Best Practices: Evidence-Based

> *Workgroup Members*: Susan Steckel, LMSW, TDMHSAS – Chairperson; Janet Todd, PhD; University of Tennessee Health Science Center; Jon S. Ebert, PsyD, Vanderbilt University; Michele R. Moser, PhD, East Tennessee State University, Center of Excellence; Karen Edwards, PhD, TDMHSAS; Kathy A. Gracey, MEd, Vanderbilt University; Robert Edmonds, MA, LPE, Volunteer Behavioral Health – Cookeville; Mona Blanton-Kitts, LCSW, Helen Ross McNabb Center; Kristy Leach, MA, TDMHSAS; and Elizabeth Power, MEd, EPower & Associates.

Overview of Evidence-Based Practices

Since the children and youth version of these TDMHSAS guidelines (2008) were last drafted, the field of children's mental health, as a part of the children's system of care, has continued to expand the discussion and expectations for the use of evidence-based practice in the children's service delivery system. To facilitate a shared understanding of the increasing expectations for evidence-based practice (EBP), we look to the definition of evidence-based practice developed by the 2005 Presidential Task Force on Evidence-Based Practice of the American Psychological Association (EBPCA: APA, 2006) and to the report of the APA Task Force on Evidence-Based Practice with Children and Adolescents (APA, 2008), which builds on the work of the 2005 Presidential Task Force by focusing specifically on psychological practice with children and adolescents and encouraging a systems approach to enhancing care. The TDMHSAS through its Best Practices Guidelines supports an evidence-based orientation to practice and expressly adopts the definitions, guiding principles and assumptions promulgated by the APA Task Force on EBPCA and summarized below.

Definition of Evidence-Based Practice

The APA Task Force on EBPCA adopted APA's definition of evidence-based practice and delineated the principles and assumptions that currently guide EBP in children's mental health (APA, 2008). The adopted APA definition of EBP is the following:

> Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. This definition of EBPP closely parallels the definition of evidence-based practice adopted by the Institute of Medicine (2001, p. 147) as adapted from Sackett and colleagues (2000). … The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological

assessment, case formulation, therapeutic relationship, and intervention. (APA, 2006, p. 5)

While the APA definition is targeted for psychologists, the definition is shared by other mental health providers, including child psychiatry. For example, the American Academy of Child and Adolescent Psychiatry (AACAP) included a similar definition in their policy statement:

> Evidence-Based Practice (EBP) comprises empirically-validated processes that facilitate the conscientious, explicit and judicious integration of individual clinical expertise with the best available external clinical evidence from systematic research in making decisions about the care of individual patients. The ultimate goal of EBP is to base clinical decision making in the areas of causation, diagnosis, prognosis, treatment and guidelines on empirical evidence (AACAP, 2006, p.1).

The broader term "evidence-based practice" is chosen over the term "evidence-based treatment" because it goes beyond treatment to encompass evidence-based assessments (EBA) and evidence-based prevention and "extends to the systemic, cultural, and structural aspects of the settings, delivery mechanisms, and organizations and institutions through which EBTs and EBAs are developed and implemented" (APA, 2008, p. 18). The TDMHSAS through its Best Practices Guidelines adopts the broader concept of evidence-based practice. Tennessee's Best Practices Guidelines are also more inclusive than simply evidence-based treatment for specific disorders. The Guidelines focus on the children's system of care, including trauma informed systems, system of care initiatives, integrated health and behavioral health, targeted behavior problems, as well as traditional diagnostic categories.

Guiding Principles and Assumptions for Evidence-Based Practice for Children and Adolescents

The Task Force on EBPCA emphasizes that an evidence-based orientation to clinical practice requires "a scientifically minded approach" that includes applying psychological science and using an ongoing process of observation and evaluation. Early in its report, the Task Force identifies the following three primary elements of EBP for children and adolescents:

(a) assessment that guides diagnosis, intervention planning, and outcome evaluation;
(b) intervention that includes, but is not limited to, those treatment programs for which randomized controlled trials have shown empirical support for the target populations and ecologies; and ongoing monitoring, including client or participant feedback, conducted in a scientifically minded manner and informed by clinical expertise (e.g., judgment, decision making, interpersonal expertise) (APA, 2008, p. 9).

In summarizing the key issues surrounding EBP for children, adolescents, and families, the Task Force on EBPCA was guided by four principles. These principles, listed below, can be used by individual providers, organizations and children's services policymakers to provide a common language for evidence-based practice across systems.

Guiding Principles for Evidence-Based Practice for Children and Adolescents

1. Children and adolescents should receive the best available care based on scientific knowledge and integrated with clinical expertise in the context of patient characteristics, culture, and preferences. Quality care should be provided as consistently as possible with children and their caregivers and families across clinicians and settings.

2. Care systems should demonstrate responsiveness to youth and their families through prevention, early intervention, treatment, and continuity of care.

3. Equal access to effective care should cut across age, gender, sexual orientation, and disability, inclusive of all racial, ethnic, and cultural groups.

4. Effectively implemented EBP requires a contextual base, collaborative foundation, and creative partnership among families, practitioners, and researchers. (APA, 2008, p. 18)

In its report, the Task Force identifies its specific assumptions underlying evidence-based practice, assumptions it views as essential components to developing and disseminating care to youth and their families. Their assumptions of evidence-based practice include the following:

(a) shared goal of effective child mental health care, uniting families, practitioners, policymakers, payers, and researchers;
(b) importance of evidence- based assessment of childhood problems;
(c) importance of prevention of child and adolescent problems;
(d) need for systems-level changes to support EBP;
(e) importance of collaborative, multidisciplinary-focused EBP;
(f) imperatives of culturally responsive EBP; and
(g) utilization of diverse bases of evidence for EBP (APA, 2008, p. 22)

The Tennessee Best Practice Guidelines are developed in accordance with the EBPCA principles and assumptions. The Guidelines for each disorder or problem address evidence-based screening and assessment and intervention while being mindful of prevention and cultural differences that must be considered with implementation. The importance of collaborative, multi-disciplinary evidence-based practice is an overarching value in these guidelines, and its importance is exemplified through the chapter summarizing the Children's Council on Mental Health. (The Children's Council on Mental Health was legislated in 2008 to design a plan for a statewide system of care for children (http://www.tn.gov/tccy/ccmh-home.shtml)).

The section below provides a summary of the benefits and risks of EBPs. It is followed by a section discussing the components of evidence-based practice and resources to assist with identification of evidence-based practices and interventions in children's mental health.

Benefits and Risks of EBPs

      Benefit: Cost-effectiveness and Resources

The benefits of EBPs focus on efficiency as well as efficacy, both of which represent good stewardship of public funds and the ability to foster the mental health of children and youth. First, utilizing EBPs represents a **wiser use of limited resources** by focusing on practices that have "been *proven* to work as compared to what people *think* will work or what has traditionally been done" (Evidence based programs: An overview. *What Works, Wisconsin* Issue 6, 2007).

In cases where cost-benefit information is available for a particular EBP, this type of information conveys the **potential economic savings** that may accrue from the appropriate use of the specific EBP.

Third, the **credibility of EBPs is a strong influencer for funders, the community, and key stakeholders** so that their adoption as part of the offerings of child and youth serving agencies is likely to garner support as well as increase access to opportunities to apply for different types of funding.

That EBPs enjoy wider support from multiple disciplines spanning the biological, sociological and psychological also make their **implementation more attractive to funders** and decreases the degree to which they may be suspect to those who provide as well as those who receive services (http://escholarship.umassmed.edu/cgi/viewcontent.cgi?article=1014&context=pib).

In a report prepared by the Washington State Institute of Public Policy, the authors summarized their findings about implementing EBPs thusly:

> **"Evidence-based treatment works.** We found that the average evidence-based treatment can achieve roughly a 15 to 22 percent reduction in the incidence or severity of these disorders—at least in the short term."

> **"The economics look attractive.** We found that evidenced-based treatment of these disorders can achieve about $3.77 in benefits per dollar of treatment cost. This is equivalent to a 56 percent rate of return on investment. From a narrower taxpayer's-only perspective, the ratio is roughly $2.05 in benefits per dollar of cost."

"The potential is significant. We estimate that a reasonably aggressive implementation policy could generate $1.5 billion in net benefits for people in Washington ($416 million are net taxpayer benefits). The risk of losing money with an evidence-based treatment policy is small." (Aos et al., 2006).

      Choices for persons receiving services

Historically, persons receiving mental health care in both the public and private sector have been offered limited choices of treatment and interventions. Often the care is limited to the traditional "talking" therapies or interventions for which there is no level of evidence and medications

which may not be approved for a particular population, or whose side effects are as challenging as the problematic behaviors they are intended to manage.

In institutional or congregate settings, the emphasis on controlling and managing symptoms often takes priority over protocols that help service recipients develop skills and abilities that people who do not receive services develop as a result of healthier relationships and interactions.

The addition of EBPs means that service recipients are now active participants in their own healing and recovery and the children and youth, along with their caregivers and families, begin to hear and weigh information about multiple options in development of a comprehensive treatment plan.

Reductions of time, trauma, and costs of mental health recovery

The work of providing care and interventions for children and youth with mental health issues can be lengthy, traumatizing for caregivers, families, and for those who provide or receive services and as a result even more costly. Efforts to make a difference for those who receive services must also work to help those who provide services manage the inevitable impact of this emotionally difficult work.

Effective prevention and treatment programs have been developed for a variety of mental health issues, including programs addressing disruptive behavior disorders, trauma exposure, post-traumatic stress disorder, depression, anxiety, and substance use and abuse. In addition, several family- and community-based programs are available to prevent placement into juvenile detention settings, residential treatment, and foster homes (http://www.cimh.org/Portals/0/Zellerbach%20report%20-%20EBP.pdf).

Evidence-based practices target improved outcomes for children and families in terms of symptoms, functional status, and quality of life. In response, progress is assessed both in terms of prevention of relapse and re-hospitalization, but also in terms of positive outcomes such as independence, employment, and satisfying relationships (Drake et al., 2001) which aligns with the mental health recovery guidelines provided by the Substance Abuse and Mental health Services Administration (SAMHSA) in their National Consensus Statement on Mental Health Recovery.

Over the years, evidence-based practices have been shown to improve healthcare outcomes as well as conserve resources by removing unnecessary and ineffective healthcare treatment (Agency for Healthcare Research and Quality, 2003). While they are far from "magic bullets," and while there are challenges in terms of how effectiveness is determined, evidence-based practices are advances in the positive direction.

For example, there are three logical inferences of implementing practices that both conserve resources and improve outcomes:

1. Decreased time receiving services because of more effective and efficient methods of intervention.

2. Service recipients who are more functional and productive members of society more quickly, preserving capacity to learn, engage and earn.

3. Clinicians and service providers are less negatively impacted by the work of providing mental health care.

Provider and Organizational Considerations

1. Resistance to change. A key challenge in implementing EBPs may be both agency and provider resistance to change. While there is a considerable amount of evidence for any number of EBPs, the evidence is often doubted, rejected, or set aside.

There are many who believe that the empirical study of psychotherapeutic interventions or the need to base interventions on documented methods of treatment is not applicable to them as practitioners or to their agencies. As Kennair, Aarre, et al. point out in their 2002 article in the *Journal of Science and Health Policy*, there is "no reason to believe that the methods one was initially trained in were the best methods ever to be discovered. The approach also ignores the duty to revise professional attitudes in the light of new evidence (p. 2)."

Resistance to change is supported by three primary issues in the world of behavioral and mental health care:

1. Personal conviction to one's way of working without documented evidence from processes grounded in science (even if lesser evidence than Randomly Controlled Trials);

2. Adherence to "the ways things have always been done," and

3. The preference for what may be called "socially constructed consensus" over "empirically informed guidelines."

2. Quality and cost. In implementing EBPs, the question of what determines quality is paramount. Using less than optimal treatment usually means not optimally alleviating the individual's suffering, but it also means that the individual will continue to be sub-optimally productive and probably cause further costs to not only treatment agencies but also other child services such as education.

Thus determining which of the evidenced based interventions or therapies to offer requires some definition of "optimal" which must also take into account the challenges of research in the field. The U.S. National Registry of Evidence-Based Practices and Programs (NREPP) evaluation protocol is one such protocol, and is the basis of determining which interventions will be added to the NREPP database. NREPP will consider adding a practice or program only if it has been evaluated using an experimental or quasi-experimental study design. Additionally, the treatment must have outcome data that has been published in a peer-reviewed journal or an evaluation report, and should include documentation such as manuals and training materials available for assisting in dissemination.

3. Organizational change required. Implementing any new practice or program requires multiple changes, which may range from operating processes to policy change, environmental

changes, staff behavior change, communication and record-keeping as well as changes to financial processes. Because the goal is to offer the optimal practices and programs with the fidelity required to achieve the desired outcomes, organizational change is a major issue for implementing evidenced based practices. There are numerous methodologies available for implementing organizational change that address the clinical as well as the administrative aspects of taking on new evidenced based practices in an agency or system (i.e. National Implementation Research Network: http://nirn.fpg.unc.edu/).

4. Fidelity to the model. The research on an evidenced based practice resulting in the attribution of a "promising," "evidence-informed" or "evidence-based" practice contains key information about specific practices, or frames, that are necessary for replication to be successful. Without these, the risk of attaining less than the optimal results offered by the EBP is high.

Adopting a model does not mean adapting it, and adaptation beyond the limits provided decreases fidelity and success, thus decreasing the cost-benefit ratios and potentially increasing frustration and disappointment by the provider. Investing in the manuals, the training, and the follow-up supervision/consultation requirements as well as working to ensure that adherence to key criteria occurs is critical to obtaining optimal outcomes for children and their families.

5. Risks. In recent years, the focus on present-focused, strength-based mental health recovery has increased. Models that focus on recovery may not yet have a body of empirical research even if they have a body of lesser-level evidence for effectiveness. Thus, a rigid implementation policy of using only EBPs can disenfranchise the voice of the child and his/her family. This risks a return to a more subtly coercive model, which is contrary to the SAMHSA National Consensus Statement on Mental Health Recovery and which may mimic the dynamics of factors contributing to mental health issues.

EBPs often focus on a **specific diagnosis rather than a broad population**. One risk of the need for interventions to be evaluated with Randomized Controlled Trials (RCTs) is that the research may limit participation to individuals with specific diagnostic criteria in order to enhance effect sizes. While serving the immediate research needs, addressing the effectiveness for the broader population may be beyond the scope of most RCTs (McKay, 2007). However, recently the field is making some progress toward modifying EBP to include cultural adaptations and address multicultural competencies to improve outcomes (i.e. Berg-Cross, L & So, D. Register Report, Fall 2011) http://www.nationalregister.org/trr_fall11_bergcross.html.

Issues of adequate funding to address training and implementation of evidence based practices to ensure fidelity to a the EBP model can impact the outcomes and sustainability of the evidenced based practice in the organization and must be addressed to provide the most successful outcomes for children and their families

Resources and Tools

A.   *Selecting/evaluating evidence-based assessments and treatments*

As stated throughout this document, evidence-based practice is an approach that encourages consideration of empirical evidence, clinical expertise, and family and cultural values. Evidence for the effectiveness of a given practice exists on a continuum from treatments supported with the most rigorous high-quality experimental research to treatments supported by theoretical constructs that have general support in the professional community. When empirical evidence exists that establishes the efficacy of an assessment or treatment approach for a specific set of symptoms exhibited by a child or adolescent, the treatment provider has an ethical duty to discuss the strengths and limitations of the approach with the client and his/her caregiver. When empirical evidence does not exist to support the efficacy or effectiveness for an assessment or treatment approach, the treatment provider provides EBP by balancing the most current empirical evidence, clinical expertise, and the family's preferences (Association for Behavioral and Cognitive Therapies and the Society of Clinical Child and Adolescent Psychology, 2010).

  1. *Evidence-based Assessment*

Mash and Hunsley (2005), in their introduction to the special section of the *Journal of Clinical Child and Adolescent Psychology* directed at developing guidelines for evidence-based assessment of child and adolescent disorders, noted that, in comparison to evidence-based interventions, little attention has been paid to developing evidence-based assessment guidelines. Their introduction enumerated several of the complexities that challenge the field when addressing evidence-based assessment.

> (a) the sheer number of assessment methods and processes for particular
> problems and outcomes relative to the number of available treatments and (b) the many
> purposes of assessment as compared with treatment. This challenge
> is compounded in assessments of children, where developmental changes in the domains
> being assessed (Lahey et al., 2004) and the embeddedness of children in the family and
> peer group require that a much larger number and variety of methods be developed and
> used than is the case for adults. (p. 364)

Because of the complexities of evidence-based assessment, Mash and Hunsley (2005) supported the idea that disorder or problem specific guidelines be developed that address what the goals of the assessment might be, such as diagnosis, treatment planning, treatment monitoring, and treatment evaluations. They noted the importance in attending to the "the psychometric properties of specific tests and measures, common assessment decisions associated with specific disorders, and the utility of assessment for treatment planning, design, and monitoring." (p. 375). Evidence-based assessment for specific disorders including anxiety, depression, bipolar disorder, attention deficit hyperactivity disorder, conduct problems, learning disabilities, and autism spectrum disorders were part of the special section. See *Journal of Clinical Child and Adolescent Psychology*, 2005, *34*(3).

Since that time, evidence-based assessment has had additional attention in pediatric psychology. APA Society of Pediatric Psychology published a special issue journal (2008) to both identify and evaluate assessment instruments available in the child health care field. Articles in the special section of Journal of Pediatric Psychology addressed evidence-based assessment in the following areas: quality of life, family functioning, psychosocial functioning and psychopathology, social support and peer relations, adherence, pain, stress and coping, and cognitive functioning.

In keeping with the idea of development of evidence-based assessment processes, not simply identification of evidenced based instruments, Kazden (2005) summarized the common themes in child and adolescent assessment that evaluators should keep in mind:

1. There is no "gold standard" to validate assessments.
2. Multiple measures need to be used capture diverse facets of the clinical problem.
3. Multiple disorders or symptoms from different disorders ought to be measured because of high rates of comorbidity.
4. Multiple informants are needed to obtain information from different perspectives and from different contexts.
5. Adaptive functioning, impairment, or more generally how individuals are doing in their everyday lives are important to assess and are separate from symptoms and disorders.
6. Influences (or moderators) of performance need to be considered for interpreting the measures, including sex, age or developmental level, culture, and ethnicity, among others. (p. 549)

2. Evidenced-based Intervention

The research literature for evidence-based psychosocial interventions continues to evolve and develop and can be overwhelming to individual clinicians who strive to be evidence- based in their treatment. Clinicians, after doing the work to identify an evidence-based treatment and looking at the strength of the science supporting the intervention, must also consider the child and family's characteristics and cultural factors in implementing the intervention.

Families have an important role on their child's treatment team. As difficult as it is for clinicians to wade through the literature on evidence-based treatments and identify evidence-based interventions, it may be even more difficult for families to navigate the evidence-based practice terrain. NAMI (2007) has developed a guide to assist families in understanding what is meant by "evidence-based practice", what evidence-based treatments have been identified for particular problems, and how to advocate for their child's needs when working with a provider to determine interventions that are the best fit for their child and family's needs.

Online resources that clinicians and families can use to identify evidence-based interventions for children and adolescents are listed below.

B.   List of online resources

California Evidence-Based Clearinghouse for Child Welfare: http://www.cebc4cw.org/.

Effective Child Therapy: Evidence-based mental health treatment for children and adolescents. Sponsored by American Psychological Association, Division 53. http://www.effectivechildtherapy.com/.

Metz, A., & Bartelye, L. (2012). Active implementation frameworks for program success: How to use implementation science to improve outcomes for children. *Zero to Three.* http://www.zerotothree.org/about-us/areas-of-expertise/reflective-practice-program-development/metz-revised.pdf.

NAMI: Choosing the right treatment: What families need to know about evidenced based practices. Retrieved from http://www.nami.org/Template.cfm?Section=child_and_teen_support&template=Content Management/ContentDisplay.cfm&ContentID=47656.

National Child Traumatic Stress Network: Empirically supported treatments and promising practices. Retrieved from http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices.

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP): http://www.nrepp.samhsa.gov/.

References

Agency for Healthcare Research and Quality (AHRQ). (2003, September). *Medical examination and treatment for victims of sexual assault: Evidence-based clinical practice and provider training* (Report to Congress: AHRQ Publication No. 03-R210). Washington, DC.

American Academy of Child and Adolescent Psychiatry (AACAP). (2006). Policy statement of the American Academy of Child and Adolescent Psychiatry on evidenced based practice. Retrieved from http://www.aacap.org/cs/root/policy_statements/evidence_based_practice.

American Psychological Association Presidential Task Force on Evidence-Based Practice (APA). (2005). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271-285. doi: 10.1037/0003-066X.61.4.271

American Psychological Association Task Force on Evidence-Based Practice for Children and Adolescents (APA). (2008). *Disseminating evidence-based practice for children and adolescents: A systems approach to enhancing care.* Washington, DC: American

Psychological Association. Retrieved from
http://www.apa.org/practice/resources/evidence/children-report.pdf.

Aos, S., Mayfield, J., et al. (2006). Evidence-based treatment of alcohol, drug, and mental health
disorders: Potential benefits, costs, and fiscal impacts for Washington State. Olympia:
Washington State Institute for Public Policy.

Berg-Cross, L & So, D. (2011). Evidenced-based multicultural therapies: The start of a
new era. *Register Report*, Fall. Retrieved from
http://www.nationalregister.org/trr_fall11_bergcross.html.

Cohen, L.L., La Greca, A.M., Blount, R.L., Kazak, A.E., Holmbeck, G.N., & Lemanek, K.L.
(2008). Introduction to special issue: Evidence-based assessment in pediatric psychology.
Journal of Pediatric Psychology, 33(9), 911-915. doi:10.1093/jpepsy/jsj115.

Cooney, S., Huser, M., et al. (2007). Evidence Based Programs: an Overview. *What Works,
Wisconsin* Issue 6. University of Wisconsin–Madison and University of   Wisconsin–
Extension.

Drake, R.E., Goldman, H.H., Leff, H.S., Lehman, A.F., Dixon,L., Mueser, K.T., et al. (2001).
Implementing evidence-based practices in routine mental health service   settings.
Psychiatric Services, 52(2), 179–182.

Kazdin, A. E. (2005). Evidence-based assessment for children and adolescents: Issues in
measurement development and clinical application. *Journal of Clinical Child and
Adolescent Psychology,* 34, 548-558.

Kennair, L., Aarre, T., et al. (2002). Evidenced based mental health: The scientific foundation of
clinical psychology and psychiatry. *The Journal of Science and Health Policy, 2*(1), 1-
300.

Lahey. B.B., Applegate, B., Waldman. I.D., Lofl, J.D., Hankin, B.L., & Rick, J. (2004). The
structure of child and adolescent psychopathology: Generating new hypotheses. *Journal
of Abnormal Psychology*, *113*, 358-385.

McKay, C.E. (2007). Evidence based practices in mental health: Advantages, disadvantages, and
research considerations. *Center for Mental Health Services.*

Marsenich, L. (2011). Using evidenced-based programs to meet the mental health needs of
California children and youth. Retrieved from
http://www.cimh.org/Portals/0/Zellerbach%20report%20-%20EBP.pdf.

Mash, E. J., & Hunsley, J. (2005). Evidence-based assessment of child and adolescent disorders:
issues and challenges. *Journal of Clinical Child and Adolescent Psychology, 34,* 362–
379.

NAMI: (2007). A family guide: Choosing the right treatment: What families need to know about evidence-based practice. Retrieved from http://www.nami.org/Template.cfm?Section=child_and_teen_support&template=/ContentManagement/ContentDisplay.cfm&ContentID=47656.

Painter, K. (2009)*. Legislation of evidence-based treatments in public mental health: Analysis of benefits and costs. *Social Work in Public Health, 24*(6*), 511-26. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19821190?dopt=Abstract.

Research Issue Brief, 4:5. Department of Psychiatry University of Massachusetts Medical School. Retrieved from http://escholarship.umassmed.edu/cgi/viewcontent.cgi?article=1014&context=pib.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2006). National consensus statement on mental health recovery. Retrieved from http://store.samhsa.gov/product/National-Consensus-Statement-on-Mental-Health-Recovery/SMA05-4129.

Williamson, E. and Dutch, N. et al. (2010). Evidence-based mental health treatment for victims of human trafficking. Department of Health and Human Services. Retrieved from http://aspe.hhs.gov/hsp/07/HumanTrafficking/MentalHealth/index.shtml.

This page
was intentionally
left blank