treatment activities such as session attendance and homework completion

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The family is involved

- Urine analyses are not conducted by therapists but instead by family members in a way that empowers them to support each other's efforts to eliminate substance use
- Cognitive behavioral interventions are not merely therapist driven processes. Rather, family members are fully engaged by the therapist to participate and lead these activities to facilitate new relational processes and individual skills,
- including core communication skills, supervision and monitoring skills,
- The process builds comfort and confidence in talking about and monitoring substance use

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Skills when therapy is over

- Families are taught new skills and strategies to combat triggers, urges, and cravings for substance use,
- Families are provided with a range of positive and negative reinforcement strategies to increase healthy behaviors that replace unhealthy behaviors.
- In the final phase of treatment, Generalization, youth and families extend the changes made during treatment into new situations and systems
- A primary focus is on anticipating future triggers for relapse and high risk situations and developing and practicing strategies that can be implemented to prevent relapse

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Outcomes

- Youth Remains in Home & School
- Improved Peer Relations
- Improved Family Functioning
- Fewer Behavior Problems
- Reduced Youth Substance Use

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Implementation Science – Bridging the gap between research and practice

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Client Benefits

Performance Assessment (Fidelity)

Systems Intervention

Competency

Coaching

Organization

Facilitative Administration

Training

Integrated & Compensatory

Decision Support Data System

Selection

Leadership

Fixsen, Panzano, Naoom, & Blasé, 2008

Legislative changes

- MTFC is a hybrid between institutional placement and foster care
- Until recently the legal position of MTFC was unclear
- MTFC is now legally defined as an «institution with homes»
- New regulations are in progress, and will define:
  - The use and limits for use of ”force” for treatment purposes
  - The obligations of the treatment team and foster home
  - The competency demands on the team and foster home
  - The need for a supervisor with responsibility for all aspects of the treatment
  - The material demands on the foster home to be used
  - The need for quality assurance of the treatment

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Norwegian Program Monitoring Results for MST

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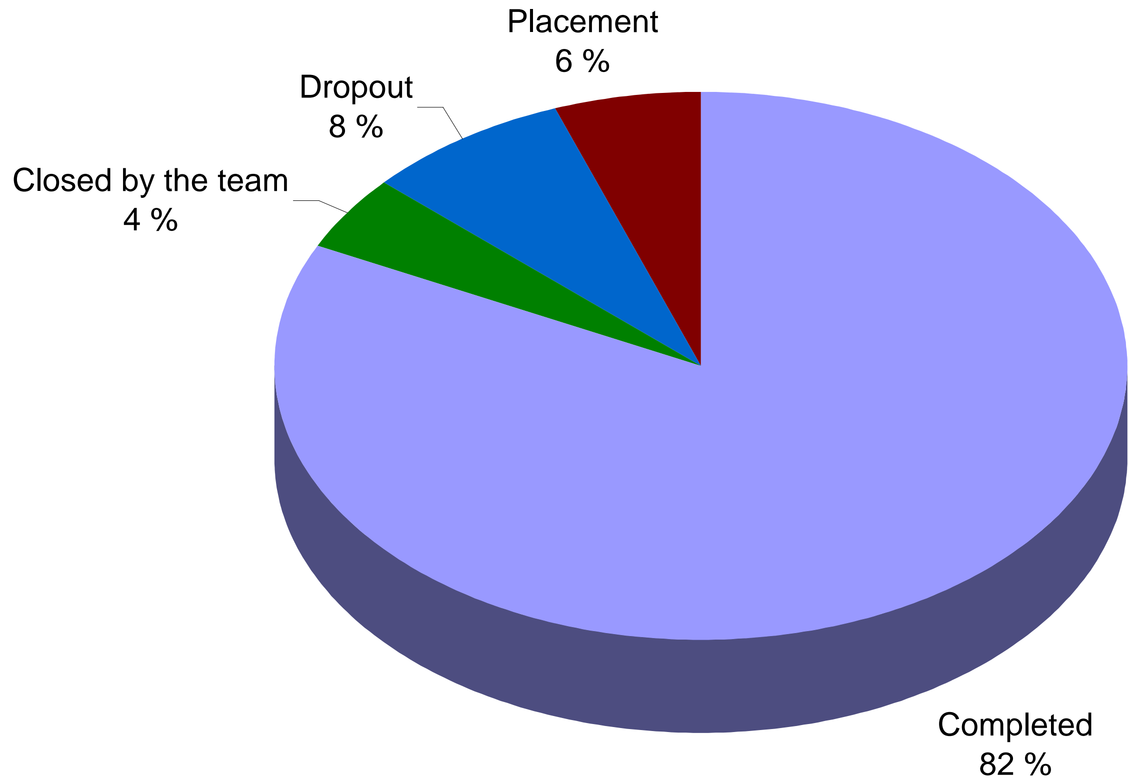
Completion rate



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Age

35 %
30 %
25 %
20 %
15 %
10 %
5 %
0 %

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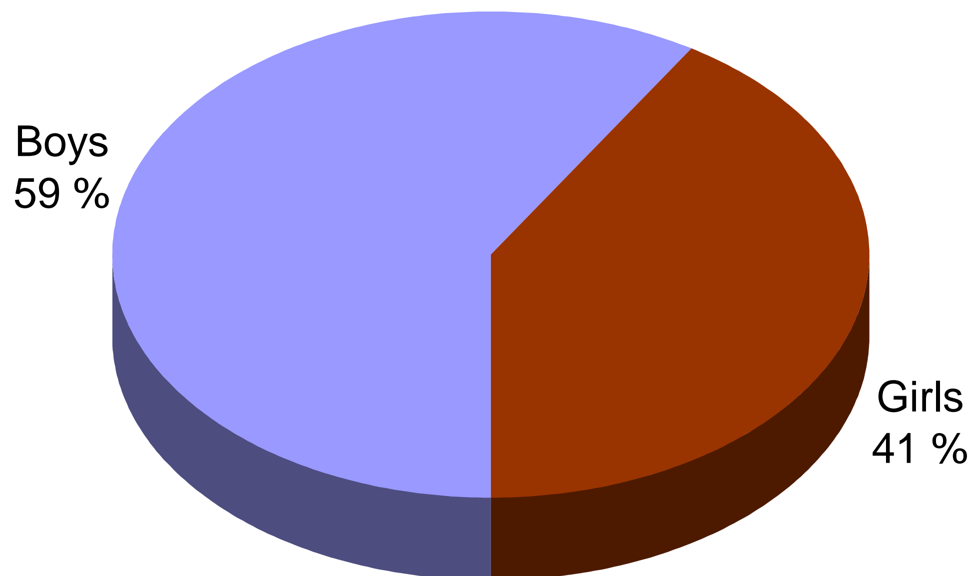
Gender



YLS/CMI: Risk domains

- Prior and current offences/dispositions
- Family circumstances/parenting
- Education/Employment
- Peer relations
- Substance abuse
- Leisure/recreation
- Personality/behaviour
- Attitudes/orientation

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Risk level (YLS)

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Lives at home (completers)

	Admission	Discharge	6 mths	12 mths	18 mths
Lives at home	93 %	97 %	89 %	85 %	83 %

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Attends school/work

Admission	Discharge	6 mths	12 mths	18 mths
26 %	88 %	82 %	80 %	80 %

100 %
90 %
80 %
70 %
60 %
50 %
40 %
30 %
20 %
10 %
0 %

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Abides the law

	Admission	Discharge	6 mths	12 mths	18 mths
Abides the law	57 %	96 %	91 %	90 %	92 %

100 %
90 %
80 %
70 %
60 %
50 %
40 %
30 %
20 %
10 %
0 %

Does not abuse substances

	Admission	Discharge	6 mths	12 mths	18 mths
Does not abuse substances	56 %	90 %	85 %	84 %	86 %

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Refrains from violence