Treatment Intervention Advisory Committee Review and Determination

Date: February 23, 2018

To: Wisconsin Department of Health Services

From: Wisconsin Department of Health Services Treatment Intervention Advisory Committee: LCK
Lana Collet-Klingenberg, Ph.D. (chairperson)

RE: Determination of Collaborative and Proactive Solutions (CPS) as a proven and effective treatment for children and adults

☐ This is an initial review

☒ This is a re-review. Previously reviewed (rated) on July 2016 (3).

☐ No new research located; determination from month, year stands (details below)

Section One: Overview and Determination

Please find below a statement of our determination as to whether or not the committee views Collaborative and Proactive Solutions (CPS) as a proven and effective treatment. In subsequent sections you will find documentation of our review process including a description of the proposed treatment, a synopsis of review findings, the treatment review evidence checklist, and a listing of the literature considered. In reviewing treatments presented to us by the Department of Health Services, we implement a review process that carefully and fully considers all available information regarding a proposed treatment. Our determination is limited to a statement regarding how established a treatment is with regards to quality research. The committee does not make decisions regarding funding.

Description of proposed treatment
Lives in the Balance is a non-profit organization (http://www.livesinthebalance.org/about-lives-in-the-balance) founded by Dr. Ross Greene based on the Collaborative and Proactive Solutions (CPS) approach (formerly known as Collaborative Problem Solving approach). The organization supports families and professionals who work with children who have challenging behavior by providing resources free of charge.

Dr. Greene developed the model and referred to it as Collaborative Problem Solving prior to 2013. At that time there was a legal intellectual property dispute. Dr. Greene now refers to his model as Collaborative and Proactive Solutions (CPS). Publications on Collaborative Problem Solving from 2013 and after are not associated with Dr. Greene or the Collaborative and Proactive Solutions approach.

According to the Lives in Balance website, CPS approach centers on the idea that rewards and punishments will not change challenging behavior. Instead adults need to work collaboratively with children to build skills and solve problems. This approach involves three steps. The first step is to view children through the lens: "kids do well if they can." The idea is that intervention will be determined by how adults view problem behavior. In this approach, problem behavior is caused by lagging skills and unsolved problems. Step two is to identify the lagging skills and unsolved problems. The website

provides the assessment, a guide, and a video clip. Step three is to solve the problems using the three step colloborative model: Empathy step, Define the Problem step, and the Invitation step.

Synopsis of current review (February 23, 2018)

Committee members completing current review of research base: Roger Bass and Jenny Asmus.

Please refer to the reference list (Section Four) which details the reviewed research.

Collaborative and Proactive Solutions (CPS) are most often used with ODD, behavior disorders, those with "challenging behaviors," and less often with ASD, for which there is less data. The studies reviewed suggest that CPS is positioning itself as a positive alternative to ABA procedures which are characterized as aversive, punitive, and ineffective. This reviewer could find no studies where CPS and ABA were compared.

Methodological concerns included:

*Reliance on standardized measures, often third-party reports instead of direct observation and functional assessments. Multiple assessments were often given that assessed similar constructs suggesting that they may have collectively weighted the outcomes.

*The CPS model requires fewer consequences to be delivered. Therefore incidents would decrease even if the offenses did not.

*Lack of direct measurement of treatment and outcomes complicates assessing actual impact. The commonly used Likert scales are not as refined as direct observation procedures that could have been used.

*Data such as Iwata's research on negative control and the importance of identifying controlling variables to mitigate extreme escape/avoidance was not cited, nor were the many tactics for controlling behavior in a positive manner.

Summary of Research Reviewed

Four studies were reviewed, three dealing with ODD, aggression, and related challenging behaviors, and one assessing the procedure's efficacy with those with ASD.

Maddox et al. (2017) studied correlations between a wide range of constructs measured with third-party rating scales and found that children who lack skills to function in a given setting experienced more difficulties which allowed them to conclude that "Treatment for challenging behaviors in this group may consider targeting the incompatibility between environmental demands and a child's lagging skills" (p 1). This is notable only because it is implied that ABA creates these problems because it relies "on behavioral principles to create or modify reinforcers in the child's environment with the desired target of behavioral compliance" (p 3). This is an inaccurate characterization of the field, inconsistent with BACB ethical guidelines, and not the result of comparative research where ABA practitioners were involved.

Three other studies addressed ODD with basically the same procedure—discussing alternatives with the oppositional/defiant client and minimizing negative control. Again ABA was set up as the punitive/aversive control standard bearer e.g., Ercole-Fricke, et al (2016) "The staff [RNs in a psychiatric hospital] viewed pre-study, negative behavior modification and resultant punitive

consequences as culturally acceptable" (p127). No comparative research was offered, no ethical guidelines cited, no writings indicating that the opposite was true were offered. I mention this not only because it is a misrepresentation, but because it is part of what appears to be what could be called "advocacy research" that is not intended to be empirically secure. This practice is worth noting and considering in our work.

Booker et al (2016) found that CPS and Parent Management Training were equally effective though again saddled with methodological issues raised above. Miller-Slough et al (2016) describe parent-child "synchrony" as critical, a construct that has the features of CPS in that less aversive control exists and more discussion of possible options for remediating problematic behaviors occurs.

Committee's Determination: After reviewing the research and applying the criteria from the Treatment Review Evidence Checklist, it is the decision of the committee that Collaborative and Proactive Solutions (CPS) receive an efficacy rating of Level 3 - Emerging Practice, for children with ODD ages 7-14 and a Level 5 - Untested, for children with ASD.

Review history
(July 2016)
We were unable to find any research using CPS with individuals who have ASD.

CPS is primarily used for children with Oppositional Defiance Disorder (ODD).

This review found four studies that attempted to evaluate CPS for individuals who did not have ASD.
-Two of the studies did not pass screening for a full review (they are listed in the results with the reason for not passing screening).
-Full reviews of the other two studies were completed.
-One did not meet all the criteria. (It is listed in the references.)
-The other study met criteria. It was a randomized control trial comparing CPS, Parent Management Training (PMT), and a waitlist control group for children 7-14 with ODD. Results incidcated significant improvements in oppositional defiant behavior for children who participated in the CPS group compred to the waitlist control group. Improvements were similar for the children who were in the PMT group.

After reviewing the research and applying the criteria from the Treatment Review Evidence Checklist, it is the decision of the committee that Collaborative and Proactive Solutions (CPS) receive an efficacy rating of Level 3 - Emerging Practice, for children with ODD ages 7-14 and a Level 5 - Untested, for children with ASD.

Section Two: Rationale for Focus on Research Specific to Comprehensive Treatment Packages (CTP) or Models

In the professional literature, there are two classifications of interventions for individuals with Autism Spectrum Disorder (National Research Council, 2001; Odom et al., 2003; Rogers & Vismara, 2008):

(a) **Focused intervention techniques** are individual practices or strategies (such as positive reinforcement) designed to produce a specific behavioral or developmental outcome, and

(b) **Comprehensive treatment models** are "packages" or programs that consist of a set of practices or multiple techniques designed to achieve a broader learning or developmental impact.

To determine whether a treatment package is proven and effective, the Treatment Intervention Advisory Committee (TIAC) will adopt the following perspective as recommended by Odom et al. (2010):

The individual, focused intervention techniques that make up a comprehensive treatment model may be evidence-based. The research supporting the effectiveness of separate, individual components, however, does *not* constitute an evaluation of the comprehensive treatment model or "package." The TIAC will consider and review only research that has evaluated the efficacy of implementing the comprehensive treatment *as a package*. Such packages are most often identifiable in the literature by a consistently used name or label.

National Research Council. (2001). *Educating children with autism.* Washington, DC: National Academy Press.

Odom, S. L., Brown, W. H., Frey, T., Karusu, N., Smith-Carter, L., & Strain, P. (2003) Evidence-based practices for young children with autism: Evidence from single-subject research design. *Focus on Autism and Other Developmental Disabilities, 18,* 176-181.

Odom, S. L., Boyd, B. A., Hall, L. J., & Hume, K. (2010). Evaluation of comprehensive treatment models for individuals with Autism Spectrum Disorders. *Journal of Autism and Developmental Disorders, 40,* 425-436.

Rogers, S., & Vismara, L. (2008). Evidence-based comprehensive treatments for early autism. *Journal of Clinical Child and Adolescent Psychology, 37,* 8-38.

Section Three: TIAC Treatment Review Evidence Checklist

Name of Treatment: Collaborative and Proactive Solutions (CPS)

Level 1- Well Established or Strong Evidence (DHS 107 - Proven & Effective Treatment)

- ☐ Other authoritative bodies that have conducted extensive literature reviews of related treatments (e.g., National Standards Project, National Professional Development Center) have approved of or rated the treatment package as having a strong evidence base; authorities are in agreement about the level of evidence.
- ☐ There exist ample high quality studies that demonstrate experimental control and favorable outcomes of treatment package.
  - ☐ Minimum of two group studies or five single subject studies or a combination of the two.
  - ☐ Studies were conducted across at least two independent research groups.
  - ☐ Studies were published in peer reviewed journals.
- ☐ There is a published procedures manual for the treatment, or treatment implementation is clearly defined (i.e., replicable) within the studies.
- ☐ Participants (i.e., N) are clearly identified as individuals with autism spectrum disorders or developmental disabilities.

Notes: At this level, include ages of participants and disabilities identified in body of research

Level 2 – Established or Moderate Evidence (DHS 107 - Proven & Effective Treatment)

- ☐ Other authoritative bodies that have conducted extensive literature reviews of related treatments (e.g., National Standards Project, NPDC) have approved of or rated the treatment package as having at least a minimal evidence base; authorities may not be in agreement about the level of evidence.
- ☐ There exist at least two high quality studies that demonstrate experimental control and favorable outcomes of treatment package.
  - ☐ Minimum of one group study or two single subject studies or a combination of the two.
  - ☐ Studies were conducted by someone other than the creator/provider of the treatment.
  - ☐ Studies were published in peer reviewed journals.
- ☐ Participants (i.e., N) are clearly identified as individuals with autism spectrum disorders or developmental disabilities.

Notes: at this level, include ages of participants and disabilities identified in body of research

Level 3 – Emerging Evidence (DHS 107 – Promising as a Proven & Effective Treatment)

- ☐ Other authoritative bodies that have conducted extensive literature reviews of related treatments (e.g., National Standards Project, NPDC) have recognized the treatment package as having an emerging evidence base; authorities may not be in agreement about the level of evidence.
- ☒ There exists at least one high quality study that demonstrates experimental control and favorable outcomes of treatment package.
  - ☐ May be one group study or single subject study.
  - ☐ Study was conducted by someone other than the creator/provider of the treatment.
  - ☐ Study was published in peer reviewed journal.
- ☐ Participants (i.e., N) are clearly identified as individuals with autism spectrum disorders or developmental disabilities.

Notes: Level 3 for children 7-14 with Oppositional Defiant Disorder. The creator of the intervention was one of the researchers.

Level 4 – Insufficient Evidence (Experimental Treatment)

- ☐ Other authoritative bodies that have conducted extensive literature reviews of related treatments (e.g., National Standards Project, NPDC) have not recognized the treatment package as having an emerging evidence base; authorities are in agreement about the level of evidence.
- ☐ There is not at least one high quality study that demonstrates experimental control and favorable outcomes of treatment package.
  - ☐ Study was conducted by the creator/provider of the treatment.
  - ☐ Study was not published in a peer reviewed journal.
- ☐ Participants (i.e., N) are not clearly identified as individuals with autism spectrum disorders or developmental disabilities.

Notes:

Level 5 – Untested (Experimental Treatment) &/or Potentially Harmful

- ☐ Other authoritative bodies that have conducted extensive literature reviews of related treatments (e.g., National Standards Project, NPDC) have not recognized the treatment package as having an emerging evidence base; authorities are in agreement about the level of evidence.
- ☒ There are no published studies supporting the proposed treatment package.

- ☐ **There exists evidence that the treatment package is potentially harmful.**
  - ☐ Authoritative bodies have expressed concern regarding safety/outcomes.
  - ☐ Professional bodies (i.e., organizations or certifying bodies) have created statements regarding safety/outcomes.

Notes: Level 5 for children with ASD. (There is no evidence this intervention is harmful.)

References Supporting Identification of Evidence Levels:

Chambless, D.L., Hollon, S.D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66(1)* 7-18.

Chorpita, B.F. (2003). The frontier of evidence---based practice. In A.E. Kazdin & J.R. Weisz (Eds.). *Evidence-based psychotherapies for children and adolescents* (pp. 42---59). New York: The Guilford Press.

Odom, S. L., Collet-Klingenberg, L., Rogers, S. J., & Hatton, D. (2010). Evidence-based practices in interventions for children and youth with autism spectrum disorders. *Preventing School Failure, 54(4),* 275-282.

Section Four: Literature Review

Literature reviewed for current determination:

Booker, J.A., Ollendick, T.H., Dunsmore, J.C., Greene, R.W. (2016). Perceived parent-child relations, conduct problems, and clinical improvement following the treatment of oppositional defiant disorder. Journal of Child and Family Studies, 25, 1623-1633.

Ercole-Fricke, E., Fritz, P., Hill, L.E., Snelers, J. (2016). Effects of a collaborative problem-solving approach on an inpa-tient adolescent psychiatric unit. Journal of Child and Adolescent Psychiatric Nursing, 127-134.

Maddox, B.B., Cleary, P., Kuschner, E.S., Miller, J.S., Armour, A.C., Guy, L., Kenworthy, L., Schultz, R.T., & Yerys, B.E. (2017). Autism, pp 1-9. DOI: 10.1`77/136236137712651.

Miller-Slough R.L., Dunsmore, J.C., Ollendick, T.H., & Greene, R.W. (2016). Parent-child synchrony in children with oppositional defiant disorder: Associations with treatment options. Journal of Child and Family Studies 25, 1880-1888.

Literature reviewed for previous determinations:

Greene, R. W., Ablon, J. S., Goring, J. C., Raezer-Blakely, L., Markey, J., Monuteaux, M. C., … Rabbitt, S. (2004). Effectiveness of collaborative problem solving in affectively dysregulated children with oppositional-defiant disorder: Initial findings. Journal of Consulting and Clinical Psychology, 72, 1157–1164. (did not meet criteria)

Ollendick, T. H., Greene, R. W., Austin, K. E., Fraire, M. G., Halldorsdottir, T., Allen, K. B.,… Wolff, J. C. (2015). Parent Management Training and Collaborative & Proactive Solutions: A randomized control trial for oppositional youth. Journal of Clinical Child and Adolescent Psychology, 0(0), 1-14. (met criteria, but author was one of the researchers)

The following articles were considered (July 2016) but did not pass screening for a full review:

Epstein, T., & Saltzman-Benaiah, J. (2010). Parenting children with disruptive behaviours: Evaluations of a collaborative problem solving pilot program. Journal of Clinical Psychology Practice (1), 27-40. (pilot study with no comparison group

Martin, A., Krieg, H., Esposito, F., Stubbe, D., & Cardona, L. (2008). Reduction of restraint and seclusion through collaborative problem solving: A five-year prospective inpatient study. Psychiatric Services, 59(12), 1406-1412. (prospective study with no comparison group)