

# The Evidence-Based Treatment Dissemination Center (EBTDC): Bridging the Research-Practice Gap in New York State

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In recent years, public recognition of the existence of scientifically validated or evidence-based treatments (EBTs) for children and adolescents with mental health problems has expanded (e.g., Chorpita, 2003; Hermann et al., 2006; Hoagwood et al., 2001). However, despite acknowledgement of these empirically based treatments, a substantial gap exists between their development and their adoption in community practice (Henderson et al., 2006; Kazdin, 2001). Several reports have documented that it can take up to 15 years for treatments that have been found to be efficacious and effective to become a part of routine clinical practice (Institute of Medicine, 2001; U.S. Department of Health and Human Services, 1999). As a consequence, few effective treatments for children and adolescents are broadly available (Bickman, 1996; Burns & Hoagwood 2004; Hoagwood & Burns, 2005; National Association of State Mental Health Program Directors [NASMHPD] Research Institute, 2005; Weissman et al., 2006; Weisz, 2004).

There are many explanations for the slow adoption of these treatments into routine practice. One reason may be the complications that arise when research-based treat-

ments are moved into the unpredictable and often chaotic world of routine practice. In the recent past, there has been an emphasis on the development of treatments in controlled (i.e., research) settings with highly trained clinicians (often doctoral students) who are supervised by the treatment developer, as opposed to the development of treatments indigenous to and developed within routine practice (e.g., Weisz et al., 1995). Weissman et al. (2006) cite a lack of commitment to EBTs in psychotherapy training programs as another cause of the research-practice gap.

Even if a commitment is made to bringing EBTs to widespread community practice, many system barriers exist for successful dissemination (Hoagwood et al., 2001;

to improve the quality of clinical care for youth and families in the system through statewide training, consultation, and support in the use of a variety of EBTs. The New York State Office of Mental Health (OMH) has contracted with Columbia University to provide expert consultation and support to front-line clinicians and supervisors.

Several factors led to the development of this training center. One of these was the creation of a service and evaluation program after the attacks of 9/11 to provide clinical services to children and adolescents who had experienced trauma related to the attacks. The Child and Adolescent Trauma Treatments and Services Consortium (CATS) was created as a state-provider partnership involving nine

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Schoenwald & Hoagwood, 2001). For example, use of EBTs may require smaller caseloads, more direct forms of supervision, and continuous monitoring of symptoms and functionings. These are generally not built into the performance or accountability standards commonly in use in public clinics (Schoenwald et al., in press).

## Impetus for the Evidence-Based Treatment Dissemination Center: The CATS Program

To address the disparity between research evidence and clinical practice, a growing number of U.S. states are beginning to experiment with different ways of incorporating EBTs into state-level training and dissemination initiatives. New York is one such state. In 2005, New York began a broad EBT training and dissemination program, the Evidence-Based Treatment Dissemination Center (EBTDC). The program, the first of its kind in New York State, is an initiative

community-based organizations in New York City; its primary mission was to train and support front-line clinicians in the delivery of evidence-based trauma treatments for children with moderate to severe trauma symptoms within a 15-mile radius of Ground Zero. An additional, much broader goal was to formally evaluate this EBT training initiative, not only in terms of its outcomes (i.e., whether trauma symptoms are reduced), but importantly in terms of the feasibility of its implementation processes (e.g., training clinicians, providing consultation, embedding ongoing monitoring/tracking, retaining families). Full details of this project are available in a series of papers; for more detailed information on the CATS project, see McKay et al. (2004).

The successes of the CATS project, coupled with growing interest in evidence-based treatment dissemination among community

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practitioners, and the recognition and dedication to advancing evidence-based mental health services by the New York State OMH, led to the creation of the EBTDC. This paper describes that initiative.

### EBTDC Project Goals and Key Research Questions

Aside from the immediate goal of training clinicians and supervisors across the state, the broad goals of the EBTDC build upon the experience of CATS and the growing scientific knowledge of EBTs and effective dissemination. To this end, we have embedded a quality improvement evalua-

### The EBTDC Model

The EBTDC project model has been created to address the limitations of past treatment training models. For instance, because studies have indicated that brief trainings alone do not lead to changes in clinicians' behaviors (Bero et al., 1998; Bickman, 1999), the EBTDC uses a two-phase approach:

- An intensive three-day training workshop; and
- A full year of biweekly phone consultation with the Columbia University consultation team.

**Trainings.** The first day of training focuses on numerous aspects of both EBTs

of the mandatory assessment measures used in the project to determine the appropriateness of the treatment for potential clients and to monitor ongoing treatment progress throughout the course of treatment. Clinicians are asked to obtain these assessments at three points in time—intake, midpoint, and discharge (see Table 1 for descriptions of the assessments and for the schedule of assessment collection). Clinicians provide depression- or trauma-focused treatment only if the child meets the appropriateness criteria.

The subsequent two days of the training focus on the specific evidence-based treatments and are led by the respective expert treatment developers or an individual designated by them, such that one day focuses on cognitive behavioral interventions for children and adolescents with depression (Curry & Stark, 2006; for more information on cognitive behavioral interventions for children and adolescents with depression, see Stark, 1990) and the other focuses on trauma-focused cognitive behavior therapy (TF-CBT; Cohen et al., 2006; for more information, see <http://tfcbt.musc.edu/>).

**Consultation Calls.** The consultation piece is designed to guide clinicians in

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## *Is it possible to train 400 people statewide in EBTs and provide high quality biweekly consultation for an entire year?*

tion into the EBTDC in order to examine three main aspects of this new project:

1. *Assess the feasibility of large-scale EBT dissemination.* Simply put, is it possible to train 400 people statewide in EBTs and provide high quality biweekly consultation for an entire year? It is crucial to analyze and assess the processes involved in not only implementing a widespread dissemination project, but also examining the practicality of sustaining it.
2. *Track clinician participation and progress.* A second goal of the project consists of monitoring and tracking clinician participation in the project. This includes tracking *learning* (clinician performance on a pre- and post-training knowledge test about the treatments and their application), *satisfaction* (clinician scores on a pre- and post-training satisfaction survey and attitudes toward evidence-based treatments survey), and *completion criteria* (whether participants comply with the specified criteria for completion).
3. *Identify barriers to large-scale EBT dissemination.* A final goal of the EBTDC is to identify what barriers stand in the way of a large-scale dissemination of EBTs. The primary method of identifying such obstacles is clinician reports on difficulties in implementing the treatments.

and CBT, including an introduction to cognitive behavioral strategies and case conceptualization from a cognitive behavioral perspective. The remainder of the first day focuses on training clinicians in the use

**Table 1: Schedule for EBTDC Clinical Assessment Measures**

	Description	Intake Assessment	Midpoint Assessment	Discharge Assessment
<b>Parent and Youth Measures</b>				
SDQ	Brief behavioral screening questionnaire, used to give indication of symptoms and other comorbid problems that may be occurring	X	X	X
PTSD-RI*	Assessment of trauma exposure and symptoms of posttraumatic stress disorder	X	X*	X*
<b>Clinician Measures</b>				
CDRS-R	Measure of child depression, as rated by the clinician via interviews with both child and parent	X	X	X
CGAS	Objective measure of children's overall functioning, as assessed by the clinician	X	X	X

Notes: SDQ = Strengths and Difficulties Questionnaire (Goodman, 1997); PTSD-RI = Post Traumatic Stress Disorder Reaction Index (Steinberg et al., 2004); CDRS-R = Children's Depression Rating Scale, Revised (Poznanski & Mokros, 1995); CGAS = Children's Global Assessment Scale (Shaffer et al., 1983).

\* The PTSD-RI was administered after intake only if the client was receiving trauma-focused CBT.

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the actual application of the treatments to the complex community cases with which they work, provide ongoing consultation and problem-solving on cases, and provide continued support and training in the use of assessment tools or specific treatment techniques (e.g., cognitive restructuring, behavioral activation).

Ninety-minute consultation calls are conducted once every two weeks, lasting for a year after the initial three-day training. Four Ph.D.-level clinical consultants divide the calls, yielding approximately 10 biweekly calls per consultant. For the first year, the number of clinicians on each call has ranged from seven to 18, with an average of approximately 12 clinicians. Although not required, supervisors of participating clinicians are strongly encouraged to attend consultation calls on a regular basis—especially when their clinicians are formally presenting cases.

Although there is some stylistic variation among consultants, consultation calls generally adhere to a consistent structure across consultants. The structure consists of the following elements:

- *Agenda setting and brief check-in* (e.g. taking attendance, setting an agenda);
- *Formal case presentations* (clinicians present their case in depth and follow a standardized case presentation form as part of their three-presentation requirement);
- *Brief case review* (a more informal “round robin,” brief discussion of how cases and treatments are going); and
- *Intervention and program issues* (consultants discuss or provide didactic instruction on an aspect of one of the treatment interventions).

**Criteria for Completion.** Clinicians are informed that in order to receive a certificate of completion from OMH, they must comply with the specific completion criteria required by the project (for a categorical listing of the criteria required for completion, please see Table 2). Participants who do not fulfill the completion criteria are divided into two categories:

- *Dropouts* are clinicians who notify program staff that they are withdrawing and indicate a reason, or who attend less than 50% of the calls with no explanation.

- *Non-completers* are fairly regular participators who do not meet all of the above requirements for completion.

measuring their satisfaction, knowledge of treatments, and feelings toward CBT/EBTs. See Table 3 for a complete listing

***Because we want to make sure that we are able to see what is working and what is not, participants are required to complete various assessments measuring their satisfaction, knowledge of treatments, and feelings about CBT/EBTs.***

**Feedback and Clinician Data Measures.** The EBTD is still in its early program evaluation stages, so participant feedback and other measures are an integral part of the model. Because we want to make sure that we are able to see what is working and what is not, participants are required to complete various assessments

of clinician data measures that were used for EBTD program evaluation.

**Two-Year Cycle.** Although this first iteration of the EBTD focuses on dissemination of trauma- and depression-focused treatments for youth and adolescents, future

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Category	Requirement
Training	Attend the three-day training and complete the 10-hour trauma-focused CBT web course
Attendance	80% or better on consultation calls
Assessments	Use of OMH-mandated assessment measures with clients
Case presentations	Three case presentations on consultation calls
Case completion	Completion of full manual treatment with at least one trauma or one depression case

Clinician Data Measure	Pre-Training	Post- Training	After One Year of Consultation
Demographic information	X		
Satisfaction with three-day training session		X	
Knowledge about CBT-trauma treatment	X	X	X
Knowledge about CBT-depression treatment	X	X	X
Beliefs survey about implementing EBTs	X	X	X
Clinician attendance on consultation calls*			X
Satisfaction with year-long EBTD consultation			X

\*Clinician consultation call attendance was tracked throughout the year.

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year planning will entail training and consultation on other EBTs, each selected for a two-year cycle. The ultimate goal is to “retool the workforce” in public mental health services for children.

participating in the first year of the EBTDC have been predominately female (82%), have been social workers (78%), have been working in outpatient settings (89.5%), and have had “some” prior CBT experience (50.2%). The majority of participants identify themselves as white (76.1%), although participants

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### What We Have Found

**Clinician Population: Who Participated?** The 417 clinicians and supervisors

of various ethnic backgrounds have been involved. For a complete breakdown of demographic information, please see Table 4.

**Table 4: Demographic Information for Participating Clinicians and Supervisors**

Gender	Number Responding	Percent
Male	73	18.0
Female	327	82.0
<b>Ethnicity</b>		
Black	23	5.7
Latin	55	13.6
Asian	11	2.7
White	306	76.1
American Indian/Alaskan Native	4	1.0
<b>Discipline</b>		
Social work	315	78.5
Marriage, family & child counselor	56	14.0
Psychology	30	8.0
<b>CBT experience</b>		
None	17	4.3
Little	102	25.8
Some	199	50.2
A lot	73	18.4
Expert/Certified	5	1.3
<b>Clinical work setting</b>		
Outpatient	359	89.5
Inpatient psychiatric unit	6	1.5
School	21	5.2
In-home services	3	0.7
Other	12	3.0

**Retention and Engagement: Did People Keep Coming Back?** Overall, clinicians have had good attendance on the follow-up consultation calls. As of July 18, 2007, the overall attendance rate for participating clinicians was 83.3%. See Table 5 for complete clinician attendance statistics overall and by consultant.

Another good sign for the project is the relatively low participant dropout rate. Of the 417 mental health professionals who were trained, only 79 clinicians and 21 supervisors have discontinued participation, for an overall retention rate of 76%. The majority of those who did drop out indicated that they did so for reasons unrelated to the project itself (see Table 6).

**Clinician Satisfaction: Were Clinicians Satisfied With the Training and Consultation?** Clinicians indicated that they were satisfied with their participation in EBTDC, both with the training and year-long consultation. Using a five-point Likert scale (ranging from 1 = very negative to 5 = very positive), clinicians indicated that they found the trainings to be highly beneficial (see Table 7).

It is also worth noting that clinicians' attitudes toward evidence-based treatments, as measured by an internally constructed EBT beliefs survey, changed significantly from pre- to post-training. On a five-point Likert scale (1 = very negative attitude toward EBTs to 5 = very positive attitude toward EBTs), more clinicians had positive attitudes toward EBTs after the training ( $M = 4.1$ ) than beforehand ( $M = 3.9$ ;  $p < 0.001$ ).

After the year-long consultation, the majority of clinicians gave positive feedback toward EBTDC. For the assessment portion of the project, 83% of participants reported that they will continue to use the assessments, 73% reported assessments were helpful in determining treatment appropriateness ( $M = 4.09$  on a five-point Likert scale, with 1 = not helpful at all and 5 = very helpful), and 54.6% reported assessments were helpful in determining clinical change in their clients ( $M = 3.59$ ). Participants indicated that they have been satisfied with the consultation calls as well; using the same five-point Likert scale, participants rated the overall quality of the consultation calls positively ( $M = 3.88$ ). Clinicians also perceived their consultants as being particularly helpful in guiding them in the clinical application of the treatments,

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including developing and modifying case conceptualization (M = 4.21), using assessment data to define treatment goals and symptoms (M = 4.09), and constructing treatment plans (M = 3.77).

**The Consultation Process: Effect of Consultant on Attendance and Completion Rates.** Statistical analyses were conducted to see if attendance rates and completion rates differed for clinicians based on who their consultants were. Attendance rates for each of the consultants were compared for the three consultants who completed calls to date. A one-way analysis of variance (ANOVA) revealed a significant difference between these consultants with regard to their clinician percentage attendance,  $F(2, 240) = 20.55, p < 0.001$ . A post hoc Tukey test confirmed this result, demonstrating that one consultant, Consultant #2, had significantly lower clinician attendance rates than the other two,  $p < 0.001$ .

Differences between consultants were also found in terms of how often clinicians fulfilled the completion criteria. A one-way ANOVA determined that the clinician completion rate differed significantly between consultants,  $F(2, 137) = 10.43, p < 0.001$ . A post hoc Tukey test demonstrated that it was Consultant #1 who had a much higher rate of completion than the other two consultants,  $p = 0.001$ .

Despite the significant variance between consultants in clinician attendance and completion rates, this was not the case for the dropout rate. A one-way ANOVA showed there was no statistically significant difference in dropout rate among consultants,  $F(2, 244) = 1.41, p = 0.25$ .

**What We Now Know About EBT Dissemination: Lessons Learned, Goals Revisited, Successes and Areas for Continued Improvement**

Although the EBTDC was never intended as a research project, everyone involved learned immensely. For the Columbia University and New York State OMH staff who make up the EBTDC team, we have learned how much effort, organization, and teamwork it takes to effectively disseminate EBTs across an entire state, as well as initial lessons in what works and what does not in such an endeavor. For the clinicians who participated in the EBTDC, there was an inevitable learning curve involved with gaining knowledge of the treatments and

their application (even more so for those who came into the project with little or no prior experience with EBTs or CBT). Because of this, it is encouraging to see that the project has been generally well received by the mental health practitioners who participated. Reviewing our goals, following are some of the primary lessons from the first year of the EBTDC:

**Feasibility: Is Large-Scale EBT Dissemination Achievable?** The short answer to this question is “yes.” Considering that this was the first EBT dissemination project on the state level, it is highly encouraging that more than three-quarters of the participants maintained their participation

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**Table 5: Clinician Attendance Rates by Consultant and Overall**

	Clinician Attendance (%)	Supervisor Attendance (%)
Consultant #1	88.5	60.1
Consultant #2	84.9	38.5
Consultant #3	84.1	49.1
Consultant #4	74.2	25.2
Overall	83.3	39.6

**Table 6: Clinicians and Supervisors Who Dropped Out and Their Reasons**

Reason for Dropout	Clinicians		Supervisors	
	N	%	N	%
Unknown	28	35.4	9	42.9
Ended employment	20	25.3	9	42.9
Time constraints	8	10.1	2	9.5
Scheduling conflict	8	10.1	0	0.0
No appropriate cases	5	6.1	0	0.0
Medical or maternity leave	4	5.1	0	0.0
Phone problems	3	3.8	0	0.0
Switching to OMH/Columbia school-based training	2	2.5	1	4.7
No longer interested		1	1.3	0
Total	79		21	

**Table 7: Mean Statewide Clinician Satisfaction With Training, by Day (N = 417)**

	CBT Overview Day	Depression Day	Trauma Day
	4.2	4.2	4.5
Content	4.1	4.1	4.4
Presenter	4.4	4.3	4.7
Overall	4.1	4.2	4.4

Note: Scores are based on responses on a five-point Likert scale ranging from 1 = very negative attitude toward the training to 5 = very positive attitude toward the training.

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in the program. Moreover, the most common reasons provided for those who did drop out (switching jobs/retirement, other time commitments, scheduling conflicts) were external factors, rather than concerns about the EBTD project itself. The fact that, to date, 82.7% of clinicians have fulfilled the completion criteria further

generally had very limited experience in using, administering, scoring, and interpreting assessment measures. Although clinicians understood from the beginning that all assessments were required to be conducted prior to treatment in order to determine treatment appropriateness, completing the full assessment battery has sometimes led to difficulties in engaging clients. However, encour-

disorders (e.g., externalizing) or have other characteristics preventing their eligibility for EBTD (e.g., psychotic symptoms or extreme violence).

- *Difficulty maintaining clients in treatment.* Clinicians have also reported that engaging clients in assessment after clinic intake can be problematic. Part of this difficulty may be due to the above-mentioned time burden of the assessments and clinicians' discomfort with the change in their typical clinical practice. However, there are other factors that are likely influential as well, such as motivation of the client's family in treatment and client frustration with the length of time needed for assessment before treatment. Despite this concern, the dropout rate for EBTD cases may not be higher than the rate typically found among New York State clinics. Analysis of this is underway.

- *Time burden.* Even if they been able to retain an appropriate trauma or depression case, some clinicians feel that adequately participating in the EBTD is time intensive. As mentioned above, some clinicians feel that the assessment measures take more time to administer than their typical clinic protocol. Of course, the time crunch was not due just to the assessments; clearly clinicians are asked to attend the initial three-day training, complete the 10-hour trauma treatment online course, participate in the biweekly phone calls, and set aside weekly client preparation time for each session with clients. Because clinicians were balancing their participation in EBTD with other clinical duties and clinic demands, the time contribution for EBTD was a notable difficulty for some. It is worth noting that clinicians participating from agencies that were committed to making these treatments a part of their routine clinical practice (and those from agencies that are cognizant of the time it takes clinicians to participate and garner the maximum skill from the program) did not experience the same problems with time.

- *Bureaucratic "red tape."* The ease with which clinicians participated in training was also likely affected by the level of bureaucracy at their respective agencies. There is usually a degree of difficulty involved in learning new clinical techniques; however, according

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suggests that they were indeed engaged in the project, despite its relatively time-intensive nature. With the proper support from the state, provider agencies, and experts in treatment development and consultation, large-scale EBT dissemination is certainly possible.

**Tracking Clinician Participation and Progress.** Keeping tabs on 417 clinicians and supervisors—their attendance, case presentations, learning, and evaluation—is somewhat daunting, but it has nevertheless been accomplished. For each of the 35 consultation call groups, the consultant was given a template on which to take attendance, log notes on specific cases, and make note of when each clinician made a formal presentation and/or completed a case. Attendance was taken on every phone call by the consultant and then logged into the larger data system. A database was created for further analysis of attendance data, as well as pre- and post-training attitudes toward EBTDs, satisfaction, and learning data. The ability to keep track of so much information has proven to be necessary in order to evaluate the project to the fullest extent possible.

**Barriers to Large-Scale EBT Dissemination.** As mentioned above, a final goal of the EBTD is to identify the barriers to the large-scale dissemination of evidence-based practices. The following is a list of such difficulties reported by clinicians:

- *Problems using assessments.* Despite the relevance of the assessments to the treatments, clinicians have reported that the assessments often either took too much time or were too difficult to interpret. This is unsurprising, because the group

agingly enough, over time, clinicians have expressed less frustration with the assessments, after gaining experience in using them. Moreover, while some of the assessment measures have caused difficulty, others have been more well received, specifically self-report and informant-report measures that could be administered in the waiting room and scored and interpreted easily (e.g., via the computer with an automatic score report generated). On yet another positive note, many clinicians stated at the end of the year that the training and use of these assessment measures made an indelible impression, and they reported that they now consider the assessment process and the information gained a critical aspect of the treatment process and critical to their ability to successfully treat a case.

- *Difficulty in finding appropriate clients.* Many clinicians indicated that finding clients who fit in with the treatment criteria has been problematic. This has been caused by a number of reasons. For example, some clinicians work for agencies that simply did not treat many children or focused on the treatment of other problems (e.g., ADHD). Others have found that although they see many traumatized and depressed children on a regular basis, often these problems are not the primary diagnoses. Another difficulty that has been raised by clinicians is that even if they encounter a substantive number of depression and trauma cases, too often the cases fit exclusionary criteria for the project, such as comorbidity with other

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to participant feedback, the level of commitment by mid-level administrators and/or supervisors varied greatly among agencies. Naturally, clinicians who worked at agencies where there was not a great deal of investment in the project faced greater difficulty in their learning. For other clinicians, it was problematic to balance the particular demands of their agency (e.g., productivity quotas) with learning new techniques.

**Another (Unexpected) Lesson.** Another important lesson we learned (albeit somewhat unexpectedly) is that despite our best efforts to standardize the consultation process, not all consultation is created equal—that is, who the consultant was made a significant impact on the attendance rate of clinicians in the project. From this, it is apparent that consultant style may be important in the engagement of clinicians. However, at this point we do not know exactly what style may maximize clinician motivation.

### Areas for Improvement and Future Directions

A number of issues are currently being considered for future EBTDC training efforts. These include:

**Tracking Clinical Outcome.** Year one of the EBTDC has tracked clinician satisfaction, attendance, etc., but has not tracked clinical outcome. Clearly, the core goal of a large-scale EBT dissemination effort is to help those individuals using clinical services get better. However, although clinician satisfaction was surveyed and engagement tracked throughout the project, we have not yet been able to track client improvement in mental health symptoms and functioning in this iteration of the EBTDC program. This is due to a number of reasons. The need to meet time constraints of participating agencies (including meeting project deadlines agreed upon by OMH and Columbia University), clinician burden, and complex IRB issues all precluded assessment at the client level in the first year. However, in future years of the EBTDC, it is hoped that some information on clinical progress will be tracked. That way, it will be more feasible to further evaluate the impact of the EBTDC on client functioning and clinical improvement.

**How Long Is “Just Right” for the Duration of Consultation Calls?** The decision was made by the EBTDC design

committee to have follow-up consultation calls for a year after the initial three-day training. However, we do not know if this was the ideal length of time. In fact, there is at least anecdotal evidence to the contrary—attendance records indicate that there was a noticeable drop-off in attendance beginning around the six-month period, and, similarly, the majority of dropouts occurred after roughly six months. Consequently, next year’s EBTDC will not only keep track of the exact time that clinicians drop out, but will also measure clinician satisfaction at the six-, nine- and 12-month periods of consultation.

model, it would be unrealistic to think that once clinicians participate in the initial training and get on the phone once every two weeks that they will automatically be masters of the treatments in which they were trained. Rather, it is up to their supervisors to facilitate this process, making sure that clinicians are using the proper techniques, and answering any issues that might come up. Given the great importance of supervision, in the second year of the EBTDC, there will be a monthly call with supervisors and EBTDC consultants to help supervisors get more involved in the dissemination

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## *The significant difference between consultants in clinician attendance and completion rate suggests that clinician retention and engagement truly depends on the individual qualities of the consultant.*

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**What Makes for a Good EBT Dissemination Consultant or Consultation Call?** We do not know what explicitly makes for a good EBT dissemination consultant or consultation call. The ability of each consultant to engage clinicians under his/her watch is crucial in a large-scale dissemination effort. The significant difference between consultants in clinician attendance and completion rate suggests that clinician retention and engagement truly depends on the individual qualities of the consultant. While at this point we do not know what exactly has caused this main effect of consultant on clinician attendance, future iterations of the EBTDC will seek to know what makes for a quality consultation. In fact, an EBTDC consultant manual is already in the works in an attempt to further systematize the consultation process and the material covered in the calls.

**Supervisor Participation.** Supervisor participation is important but has not been a requirement in year one. During the first year of the EBTDC, supervisors have been encouraged to participate in consultation calls but have not received any specific consultation on supervision practices in CBT. Perhaps not surprisingly, the participation of clinicians’ immediate supervisors has ranged from nonexistent to extremely heavy. Supervision is important in any kind of clinical psychology setting, but it is even more imperative on a large scale such as this. As optimistic as we are about the EBTDC

process. Moreover, we believe that the participation of supervisors is not only crucial for initial learning but will also prove to be extremely important in terms of sustaining the use of these treatments in OMH-licensed clinics in the long term.

**Future Modifications.** Based on what we initially planned and what we learned—as well as participant feedback—the following are changes planned for future iterations of EBTDC:

- *Modify assessment battery:* The next year of the EBTDC is incorporating clinicians’ suggestions and using fewer clinician-interpretive measures.
- *Extend EBTDC training to incorporate other mental health disorders:* Clinicians have expressed a keen interest in extending the EBTDC to treat other disorders, especially oppositional defiant disorder (ODD) and other disruptive behavior disorders. While year two will still include depression- and trauma-focused CBT, plans are already underway to incorporate other interventions in future EBTDC installments.
- *Shorten consultation calls and make them more individualized:* Although consultants have done their best to give personal attention to each clinician on consultation calls, some clinicians have felt that they could benefit from

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more individual consultation. However, it has been found that clinicians expressing this concern generally have been participating in calls with more than 10 clinicians. To try to resolve this issue, we are imposing a limit of

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seven clinicians and supervisors on each consultation call for the second year of the EBTDC.

- *More consultation on engagement and working with difficult parents:* Clinicians and supervisors alike have reported that one of the biggest barriers in providing the treatments is either too little or too much involvement from the families. This is a crucial issue not just in the EBTDC, but in mental health treatment in general. To do more investigation on this matter, an offshoot project involving EBTDC, client engagement, and family empowerment is planned for September of this year.

Although the EBTDC remains an ever-evolving project, it is noteworthy that New York State has undertaken this kind of intensive effort to bridge the gap between research and practice. To the best of our knowledge, this is one of only a handful of state-level initiatives to train front-line clinicians on specific empirically validated therapies for children (Bruns & Hoagwood, in press; Bruns et al., in press). With year two already underway, and nearly 400 additional clinicians and supervisors signed up for upcoming trainings, we believe that this model holds promise for redirecting clinical practice toward more evidence-based methods and for providing a useful guidepost for other initiatives disseminating systemic evidence-based practices.

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