Using Evidence-Based Programs to Meet the Mental Health Needs of California Children and Youth

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Introduction

Recent estimates suggest that 10 to 20 percent of children and youth have a diagnosable mental disorder (U.S. Department of Health and Human Services, 2000), and that only a minority of youth with mental health disorders receive specialty mental health care (Child and Adolescent Health Measurement Initiative, 2007). Despite a growing body of evidence indicating the benefits of timely prevention, diagnosis and intervention, the child-serving systems continue to miss opportunities to improve outcomes for these children and their families.

The 2004 passage of Proposition 63, known as the Mental Health Services Act (MHSA), provided increased resources to support county mental health programs. The goal of the MHSA is to improve the lives of children and youth (as well as adult populations) by focusing on prevention, early intervention, and the provision of evidence-based services. Funding provided by the MHSA has contributed significantly to improved outcomes by increasing the utilization of evidence-based programs in children's mental health in California.

Through an examination of interview data surrounding key issues in children's mental health, including the benefits of providing evidence-based programs to achieve the goals set forth in the MHSA, this policy report synthesizes information and proposes recommendations to maximize outcomes for children and their families.

Prevalence of Mental Health Disorders in Children and Youth

An estimated one in every five children and adolescents in the United States has a mental disorder (Kataoka et al., 2002). Prevalence rates are somewhat higher for youth in the child welfare and juvenile justice service systems. Specifically, rates of significant mental health problems are estimated to range from 30 to 80 percent for youth in the child welfare system (Leslie et al., 2004), and from 65 to 70 percent of youth in juvenile detention and residential settings (Teplin et al., 2003).

Despite the evidence documenting significant rates of mental health problems for children and youth, 40 to 80 percent of children with mental health problems do not receive the services they need (Kataoka et al., 2002). Research documents that disparities in access and utilization of mental health services is highest among those from culturally diverse populations, particularly Latinos (Kataoka et al., 2002), preschool-aged children and youth who struggle with depression and anxiety (Merikangas et al., 2011).

Effective Prevention and Treatment Exists

In response to the recommendations of the landmark report of the Surgeon General on mental health (U.S. Department of Health and Human Services, 1999), the National Institutes of Mental Health and Drug Abuse established several research initiatives to fund development of intervention and prevention programs, as well as research on strategies for moving science to practice more rapidly. Further, the Office of Juvenile Justice and Delinquency Prevention and the Centers for Disease Control funded large-scale dissemination of youth violence prevention practices and programs. As a consequence, we now have a robust body of intervention and prevention research from which "evidence-based" programs have emerged. Effective prevention and treatment programs have been developed

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for disruptive behavior disorders, trauma exposure, including 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.

While eliminating disparities in access, utilization and outcomes for ethnic minority youth continues to be a focus for researchers and policy advocates, there has been tremendous progress in the past 10 years. This results from ethnically diverse scholars making significant contributions to the body of evidence. The Center for Multicultural Mental Health research at Harvard, the Latino Research Center at the University of California, San Francisco, and the Asian American Center on Disparities Research at the University of California, Davis, are examples of institutions with research programs dedicated to improving the science regarding mental health disparities.

As the body of evidence has continued to grow, policy makers and funding sources have begun to encourage and, in some cases, require the use of evidence-based programs and practices for both prevention and treatment. This has led many federal and state agencies to develop evidence-of-effectiveness criteria and to publish lists of programs that meet these criteria. There are numerous examples, a review of which is beyond the scope of this report. However, those that have the most impact nationally and at the state level, bear mentioning.

- Substance Abuse and Mental Health Services Administration (SAMSHA) – National Registry of Evidence-Based Programs and Practices (NREPP). NREPP offers a searchable online registry of interventions supporting mental health promotion, substance abuse prevention and mental health and substance abuse treatment.
- The Coalition for Evidence-Based Policy. A non-profit, non-partisan group that seeks to increase government effectiveness through the use of rigorous evidence about what works. The Coalition's work with key executive branch and congressional officials has helped inform and/or shape major new evidence-based policy initiatives. The Coalition sponsors the *Social Programs That Work* website.
- The Center for Disease Control offers a *Community Guide to Preventive Services*, which is a searchable database offering evidence of effectiveness for violence prevention programs and mental health promotion programs.
- The California Evidence-Based Clearing House for Child Welfare (CEBC). The clearing house website provides child welfare professionals with easy access to information about programs and practices advancing the federal child welfare outcomes (i.e., safety, permanency, well-being). The primary task of the CEBC is to inform the child welfare community about the research evidence for programs being used or marketed in California.
- National Child Traumatic Stress Network (NCTSN). The mission of the NCTSN is to raise the standard of care and provide access to services for traumatized children, their families and communities. The organization's website includes a wealth of information for both parents and professionals, including a compendium of effective trauma practices.
- Promising Practices Network (PPN), operated by the Rand Corporation. The PPN website offers research-based information on what works to improve the lives of children and families. PPN also links to additional research information in all areas related to child well-being, including their mental and physical health, academic success, and economic security.

These website resources are examples of efforts at both the federal and state levels to promote the availability of evidence-based practices to improve the health and well-being of children, youth, and families.

Why Implement Evidence-Based Programs?

The most compelling reason for implementing evidence-based programs (EBPs) in children's mental health is that they have the greatest likelihood of producing positive effects and more quickly than "usual care" mental health interventions. Because the (EBPs) have been rigorously evaluated, we have reason to be confident, that if implemented with fidelity, they will be effective.

Effective interventions alleviate suffering, promote adaptive behavior and improved coping strategies, and ameliorate stress (for both youth and their families). They also decrease the likelihood of long-term mental health problems (Weisz et al., 2005).

Additionally, recent research has demonstrated a negative effect for children of untreated or ineffectively treated childhood mental health problems and poor economic outcomes much later in adulthood. The study found large effects on the ability of children with mental health problems to work as adults. Educational accomplishments were diminished and adult family incomes reduced by about 20%, or $10,400 per year. The study concludes, that effective treatments for children that lower the risks of experiencing a mental health disorder and mitigate their adult psychological and economic consequences are likely to have long-lasting payoffs and be very cost-effective (Smith & Smith, 2010).

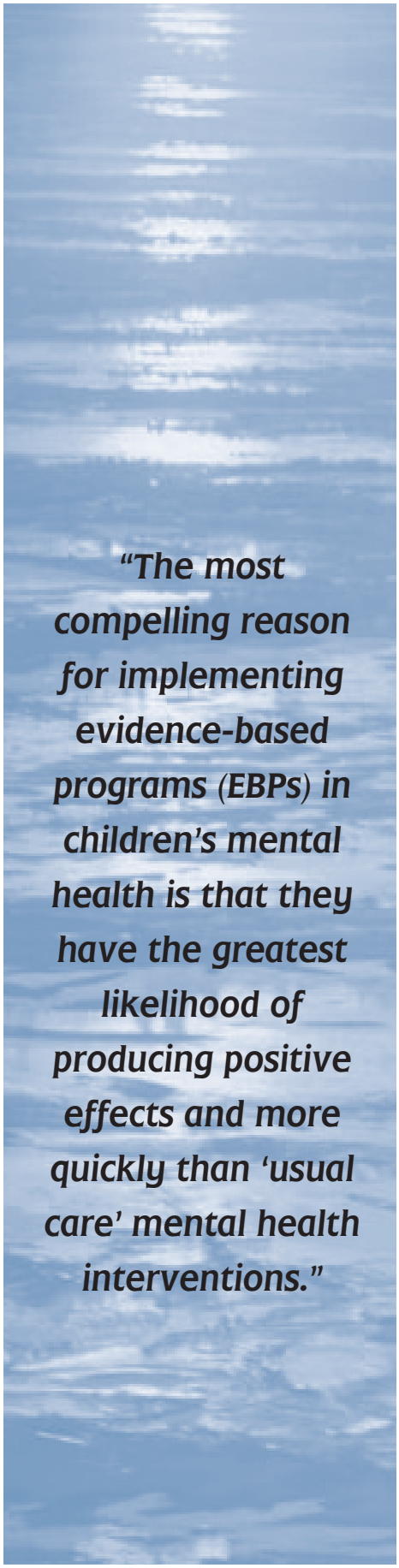
Further, research has shown that even well-intentioned, theoretically sound and often popular programs sometimes show no positive effects, and in some cases actually increase poor outcomes (Dishion et al., 1999; Ennett et al., 1994). Recent research using data from the National Survey of Child and Adolescent Well-Being (NSCAW) were examined. The study measured caregivers' reported change in children's emotional and behavioral problems. All children received child welfare services. Although behavior and emotional problems improved over time, children who received mental health services got slightly worse. In addition, disparities were identified across ethnic groups. The authors report, "young Black, Hispanic, and other racially identified children had more problems than young White children, regardless of service" (McCrae et al., 2010). The authors argue that while the findings were not unexpected, they should serve as an impetus to ensure that young children in the child welfare system receive evidence-based practices.

In sum, given the possibility that prevention and treatment programs and practices might actually exacerbate poor outcomes for children, youth, and their families, there is an increased responsibility to incorporate EBPs strategies that have been proven to work. Of course, where gaps in research evidence exist, we must proceed with caution and evaluate outcomes. As in other disciplines, scientific research has proven to be our most reliable guide for policy.

Finally, in times of shrinking budgets with increasing state and federal deficits, it is incumbent upon policy makers, advocates, and practitioners to make efficient use of resources by choosing to implement programs with the greatest likelihood of achieving positive results, as well as reducing treatment costs and negative economic impacts.

Implementation of Evidence-Based Practices and Programs in California

It has been almost 10 years since the publication of the Zellerbach Foundation funded monograph titled *Evidence-Based Practices in Mental Health Services for Foster Youth*. As a



"...it is incumbent upon policy makers, advocates, and practitioners to make efficient use of resources by choosing to implement programs with the greatest likelihood of achieving positive results..."

result of the findings published in the report the California Institute for Mental Health (CiMH) began to facilitate the dissemination and implementation of evidence-based programs for youth in the juvenile justice and child welfare services systems and more recently for youth receiving prevention and early intervention through the MHSA.

The current project, again funded by the Zellerbach Foundation, provided an opportunity to survey the landscape of EBPs in California to determine what impact EBPs may be having in the lives of children, youth, and families.

California Implementation of EBPs: Sources, Methods, and Results

Information for this report was gathered from organizations and agencies implementing EBPs supported by the CiMH, which represents one of the largest dissemination efforts in the state. It is however, not the only organization sponsoring EBP implementation. In addition, information was gathered from organizations with robust EBP implementation initiatives.

A set of interview questions were developed to determine: a) when the EBP implementation began; b) the number of agencies or organizations trained and utilizing the EBP; c) utilization with ethnically and culturally diverse populations, including adaptations for specific cultural groups; d) description of the training protocols; e) outcomes; and f) impact. In addition, we asked if there had been attrition and if so what factors contributed to sustainability challenges.

The results of the interviews are summarized in the table on page 5. Overall, the 10 interventions that were the focus of the interviews are having very positive outcomes, and significant impact in California.

For comprehensive review of each EBP implementation, please see the companion document to this policy report: "Supplmental Report on Evidence-Based Programs" (www.cimh.org).

EBPs Delivered Through County Mental Health Departments

In order to determine the impact of EBPs more broadly, we designed a brief survey to be completed by children's coordinators in California mental health departments. The survey was reviewed and then disseminated through the California Mental Health Directors Association. The findings from this survey are summarized in the table below.

Continued on page 6

Response Rate	16 of 58 counties
Estimate of children enrolled in mental health services in fiscal year 2009-2010	54,975
Estimate of children receiving EBPs in fiscal year 2009-2010	13,954 or 25% of enrolled children are receiving EBPs
EBPs with highest frequency	PCIT – 9 counties Incredible Years Parenting Program – 7 counties TF-CBT – 10 counties

* The responses were evenly distributed among large, medium, and small counties. Los Angeles County is not represented in this table.

Intervention	Treatment Focus & Aims	Outcomes Achieved	Impact
Aggression Replacement Therapy (ART)	Age: 12-18 years Treatment Focus: Disruptive Disorders	Improved: -Social skills Reduced: -Juvenile Justice Recidivism -Impulsive & aggressive behavior	# of Implementing Organizations: -32 provider agencies -22 probation departments Estimate of youth served per year: 3,500
Depression Treatment Quality and Improvement (DTQI)	Age: 12-18 years and their caregivers Treatment Focus: Depression and youth with depressive symptoms	Improved: -Functioning such as school performance Reduced: -Depressive symptoms	# Implementing Organizations: -12 provider agencies which includes county mental health -Estimate of youth served per year: 250
Functional Family Therapy (FFT)	Age: 11-18 years and their families Treatment Focus: Disruptive Disorders	Improved: -Family functioning Reduced: -Juvenile Justice recidivism -Substance use -Prevention of further out-of-home placements	# of Implementing Organizations: -25 provider agencies including county mental health and probation departments -Estimate of youth served per year: 1,200
Multisystemic Therapy (MST)	Age: 12-18 years and their families Treatment Focus: Disruptive Disorders	Improved: -Family functioning Reduced: -Juvenile Justice recidivism -Out-of-home placement -Mental health problems	# of Implementing Organizations: -10 provider agencies including schools, county mental health and public health -Estimate of youth served per year: 300
Multidimensional Treatment Foster Care (MTFC)	Age: 3-18 years and their caregivers Treatment Focus: Disruptive and emotional disorders	Improved: -School attendance and performance -Parenting skills -Permanency Reduced: -Juvenile justice recidivism -Placement disruption -Teenage pregnancies -Substance use	# of Implementing Organizations: -16 provider organizations including county operated programs -Estimate of youth served per year: 130
Nurse Family Partnership (NFP)	Age: First-time, low-income mothers and their children Treatment Focus: prenatal and infancy nurse home visiting prevention program to improve the health and well-being of first time, low income mothers	Improved: -Maternal health and self sufficiency -School readiness Reduced: -Child maltreatment -Number of subsequent pregnancies and birth intervals	# of Implementing Organizations: -17 programs in 13 counties in public health and public schools -Estimate of mothers served per year: 9,700
Parent -Child Interaction Therapy (PCIT)	Age: 2-7 years and their caregivers Treatment Focus: Disruptive Disorders	Improved: -Parenting skills and attitudes Reduced: -Child behavior problems -Re-reports of physical child abuse	# of Implementing Organizations: -95 sites throughout the state of California -Estimate of families served per year: 5,000
SAFECARE	Age: Families of children under 6 who are at risk for neglect or abuse or has been reported for maltreatment Treatment Focus: home visiting parenting prevention program focusing on home safety; child health and parent child/infant interaction	Improved: -Parental safety and health skills Reduced: -Reoccurrence of child maltreatment	# of Implementing Organizations: -7 sites in the state; 3 in Central California, 2 in Northern California and two in Southern California -Estimate of families served per year: 1,440
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Age: 3-18 and their caregivers Treatment Focus: Emotional/behavioral problems resulting from exposure to trauma	Improved: -General functioning -Positive Parenting Skills -Parent and child coping skills Reduced: -PTSD symptoms -Self-reported fear and anxiety -Symptoms of depression	# of implementing organizations: -200 agencies throughout the state -Estimate of children served per year: 10,000
Triple P (Positive Parenting Program)	Age: 0-16 and their caregivers Treatment Focus: Disruptive behavior in children	Improved: -Positive parenting practices Reduced: -Negative and disruptive child behaviors	# of Implementing Organizations: -65 agencies operating in 15 counties throughout the state -Estimate of children served per year : 1,000

"California has made significant progress toward closing the gap between routine mental health care practice and evidence-based practice."

Consistent with results from national surveys, approximately 1/3 of the counties responded. The finding that 25% of children enrolled in mental health services are receiving EBPs is impressive and, undoubtedly, is an under-representation of the true numbers statewide. So there is reason for cautious optimism. Only five years after the New Freedom Commission on Mental Health reported that "The gap between routine mental health care practice and evidence-based practice represents a significant public health problem" (U.S. Department of Health and Human Services, 2005), it appears that California has made significant progress toward closing that gap.

The reader will note differences in the findings from interviews with developers and those from county mental health. In many cases, the data comes from different sources and it is not always overlapping. For example, Nurse Family Partnership is delivered through public health not mental health.

Factors That Influence Effective Implementation of EBPs

Over the past five years, the staff at the CiMH has been studying the processes by which children's service organizations consider, select, adopt, implement, and sustain EBPs. As anyone who has attempted to innovate in human service organizations knows, the process of implementing EBPs is complex and fraught with challenges (Panzano & Roth, 2006).

Factors that influence adoption, implementation and, ultimately, sustainability of EBPs in California are organized in response to two broad questions:

1. What factors and/or processes influence the adoption and implementation of EBPs?
2. What factors and/or processes contribute to the longer-term assimilation and achievement of outcomes by the adopting organizations?

Several researchers have developed relatively comprehensive models that describe key factors affecting the success of implementing EBPs into real-world service settings (Aarons et al., 2011). Each of the models suggests core themes.

We will focus on four core themes that have positively affected implementation of EBPs in children's service systems in California: 1) program fit, 2) leadership, 3) training, and 4) evaluation.

EBP Fit to Implementing Organizations

Information gathered for this report suggests that adopters of EBPs report a good fit with their organization's mission, values, and operations. Because the EBP was a fit, administrators sought and obtained support from external stakeholders and capitalized on funding opportunities, which provided resources to support initial implementation costs.

Two examples of EBPs that have wide-scale implementation in California will be used to illustrate the concept of organizational fit.

The **Nurse Family Partnership (NFP)** has been operating in California since 1997 and currently serves almost 10,000 first-time mothers, primarily through county public health departments. The goals of the NFP are a fit with those of public health departments in that a public health approach is used to improve pregnancy outcomes for poor young women as well as to improve developmental outcomes for their children. The Prevention and Early Intervention initiative under the MHSA has provided opportunities for public health departments to partner with child welfare, early childhood, and mental health agencies to improve access to services and outcomes for culturally underserved populations. The demographic data from the NFP demonstrate that the majority of program recipients come from underserved cultural populations – 81% in 2010 (NPF flyer). Because the program can be tailored to meet the needs of specific populations and communities, NFP is making significant progress in helping to reduce health disparities for poor women from underserved cultural populations. The positive outcomes

being achieved continue to garner the support of community stakeholders as well as funding agencies such as the federal government.

Aggression Replacement Therapy (ART)© is one of the few EBPs that can be implemented in residential, detention, and probation camp settings. It is therefore not surprising that there are 22 juvenile probation departments implementing ART© in California. ART© is consistent with the mission and values of juvenile probation in that recidivism is reduced, youth learn skills that decrease aggression, and it can be delivered by practitioners with a bachelor's degree. The California Standards Authority is supporting implementation of ART© through funding from the Gang Reduction, Intervention and Prevention Program. The positive outcomes achieved through another California initiative – the Mentally Ill Offender Crime Reduction Program – helped to garner support from community groups and law enforcement to promote ART© more widely.

While there are a variety of factors that may impede an organization's efforts to sustain the implementation of EBPs, potential adopters need to carefully consider the likelihood of getting support from both internal and external stakeholders. At the outset, organizations need to assess the extent to which the EBP fits the organization's mission, values and operational capabilities.

Leadership

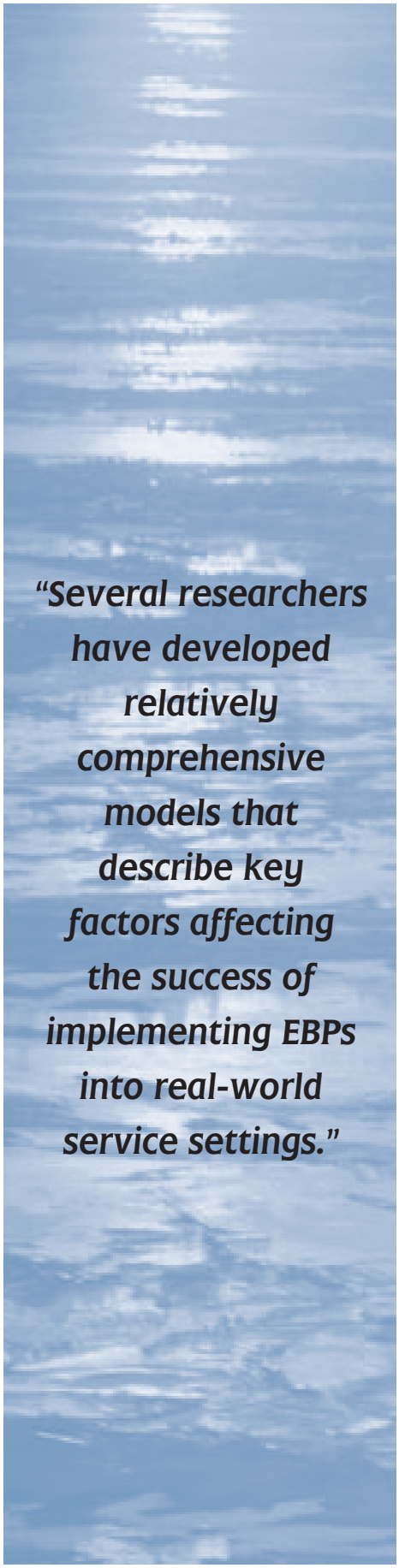
It is our observation that leadership has been a crucial variable in creating organizational climates and cultures conducive to EBP selection, implementation and sustainability not only at the outset but throughout the implementation process. Effective EBP champions are not always at the top of an organization, but they are individuals with both the authority and responsibility to facilitate solutions to barriers and advance implementation. In addition, they assume responsibility for ensuring the organization has the infrastructure and resources to sustain and refine the program over time.

Implementation of EBPs is not a linear process. There are both expected and unexpected roadblocks and detours along the path to sustaining a new practice in an organization. For most children's services agencies, the adoption of EBPs often means reallocation of resources, not the least of which is staff time – time to learn a new practice, time to participate in ongoing coaching and consultation, and time to adjust to different documentation requirements. Supervisors and managers committed to ensuring the success of adopting a new practice make the needed adjustments in "productivity" requirements and renegotiated statements of work, defining what services can be reimbursed. Our experience is consistent with research findings (Aaron, 2006) in that administrative staff who support and guide change increase the likelihood that staff will view EBPs more positively.

When the success of an EBP depends upon collaboration, leadership that spans organizations and systems is necessary to shepherd the process. Multidimensional Treatment Foster Care (MTFC) is an example of an EBP that requires a "leader" who can take on boundary-spanning roles. MTFC in California requires funding from at least three sources, and serves youth and families who overlap more than one service system. The boundary spanning roles involve identifying and assembling key parties (i.e. mental heath, child welfare and juvenile justice system leaders); coordinating communication among the organizations carrying out the implementation; facilitating ongoing, collaborative, decision-making processes; and championing the EBP to members of the community and members of the collaboration. The CiMH has assumed this role through our Community Development Team model, which will be described in more detail in a later section of the report.

Training

While the last decade has seen a surge in the development of EBPs for children and youth, there is a lag in the development of practitioners who are adequately



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trained and supported to provide EBPs (Lyon et al., 2010). There are increasing calls for professional schools and universities to develop curriculum designed to prepare practitioners to deliver EBPs in real-world service settings. However, the evidence suggests that few educational programs transfer EBP knowledge into the curriculum at a pace needed to meet the demand (Barwick, 2010), which has led to wide-spread concern about the capability of the behavioral health care workforce to provide quality care (Annapolis Coalition on the Behavioral Health Workforce, 2007).

Implementation research demonstrates that in order to change, practice training must involve a) knowledge development; b) demonstration of skills; and c) actual use with clients in real-world agencies. Ongoing coaching and mentoring during the active phase of implementation supports what has been learned and provides the opportunity to build confidence and competence among practitioners (Joyce & Showers, 2002).

All of the EBPs reviewed for this report are those with robust training protocols. They include:

- Initial face-to-face training in which participants are encouraged to practice through role play and discussion of case vignettes.
- Materials that support implementation, such as manuals, work books for clients, curriculum and/or videotapes.
- Booster training, which occurs three to four months after the initial training.
- Consultation telephone calls, providing the opportunity to problem solve while delivering the intervention to agency clients.
- Certification or credentialing, whereby staff can demonstrate their proficiency with a new practice.
- Some of the EBP's provide a pathway to develop an agency- trainer.

Given that it is unlikely that most practitioners working in the children's service systems in California will come equipped to provide EBP, it is essential that comprehensive training be provided in order to achieve implementation. Successful training is resource intensive and attends to practitioner engagement, utilizes role-play and practice to promote initial skill acquisition, and provides ongoing support to ensure transfer of learning.

Evaluation

A growing body of evidence from a variety of fields suggests that innovations often fail, not because they are inherently ineffective but because they are often not implemented with fidelity. In other words, implementation failure rather than EBP failure frequently explains why desired outcomes are not achieved. Therefore, it is essential that evaluation efforts begin with assessing implementation outcomes, in addition to service system or client-level outcomes. Assessment of implementation should include:

- Training dosage – Did all of the practitioners receive all of the required training, including booster sessions?
- Consultation dosage – Are all of the practitioners participating in consultation/coaching activities?
- Caseload – Do the clinicians have the recommended number of clients to adequately learn the practice and or program?
- Fidelity indicators – Is the program being implemented as the developer(s) intended?

Measuring implementation variables allows for mid-course corrections and increases the likelihood that positive outcomes will be achieved for children, youth, and their families. Data is collected from individual agencies and analyzed by a CiMH evaluation staff and then returned to the agency in the form of program performance dashboard reports. Much like the dashboard on one's car gives the driver a quick report on the health of the vehicle, the outcome dashboard is designed to give agencies information about the health of their EBP implementation. All dashboard reports include:

- The number of clients that were "enrolled" in the EBP at the beginning of the reporting period;
- The number and percentage of clients that drop out before completing the program;

- Client characteristics, which include age, gender and ethnicity;
- Axis I diagnosis – if relevant; and
- Outcomes relevant to children, youth and their families.

We encourage agencies to use two outcome measures – one broad measure and one that is EBP specific. The broad measure of change is the Youth Outcome Questionnaires (YOQ) that include a parent report measure and youth self-report used to track changes in mental health functioning.

In addition, we assess differential attrition and outcome by ethnicity and gender. These analyses are important, as we want to ensure that children and youth from underserved cultural groups have equal access to effective interventions and that they achieve positive outcomes. The CiMH statewide dashboard reports demonstrate that significant numbers of youth from diverse cultural groups are receiving EBPs and that outcomes are comparable across ethnic groups.

In sum, paying attention to both implementation processes and outcomes is key to helping policy makers interested in promoting the adoption of EBPs to make sound decisions about future investments.

As is evident from the discussion in the preceding section of this report, a number of factors can impact the success of EBP implementation efforts. Implementing EBPs can be a daunting challenge, particularly if organizations try to take it on by themselves and with no prior experience with successful implementation of innovations. In response to this challenge, the CiMH developed a multifaceted intervention to promote the sustainable, model-adherent use of EBPs in publicly funded mental health agencies and, in turn, to improve outcomes for child and adult consumers. The intervention is called the Community Development Team.

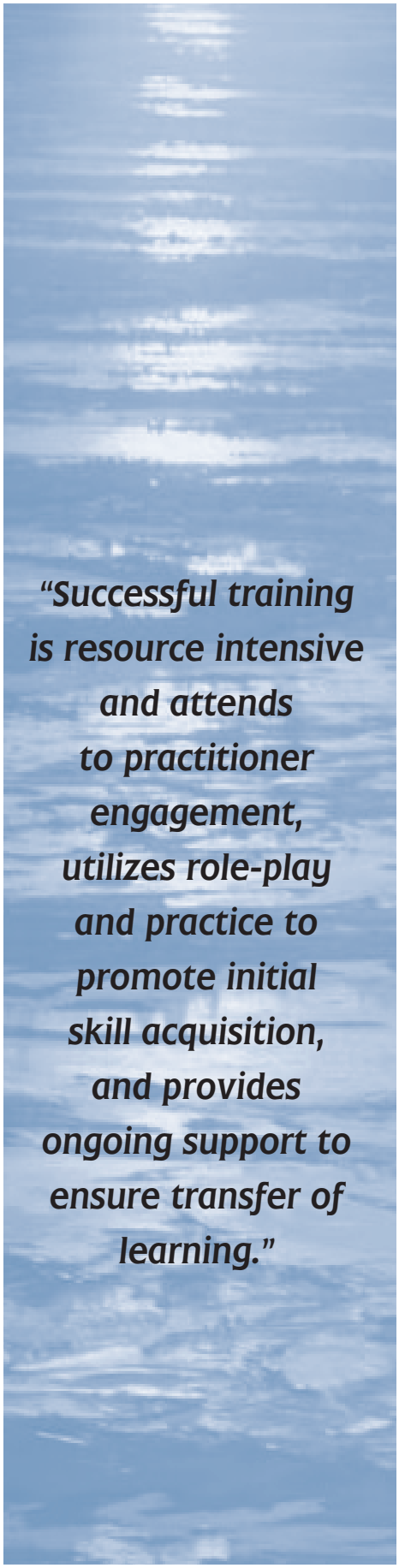
Community Development Team Model

The Community Development Team (CDT) model was designed to assist agencies in successfully overcoming the barriers to the adoption of EBPs. In sponsoring CDTs, CiMH functions as an intermediary purveyor organization (IPO) as articulated by Fixsen and Blase (Fixsen et al., 2005). An IPO is an organization with specialized expertise in managing change that encourages and supports the adoption of an EBP. Technical assistance is provided to a group of agencies (all implementing the same EBP) to help them overcome barriers at three distinct phases of adoption of an EBP: pre-implementation, implementation, and sustainability. During each of these phases, seven core processes occur that are designed to facilitate implementation and sustainability of a new practice. A complete description and discussion of the CDT can be found in the California Institute for Mental Health CDT manual, 2006.

The CDT has been used to implement the following EBPs:

- Multidimensional Treatment Foster Care
- Functional Family Therapy
- Aggression Replacement Training
- Depression Treatment and Quality Improvement
- Multidimensional Family Therapy
- High-Fidelity Wraparound
- Trauma-Focused Cognitive Behavioral Therapy

CiMH has partnered with Patricia Chamberlain from the Center for Research to Practice in Eugene, Oregon, to test the effectiveness of the CDT through a large-scale federally funded implementation study. This is a randomized design trial to test two methods (CDT and implementation as usual) of implementing MTFC in 40 non-early adopting California counties. The study utilized both quantitative and qualitative methods to assess implementation at four stages: exploration, adoption, implementation, and sustainability (Chamberlain et al., 2006; Wang et al., 2010). The results from the study will make a major contribution to the field of implementation science and will help CiMH refine its technical assistance activities.



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Recommendations

Based upon the information gathered for this report, it is clear that significant strides are being made in providing children, youth, and families mental health services that are research informed. However, our child-serving systems face the ever-growing challenge of serving the diverse mental health needs of an increasing number of children, while capacity and funding do not keep pace. In order to maximize benefits for the greatest numbers of children youth and families, the following recommendations are offered:

1. Provide funding for ongoing staff training in EBPs, and for program evaluation to increase capacity and ensure that interventions are delivered with fidelity, whether delivered in the public or the private sector.
   - Providing the necessary financial support to promote the adoption of EBPs by practitioners will require changes in third-party coverage, as well as documentation and claiming requirements.
2. Require evaluation for all children's mental health programs.
   - Mental health interventions are not benign, and they require evaluation to ensure safety and effectiveness for clients.
3. Provide evidence-based programs to children, youth, and families in the child welfare and juvenile justice systems.
   - Both high rates of mental health problems and poor developmental outcomes argue for the use of science informed interventions.
4. Ensure commitment by policy, administrative, and clinical leadership throughout the implementation of evidence-based programs. Such commitment is essential both within systems and across systems.
   - Create incentives for cross-system collaboration, since a significant number of children are receiving services in more than one system.
5. Agencies should develop an implementation plan prior to adopting and implementing an evidence-based program. Consider the following:
   - The fit of the EBP
   - Funding for implementation and evaluation
   - Staffing-up for implementation
   - Prioritize training protocols to include face-to-face initial sessions, booster sessions, coaching, and certification

Conclusion

The information in this report suggests that evidence-based programs are increasingly being used to support the mental heath and well-being of children, youth, and families involved in public sector agencies, including child welfare, juvenile justice, mental health, and public health. The report presents policy, funding, training, and evaluation actions to improve the implementation of EBPs in order to improve outcomes for children and their families.

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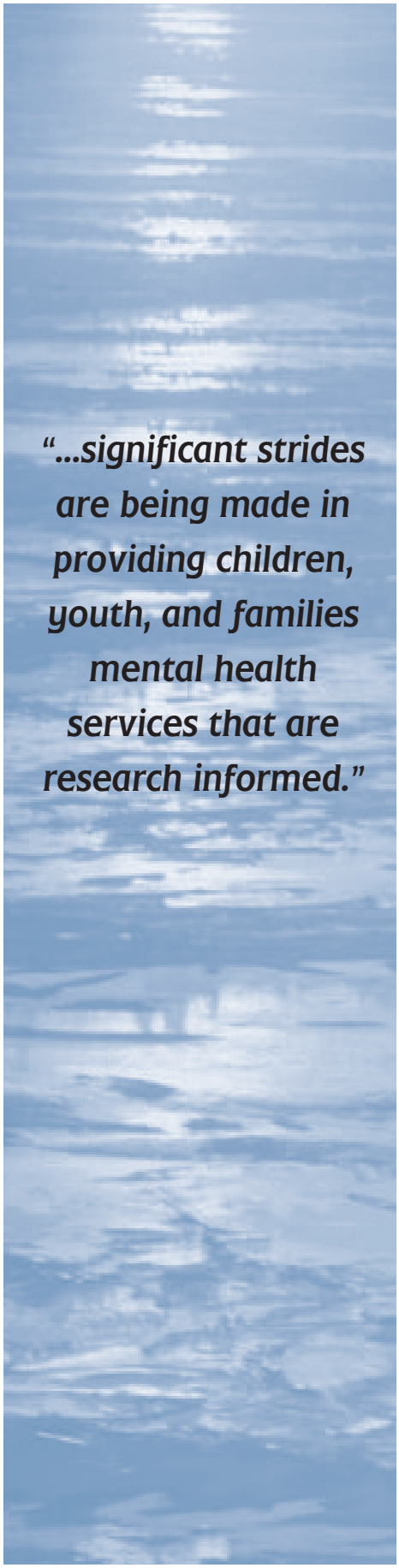

"...evidence-based programs are increasingly being used to support the mental heath and well-being of children, youth, and families involved in public sector agencies, including child welfare, juvenile justice, mental health, and public health."

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