CLOSING THE QUALITY CHASM IN CHILD ABUSE TREATMENT: IDENTIFYING AND DISSEMINATING BEST PRACTICES

The Findings of the Kauffman Best Practices Project

to Help Children Heal From Child Abuse.

FOREWORD

Over the past 27 years, inspired by the leadership of Dr. David Chadwick, the Center for Child Protection at Children's Hospital - San Diego has made a major commitment to the prevention, treatment, and education of child abuse and neglect. The Center for Child Protection (renamed The Chadwick Center for Children and Families in 2002) is now the most comprehensive multidisciplinary program in the country connected to a children's hospital. We have been pleased to be active participants in the National Call To Action, a unique social movement aiming to end child abuse in America.

Over the last 10 years, Children's Hospital - San Diego has made a major commitment to relentlessly improving all phases of the quality of care it provides through rigorous use of clinical pathways developed based on the best evidence available. Coordinated by our Center for Child Health Outcomes, over 65 pathways have been developed covering 35% of the children we treat with a 90% compliance rate. We have greatly benefited from the leadership and work of Dr. Donald Berwick and the Institute for Healthcare Improvement (IHI) in Boston, and from being part of the Child Health Accountability Initiative (CHAI) – a collaborative with other Children's Hospitals to improve care.

One of the lessons learned from IHI and the pioneering study "Crossing the Quality Chasm" by the Institute of Medicine was the tremendous gap between best care and everyday care in hospitals and office practices, and the fundamental system changes that were needed to close this chasm. It occurred to us that the child abuse field could benefit by learning from many of the methodologies designed by the IHI and building them on to identified best practices in child abuse.

We set out to engage some of the nation's leaders in child abuse and asked their guidance in how the best thinking of both fields could be brought together. We are particularly grateful to Dr. Ben Saunders and to the other advisors, many of whom are active members of the National Child Traumatic Stress Network, mentioned in this document for their contributions. We are also grateful to the Ewing Marion Kauffman Foundation for their support of this work. We hope that this document will stimulate further collaboration between the healthcare and child abuse fields, and will accelerate the improvement of care provided so that, one day, every child in America who is the victim of abuse will receive the best treatment provided in the most effective way.

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In 2001 alone, 2.6 million reports of child abuse were made to child protection authorities, resulting in over 600,000 substantiated cases involving over 900,000 children (ACYF, 2003).

CLOSING THE QUALITY CHASM IN CHILD ABUSE TREATMENT

The Findings of the Kauffman Best Practices Project to Help Children Heal From the Effects of Child Abuse.

Background: Child abuse touches the lives of millions of American children each year. In 2001 alone, 2.6 million reports of child abuse were made to child protection authorities, resulting in over 600,000 substantiated cases involving over 900,000 children (ACYF, 2003). Victimization surveys of adults and adolescents indicate that 8.5% of American youth have suffered severe physical abuse and, at least, 8.1% have experienced a completed rape (Kilpatrick, et al., 2003; Saunders, et al., 1999; Boney-McCoy & Finkelhor, 1995). The short and long-term effects of maltreatment in childhood are well-documented. Over 1300 children die each year at the hands of their caregivers (ACYF, 2003). Child abuse has been found repeatedly to be a major risk factor for many mental health disorders, emotional problems, behavior difficulties, substance abuse, delinquency, and health problems (Beitchman, et al., 1991; Beitchman, et al., 1992; Browne & Finkelhor, 1986; Duncan, et al., 1996; Felitti, et al., 1998; Fergusson, et al., 1996; Flisher, et al., 1997; Gomes-Schwartz, et al., 1990; Hanson, et al., 2001; Kendall-Tackett, et al., 1993; Kessler, Davis, & Kendler, 1997; Kilpatrick, et al., 2000; Kilpatrick, et al., 2003; Pelcovitz, et al., 1994; Polusny & Follette, 1995; Saunders, et al., 1992; Saunders, et al., 1999).

Millions suffer long term emotional consequences of maltreatment in childhood, including depression, anxiety disorders, posttraumatic stress disorder, alcohol or drug abuse, smoking, and relationship problems. These problems often lead to more subtle effects on behavioral choices in childhood and adolescence that shape later adult life styles and produce long term health impacts, sometimes including early death from heart disease and cancer (Felitti, et al., 1998). Despite tremendous efforts for prevention and intervention over the past thirty years, child abuse remains the most common type of major childhood trauma today, and its impact is pervasive in society.

Many of the nearly one million children identified as abused or neglected each year are offered some form of intervention designed to make them safe, and to help them recover from the after-effects of the maltreatment. These children and families are seen by a wide range of practitioners, working in a variety of practice settings. They offer a dramatic, often dizzying, array of interventions. Twenty years ago, as child abuse emerged as a major topic in the clinical intervention literature, most treatment providers were guided by their past training and experience. Mental health practitioners naturally tended to deliver treatment they were familiar and comfortable with, and presumably skilled in. Interventions developed for populations of children, families, and adults commonly seen in clinical practice were applied to victims of child abuse and their families. At the same time, prominent figures in the developing child abuse community shared their treatment ideas and experience through books, professional journal articles, and lectures at child abuse conferences across the nation. What was considered to be best practice at that time emerged from this mix of applying existing ideas to cases of child abuse and emerging anecdotal clinical reports from well-known practitioners who produced professional writings. Empirical data from scientific evaluations of treatments used with abused children and their families were not part of this discussion because it did not exist.

The past two decades have seen considerable efforts devoted to exploring the treatment of child abuse in a more systematic manner. Particularly in the past five years, a significant body of empirical research has emerged supporting the efficacy of certain treatment protocols with abused children and their families (Cohen, et al., 2000). Saunders and colleagues (2003) described 16 treatment protocols for abused children and their families that had at least some empirical support. At the same time, sophisticated research on the prevalence and characteristics of particular outcomes associated with child abuse, and the biological, psychological, and social mechanisms that explain these relationships has been conducted (Boney-McCoy & Finkelhor, 1995; Cicchetti & Carlson, 1989; Caspi, et al., 2003; Kilpatrick, et al., 2003; Moffit, et al., 2004; Pynoos, et al., 1995; Saunders, et al., 1999; Wolfe, 1999). This body of research has enhanced the theoretical development and refinement of empirically based interventions. Additionally, the shared direct practice experience with abused children and their families of thousands of clinicians has contributed to more useful and deliverable treatments. Thus, the past twenty years have seen theoretical, empirical, and clinical developments that can guide practitioners

In the past five years, a significant body of empirical research has emerged supporting the efficacy of certain treatment protocols with abused children and their families.

far more effectively than the mix of interventions traditionally relied upon to treat child abuse victims. While there is still much to learn and current knowledge has likely only begun to scratch the surface of understanding the most effective means of helping these children and their families, it is clear we now know enough about the outcomes of child abuse and efficacious treatments to deploy those ideas across the nation in more systematic ways.

Despite the emerging evidence regarding effective treatments, there is a strong perception by many leaders in the field that use of this evidence in a reliable way is still rare in the child abuse field.

Despite the emerging evidence regarding effective treatments, there is a strong perception by many leaders in the field that use of this evidence in a reliable way is still rare in the child abuse field. The slow pace of diffusion of best practices is not unique to child abuse or even mental health. Indeed, the Institute of Medicine found that it requires 17 years for scientific knowledge generated in randomized clinical trials to be routinely incorporated into everyday medical practices across the nation (IOM, 2001). Likewise Torrey and colleagues writing in Psychiatric Services, noted "practices validated by research are not widely offered in routine mental health practices settings" (Torrey, et al., 2001). The same is true in the child abuse field as evidence based practices remain remarkably rare despite considerable publication in peer reviewed journals, books, innumerable conference presentations and available training.

In this context, the Ewing Marion Kauffman Foundation in Kansas City agreed to support the systematic identification of best practices on helping children heal from the impact of child abuse, and spread those effective interventions. This effort was conducted under the broad overview of the National Call To Action: A Movement to End Child Abuse and Neglect (NCTA). The National Call is an unprecedented collaboration of major national organizations concerned with child abuse including Prevent Child Abuse America, the National Children's Alliance, the National Association of Children's Hospitals and Related Institutions, the American Medical Association, American Academy of Pediatrics, Parents Anonymous, Child Welfare League of America, Children's Hospital-San Diego and others (see www.nationalcalltoaction.org). This coalition is committed, in the decades ahead, to the long-term elimination of child abuse. The Board of Directors of the National Call To Action quickly realized that professional organizations were important but not enough to achieve the mission. The Board concluded what was needed was a national movement of those more personally affected by abuse: the survivors of abuse and those parents whose children were touched by abuse. This component of the National Call emerged in a shared leadership role as the "Authentic Voices" and is serving as the epicenter of a nascent social movement that some day will involve millions of Authentic Voices in a coordinated effort to end child abuse through collective action, and social and political advocacy.

The work of the Best Practice Project has been led by the staff of Children's Hospital San Diego, one of the founding members of the National Call To Action, and it's Chadwick Center for Children and Families. The Chadwick Center (formerly the Center for Child Protection) is one of the oldest and largest hospital-based multi-disciplinary child abuse and family violence programs in the world with over 120 staff working from over ten locations in San Diego, California and providing professional education around the world. Among the services offered by the Chadwick Center is the Trauma Counseling program providing specialized trauma assessment-based therapy to over a thousand children each year through a staff of over 40 therapists.

In 2002, the Chadwick Center was selected by US/HHS-Substance Abuse and Mental Health Administration (SAMHSA) to serve as one of ten (at that point) Intervention Development and Evaluation Centers in the nation. These centers are part of the SAMHSA funded National Child Traumatic Stress Network (NCTSN). This network, under the leadership of the National Center for Child Traumatic Stress at UCLA and Duke, is composed of many of the nation's most prominent centers in the research and treatment of childhood traumatic stress from all forms of trauma ranging from child abuse and exposure to domestic violence, to painful medical procedures, and on to terrorism and major natural disasters. The National Center and Network joined forces with the Chadwick Center and National Call To Action to conduct this project.

To lead this undertaking, the Chadwick Center reached out to Benjamin E. Saunders, Ph.D., to act as lead consultant on the project. Dr. Saunders is Professor and Director of the Family and Child Program of the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. As a therapist, researcher, educator, and administrator, Dr. Saunders brought 25 years of experience with all aspects of clinical treatment in the child abuse field to this project. His research on the epidemiology and impact of child abuse has been funded by a variety of federal agencies, including the National Institute of Mental Health, the National Institute on Drug Abuse, the National Institute of Justice, the Centers for Disease Control and Prevention, and the U. S. Department of the Navy, and he has a conducted a treatment outcome study funded by the National Center on Child Abuse and Neglect. Most relevant to this project, Dr. Saunders recently directed a project funded by the U.S. Department of Justice to review current clinical research and practice and develop clinical treatment guidelines for victims of child physical or sexual abuse and their families (Saunders, et al., 2003). Currently, as part of his work with the National Child Traumatic Stress Network, he and his colleagues are conducting several projects to implement evidence-based practices for abused and traumatized children in a variety of youth-serving systems.

Significant Performance Improvement will only be accomplished by tackling dramatic, system-level changes.

Don Berwick

Candidate practices were sought that met several minimum criteria.

Working with Dr. Saunders, the Chadwick Center invited a broad range of nationally prominent researchers, treatment providers, and managers of clinical service delivery programs for victims of child abuse and their families from within and outside the NCTSN to act as advisors to the project. This group was supplemented by Authentic Voice representatives and well-respected service providers from Kansas City, suggested by the Kauffman Foundation staff to form the project's National Advisory Committee (see Appendix A). These advisors provided information, consultation, insight, and perspective that have been invaluable to the successful completion of the project. Through a working meeting of the full committee held at the Kauffman Foundation headquarters in Kansas City, several formal interviews and surveys conducted by telephone and E-mail, and numerous informal contacts, the Committee provided critical guidance at every stage of the project.

The first task before the Chadwick Center and its consultants was to identify three intervention protocols as "Best Practices" in helping children recover from the impact of abuse experiences, and that were likely to reduce the long-term consequences of maltreatment. Developing a strong consensus among project staff, consultants, and advisory committee members about the three clear choices as best practice interventions was crucial to the project. Therefore, significant time and effort were devoted to delineating the criteria for best practice candidates, reviewing the support for candidates, exploring challenges to the credentials of candidates, and conducting consensus building activities among participants.

This search for best practice candidates was limited to psychotherapeutic interventions primarily because the research literature on the use of pharmacological treatments with abused and traumatized children is very sparse, and little consensus has emerged. For the identification of best practices, the project staff, consultants, and members of the National Advisory Committee agreed to accept the premise that "best practice" did not mean "perfect practice." Participants in the project acknowledged that it was unlikely that any intervention protocol would be found that had been tested in scores of clinical efficacy and effectiveness studies, with a range of ethnic and cultural groups from diverse geographic settings, using practitioners with varying levels of qualifications working in many types of clinical settings. Virtually no intervention in the child mental health field has received such rigorous testing. Rather, candidate practices were sought that met several minimum criteria.

To be considered a candidate for best practice, a treatment protocol had to meet the following criteria concerning its clinical utility:

1. The treatment has a sound theoretical basis in generally accepted psychological principles indicating that it would be effective in treating at least some problems known to be outcomes of child abuse.
2. The treatment is generally accepted in clinical practice as appropriate for use with abused children, their parents, and/or their families.

3. A substantial clinical-anecdotal literature exists indicating the treatment's value with abused children, their parents, and/or their families from a variety of cultural and ethnic backgrounds.
4. There is no clinical or empirical evidence, or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
5. The treatment has at least one randomized, controlled treatment outcome study indicating its efficacy with abused children and/or their families.
6. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

In addition to these criteria supporting the efficacy of the treatment, the following criteria about its transportability to common clinical settings had to be met:

7. The treatment has a book, manual, or other writings available to clinical professionals that specifies the components of the treatment protocol and describes how to conduct it.
8. The treatment can be delivered in common service delivery settings serving abused children and their families with a reasonable degree of treatment fidelity.
9. The treatment can be delivered by typical mental health professionals who have received a reasonable level of training and supervision in its use.

Once these candidates were identified, the project focused on reviewing the support for each one, understanding their weaknesses in clinical or empirical support, and building consensus among the participants.

Identification of Best Practices

Under the leadership of Dr. Benjamin Saunders, the existing best practices literature was reviewed and several relevant sources of potential best practices were identified. These sources included the University of Colorado-Boulder's Blue Prints project (www.colorado.edu/cspv/blueprints), the work of the Hawaii Empirical Basis to Service Task Force (Chorpita, 2002), and the publications of the USHHS/ACYF Office of Child Abuse and Neglect. While these sources were valuable, the evidence-based practices described often targeted different populations of children. Other existing documents, such as the Emerging Practices in the Prevention of Child Abuse and Neglect, lacked a critical review of the evidence that supported their selection. One of the best existing sources for evidence-based practice relevant to this effort is the publication Child Physical Abuse and Sexual Abuse Guidelines for Treatment (Saunders, et al., 2003). These guidelines reviewed 24 treatment protocols often used with abused children and their families, and a brief description of each protocol was provided.

(TF-CBT)

Trauma Focused Cognitive Behavioral Therapy

(AF-CBT)

Abuse Focused Cognitive Behavioral Therapy

(PCIT)

Parent Child Interaction Therapy

Each of these protocols was reviewed by an advisory committee of experts in the treatment of problems related to child abuse (60% who subsequently served as advisors to the Kauffman Best Practices Project) and classified into one of six categories:

1. Well supported, efficacious treatment
2. Supported and probably efficacious treatment
3. Supported and acceptable treatment
4. Promising and acceptable treatment
5. Innovative and novel
6. Experimental or concerning treatment

Sixteen of the treatments were classified as category 3 or higher, meaning they had at least some empirical support for their efficacy. Of these 16, only one, Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), was identified in the most rigorous category, "Well supported, efficacious treatment". One other intervention, targeted at adult sex offenders, was rated in the second category "supported and probably efficacious treatment". And fourteen were judged to fit within the third category "supported and acceptable treatment." These treatment protocols constituted the initial pool of best practice candidates.

Through an ongoing process of information sharing and consensus building, project staff, the consultants, and the National Advisory Committee explored the credentials of the candidate protocols, including new research findings and recent experiences with attempting to deploy some protocols in front-line clinical settings.

Through this process, three intervention protocols emerged as clear, consensus choices as "Best Practices" in the field of child abuse treatment:

1. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)
2. Abuse Focused-Cognitive Behavioral Therapy (AF-CBT)
3. Parent Child Interaction Therapy (PCIT)

It is important to note that these three Evidence Based Treatments (EBTs) are not the only protocols that could have been described as "best practices." Indeed, there is evidence emerging with each passing month of other solid well-supported practices. However, these three protocols enjoyed the greatest level of theoretical, clinical, and empirical support, and the most agreement among the participants in the consensus-building process.

TRAUMA FOCUSED-COGNITIVE BEHAVIORAL THERAPY FOR CHILD SEXUAL ABUSE

Why use Trauma Focused-Cognitive Behavioral Therapy for Child Sexual Abuse?

Children who experience sexual abuse respond in many ways. Some sexually abused children have few clinically measurable symptoms, while others suffer from serious mental health disorders such as major depression and posttraumatic stress disorder. Children often have developed maladaptive beliefs and attributions related to the abusive event(s) such as a sense of guilt, powerlessness, and stigmatization. The most abuse specific outcome of sexual abuse is posttraumatic stress symptoms. Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) has proven to be an efficacious treatment for PTSD symptoms for sexually abused children. Multiple randomized clinical outcome studies have found it to be useful in reducing symptoms of PTSD among sexually abused children, as well as symptoms of depression and behavioral difficulties. It has been identified as a well-supported and efficacious treatment for this population in several major reviews (Saunders, et al., 2003; Chorpita, 2002; Cohen, et al., 2000). There was broad agreement within the National Advisory Committee that TF-CBT clearly represents the best practice to use with sexually abused children with PTSD symptoms.

TF-CBT has proven to be an efficacious treatment for PTSD symptoms for sexually abused children.

Definition of Trauma Focused-Cognitive Behavioral Therapy (TF-CBT).

TF-CBT is an intervention designed for children, adolescents and their parents or guardians. It is an empirically supported intervention based on learning and cognitive theories, and is designed to reduce children's negative emotional and behavioral responses, and correct maladaptive beliefs and attributions related to the abusive experiences. It also aims to provide support and skills to help non-offending parents cope effectively with their own emotional distress and optimally respond to their abused children.

Components of TF-CBT

TF-CBT uses well-established cognitive-behavioral therapy and stress inoculation training procedures originally developed for the treatment of fear and anxiety in adults (Wolpe, 1969; Beck, 1976). These procedures have been used with adult rape victims with symptoms of PTSD (Foa, et al., 1991) and have been applied to children with problems with excessive fear and anxiety (Biedel & Turner, 1998). The TF-CBT protocol has adapted and refined these procedures to target the specific difficulties exhibited by sexually abused children with significant symptoms of PTSD.

Components of the TF-CBT protocol

- Psychoeducation about child abuse, typical reactions of victims, normalization of reactions, safety skills and healthy sexuality.
- Stress management techniques such as focused breathing, progressive muscle relaxation, emotional expression skills, thought stopping, thought replacement, and cognitive therapy interventions.
- Constructing the Trauma Narrative —Gradual exposure techniques including verbal, written and/or symbolic recounting (i.e. utilizing dolls, puppets, etc.) of abusive event(s).
- Cognitive Processing or Cognitive reframing consisting of exploration and correction of inaccurate attributions about the cause of, responsibility for, and results of the abusive experience(s).
- Parental participation in parallel or conjoint treatment including psychoeducation, gradual exposure, anxiety management and correction of cognitive distortions.
- Parental instruction in child behavior management strategies.
- Family work to enhance communication and create opportunities for therapeutic discussion regarding the abuse.

Symptoms/Presenting Problems Appropriate for TF-CBT

The TF-CBT protocol was designed specifically for sexually abused children, who have clinically significant levels of PTSD symptoms, usually defined as four or more symptoms with at least one in each of the three symptom spheres of PTSD. It is not restricted for use only with children who meet full diagnostic criteria for PTSD. TF-CBT also has been found to be effective with sexually abused children with clinically significant levels of depression, anxiety, shame or other dysfunctional abuse-related feelings, thoughts or developing beliefs. Clinical research has found that behavioral problems, especially age inappropriate sexual behaviors, also improve through use of this treatment.

Contraindications

Children and adolescents whose PRIMARY presenting problems include conduct problems or other significant behavioral problems that existed prior to the trauma may respond better to an approach that focuses on overcoming these problems first.

The gradual exposure component of TF-CBT may be contraindicated for children who are acutely suicidal or substance dependent, as this component may transiently worsen symptoms. However, other components of TF-CBT have been used successfully to address these problems. So, it may be that for these children, the pace or order of TF-CBT interventions need to be modified (as has been done in the Seeking Safety model), rather than that TF-CBT is contraindicated for these populations. In cases in which adolescents have a history of running away, cutting themselves or engaging in other parasuicidal behavior, a stabilizing therapy approach such as Dialectical Behavior Therapy may be useful prior to integrating TF-CBT into treatment.

ABUSE FOCUSED-COGNITIVE BEHAVIORAL THERAPY FOR CHILD PHYSICAL ABUSE

Why use Abuse Focused-Cognitive Behavioral Therapy For Child Physical Abuse

Research in the field of child maltreatment over the past few decades has documented various risk factors and sequelae associated with child physical abuse. This work has broadened our initial understanding of associated parent and family characteristics by identifying the types of competencies and clinical problems found among children who have been physically abused. The diversity of individual problems and contextual family circumstances associated with child physical maltreatment, at times, may warrant the use of a comprehensive treatment approach that targets both the contributors to physically abusive behavior and children's subsequent behavioral and emotional adjustment. Applications of behavioral treatment (BT) procedures and extensions of the BT approach that incorporate specific Cognitive Behavioral Therapy (CBT) methods have effectively targeted these two general domains.

Abuse Focused-Cognitive Behavioral Therapy (AF-CBT) reflects the integration of many of these BT and CBT procedures in an effort to target child, parent and family characteristics related to the abusive experience.

Abuse Focused-Cognitive Behavioral Therapy (AF-CBT) reflects the integration of many of these BT and CBT procedures in an effort to target child, parent and family characteristics related to the abusive experience and the larger family context in which coercion or aggression occurs. This approach can be used to address parent or family risks/correlates of physical abuse and/or common sequelae exhibited by children following the abuse. Because both individual and family factors often are targeted, several methods may be used rather than a specific intervention strategy to address a particular problem. The methods that are incorporated in AF-CBT have been found efficacious in several outcome studies conducted with various populations of parents, children, and families over the past three decades (see Chalk & King, 1998; Kolko, 2002).

Definition of Abuse Focused-Cognitive Behavioral Therapy (AF-CBT)

AF-CBT represents an approach to working with abused children and their offending caregivers based on learning theory and behavioral principles. The integration of specific techniques directed towards these individuals and the larger family system is described in a recent model that extends prior work in the area (Kolko & Swenson, 2002). The model emphasizes an evaluation of risks for or contributors to physically abusive behavior within the child, parent, family, and community domains (Kolko, 2002). Potential contributors include negative perceptions of children, heightened anger or hostility, and harsh or punitive parenting practices, as well as coercive family interactions and heightened stressful life events. The sequelae of abuse also may vary and

have included such clinical problems as aggression or behavioral dysfunction, poor social competence, trauma-related emotional symptoms, developmental deficits in relationship skills and cognitive impairment. Certainly, the specific types of problems experienced across samples have varied considerably. In general, the approach is designed to promote the expression of appropriate/prosocial behavior and discourage the use of coercive, aggressive, or violent behavior by focusing upon instruction in specific intrapersonal and interpersonal skills. These interventions may target an array of client's behavioral, cognitive, and affective repertories, in relation to heightened risk for coercive/abusive interactions or involvement in aggressive behavior, as applied both individually and in the family context.

Key components of AF-CBT

Child-Directed Components

- Socialization to brief conceptual models of stress and cognitive-behavioral therapy
- Understanding the child's exposure to family hostility and violence, and cognitive processing of the circumstances and sequelae of the referral incident, in part, to modify aggression supporting beliefs/distortions and other misattributions about the incident
- Psychoeducation about child abuse laws, child safety/welfare, and common abuse-related reactions
- Affect-focused interventions such as training in affect identification, expression, and management skills (e.g., abuse-specific triggers, anxiety/stress management, anger-control)
- Coping skills discussions (healthy vs. unhealthy coping) and training to address everyday problems
- Development of social support plans and skills training to enhance social competence

Caregiver/Parent-Directed Components

- Socialization to brief conceptual models of stress and cognitive-behavioral therapy, focusing on contributors to violent or coercive behaviors
- Understanding the parent's views on hostility and violence, including an examination of the role of child-related developmental expectations and general attributions that may promote coercive interactions
- Affect-focused interventions such as identifying and managing reactions to abuse-specific triggers, heightened anger or anxiety, and depression, to promote self-control
- Training in alternative disciplinary strategies that minimize the use of physical force through instruction in several behavior management principles and techniques to promote effective discipline (e.g., attention/reinforcement, response-cost, time-out)

Parent-Child or Family-System Components

Where relevant, parent-child or family-system interventions may be applied before, during, and/or after these individual services:

- Discussion of no-violence agreement and development of safety plans
- Family assessment using multiple methods (rating scales, observations) and identification of family treatment goals
- Clarification sessions to clarify attributions of responsibility for the abuse, focus treatment on the needs of the victims/family, and develop safety and relapse prevention plans, as needed
- Communication skills training to encourage constructive interactions
- Non-aggressive problem-solving skills training to minimize coercion, with home practice applications identified to establish family routines
- Community and social system involvement, as needed

Symptoms/Presenting Problems Appropriate for AF-CBT

AF-CBT is appropriate for use with physically abusive parents and their children. Parents of physically abused children, who have poor child behavior management skills, who rely primarily on punishment methods of child discipline, and who have a high level of negative interactions with their child are good candidates for this protocol. The protocol is useful with physically abused children with significant externalizing behavior problems, problems with aggressive behavior, and poor social skills with peers.

Most Behavioral Therapy and CBT applications in this area have sought to alter several targets or problems, rather than a primary symptom. Studies generally support the efficacy of these approaches with a broad range of parents varying in age, ethnic background, and SES, and with children ranging from preschoolers to older adolescents. **Perhaps the most robust caregiver outcome has been in the area of parenting skills or practices, including increased use of positive management practices and reductions in the use of harsh or coercive discipline.** Gains also have been found in the use of appropriate parental self-control strategies. Improvements in family-system outcomes have been found, such as the level of observed positive family interactions or self-reported levels of family cohesion or family conflict. In terms of child-level improvements, reductions have been found in the severity of children's behavior problems, and increased social behavior and improvement in peer interactions.

Several studies have reported reductions in the severity of children's behavior problems, and increased social behavior and improvement in peer interactions.

Contraindications

Based on clinical experience, parents with serious psychiatric disorders that may significantly impair their general functioning or their ability to learn new skills (e.g., substance use disorders, major depression) may benefit from alternative or adjunctive interventions designed to address these problems. In addition, children or parents with very limited intellectual functioning, or very young children, may require more simplified services or translations of some of the more complicated treatment concepts. Children with severe psychiatric disorders such as attention deficit disorder or major depression may benefit from additional interventions.

PCIT is a highly specified, step-by-step, live-coached behavioral parent training model.

Why use Parent Child Interaction Therapy (PCIT)?

In examining the current clinical and research literature on physically abusive and 'at-risk' families, it is apparent there are many underlying factors that contribute to physically abusive and violent behaviors. Central among these factors is the coercive relationship between the parent and child. In examining this relationship, abusive and 'at-risk' parents are characterized by high rates of negative interaction, low rates of positive interaction, and ineffective parental disciplining strategies, typically an over-reliance on punishment. Conversely, physically abused and 'at-risk' children have been reported to be aggressive, defiant, non-compliant, and resistant to parental direction. These 'patterns of interaction' characterize a negative, coercive parent-child relationship that often escalates to the point of severe corporal punishment and physical abuse. Such coercive 'patterns of interaction' (i.e., using aggression to acquire child compliance resulting in defiance and further behavioral disturbance in the child) eventually becomes a relatively stable form of responding to parent-child conflict, though it is often ineffective and carries significant negative side-effects for the child. While it is likely that there are many different types of abusive and 'at-risk' parent-child relationships, this cycle appears to explain a common form of parent-child physical violence.

PCIT is an intervention which traditionally has targeted families with oppositional and defiant children (Eyberg, 1988; Hembree-Kigin & McNeil, 1995). For purposes related to child physical abuse related intervention, however, Parent Child Interaction Therapy may serve either as a parent-mediated treatment for externalizing child behavior problems among children ages 2-8, or as a treatment designed to change the behavior of physically abusive parents with children ages 4-12, irrespective of child behavior problems. There is evidence supporting the efficacy of PCIT for either of these goals, or potentially for both simultaneously. PCIT accomplishes three important outcomes:

- Improved parenting skills;
- Decreased child behavior problems; and
- Improvement in the quality of the parent-child relationship.

Definition of Parent Child Interaction Therapy (PCIT)

PCIT is a highly specified, step-by-step, live-coached behavioral parent training model. It provides immediate prompts to a parent while they are interacting with their child conducted either by use of a 'bug-in-the-ear' system (an ear-mounted receiver worn by the parent; while the therapist provides prompts from an adjoining observation room via a transmitter, which uses a short-range FM signal) or through 'in-room' coaching.

Key components of treatment

An initial component of treatment is to establish a therapeutic alliance and explain the treatment process. The PCIT curriculum uses a two-stage approach to address 1) relationship enhancement, and 2) strategies to improve compliance (i.e., discipline). Over the course of 14-20 weeks, parents are "coached" to engage specific positive relationship skills, which then results in child compliance to parent commands. PCIT is unique in that it is the only intervention which provides parents with treatment information, provides clients with the opportunity to practice skill acquisition, practice skills to a point of mastery, and then generalize adaptation of skills to other settings.

Reductions in child behavior problems related to PCIT have been found to be robust and durable over time, and generalizable from home to school environments.

PRIMARY TREATMENT COMPONENTS ARE THEN FURTHER DELINEATED AS CHILD DIRECTED AND PARENT DIRECTED INTERACTIONS.

Relationship Enhancement

- Parent is taught the elements of the acronym PRIDE. (P = praise, R = reflection, I = imitation, D = description, E = enthusiasm)
- Parent is encouraged to avoid the use of "No-Don't-Stop-Quit-Not" in interactions with the child.
- The parent is instructed to interact/play with the child during the treatment session, eventually resulting in the effective delivery of child commands–with an appropriate parent response for child compliance (i.e., Command, Comply, Praise); all while being observed/coached through a one-way mirror.
- The parent wears an FM-signal audio reception device (i.e., earbug) to listen to directions, prompts and instructions from the therapist/coach.
- The PCIT therapist is in an adjoining observation room and observes specific behaviors and interpersonal dynamics, then provides prompts and immediate feedback (i.e., suggestions, praise, correction) to the parent to promote PRIDE and decrease "No-Don't-Stop-Quit-Not". At least 50% of the session is spent "coaching".
- Specific behaviors are tracked and charted on a graph at periodic intervals to provide parents with specific information about progress in positive interactions and the achievement of mastery.

Strategies to Improve Compliance

- Parent is instructed in giving commands and directions.
- Child is given a difficult task that may evoke disobedience/defiance or other inappropriate/problem behaviors.
- Parent receives coaching through the earbug to help the child practice minding.
- Parent is instructed in ways to generalize the skills to siblings, and "problem times".
- Parents are given homework to aid in the speed of skill acquisition.

Presenting Problems Appropriate for PCIT

PCIT is an appropriate treatment for externalizing behavior problems in children ages 2-8. This includes children who meet criteria for oppositional

defiant disorder, adjustment disorder with disturbance of conduct, or show similar but sub-clinical or atypical behavior problems not meeting full diagnostic criteria. Reductions in child behavior problems related to PCIT have been found to be robust and durable over time, and generalizable from home to school environments. Benefits also appear to generalize to untreated children in the same family, and include improvements in the quality of parent-child relationships. PCIT as a child treatment may be conducted with parents, foster parents or others in a parental role. Benefits have been found to be stable across genders and a variety of ethnic groups.

PCIT may also be useful for behavior problems associated with Attention Deficit Hyperactivity Disorder (ADHD). However, treatment for children with behavior problems involving ADHD should also be evaluated for specific concurrent ADHD interventions, such as stimulant medication.

As a treatment for physically abusive parents, PCIT has also been found to be efficacious for parents with children ages 4 - 12 where physical abuse occurred within the context of child discipline, which is the most common context for physical abuse. Efficacy as a parent treatment has been found among multi-problem parents with significant past child welfare report histories, and PCIT appears to be fairly sufficient as a parent treatment, in that efficacy does not appear to be enhanced by the addition of supplemental services such as individual or family counseling. Benefits have been found to be stable across parent gender and ethnic groups.

Contraindications

While PCIT is very effective in addressing certain types of problems, there are clear limitations in its use. These include:

- Parents and children need to have consistent ongoing contact in order to be able to effectively change parent-child patterns of interaction. PCIT is not appropriate for families in which the parent and child have very limited (i.e., one hour weekly visitation) or no ongoing contact.
- There is no research to support the use of PCIT with very young children (less than two and a half years of age) and only limited research with older age children (older than eight years of age). There is no research to support the use of PCIT with adolescents.
- PCIT is not appropriate for parents with mental health problems that may include auditory/visual hallucinations and/or delusions.
- Due to the process of 'coaching' parents, it is difficult to conduct PCIT with parent/child who are hearing impaired and/or who have significant expressive or receptive language skills.

PCIT has also not been evaluated with sexually abusive parents, parents engaging in sadistic physical child abuse, or seriously mentally ill parents. At this point, it is contraindicated with these groups. In fact, given the underlying dynamic of parental control and misuse of power over the child, teaching the abusive parent better means of control over the child may be harmful.

SPREADING BEST PRACTICES: THE ART & SCIENCE OF DIFFUSION

Despite the demonstrated efficacy of these interventions, there is little evidence that they have rapidly spread across the nation and are being widely offered to abused children and their families. There are many reasons for this poor adoption of these clear best practices. First, among these is the inherent inertia of any system or person to resist change. Put simply, therapists and the service delivery system they work in tend to resist adopting new and innovative practices. Layered on top of this natural resistance to change are several factors specific to these treatments and to the child abuse field that work to inhibit adoption.

Despite the demonstrated efficacy of these interventions, there is little evidence that they have rapidly spread across the nation and are being widely offered to abused children and their families.

Innovation vs. Replication: The child abuse field is relatively young, with the topic coming to professional prominence only within the last thirty years. During this early phase of developing effective interventions, the culture of the child abuse treatment community has not supported replication of proven practices. Rather, the interest of many funding sources supports the notion of novel innovation over application or replication of proven practices. Consequently, funding has been more readily available to create something new rather than support the regular delivery of a scientifically proven service.

Art vs. Science of Therapy: Many mental health therapists serving abused children see therapy as more an art than a science. The relationship between rigorous scientific research and the everyday practice of therapy has been tenuous through much of this century. Therapists may resist following what they believe are highly structured and confining evidence-based treatment protocols because they believe they ignore the creativity needed in therapy.

Anti-Research Bias: Many in the child abuse field are skeptical about the ability of research to fit their real world experience. They often do not see results of research as applicable to their clients and their professional setting. This concern often takes the form of an almost anti-research bias among some child abuse professionals.

At the other end of the continuum are those in our field who suggest "We really can't say anything works." Clinical scientists often take this view citing reasons such as there simply are not enough outcome research studies with all the populations seen in all the treatment settings, the research we do have has too many methodological limitations, and, until we amass far more carefully controlled efficacy and effectiveness clinical trials, we cannot state unequivocally that an intervention is useful. These views, while having some basis from a strictly scientific viewpoint, can be frustrating to front-line therapists who are less concerned with the esoteric nuances of clinical trials than with the stark reality that they need some direction about what to do with the clients in their office today.

TRANSTHEORETICAL MODEL OF CHANGE

This model divides that continuum into five phases:

Precomtemplation Phase
In which individuals are not intending to take action to change their behavior and are either uninformed or under informed about the consequences of their behavior.

Contemplation Phase
In this phase, people are actively thinking about and may even plan to change their behavior but may remain in this phase for years.

Preparation Phase
Now people are actively planning to take action and have initiated preliminary steps such as self-education or enrolling in classes that will help them make the change.

Action Phase
At this level, people are actively engaged in a change effort. In smoking cessation work, the action they take must be considered sufficient to reduce the risk (example: cutting down to two packs a day from two and a half is insufficient to meaningfully reduce the risks - more action is needed to be meaningful).

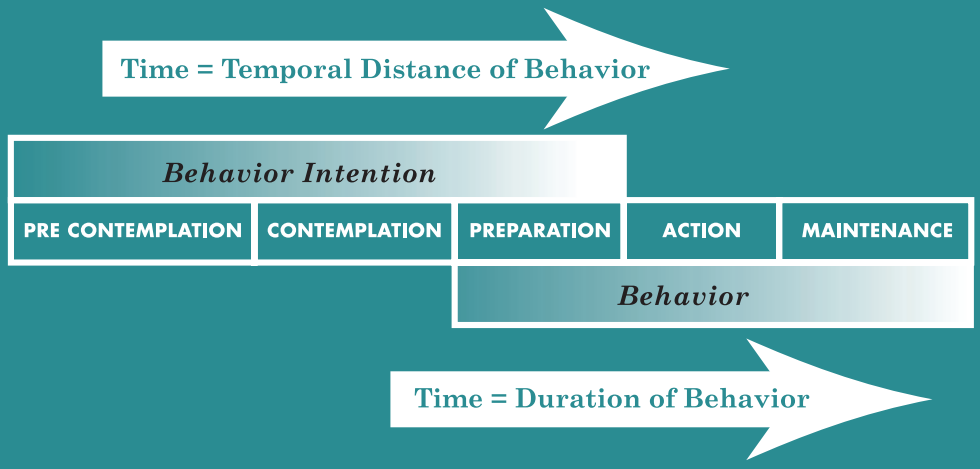
Maintenance Phase
The stage in which people have behaviorally achieved their goal but must actively work to prevent relapse. They are less tempted to relapse and increasingly more confident that they can continue their change.

In the face of these challenges, some leaders in the child abuse field have tried to spread these and other evidence-based interventions nationally. In fact, considerable efforts have been underway for years by advocates for each of the selected interventions. While these experiences have had some success from which we can learn, these efforts also have encountered numerous barriers to diffusion that have limited the pace of adoption. To expand the use of these best practices, we must understand **change** on a variety of levels.

The Change Process: There are several models of change from which the Kauffman Project can draw lessons ranging from the Transtheoretical Model of Change, a framework most commonly applied in health promotion efforts, to models of spreading innovation in other industries such as healthcare.

The Transtheoretical Model of Change: This is a useful model to understand the change process in individual behavior such as smoking. If one wishes to influence a wide spread change in behavior, like smoking, one must understand where the individuals are on a continuum of change. This ranges from those who have no intention of quitting smoking to those who have achieved their goal and are working to maintain their progress. *We need different strategies focused at persons based on where they are currently in this process.*

FIGURE 1



Detailed Overview of the Transtheoretical Model-Velicer, W. F, et al. (1998)

The goal of the change agent is to get those who are not actively engaged in the change to move in the direction of the change. In the early phases of this effort, the goal is to get people to contemplate the need to change and to begin to prepare to take action. As the person moves into the action phase, the goal is to encourage their continued progress and maintenance of the behavior. To achieve progress, they must believe in their ability to succeed and to maintain that success - "efficacy".

For purposes of the best practices project, mental health practitioners working with abused children and their families can be categorized in one of these five phases:

Precontemplation Phase - Practitioners are comfortably unaware of what they do not know about best practices or the advantages of using these evidence based treatments. These practitioners currently have no plan to change their approach to incorporate the best practice into their clinical work. They are, as with the committed smoker, uninformed, misinformed, or under informed.

Contemplation Phase - Practitioners have become aware of the evidence for a best practice and are considering incorporating it into their clinical work. They must first overcome the natural inertia for resisting change and a host of logistical barriers, from training and support to acquisition of needed skills and knowledge. These professionals are actively exploring the concepts of best practices through professional literature and conference presentations.

Preparation Phase - Those practitioners who have actively made the decision to understand and apply the best practice concepts in one form or another. This would include those seeking out in-depth training, and organizations committing resources to training and consultation. To move to action, these professionals must believe that the intervention will work and that they, as individuals, have or can acquire the capacity (knowledge, skills, time, support) to deliver the treatment effectively.

Action Phase - Those practitioners who have completed the preparation phase and are actively applying what they have learned in an organized way. This could arguably include those who are adhering closely to treatment manuals as well as those integrating the scientific principals learned in the preparation phase in a thoughtful way, delivering what one advisor, Lucy Berliner, MSW characterized as "evidence-informed therapy." The question is "to what degree are the principals of the Best Practice integrated into the practice adequate to achieve the benefit of the proven practice?"

Maintenance Phase - Today, only a handful of practitioners so far can be said to have fully integrated the best practices into their everyday practice at a level necessary to replicate the results of the trials. Those who have achieved a level of success must now work to maintain what they have achieved in the face of barriers in funding and a lack of understanding in the value of the best practice by referral sources and others.

As we contemplate strategies for spreading our best practices, one of our goals must be to move potential providers of mental health services for abused children along this continuum. We must inform them of the advantages of these best practices and they must believe they can apply the practice in their real world.

For purposes of the Best Practices project, we can see mental health practitioners working with abused children and their families categorized in one of five phases.

If we want to speed the pace of "spread" and close the gap from the early adopters to the traditionalists, we must understand the barriers.

The IHI Experience

Seeking lessons from the experience of others, the Kauffman Best Practices Project staff also reviewed the diffusion experience in other industries. The most relevant analogue for the child abuse field proved to be healthcare and the work in spreading medical best practices. Of particular note is the work of the Institute for Healthcare Improvement - IHI (www.ihi.org), National Initiative for Children's Healthcare Quality (NICHQ), the National Academy of Science's Institute of Medicine (IOM), and the National Health Services (United Kingdom). **Our review of the literature on spreading best practices confirms that a wide gulf in time exists between the development of a best practice and the adoption of it in everyday practice across the nation.** Using IHI's model (Berwick, 2003), best practices are developed by "innovators" and their ideas and models are then implemented elsewhere by "early adopters" who replicate and adapt the practice for their world. In the traditional model of "spread", the experiences of these early adopters are later implemented by a number of others who, in time, form an "early majority". As the practice is widely accepted and becomes commonplace, most others adopt the practice and are referred to as the "late majority". The ultimate end of the continuum are the "traditionalists", who only begrudgingly adopt the practice long after it has become commonplace.

FIGURE 2

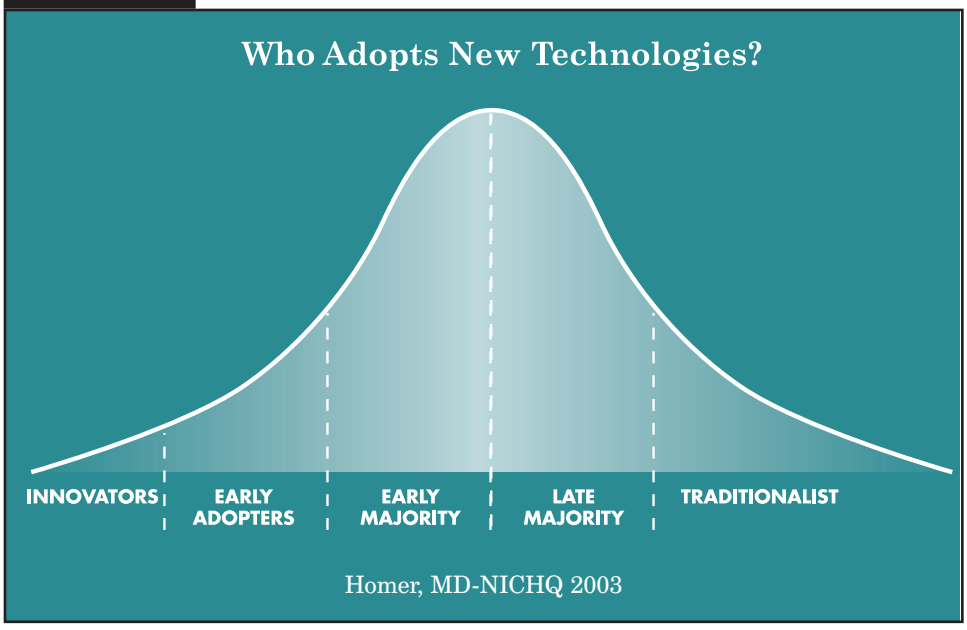
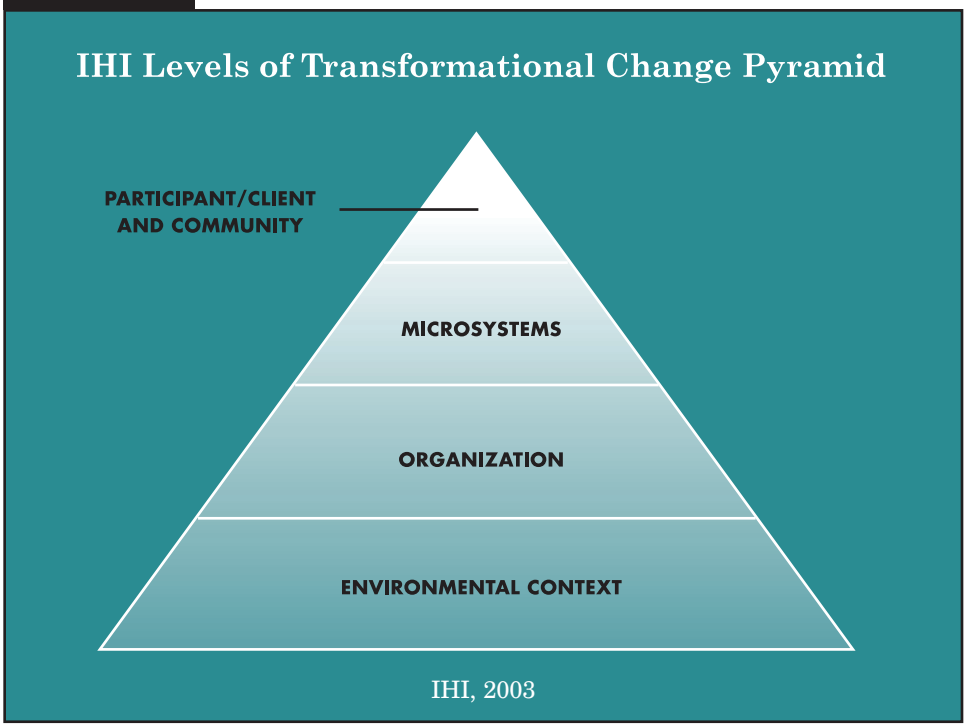


FIGURE 3



If we want to speed the pace of "spread" and close the quality of care gap from the early adopters to the traditionalists, we must understand what barriers exist to diffusion, and develop strategies for overcoming the barriers. Those barriers exist on a variety of levels, as do the strategies for overcoming them. In fact, we would speculate that one must acknowledge the barriers at each level and pursue a multi-level strategy if we are to influence the adoption of our three Best Practice Interventions. IHI describes these levels as part of a "Transformational Pyramid".

UNDERSTANDING THE BARRIERS

To speed the pace of spread and close the quality gap, the advisors identified barriers to diffusion and strategies for wide spread adoption.

The Best Practices we have identified have all been developed by innovators who took clinical models proven efficacious in other fields of mental health and adapted them and applied them in a research environment to the field of child maltreatment. All have proven efficacious in that setting and all have been replicated with fidelity by other sites (early adopters). In each case, still other sites are implementing them in less structured or controlled ways. The question to the Kauffman Best Practices Project Advisors was "what barriers on the four levels of the IHI Transformational Change Pyramid are preventing more individuals, agencies, and communities joining the early adopters"?

What barriers in the broad ***environment/community*** must be overcome to implement each best practice? The environment/community would include barriers related to community acceptance of this or any evidence-based practice, cultural barriers to accepting this practice, regulatory barriers, specific financial support barriers, etc.

What barriers exist within ***organizations*** (mental health agency, Child Advocacy Center, social service agency, hospital, etc.) to adopting and implementing the best practice?

What barriers exist at the ***microsystems*** level within organizations to adopting the best practice? Microsystems for our purposes would be departments within organizations such as the counseling department of a multi-service agency or the mental health component of a Child Advocacy Center.

What barriers exist to adoption in the interaction of ***individual clinicians*** and individual families? This would include barriers to therapists accepting and/or properly using the practice, or to a family or child's willingness to engage in this specific intervention.

Not surprisingly, the Project Advisors identified a wide range of factors as barriers to implementation of all three Best Practices.

Some were common to all three interventions.

Environment/Community Level

Funding/Reimbursement Issues - A common barrier raised in all three Best Practices. Adopting a new intervention with fidelity is not inexpensive, especially when one considers the training and consultation costs and the lost productivity during training and start up. This is compounded by the fact that many reimbursement sources do not understand nor value the use of EBT and do not support the costs of starting up a new program or major program revision.

Lack of Advocacy - There are few advocates who are encouraging agencies to adopt these Best Practices or influencing funding sources to provide proper reimbursement.

Lack of Incentive or Link of Rewards to Outcomes - Despite the evidence these Best Practices work, there is little, if any, connection between these effective and efficient intervention and reimbursement streams flowing from insurance providers, victims of crime boards, and other funding sources.

Organization Level

No Tradition as a Learning Organization/No Plan for Process Improvement - Many organizations lack the attributes of "learning organizations," which includes strong leadership, an open and inclusive management culture, a stable resource base from which to launch process improvement, and transparent and accessible performance data. Learning organizations continually scan the environment to identify external best practices to adopt and adapt in an effort to continuously improve quality of care.

Learning organizations continually scan the environment to identify external best practices to adopt and adapt in an effort to continuously improve quality of care.

Lack of Awareness/Understanding the Best Practice - Despite considerable publication track records, frequent conference presentations, and inclusion in such documents as the OVC Guidelines on Physical and Sexual Abuse Treatment or the Blueprints projects many, if not most, providers of services to abused children are still largely unaware of these three Best Practices.

Entrenched Status Quo/Lack of Tradition of Adopting EBT/Implications of Change for Current Practice - This is a complex mix of inertia associated with the natural tendency to maintain the status quo and concern that making a planned shift to a new intervention suggests that the provider has not been providing the best service in the past.

Few Organizational Role Models - In his book the Tipping Point (Gladwell, 2000), Malcolm Gladwell discusses how isolated events become trends or movements. Key to the process are those early adopters who serve as role models and spread the word. There is a perception that there are currently few organizations that have successfully replicated the Best Practices in ways that others will wish to emulate.

Training/Supervision - Faithful adoption of these Best Practices requires in-depth training, and knowledgeable and skillful (and consistent) supervision. Such training and supervision is in short supply across the nation and, at least initially, is not compatible with the requirements for high staff productivity that are a common requirement in most agencies.

High Staff Turnover -Organizations which see frequent staff turnover are hard pressed to implement new evidenced-based practices due to the constant need to orient and train new staff in a complex intervention.

Microsystem Level

Believe Their Population is "Different"- Many organizations perceive their client population is unique due to there idiosyncratic blend of cultural factors. They are quick to dismiss the relevance of clinical trials conducted in other communities.

Individual Clinicians/Individual Families Level

Misperception about model and "Manualized Treatment" (Art vs. Science of Therapy) - One of the tools required to spread the Best Practice is a treatment manual. Many therapists have a bias against such manualized treatments, believing they are too structured and lack the spontaneity needed in the dynamic world of therapy-stating things such as "my work will be artificial," "it reduces therapy to a technique instead of a relationship." (Power, 2003). They also believe such treatments rob them of their ability to use their skills in what they perceive as a "cookbook approach."

In addition to these barriers, the Advisors identified some barriers unique to each Best Practice.

Trauma Focused-Cognitive Behavioral Therapy

Organization Level

Disincentive at the agency level to use shorter-term intervention - TF-CBT has been demonstrated to achieve success in fewer sessions than traditional interventions. Agencies with limited numbers of clients and a liberal session limit or fee for service funding streams may see the efficiency of TF-CBT as a financial disincentive.

Abuse Focused-Cognitive Behavioral Therapy

Environment/Community Level

Lack of Appreciation of Trauma Issues in Physical Abuse Intervention - Many who are responsible for making referrals in physical child abuse cases may focus almost exclusively on child protection and fail to understand the psychological effect of the trauma on the child in these cases.

Lack of Appreciation in Clinical Approach to Parenting/Conflict (vs. Parenting Education) - Many who are responsible for managing physical abuse cases traditionally rely on parent skills training as a primary intervention and may not recognize the value of a clinical approach to the problem.

Parent Child Interaction Therapy

Environment/Community Level

Community Stakeholders may see PCIT as Insufficient Treatment - PCIT appears to the casual observer as a form of parent training and the clinical underpinnings may not be evident, leading some to believe that it is just another form of parent skills training.

Organization Level

Room and Equipment Costs - PCIT typically involves the use of specially equipped rooms with one way mirrors, and video and audio equipment which can cost as much as $10,000 to prepare, plus the loss of the space to normal clinical office space. Although PCIT can be delivered without the use of audio/video equipment (i.e., in-room coaching), current training involves a center-based service. Current efforts are underway to finalize the development of a home-visitation component of PCIT (i.e., Relationship Enhancement Training) delivered by paraprofessionals.

Microsystem Level

Possible resentment by Non-PCIT Therapists or Teams for the Special Attention (expense, space and equipment) and Perception of Inequities - PCIT requires physical modifications of office space and the acquisition of special equipment. Some fear the non-PCIT therapists will resent the special attention and that will create office morale issues.

Individual Clinicians/Individual Families Level

Some may perceive PCIT will not provide the Traditional Therapeutic Relationship Satisfaction they are accustomed to- With much of the PCIT session spent with the caregiver and child in one room and the therapist in another connected by audio equipment following a protocol, some therapists may think they will lose the warm and nurturing relationship they may currently have with their clients. (Note: experience typically does not bear this out, with PCIT therapists often reporting improved relationships).

Some may perceive that PCIT may feel more like training or coaching than therapy and some therapists may resist adoption of PCIT on that basis.

STRATEGIES FOR ACCELERATING THE PACE OF SPREAD OF BEST PRACTICES

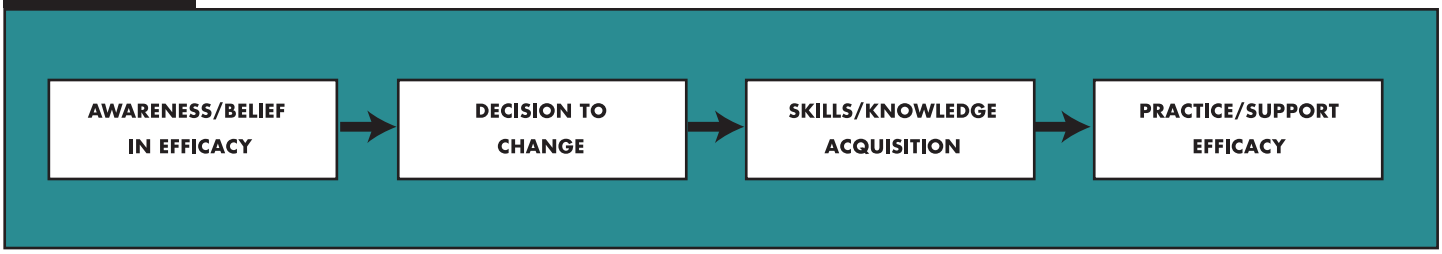
At the present rate of diffusion, the identified best practices will take decades to become everyday practice. If we are to accelerate the pace by which evidence-based practices become everyday practice, we need to develop strategies that overcome the barriers identified in the previous chapter and build upon our understanding of the change and diffusion processes.

Our goal is to move potential providers of mental health services for abused children along this continuum from unaware or under informed to actively engaging in the delivery of the selected best practices.

TO ACCOMPLISH THIS:

1. We must seek to raise awareness of the Best Practices, and potential practitioners of the Best Practices must believe in the efficacy of the practice as well as their own efficacy in learning and applying the practice;
2. They must decide to seek to change their practice behavior;
3. They must prepare to apply the practice by learning the knowledge and skills necessary to deliver the practice as intended; and
4. They must secure clients willing to accept the practice and funding sources willing to support the intervention, and gain successful experience in delivery of the Best Practice.

FIGURE 4



The first phase of this process involves making potential practitioners of the best practice aware of their existence and the evidence of their efficacy.

TF-CBT, AF-CBT, and more recently PCIT have been the topics of multiple journal and book publications, and training workshops at national child abuse conferences for a number of years. These sessions typically last 90 to 180 minutes and can, at best, serve to acquaint the participants with the basic principals of the intervention and raise their interest in learning more. Few believe such training experiences impart the necessary knowledge and clinical skill to actually implement these treatments. Consequently, it is unlikely that this type of dissemination alone will result in meaningful change by large cohorts of therapists or service delivery systems. These activities are, however, important first steps in moving potential practitioners of these services into the contemplation phase.

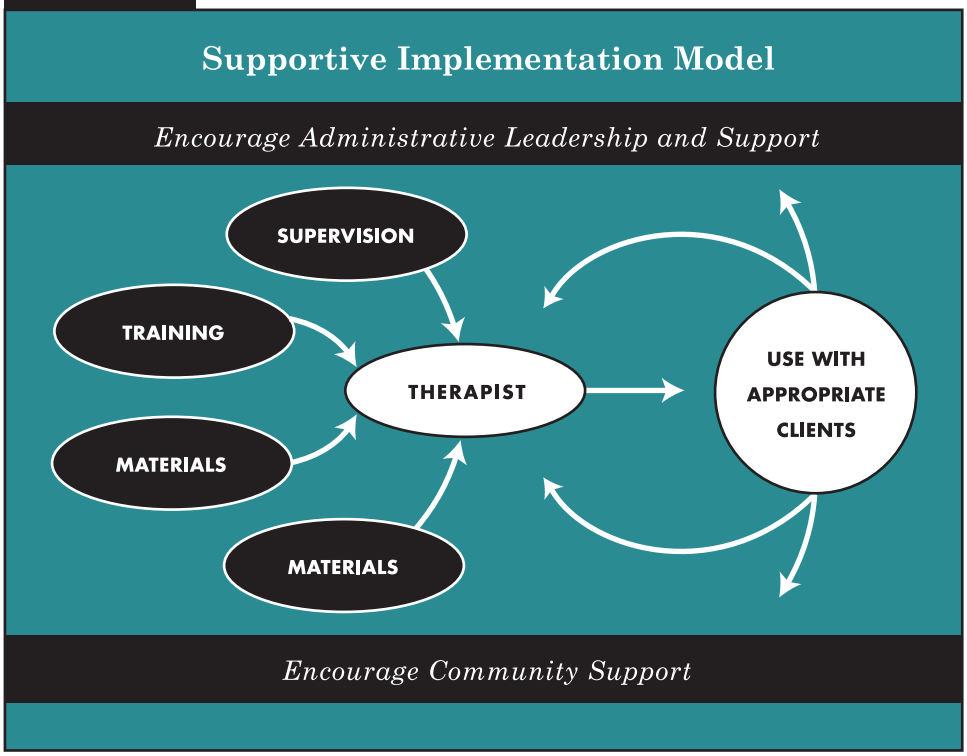
Further interest has been facilitated by the endorsement of these treatments by respected sources of evidence-based practice such as the Child Physical and Sexual Abuse Guidelines project, the Blue Prints Project, activities of the National Child Traumatic Stress Network, and even the Kauffman Project itself. Still too few frontline providers and managers are even aware of these reviews and endorsements.

While some practitioners have sought to prepare themselves by attending traditional one and two day training institutes, it is clear that more effective training time, ongoing clinical supervision, and access to expert consultation is needed to acquire the skills and knowledge required to apply these best practice interventions skillfully, confidently, and effectively. In addition, support for program administration and consumer populations is required to implement a new protocol successfully. A recent review of the limited dissemination research in child mental health (Herchell, et al., in press) found evidence for successful dissemination models for PCIT (Urquiza, et al., 2003), Multi-Systemic Therapy (Henggeler, et al., 2002), and Multidimensional Treatment Foster Care (Chamberlain, 2003). These programs have met with some success in spreading their intervention with a high level of treatment fidelity. These successful dissemination models have several important characteristics in common. These characteristics are depicted below and can be termed the Supportive Implementation Model.

There is always one moment in childhood when the door opens and lets the future in.

Graham Greene

FIGURE 5



These models include providing therapists with intensive clinical training through courses lasting from three to five days. This intensive training is supplemented with extensive training materials that may include printed manuals and other self-study materials, and videotapes illustrating the treatment procedures. The models include ongoing, regular supervision by clinical supervisors skilled in the use of the treatment. They also provide access to consultation with experts in the treatment for particularly difficult clinical problems. Each of these models also seeks formal feedback, evaluation, and comment from clients regarding the treatment and its impact. Each seeks to encourage strong administrative leadership and support for the service delivery organization, and community support by consumers and stakeholders. This model of dissemination seeks to provide not only the training and clinical skills required for the therapist to implement the treatment model, but also to create a strong, supportive organizational and community context for delivery of the treatment.

This dissemination model has proved effective, but it has several basic requirements for success. It requires a highly motivated organization that is committed to the implementation of a particular treatment. The organization must have the resources to acquire the needed training for therapists and supervisors, and maintain the ongoing expert consultation. The organization must have strong administrative leadership that is willing to stay the course and meet the inevitable challenges during the transformation. Finally, the organization must have the ability to use resources to encourage the community to "buy in" to the treatment approach. While this model clearly holds a great deal of promise for implementing a best practice at a given site with a high degree of treatment fidelity, it does not help us understand what is necessary to speed the spread of Best Practices nationally.

It is here we apply the framework of the IHI "Transformational Pyramid" and what appears is a blueprint for increasing the spread of the identified Best Practices.

RECOMMENDATIONS OF THE KAUFFMAN BEST PRACTICES PROJECT

WHAT STRATEGIES EXIST AT THE BROAD ENVIRONMENT/COMMUNITY LEVEL TO SUPPORT DIFFUSION OF THE BEST PRACTICE?

1. Funding - Not surprisingly, funding was the most frequently mentioned barrier to adopting the Best Practices in our barriers survey.

2. Grants encouraging the adoption of Best Practices. A related strategy would be to encourage funders to provide incentives to agencies adopting evidenced-based practices such as the identified Best Practices. These incentives could take several forms. For example, Transition Grants could be offered to cover not only the direct costs of the training and consultation needed for successful implementation of Best Practices, but these grants might also cover the revenue lost due to lowered clinician productivity during training and initial implementation periods.

3. Differential payments for use of Best Practices. One of the more powerful change methods available would be for funders of clinical services to make differential payments for the use of best practice interventions. This approach, for example, has been suggested to the California Victims Compensation and Government Claims Board with the idea of paying a higher rate to those providers certifying compliance with state evidence-based standards of care.

4. Payment based upon client outcomes. Funding sources could base reimbursement rates based upon efficiency and client outcomes, rather than on a fee for service. This would provide financial incentives to therapists to use the most effective and efficient treatments available.

5. Influence payers to support selected intervention, including family work. Some funding sources pay less for time spent with parents and caregivers than with the primary child client. The evidence is clear that the parents/caregivers have a powerful influence on the child's recovery and each of the identified Best Practices include significant parent intervention components. Payment should encourage rather than discourage the implementation of family components of Best Practice protocols. We must reach out to the primary funders of these services to correct this.

   Funding Sources should be encouraged to provide equal funding for face-to-face therapy time spent with caregivers as with child victims, or reduced funding if parents/caregivers are not included in therapy services.

Foundations and Government agencies alike should be encouraged to focus their available funding on the delivery of evidenced-based services such as the identified Best Practices.

Funding can be used to support planning, training, materials, physical modifications and equipment (PCIT), lost productivity due to training and time associated with retooling therapist skills, time and travel for peer support networks, assessment costs, consultation, and even senior management time.

Example: In California, the Governor's Office of Criminal Justice Planning (now the Governor's Office of Emergency Services) through an RFP process, provided supplemental funding to agencies that had grant awards for child abuse treatment services. The supplemental funding was specifically designated to disseminate the use of PCIT as an intervention in these agencies. The supplemental financial support provided each agency with funding for staff training and ongoing supervision, purchase of the recommended equipment, construction of the required space, and purchase of standardized assessment measures.

6. Professional education/marketing - Professional education and literature serve as primary sources to introduce these three Best Practices to an ever-widening base of practitioners and administrators.

The major sources of education of professionals providing treatment to abused children and their families must be identified, and then encouraged to offer workshops and training sessions in the selected interventions during their annual conferences and highlighted in their professional journals and newsletters.

Example: Children's Hospital–San Diego's internationally attended San Diego Conference on Child and Family Maltreatment offers workshops on all three Best Practices along with a day long institute on TF-CBT hosted by the American Professional Society on the Abuse of Children (APSAC).

Example: There are over 400 Child Advocacy Centers across the nation and all must, by requirement of membership, have some mental health services available to the abused children they serve. Anecdotal experience with many of these centers suggest that they are not fully aware of the power of the identified Best Practices and can be characterized as at the Pre-contemplative stage. The National Children's Alliance (NCA), a network of child advocacy centers, is offering training at their annual meeting in 2004 to acquaint the Directors of these programs with the Best Practices and citing examples of CACs that have implemented them.

State authorities who establish the ground rules by which Continuing Education credits are awarded should establish criteria for awarding Continuing Education credits that include documentation of the evidence base upon which the training is being offered.

7. Teach best practices in graduate and professional schools - Many practitioners draw upon their graduate education for direction and guidance for years after graduation.

Graduate schools of psychology, social work, psychiatry, and marriage and family counseling all need to incorporate the emerging evidence base into their curriculum so students learn what works and what does not while still in school, at least as is practical in a constantly evolving field.

Example: A guide for graduate educators in teaching these Best Practices should be developed.

8. Professional society or government agency endorsements - Many conferences and continuing education programs routinely offer training in unproven practices with unsupported claims of a research base.

Professional Societies should be encouraged to endorse proven evidence-based practices so their members and others can better separate the false claims of efficacy from the legitimate ones.

In addition, government agencies should consider the rigorous review of evidence-based practices and publication of their findings.

Example: DOJ/OVC Child Physical Abuse and Sexual Abuse Guidelines for Treatment or the new California Department of Social Services Clearinghouse on Evidence-Based Practice.

9. Introduction of a social movement as a driver - As suggested in the barrier survey, these practices often lack committed advocates at the local and state levels. The United Kingdom's National Health Services efforts at "modernization" using the IHI Breakthrough Series concept have met with limited success. Concerned about the pace of modernization, a NHS Think Tank concluded that **what was missing was the presence of a powerful social movement to drive the pace of change.** This concept suggests that determined and vocal advocates from the ranks of consumers and interested parties would accelerate the pace of spread of innovation in health services. Likewise, if an organized body of advocates for abused children began to ask educated questions about the uses of these three Best Practices to local service providers and those who fund such services, the effect would be significant. Coincidentally, the **National Call To Action is already in the process of organizing such a national social movement led and populated by "Authentic Voices". If these hundreds, thousands, and later millions of voices were demanding children in their community receive the best available practice, they could and would rapidly expand the pace of diffusion.**

The Executive Committee of the National Call Authentic Voices should be encouraged to review these Best Practices and develop a strategic plan on how the Voices can be mobilized to drive the spread of these proven Best Practices through public awareness, development of consumer demand for Best Practices, and efforts to influence funding sources to support these practices.

Example: The National Alliance for the Mentally Ill, founded in 1979, is a social movement of persons with or families of persons with mental illness, who have transformed the nation's response to chronic mental illness through advocacy.

10. Recruit national and state advocates at political level - Key Messengers - The social movement effort should be supplemented by leaders within professional organizations who become outspoken advocates for the adoption of the Best Practices.

Leaders of key professional groups and political leaders should be recruited to advocate for the spread of the identified Best Practices to act as key messengers.

Example: This is already occurring in the National Child Traumatic Stress Network as Anthony Mannarino, Ph.D. and Judith Cohen, MD have emerged as major leaders of the Network and its efforts to translate research into practice. Dr. Mannarino is now serving as President of the American Professional Society on the Abuse of Children and can use this prominent position to advocate for best practices to the membership.

What strategies focused on the organization level (mental health agency, child advocacy center, social service agency, hospital, etc.) to support the adoption and implementation of best practices?

11. Organizational leadership - Effective organizational leadership is a critical component to the adoption of Best Practices. Agency and program leaders must become acquainted with the Best Practices and develop plans for how to lead their organizations in a transformation to an evidence-based approach.

Agency and program directors should be encouraged to learn enough about these three Best Practices and develop plans to build support for adoption in their agency.

12. Learning organization - Organizations need to develop the capacity of "learning organizations" with the capacity to seek out, adopt, and adapt practice improvements such as these Best Practices. To improve the quality of care, the "learning organization" or context in which there is a continuous flow of information regarding current practice and outcomes, embodies certain key components that may be necessary for establishing a strong foundation to support continued program improvements (Kline and Saunders, 1998; Senge, 1990). The Child Abuse Prevention Study Team of the Kauffman Best Practices Project observed four characteristics as being critical "first steps" in building a learning organization – **strong leadership, open and inclusive management culture, resource stability, and transparent and accessible performance data.**

Agency and program directors should be encouraged to develop their capacity to adopt practice improvements, developing systems to introduce new idea evidence-based ways of providing services. Effective organizations both identify external EBTs to assess their organization's quality of care and integrate EBTs into their services, and continuously measure and track performance. In fact, they relentlessly pursue quality of care through some type of Performance Improvement program (i.e., Continuous Quality Improvement–CQI or Total Quality Management–TQM, etc.). An effective Management Information System, coupled with an open and inclusive culture, are crucial Key Processes for communicating quality of care and need for continuous improvement to all stakeholders within an organization (Carrilio, et al., in press).

Example: The Chadwick Center at Children's Hospital-San Diego has adapted the evidence-based Clinical Pathways (algorithms) concept from physical medicine to the Trauma Counseling Program as a way to introduce evidenced-based assessment and therapy to a staff of 40 trauma therapists.

We need to assist agencies to track implementation by development of common, clear and accessible performance measures that can be used across sites implementing each Best Practice.

Example: The Institute for Healthcare Improvement routinely does this as they work with organizations on diffusion of innovation.

13. Development of a dissemination plan including materials, training, supervision, and consultation (Supportive Implementation Model) - Success in implementing these Best Practices can best be achieved in an organized and supportive environment.

Organizations should develop an action-oriented integrated implementation of Best Practices building on the expertise and experience of the resources listed in Appendix B.

Examples: Kevin Gully at Child Trauma Treatment Network Intermountain West Primary Children's Medical Center and Karen Mallah at Mental Health Corporation of Denver's Family Trauma Treatment Program.

14. Non-Offending Caregiver Support - The disclosure of abuse will overwhelm many families, especially when the abuser resides in the home and may be the primary source of income to the family. The non-offending parents may require significant support throughout the process so they can in turn support the child.

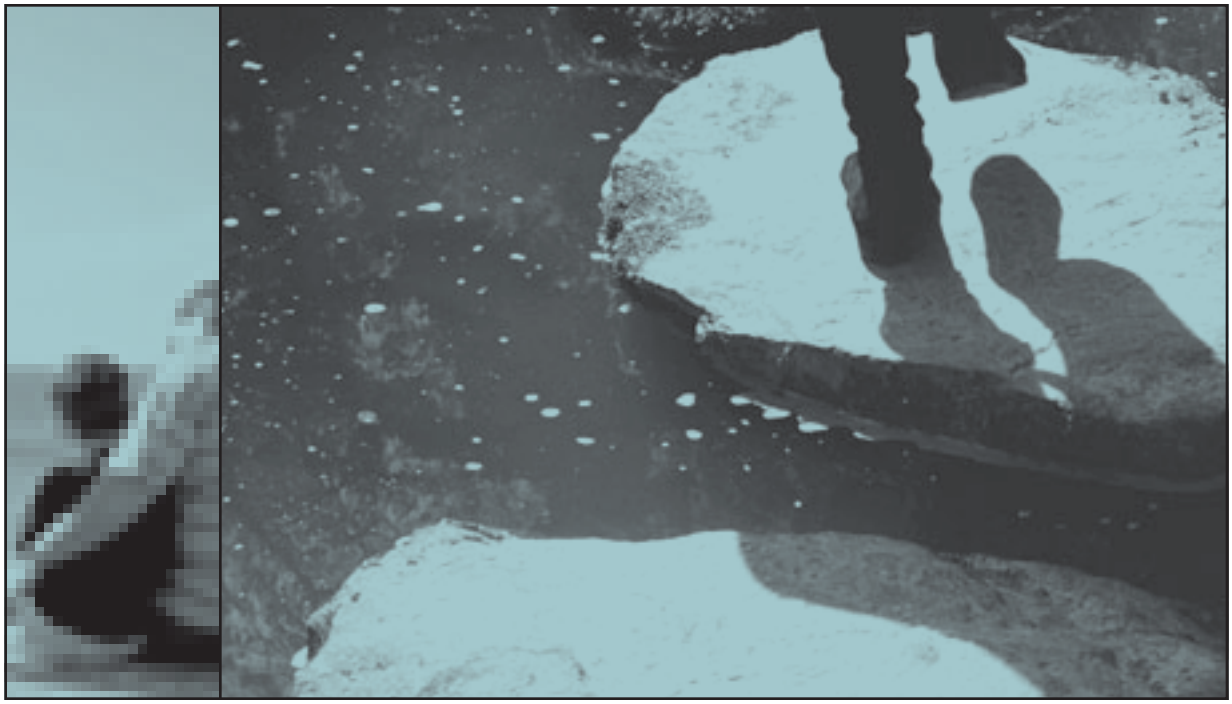
Organizations should develop support programs for the non-offending parents that focus on the needs of the parent so they can support the child.

Example: The Family Advocate Model developed at the National Children's Advocacy Center in Huntsville, Alabama (www.nationalcac.org).

15. Reach out to isolated cultural communities - Some cultural groups, especially recent immigrants, may not readily enter into mental health services for their children and some may find the nature of these Best Practices particularly uncomfortable.

Agencies should assess their community mix and develop action plans that reach into significant cultural groups; perhaps developing trained neighborhood or cultural advocates for mental health services for children.

Example: Annie Casey Foundation Urban Mental Health Initiative.



What strategies focused at Microsystems level within organizations to adopting the best practice? Microsystems for our purposes would be departments within organizations such as the counseling department of a multi-service agency or the mental health component of a CAC.

16. Trained Clinical Supervision/Consultation - The clinical supervisor and the availability of clinical support and consultation is often a key component to applying any new clinical intervention. Such support is necessary to gain therapist acceptance and to establish clinical accountability for adopting the practice and then clinical support as the therapist is learning new behavior.

Organizations should seek in-depth training for clinical supervisors in the selected Best Practices and then arrangements should be made with a mentor agency to provide on-going consultation until the agency has developed adequate experience to operate independently.

Example: Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents provided clinical supervision training and on-going consultation to Child Trauma Treatment Network Intermountain West Primary Children's Medical Center.

Knowledge of, or at least real interest, in learning evidenced-based interventions such as these Best Practices should be criteria for selection as a new supervisor.

Example: When a clinical supervisor is hired at the Chadwick Center, knowledge of and experience with EBT is part of the interview. Openness to supporting the implementation of such practices is considered a requirement for the position. Candidates are provided with a copy of the OVC Guidelines during the interview, which then serves as a focus for further discussion.

17. Change Hiring and Performance Evaluation Practices for Therapists - Organizations should constantly send the message that evidence-based practice is valued in the organization and that staff are accountable for their willingness to learn new evidence-based skills such as the Best Practices.

Knowledge and preparation in selected Best Practices or at least a strong interest in learning evidence-based practices should be criteria for employment and for performance evaluation of therapists.

18. Training/Consultation - All three Best Practices require professional knowledge and skills that are unique to this application and that cannot be obtained solely by reading published material.

Organizations interested in adopting one or more of the Best Practices are encouraged to arrange in-depth training from an experienced provider such as the resources listed in Appendix B.

Examples: Mental Health Corporation of Denver's Family Trauma Treatment Program arranged training and consultation (Supportive Implementation Model) needed to introduce TF-CBT with Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents.

San Diego's Chadwick Center contracted with the University of California Davis to provide training and consultation (Supportive Implementation Model) and The Child and Adolescent Research Center (through the work of Kristen McCabe) for training and supervision of staff in implementing Parent Child Interaction Therapy.

19. Create peer support networks/Community of Practice - Adopting a new practice presents unique challenges as well as problems others will encounter along the way as well. One way to speed adoption is to create peer support networks or communities of practice that act as learning collaboratives where people with like preparation, implementing a similar innovation, are in consistent contact sharing their experiences and solutions to problems they encountered.

Agencies should create internal peer support networks for therapists implementing these practices and/or cross agency collaboratives within similarly motivated organizations and networks such as the National Child Traumatic Stress Network or the National Children's Alliance.

These networks can be enhanced by inclusion of researchers/innovators at some level creating practitioner/researcher collaboratives.

Example: The Child Sexual Abuse Treatment Task Force of the National Child Traumatic Stress Network.

20. Overcoming Difficulty-Tracking what actually happens in therapy sessions - If an organization wishes to adopt the Best Practice, it is difficult (except for PCIT) to know if the therapist is implementing the Best Practice in the privacy of the therapy room.

Departments should develop tools to track clinical activity (in addition to outcomes) such as clinical activity checklists.

Example: The Chadwick Center has recently designated a staff person as a Clinical Supervisor. This is a position that will supplement the functions of the primary supervisor for each team. The functions of the Clinical Supervisor will include monitoring compliance with the clinical pathways. Monitoring will be completed through the use of chart review. Additional monitoring will occur as the Clinical Supervisor and a therapist review very specific interventions in face-to-face supervision. The therapist will be asked to describe the thought process that led them to select the particular intervention and to describe the intervention in step-by-step detail. Documentation that reflects both components will be maintained for quality assurance purposes. Therapists will also be asked to audio and videotape a specified number of sessions to be reviewed in supervision with both their primary supervisor and the Clinical Supervisor.

What strategies are focused on adoption of the best practice at the practitioner level and at the interaction between individual clinicians and individual families?

21. Develop parental engagement strategies - Successful adoption of these Best Practices requires the child to attend therapy sessions and to stay the course until the intervention is complete. A lack of parental engagement is reported to be a major barrier to successful mental health intervention for abused children. If the parents do not bring the children to therapy, if they discourage the new behaviors developed in therapy, or withdraw the child prematurely as symptoms begin to subside, the child will not gain the full affect of the intervention.

Agencies and therapists should develop formal plans to engage the parents and educate them as to what to expect in the process of therapy.

Therapists must expect a significant number of parents who have unresolved abuse experiences in their own background that may influence their ability to meet the child's needs and be prepared to address. Engage the parent in a long-term group where they do not feel stigmatized or threatened.

Example: The Chadwick Center staff have found this to be true. As child clients enter treatment, every non-offending parent is provided with information on the importance of their participation in the treatment process through their own individual therapy or through parent-child sessions, as appropriate. It is useful to have both individual and group therapy available for parents. In the initial treatment process, some parents are more comfortable participating in individual therapy rather than a group. Another treatment modality may be recommended as treatment proceeds.

22. Use of Assessment to drive clinical practice - Many practitioners lack the tradition of using assessment tools in their clinical practice to drive their selection of intervention.

Tool kits should be developed to help therapists see assessment instruments as decision aides as well as ways to track progress and outcomes.

The Chadwick Center has developed a protocol that guides therapists through the process of using standardized assessment tools to complete baseline and follow-up assessments on child trauma clients. The protocol designates instruments that are to be used with a specific age group, such as ages 6-9, 10-17, etc. The protocol also includes instructions for interpreting the scores obtained on the assessment tools, the intervals at which the tools should be administered, and the tools that are available in other languages. The protocol is supported by consultation from staff assigned to the outcome/assessment program and by ongoing training.

23. Overcoming Practitioner Resistance to Manualized Protocols - Many therapists appear to resist the use of manualized treatment protocol as documented in the barriers discussion.

Therapists should challenge their own biases here learning more about the Best Practices and other evidence-based interventions to learn that they provide far greater flexibility than some expect, and require skillful and creative clinical application.

NEXT STEPS

To bridge the Quality Chasm by spreading these evidence-based Best Practices, it is highly recommended that the following four steps are implemented.

Disseminate the customized overview of relevant findings of this document to selected audiences:

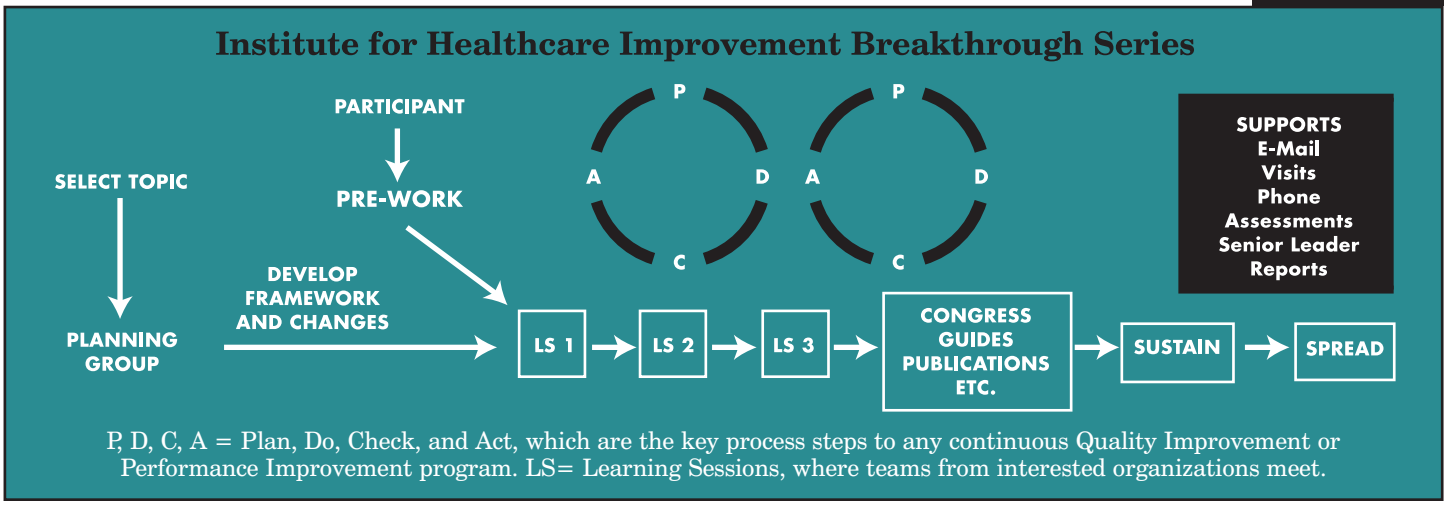
- State Victim Compensation Boards
- Major mental health insurance providers
- State and County social services and mental health directors
- Directors of Child Advocacy Centers
- Directors of trauma mental health organizations
- Relevant professional organizations
- Major child abuse related conference planners

Indeed, this publication will be shared with many of the above stakeholders in an effort to accelerate improvement.

Support development of a tool kit for agencies interested in adopting each Best Practice - Based on the model SAMSHA's successful partnership with the Robert Wood Johnson Foundation to produce 8 implementation Resource Kits on interventions for adults with chronic mental illness (currently in field testing), the NCTSN is working on an Implementation Toolkit on Trauma-Focused CBT for Sexual Abuse. This "toolkit" model includes not only a treatment manual, but also several other components thought to additionally augment the implementation of Trauma-Focused CBT into a community practice site. These include an implementation manual, with user-friendly sections targeting stakeholders' (clinicians, organizational administrators, supervisors, family members) concerns; information sheets; full set of PowerPoint teaching slides with notes to facilitate train-the-trainer strategies; fidelity checklists; cultural competence tips; and 2 videos – a short, concise description of the treatment and the toolkit, and a longer training video. These are designed to increase the efficiency of the treatment developers ability to respond to requests for trainings. The basic tenets and potential barriers are addressed up front; freeing the developers to do advanced training and serial supervision sessions.

Secure financial support to conduct one to three Breakthrough Series for these Best Practices - The Breakthrough series is a model developed by IHI that brings together like organizations in a common effort to implement an innovation at the same time. The model involves selection of a topic (in this case, one of our three Best Practices), development of a framework and training materials, identification of key data elements that can be used to track progress, basic introduction and training for 10 to 15 organizations at the same time, and a series of, at least, three "learning sessions" in which the programs come together and share their experiences applying the model and how they have responded to barriers they have encountered. **This model would allow us to marry the Supportive Implementation Model to the IHI experience in a way that provides peer support networks and communities of practice across agencies and accelerates the pace of diffusion of the selected practice.**

FIGURE 6



P, D, C, A = Plan, Do, Check, and Act, which are the key process steps to any continuous Quality Improvement or Performance Improvement program. LS= Learning Sessions, where teams from interested organizations meet.

Develop plan for Authentic Voices to focus elements of their social movement on the spread of these Best Practices - While we have learned much about how a motivated organization can adopt these Best Practices, such motivation to seek out and adopt evidence-based intervention is often absent in many, if not most, organizations providing therapy to abused children and their families. What's more, the broader political and funding environment does not support, much less demand, delivery of these efficacious services. A Social Movement, which is led by people who know the pain of abuse first hand, can become an important driver in spreading interest in the Best Practice interventions. The National Call To Action's Authentic Voice Movement is ideally suited to take up this cause. Composed of persons from across the nation and from all walks of life that share a common bond: they know personally, or through the experience of a loved one, the pain of abuse. If the National Call Authentic Voice Leadership equipped it's growing membership with knowledge and strategies on how to raise awareness of the identified Best Practices in their states and communities, we could influence the pace by which government, funding, and service delivery organizations became aware of the Best Practices and, with that awareness, move them from the Precontemplative or Contemplation stage to the Preparation and Action stages – change to provide the highest quality of care possible.

CONCLUSION

In the field of child abuse and neglect, there is a chasm between Best Practice and everyday practice. Each day, children receive a wide variety of therapeutic interventions of which disturbingly few are scientifically proven. As a result, children and their families receive a wide variation in the quality of care. To address these limitations and advance the field, the Kauffman Foundation provided support to the Chadwick Center and National Call to determine how to ensure effective outcomes for children and families in helping children heal from the traumatic effects of child abuse. Rapid widespread implementation and utilization of TF - CBT, AF - CBT, and PCIT Best Practices are vitally important first steps to crossing this quality chasm.

In the final analysis, the use of Evidenced Based Treatment provides therapists with choices in the interventions they may select to use to resolve the specific problems with which a client presents. The use of EBT also provides support to therapists in that they can be assured that the interventions they use are empirically grounded. The Kauffman Project has introduced three Best Practices to the reader. The early foundations of EBT are now in place. It will take training, funding, peer support and intense effort from all of us to build on these existing foundations. The provision of the best possible interventions to traumatized children is a professional value that few would disavow. The efficacious and compassionate healing of the trauma for these children is a worthy goal towards which we must strive as professionals.

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Perfection is something we never reach, but like the North Star, it serves as a beacon to guide us... We seek perfection by focusing on measurable improvement in all areas, including best practices of care. Everyday, we strive to be even better than before. Our dedicated caregivers should seek to attain it; our patients and families deserve it.

- BLAIR L. SADLER

"The American healthcare delivery system is in need of fundamental change... Americans should be able to count on receiving care...that is based on the best scientific knowledge. Between the healthcare we have and the care we could have lies not just a gap, but a chasm.... The current care systems cannot do the job. Trying harder will not work. Changing systems of care will."

Crossing The Quality Chasm, 2001
INSTITUTE OF MEDICINE

"We have an unprecedented opportunity to combine the pioneering improvement work in healthcare with knowledge of best practices in child abuse. I hope that this project will stimulate further collaboration between the healthcare and child abuse fields, and will accelerate the improvement of care provided so that, one day, every child in America who is the victim of abuse will receive the best treatment provided in the most timely, appropriate, and effective way."

BLAIR L. SADLER
President and CEO, Children's Hospital – San Diego

"Significant performance improvement will only be accomplished by tackling dramatic, system-level changes. The courageous among us will get there first, achieving performance levels never imagined by previous generations."

DONALD M. BERWICK, MD, MPP
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A COLLABORATION OF

CHILDREN'S HOSPITAL - SAN DIEGO
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