

Supplemental Report on Evidence-Based Programs in California

Introduction

This report was written as a companion piece to the policy report titled “Using Evidence-Based Programs to Meet the Mental Health Needs of California Children and Youth.” The report provides detailed descriptions of each of the programs featured in the policy report – descriptions that include unique implementation features and that highlight success with culturally diverse populations.

Evidence-Based Programs Supported by the California Institute for Mental Health

This section of the report describes the evidence-based programs for which the California Institute for Mental Health (CiMH) provides implementation support. Each case contains a description of the practice, including target population, goals, funding both for training and for service delivery, training protocols and, in some cases, unique implementation strategies. Finally, information is provided on the number of organizations currently implementing and, if known, sites that have dropped out and reasons why.

Aggression Replacement Training

Aggression Replacement Training (ART[©]) is a cognitive behavioral intervention that helps youth improve social skills and moral reasoning, better manage anger, and reduce aggressive behavior. The program consists of 10 weeks (30 sessions) of intervention training administered to groups of eight to 12 youths, and is divided into three components – social skills training, anger control training, and moral reasoning. Incremental learning, reinforcement techniques, and guided group discussion enhance skill acquisition. Descriptions of the three components are provided as follows:

Social Skills Training: teaches youth what to do in stressful or threatening situations. ART[©] is based upon social learning theory, and activities include modeling, role-playing, and performance feedback.

Anger Control Training: teaches alternatives to aggression for anger-provoking situations.

Training in Moral Reasoning: promotes a value that respects the rights of others through teaching perspective taking.

Target population: ART[©] was developed for adolescents from 12 to 18 who have difficulty managing aggression.

Goals: The primary long-term goal is to reduce juvenile justice recidivism. The treatment goals are to decrease impulsive and aggressive behavior while increasing social skills and helping youth develop alternatives to aggression.

Funding: Most agencies have funded the training for ART[©] out of their own budgets. In some cases, programs were initiated with grants from the Mentally Ill

Offender Crime Reduction Program (MIORCR) sponsored by the California Board of Corrections. More recently, agencies have procured funding for training through the Prevention and Early Intervention component of the Mental Health Services Act. In most cases, service provision is billed to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medi-Cal.

Training Protocols: ART© practitioners receive an initial two-day clinical training, followed by a one-day booster training, as well as telephone or in-person coaching and consultation. Upon submission and review of fidelity tools and videotapes, practitioners may be deemed proficient to provide ART© without ongoing consultation. For those interested, a train-the-trainers option is available as well.

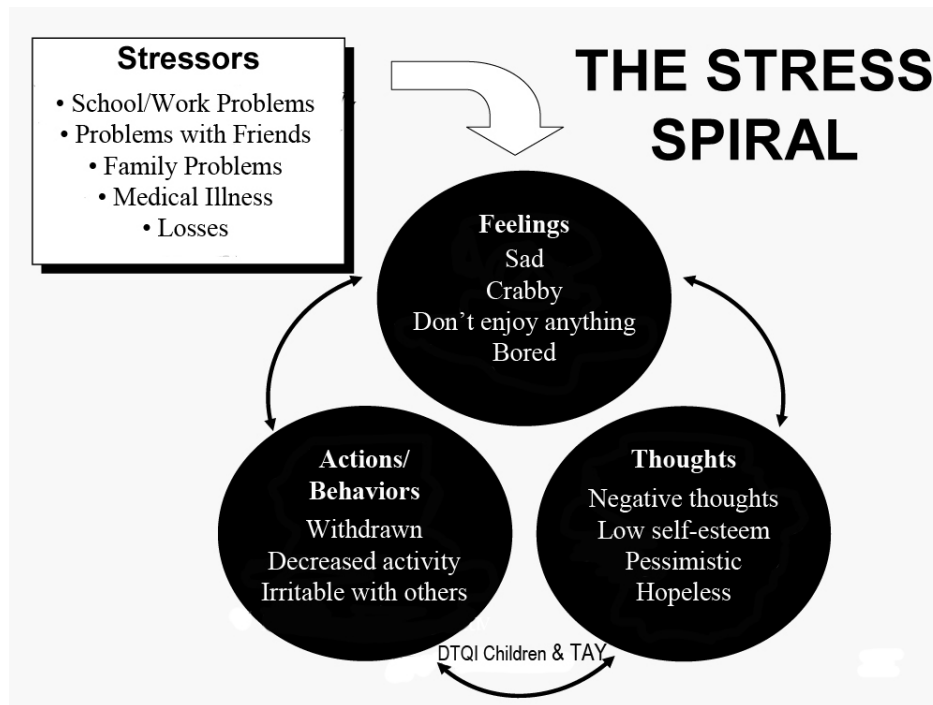
Impact: CiMH began supporting implementation of ART© in 2005. Since that time, 27 counties and 32 provider agencies have participated in expert clinical training and running ART© groups for youths. To our knowledge, only two agencies have discontinued use of the practice – both citing budget reductions as the reason. ART© has been a widely adopted practice because it allows a flexible application across settings and practitioners. It can be implemented in juvenile halls, group homes, classrooms, probation ranches, court and community schools, and outpatient mental health departments. Practitioners range from clinicians with Ph.D.s to probation officers, teachers and behavior aides. It is clear that ART© has been a good fit for youths in the Juvenile Justice system, who are receiving services in group settings.

CalGRIP – ART© Implementation

On May 5, 2007, Governor Schwarzenegger launched the California Gang Reduction, Intervention and Prevention (CalGRIP) program. The initiative included an agreement with the Corrections Standards Authority to spend \$1.1 million to support efforts to build capacity within probation departments to implement or expand the evidence-based model of anger management and youth violence training for juvenile offenders. CiMH in partnership with Educational and Treatment Alternatives Inc. (a national training center for ART©) was selected as the provider for this effort. Training began in December 2009 and currently 22 probation departments in the state are implementing ART© under this project. The evaluation will include recidivism, detention and placement rates, and will track school attendance.

Depression Treatment and Quality Improvement (DTQI)

DTQI is a comprehensive approach to managing depression that includes screening and assessment, Cognitive Behavioral Therapy as a psychosocial treatment, symptom monitoring and management and relapse prevention. Cognitive Behavioral Therapy (CBT) for major depression is an action-oriented form of therapy that assumes that maladaptive or faulty thinking patterns cause maladaptive behavior and negative emotions. The treatment focuses on changing an individual's thoughts or cognitive patterns, in order to change his/her behavior and emotional state. The graphic depiction of the stress spiral helps to explain the relationship between, thoughts, emotions, and behavior.



The DTQI treatment model is delivered across three separate modules:

Fun activities module – four sessions that include tracking moods and activities, such as setting goals, plans for reaching goals, and making plans work.

Thoughts module – four sessions that include thoughts and feelings, including arguing against negative thoughts, practice in arguing against negative thoughts, and other ways to handle negative thoughts.

Social relationships module – four sessions that include communication, such as negotiation and problem-solving, including defining the problem, finding solutions, and negotiation and problem-solving practice.

Treatment can be delivered in groups of 12-16 people or individual sessions.

Each module should be offered in a four-session format but can be lengthened if necessary.

Target population: DTQI was developed for adolescents (12-19) who are experiencing depressive symptoms that impair functioning (e.g., school performance) and adolescents diagnosed with a depressive disorder.

Goals: The primary goal of DTQI is a decrease in depressive symptoms, which is achieved through improvements in mood and activity level. The secondary outcome is improvement in functioning, such as school performance.

Funding: The initial DTQI training was partially funded by CiMH with funds from the California Department of Mental Health. Subsequent training is being funded by MHSA prevention and early intervention funds. In all cases, service provision is billed to EPSDT Medi-Cal.

Training Protocol: The training consists of three 8-hour workshops: 1) overview and presentation of fun activities module; 2) review of implementation and presentation of the thoughts module; and 3) review of implementation and presentation of the social relationships module. During implementation, clinicians receive 24 consultation calls that are provided weekly to groups of six. A train-the-trainers opportunity is available for clinicians who not only demonstrate competency in the practice, but also demonstrate leadership and teaching skills.

Impact: To date, seven county mental health departments have been trained and implemented DTQI. Riverside and San Joaquin have supported clinicians to participate in the train-the-trainers program, and they continue to provide supervision and consultation to staff in their respective mental health departments. While none of the seven counties trained have discontinued use of DTQI, we have not experienced a high demand for training in the practice. To some degree, this is has been surprising given the number of adolescents who are served by publicly funded mental health programs and who are referred for problems with depression. It may be partially explained by the fact that there has been no policy initiative or source of funding that has motivated interest.

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a components-based model of psychotherapy that addresses the unique needs of children with Post-traumatic Stress Disorder (PTSD) symptoms, depression, and behavior problems related to traumatic life experiences. TF-CBT is a short-term treatment approach delivered in 12 to 20 sessions. Individual sessions for the child and for the parents or caregivers, as well as joint child-parent sessions, are part of the treatment. The specific components of TF-CBT are summarized by the acronym PRACTICE:

- Psychoeducation is provided to children and their caregivers about the impact of trauma and common childhood reactions.
- Parenting skills are provided to optimize children's emotional and behavioral adjustment.
- Relaxation and stress management skills.
- Affect expression and modulation are taught to help children and parents cope with a range of emotions.
- Cognitive and coping processing is enhanced by illustrating the relationships among thoughts, feelings and behaviors. This helps parents and children modify inaccurate or unhelpful thoughts about the trauma.
- Trauma narrative in which children describe their personal traumatic experiences. This is accomplished in art or story form, depending upon the age of the child.
- *In Vivo* mastery of trauma reminders is used to help children overcome their avoidance of situations that are no longer dangerous, but which reminds them of the original trauma.

- Conjoint child-parent sessions help the child and parent talk with each other about the child's trauma.
- Enhancing future safety and development (the final phase of treatment), addresses safety, helps the child regain developmental momentum, and covers any other skills the child needs to complete treatment.

Target population: TF-CBT was developed for youth ages 4 through 18 who have experienced a traumatic event. Not all youth will meet the full diagnostic criteria for PTSD but will have symptoms that interfere with developmental functioning.

Goals: The primary goal of TF-CBT is to reduce or eliminate the symptoms associated with traumatic stress, which include:

- Intrusive and upsetting memories, thoughts, or dreams about the trauma.
- Avoidance of things, situations or people that are trauma reminders.
- Emotional numbing.
- Physical reactions of hyperarousal, trouble concentrating or irritability.

A secondary goal is to assist parents and other caregivers in managing their own feelings about the child's trauma experience. That is why TF-CBT typically includes the child's caregivers in treatment. TF-CBT is effective in helping parents and other caregivers to:

- Overcome general feelings of depression,
- Reduce emotional distress about the child's trauma,
- Improve parenting practices, and
- Enhance their ability to support their children.

Funding: Training funds for TF-CBT has come from several sources: 1) The Los Angeles County Department of Mental Health began funding training for TF-CBT in 2006 in order to ensure that children who had trauma histories and were placed in foster care received effective trauma treatment. 2) The Zellerbach Foundation provided funding for a cohort (2008) of county mental health and county child welfare staff to receive training in TF-CBT (mental health) and trauma-informed child welfare practice. 3) California Alliance of Child and Family Services member agencies funded a CiMH Development Team focused on the model adherent implementation of TF-CBT, which included eight agencies. 4) More recently, counties are funding TF-CBT training with MHSA – PEI funds, as reducing the impact of trauma is one of the key community mental health needs identified in the PEI guidelines.

Service delivery is funded by EPSDT Medi-Cal. For sites that are utilizing TF-CBT as prevention service delivery has been funded by grants or by PEI funds.

Training Protocol: By way of introduction to the concepts, trainees are asked to complete an online training course prior to the initial face-to-face training. Practitioners and their supervisors participate in a two-day clinical training and

supervisors get one half day of additional training. Approximately three months after the initial training, practitioners and their supervisors participate in a one-day booster training – supervisors are provided with an additional half day of training, focused on maintaining fidelity and helping practitioners avoid secondary trauma. Practitioners receive clinical telephone consultation from national trainers on a weekly basis for approximately four months. Four to six practitioners (and their supervisors) join each call, which provides an opportunity to ask client-specific questions. The consultant uses a fidelity checklist with practitioners, and a standardized measure is used to assess trauma symptoms prior to and after treatment.

Impact: TF-CBT has been widely adopted in the state of California. To date, CiMH has sponsored 112 TF-CBT programs in 17 counties and, as of July 2010, we are supporting 88 programs in Los Angeles County. The interest in TF-CBT is likely explained by heightened public awareness of the scope and serious impact of child traumatic stress on the safety and healthy development of America's children and youths. Nationally, the Substance Abuse and Mental Health Services Administration and the National Center for Children in Poverty (founded by the late Jane Knitzer) have urged policy makers to support service delivery systems that identify and implement strategies to prevent trauma, increase capacity for early identification and prevention, and to provide comprehensive treatment. In California, the National Center for Child Traumatic Stress at UCLA, has generated new research and expanded capacity, and the Prevention and Early Intervention component of the MHSA has provided funding to help reduce the psychosocial impact of trauma on individuals exposed to trauma. By definition, children and youths in the child welfare system are the most vulnerable, so it is no surprise that most TF-CBT programs have been supported by local child welfare organizations.

Functional Family Therapy

Functional Family Therapy (FFT) is a family based intervention for adolescents who are involved with the juvenile justice system or whose behavior puts them at risk to school failure, substance abuse, and delinquency. FFT is a short-term intervention with an average of 12 sessions over a three- to four-month period. The intervention program consists of five major components in addition to pretreatment activities.

Pretreatment: The goals of this phase involve responsive and timely referrals. Activities include establishing collaborative relationships with referring sources, ensuring availability, and reviewing referral information.

Engagement Phase: The goals of this phase involve demonstrating a desire to help, respect, and “match” (aligning with the family), and addressing cultural competence. The therapists focus in on immediate responsiveness and maintaining a strengths-based relational focus. Activities include high availability, telephone outreach, providing transportation or in-home services, contact with as many family members as possible, and maintaining a respectful attitude.

Motivation Phase: The goals of this phase include creating a positive motivational context, minimizing hopelessness and low self-efficacy, and changing the meaning of family relationships to emphasize possible hopeful experience. Activities

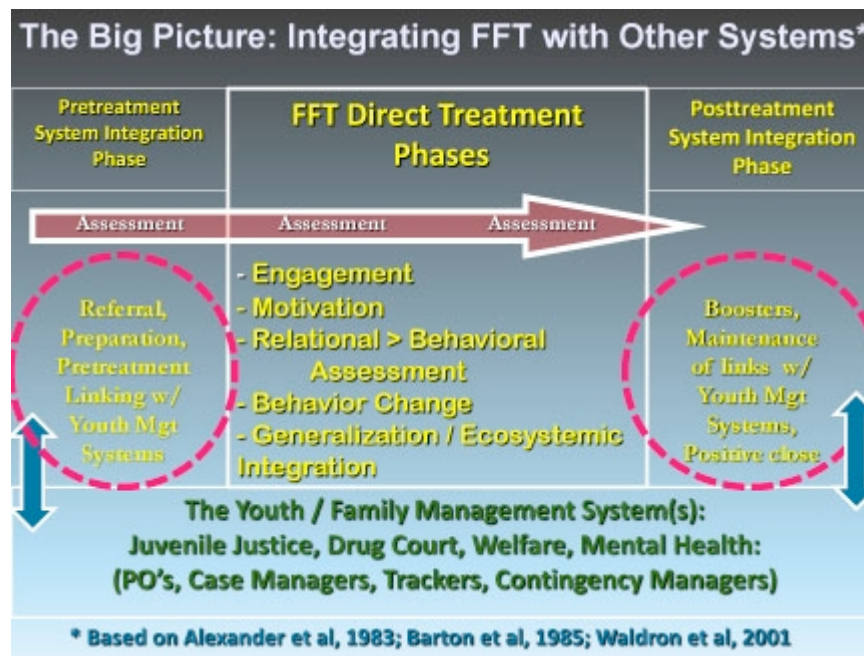
include the interruption of highly negative interaction patterns and blaming, changing meaning through a strengths-based relational focus, sequencing and reframing of the themes by validating negative impact of behavior, while introducing possible noble (but misguided) motives for behavior.

Relational Assessment: The goals of relational assessment include eliciting and analyzing information pertaining to family interactions and relationships, as well as developing plans for behavior change and generalization. The focus is directed to intrafamily and extrafamily context and capacities (e.g., values, attributions, functions, and interaction patterns, sources of resistance, resources and limitations).

Behavior Change Phase: Behavior change goals consist of skill building, changing habitual problematic interactions, and other coping patterns. Phase activities are focused on modeling and promoting positive behavior, providing directives and information, developing creative programs to change behavior, all the while remaining sensitive to family member abilities and interpersonal needs.

Generalization Phase: The primary goals of this phase are extending positive family functioning, planning for relapse prevention, and incorporating community systems. Activities include knowledge of community resources, developing and maintaining contacts, initiating clinical linkages, creating relapse-prevention plans, and helping the family develop independence – relying upon their own resources.

The graphic depicts the conceptual model utilized by Functional Family Therapy:



Target Population: FFT was developed for adolescents, aged 11-18, at risk to or involved in the juvenile justice system, as well as youths with substance use/abuse and significant behavior problems. Often the youths present with additional comorbid challenges such as depression.

Goals: The primary goal of FFT is to reduce juvenile justice recidivism and prevent further out-of-home placements. The secondary goals are to improve family communication, interaction, and self-efficacy.

Funding: CiMH began helping to implement FFT in 2006 with a grant from the California Endowment. Our initial effort involved seven county mental health departments and one private agency – probation department collaborations. Several implementations of FFT have been funded by probation departments using federal and state funding targeted to efforts to reduce recidivism. Despite the budget crisis, FFT is expanding in California due to gang reduction initiatives, money provided by the PEI component of the MHSA, and the Residentially Based Services Group Home initiative. Service delivery is funded by the initiatives just described and by billing EPSDT Medi-Cal.

Training Protocol: FFT has a multi-stage, three-year training progression intended to help sites become certified and self-sufficient. The three-phase process is described as follows.

- *Phase I:* Clinical training is delivered to a team of six to eight practitioners. The site purchases the FFT Client Services System (CSS), which is a computer database used to measure both fidelity and outcome. The initial clinical training is a two-day, on-site event. The next three steps happen concurrently during the training year: the team receives telephone clinical consultation from an FFT trainer/consultant; each team has one member who attends an externship that is an intensive, hands-on training experience with real clients and includes a supervisor from behind a mirrored window; and two on-site follow-up sessions and one two-day, off-site clinical booster training.
- *Phase II:* At the beginning of Phase II, the FFT site lead (the individual who went to the externship program) attends a two-day supervisor training. The site lead is then considered the site supervisor. Site supervisors are provided consultation to help them develop the skills to work independently with their team in assuring competence and fidelity to the model. Finally, the site supervisor completes a one-day on-site and a two-day off-site supervisor training.
- *Phase III:* The site is assigned a national consultant, who reviews the CSS database for site/therapist model adherence, service delivery trends, and client outcomes. The national consultant provides a monthly call to the FFT site supervisor. Finally, one on-site training and consultation takes place to review progress. The goal of the third phase is to move into a partnering relationship to assure ongoing model fidelity.

Impact: CiMH is currently supporting 29 FFT teams in 12 California counties. We have helped to train 33 teams since 2006 and have experienced relatively low attrition. Of the four sites no longer implementing, two sited budget problems and the other two had organizational difficulties.

Unique Implementation Features: Functional Family Probation Services (FFPS) is an adaptation to FFT in which probation officers provide community supervision

for youth. Probation officers are trained to use engagement and motivational skills drawn from FFT to help families move beyond blaming and negative expectations, and reinforce the positive changes made by youths while in out-of-home placement. Three counties in California, including Los Angeles, have trained probation officers using the FFPS model of case management and supervision.

CiMH has formed a partnership with FFT Inc., wherein we facilitate all FFT training in the state of California. Through our agreement with FFT Inc., we ensure that training for all new sites is provided in state, so the people do not have to travel. If there is a critical mass, replacement training can also be provided in state. California also has five state consultants who monitor all of the Phase III FFT teams that help to ensure fidelity and sustain teams.

Triple P – Positive Parenting Program

Triple P is a multilevel system or suite of parenting and family support strategies for families with children from birth to age 12, with extensions to families with teenagers, ages 13 to 16. Developed for use with families from many cultural groups, Triple P is designed to prevent, social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. The program, which can also be used for early intervention and treatment, is founded on social learning theory and draws on cognitive, developmental, and public health theories.

Triple P has five intervention levels of increasing intensity to meet each family's specific needs. Each level includes and builds upon strategies used at previous levels:

- Level 1 (Universal Triple P) is a media-based information strategy designed to increase community awareness of parenting resources, encourage parents to participate in programs, and communicate solutions to common behavioral and developmental concerns.
- Level 2 (Selected Triple P) provides specific advice on how to solve common child developmental issues (e.g., toilet training) and minor child behavior problems (e.g., bedtime problems). Included are parenting tip sheets and videotapes that demonstrate specific parenting strategies. Level 2 is delivered mainly through one or two brief face-to-face 20-minute consultations.
- Level 3 (Primary Care Triple P) targets children with mild to moderate behavior difficulties (e.g., tantrums, fighting with siblings) and includes active skills training that combines advice with rehearsal and self-evaluation to teach parents how to manage these behaviors. Level 3 is delivered through brief and flexible consultation, typically in the form of four 20-minute sessions.
- Level 4 (Standard Triple P and Group Triple P), an intensive strategy for parents of children with more severe behavior difficulties (e.g., aggressive and oppositional behavior), is designed to teach positive parenting skills and their application to a range of target behaviors, settings, and children. Level 4 is delivered in 10 individual or eight group sessions, totaling about 10 hours.
- Level 5 (Enhanced Triple P) is an enhanced behavioral family strategy for families in which parenting difficulties are complicated by other sources of family distress

(e.g., relationship conflict, parental depression or high levels of stress). Program modules include practice sessions to enhance parenting skills, mood management strategies, stress coping skills, and partner support skills. Enhanced Triple P extends Standard Triple P by adding three to five tailored sessions to the needs of the family.

Target population: Triple P was developed for all families with children from birth to age 12 and for parents of teens ages 13 to 16. When used as a treatment intervention, Triple P demonstrates effectiveness for parents whose children have disruptive behaviors, including conduct problems in adolescents.

Goals: Triple P goals are as follows:

- To develop positive parenting practices as a protective factor for later child behavior problems,
- To decrease negative parenting practices as a risk factor for later child behavior problems, and
- To decrease negative and disruptive child behaviors – in treatment levels of Triple P.

Funding: Triple P service delivery is largely funded through EPSDT and from child welfare funds through contracts with community-based organizations. A variety of initiatives in California have funded training: First 5, Prevention and Early Intervention money from the MHSA, and Title IV-E (child welfare).

Training: Triple P training consists of attendance at an initial workshop, which lasts from two to five days, depending upon the program level being trained. Triple P implementation relies heavily on peer support and feedback such that organizational peer networks are highly encouraged. After implementing for a period of time, clinicians are encouraged to attend two booster training events – one pre-accreditation and one post-accreditation. It should be noted, Triple P implementation supported by CiMH includes 20 clinical consultation calls that are intended to increase clinician competency and confidence.

Clinicians demonstrate proficiency in Triple P by becoming accredited, which is a two step process: 1) completion of a 30-question, multiple-choice quiz, and 2) attending an accreditation session. Participants at the accreditation session have the opportunity to demonstrate, via role-play, their proficiency in the areas targeted for accreditation. Practitioners must be accredited at each level of Triple P they wish to deliver.

Impact: Triple P has been operating in California for approximately five years, with the most mature sites implementing all five levels of Triple P. Currently, 15 counties are implementing Triple P, serving approximately 1,000 families per year.

Multidimensional Treatment Foster Care – MTFC

MTFC was developed as an alternative to institutional, residential and group care placements for adolescent boys in the juvenile justice system. Subsequently, the MTFC model has been adapted for and tested with children and adolescents with

severe emotional and behavioral disorders, girls referred from the juvenile justice system, and for very young children who experience placement disruptions. Three MTFC programs are available; one for adolescents, ages 12-17, one for school-aged children, ages 6-11, and one for pre-school children, ages 3-6. MTFC is best conceptualized as a treatment intervention rather than a placement, which is why only one foster youth is placed in the home.

Placements in MTFC are typically six to nine months for youth in the juvenile justice system, and nine to 12 months for youth in the child welfare system. The program relies on intensive, well-coordinated, multi-method interventions conducted in the foster home, with the youth's aftercare family, and in the case of adolescents, through individual therapy. Additionally, all children and youth receive skills training and academic support. In the preschool program, the academic focus is upon school readiness. A program supervisor (with a caseload of 10) oversees the interventions, which are implemented across multiple settings (e.g., home, school, community). Involvement of each youth's family or aftercare resource is emphasized from the outset of treatment in an effort to maximize training and preparation for post-treatment care for youths and their families. Progress is tracked through daily phone calls with treatment foster parents at which time data is collected on youth behavior.

Target population: MTFC was developed for youths ages 7-17 with significant emotional and behavioral problems warranting placement. MTFC was developed as an alternative to group care for these youth. The MTFC-P program was developed for young children, ages 3-6, who have significant emotional and behavioral problems and who experienced at least two disrupted placements.

Goals: There are two main aims of the MTFC program for school-aged children and adolescents: to create opportunities so that youths are able to live successfully in families rather than in group or institutional settings, and to simultaneously prepare their parents, relatives, or other aftercare resources to provide youths with effective parenting so that the positive changes made while they are placed can be sustained over the long-run. The preschool version of MTFC has the additional goal of helping children to create secure attachments to caregivers, which increases the likelihood of permanency.

Funding: service delivery requires three sources of funding: 1) costs of the placement, including the specialized rate for the foster parent, generally comes from the department of social services; 2) costs of treatment are funded through EPSDT; and 3) flex funds from a variety of sources. In addition, some counties have funded their program through SB 163 wraparound and, in some cases, as a full-service partnership program using MHSA funds – in both cases the funding is comprehensive.

Training for MTFC has been funded by grants from The California Endowment and the National Institute of Mental Health – all administered through the California Institute for Mental Health.

Training: TFC consultants, the dissemination arm of MTFC, offers several implementation activities focused on ensuring a model adherent program.

- Agency staff attends a four-day training program (five days for program supervisors) at the developer site in Eugene, Oregon.
- Consultation is provided regarding foster parent recruitment.
- The first group of foster parents receives an on-site two-day training.
- Sites install a web-based parent daily report system and are trained on its use.
- Ongoing weekly telephone consultation is provided to the program supervisor, who sends videotapes of the foster parent and clinical team meetings. Treatment plans, progress, and challenges are reviewed weekly.
- Written quarterly reviews are sent to the program administrator on implementation progress.
- Up to six days of on-site consultation can be provided at the program's request.

Programs demonstrate model adherence and proficiency through a certification process. Once the program has been in operation for one year and has successfully graduated seven youths, staff can apply to be certified. Once certified, the program may operate "independently" for two years and then must reapply for certification.

Impact: The first MTFC programs began operation in California in 2003. Currently, 16 provider organizations are offering MTFC in 12 California counties. Approximately 130 youths are served each year.

Evidence-Based Programs Supported Independently of CiMH

The information on the following programs was obtained through a telephone interview with staff responsible for training and or dissemination. These programs were chosen because they have large-scale implementations in the state. The interview questions were intended to solicit the same information used to describe the programs supported by CiMH.

Nurse Family Partnership

Nurse Family Partnership (NFP) is a prenatal and infancy nurse home visitation program that aims to improve the health, well-being, and self-sufficiency of low-income, first-time mothers and their children. The NFP program activities are designed to link families with needed health and human services, promote good decision making about personal development, assist families in making health choices during pregnancy and providing proper care to their children, and to help women build supportive relationships with family and friends.

Nurse home visits begin early in pregnancy and continue until the child's second birthday. The frequency of home visits changes with the stages of pregnancy and infancy and is adapted to the mother's needs, with a maximum of 13 visits occurring during pregnancy and 47 occurring after the child's birth. Nurses follow a detailed visit-by-visit guide that provides information on:

- Dietary intake,

- Reducing cigarette, alcohol, and illegal drug use,
- Identifying symptoms of pregnancy complications and signs of children's illnesses,
- Communicating with health care professionals,
- Promoting parent-child interactions,
- Creating safe households, and
- Considering educational and career options.

Target Population: NFP is intended for first-time low-income mothers. However, each community implementing NFP is encouraged to identify the population most at risk to poor pregnancy outcomes for women and poor developmental outcomes for their children.

Goals: Program goals include:

- Improved maternal health,
- Increased maternal self-sufficiency, and
- Improved child outcomes, including school readiness.

Funding: In most cases, NFP is delivered through county public health programs, so Medicaid is the most significant source of funding. Services not covered by Medicaid have been funded by a variety of sources – the most significant being the Prevention and Early Intervention (PEI) component of the MHSA and First 5 county initiatives. Training for local nurses has been funded by PEI and First 5.

Training Protocol: NFP requires that the program be delivered by professionally trained nurses and that they carry a caseload of no more than 25 families at any one time. Training is sequenced and begins with an online course followed by face-to-face initial training in Denver, which consists of theory and visit-to-visit guidelines for 64 home visits. A parallel training is provided for nurse supervisors who support local implementation and ensure ongoing quality and adherence to the NFP principles. Yearly ongoing education is provided to the entire team in order to promote sustainability.

Impact: NFP has been operating in California since 1997. Currently, 13 counties and 17 public health sites are delivering the program and, as of September 30, 2010, 9,700 mothers were enrolled in the program. It is likely that the number of programs will grow as home visiting is being funded through health care reform as an effective prevention strategy.

Unique Implementation Features: NFP encourages communities to focus on the needs of specific populations – often those at greatest risk of poor birth and developmental outcomes. For example, Los Angeles, Orange, Santa Clara, and Solano counties have focused their NFP programs on serving young women who had been in the foster care system. Sonoma and Sacramento counties' NFP programs focus on underserved cultural populations, specifically Latinas and African American women.

Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT) was developed for families with young children experiencing behavioral and emotional problems. Therapists coach parents during interactions with their child to teach new parenting skills. These skills are designed to strengthen the parent-child bond; decrease harsh and ineffective discipline; improve child social skills and cooperation; and reduce child negative behaviors. The intervention intensity is one to two one-hour sessions weekly for 10-20 weeks. The average length is 14 weeks.

PCIT consists of two components: Child-directed interaction (CDI) and parent-directed interaction (PDI). During the CDI, a parent and child attend treatment sessions together, and the parent learns how to follow the child's lead in play. The primary goal is to teach the parents how to decrease the negative aspects of their relationship with their child and to develop positive communication. The PDI component is designed to teach parents how to direct the child's behavior when it is important that the child obey their instruction. The parent is observed and coached through a one-way mirror at each treatment session. At least half of the PDI sessions are conducted using a "bug in the ear" device. As parents master skills in the session, they are given homework so that they can practice later and thereby increase generalization to the home environment.

Target Population: PCIT was developed for children ages 3-6 with behavior and parent-child relationship problems. An adaptation is available for parents who have physically abused their children, and the age range is 4-12. The intervention may be conducted with parents, foster parents, or relative caregivers.

Goals: PCIT is intended to strengthen parenting skills and competencies. Goals include:

- Improve parent/caregiver-child relationship,
- Improve children's minding and listening,
- Increase children's abilities to manage frustration and anger,
- Increase children's appropriate social skills,
- Improve children's attention skills, and
- Improve children's self esteem.

Funding: PCIT is delivered as an outpatient service, so that most cases of service delivery are funded by billing EPSDT Medi-Cal. Most of the sites in California have used one or more of the following sources for funding training and ongoing consultation and support: a) First 5 county initiatives; b) Title IV-E for child welfare populations; and c) PEI funding provided through the MHSA.

Training: PCIT training is delivered by the University of California, Davis, PCIT Training Center, which offers a robust program to help ensure effective implementation. The training center offers a year-long program and focuses on training groups of practitioners in agencies rather than individual practitioners. The components of the year-long training model include:

- An agency readiness process to ensure that administrators understand the organization and clinical requisites for effectively implementing PCIT;
- A three-hour didactic training for clinicians, supervisors, and other stakeholders, which entails an overview of PCIT including expected outcomes if implemented with fidelity;
- Sixteen hours of fundamental skills training for clinicians and supervisors;
- Sixteen hours of intensive skill building, which includes developing effective coaching skills;
- Eight hours of parent-directed interactions skills training. This focuses on the behavioral management skills in PCIT; and
- Live on-site consultation and supervision.

Strategies to help sustain PCIT beyond the initial year of training include identification of staff, which in addition to having sound clinical skills also has the ability to serve as agency trainers. In addition, PCIT offers regional and yearly conferences.

Impact: PCIT has been operating in California for approximately 13 years. Currently, 95 sites are serving approximately 5,000 families a year.

Multisystemic Therapy

Multisystemic Therapy (MST) is an intensive family and community-based treatment that addresses the multiple determinants of criminal offending in juveniles. The MST approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, peer, school, and neighborhoods. Intervention may be necessary in any one or a combination of these systems.

MST services are delivered in the natural environment (e.g., home, school, and community). The treatment plan is designed in collaboration with family members and is, therefore, family driven rather than therapist driven. The ultimate goal of MST is to empower families to build an environment, through the mobilization of indigenous child, family, and community resources that promotes health. The typical duration of home-based MST services is approximately four months, with multiple therapist-family contacts occurring each week, determined by family need.

Target population: MST was developed for adolescents (ages 12-17) with conduct problems who are at risk to out-of-home placement. Additionally, there are three adaptations to the model: a) children, ages 6-17, who have come to the attention of child protective services and who are at risk of out-of-home placement; b) MST Psychiatric was developed for children and youths with serious behavior and psychiatric problems; and c) MST for problem sexual behavior offers intervention to youths whose criminal behavior includes sexual offending.

Goals: The major goal of MST is to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems.

Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family for responsible behavior. Intervention strategies are integrated into a social ecological context and include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapies.

Funding: MST service delivery is billable to EPSDT Medi-Cal when the youth is being served by the mental health department. However, most of the sites in California are funded through juvenile probation.

Training: MST has a robust training program for both practitioners and supervisors. The training progression begins with a five-day orientation. Practitioners are supported by MST-trained supervisors, who attend initial two-day training and then a yearly training thereafter. Teams and their supervisors must become licensed through MST services. A yearly license fee is required to maintain status as an MST program.

Impact: MST has been operating in California for approximately 10 years. Currently, 10 teams are serving youths in five California counties. It is estimated that 300 families receive MST services in one year.

SafeCare

SafeCare is a parent-training curriculum for parents who are at risk or have been reported for child maltreatment. SafeCare is an in-home parenting program that provides direct skill training to parents in child behavior management and planned activities training, home safety training, and child health care skills to prevent child maltreatment. SafeCare is generally provided in weekly home visits, lasting from one to two hours. The program typically lasts 18-20 weeks for each family.

The SafeCare program utilizes four modules:

1. Health,
2. Home Safety,
3. Parent-child/parent-infant interactions, and
4. Problem solving and counseling.

All of the modules involve a baseline assessment, intervention and follow-up assessments to monitor change. Staff conducts observations of parental knowledge and skills for each module by using a set of observation checklists. Service providers and parents receive the same training, which uses the following seven-step format:

1. Describe desired target behaviors,
2. Explain the rationale or reason for each behavior,
3. Demonstrate desired behavior,
4. Ask the parent to practice the behavior,
5. Provide positive feedback,
6. Provide constructive feedback, and

7. Review parents' performance. Have them practice areas that need improvement, and set goals for the week.

Target population: SafeCare was developed for families, with children 0-5 years of age, who are at risk of maltreatment or who have been referred to a child welfare agency for child maltreatment.

Goals: The goal of SafeCare is to reduce the risk of child maltreatment by improving parental safety and child management skills.

Funding: In California, SafeCare is funded by child welfare departments, primarily through Title IV-E funds. In some cases, service delivery is carried out by child welfare workers and in others; the program is contracted to local community-based organizations.

Training: On-site training is provided for both practitioners and supervisors who function as SafeCare coaches. Training for line staff includes an initial five-day workshop. Trainees learn to implement the three SafeCare modules (Health, Safety, and Parent-Child/Parent-Infant Interaction), and also receive training on communication and structured problem solving.

Following the training workshop, trainees receive feedback on their implementation of SafeCare in the field with families from a SafeCare coach. Once trainees demonstrate proficiency in the practice, they become certified as SafeCare providers.

The SafeCare coach training prepares an individual (usually the organizational supervisor) to provide on-site coaching for home visitors. There is an on-site two-day workshop in which trainees learn about the role of a SafeCare coach, how to conduct coaching, and how to provide feedback to home visitors. Following the workshop training, coach trainees must demonstrate coaching skills in live sessions with their home visitors and also must demonstrate mastery of fidelity monitoring to become certified.

SafeCare provides a train-the-trainer option, which increases the likelihood that sites are able to sustain the program after investment in initial training.

Impact: SafeCare began operating in California in 2008. There are currently seven sites operating in the following counties: Fresno, Shasta, Ventura, Santa Clara, Santa Barbara, Tulare, and Madera. San Francisco County plans an implementation in July 2011. It is estimated that 1,440 families per year will be served through the implementation of SafeCare.

Unique Implementation Features: The Chadwick Center for Children & Families at Rady Children's Hospital in San Diego has been funded by the Children's Bureau of the Administration for Children and Families to implement, adapt and evaluate SafeCare in multiple California counties. The project is known as Safe Kids California. Over the course of the project, SafeCare will be cascaded across multiple counties, while building the local infrastructure, and ongoing training and coaching capacity. An additional unique feature of the project will be a cultural adaptation of SafeCare for Latino families. This includes staff support and coaching in Spanish for Spanish-speaking staff and families.

Evaluation of Treatment Outcomes

This section on evaluation addresses a key question: Do evidence-based programs (EBPs) have good treatment *outcomes* for clients?

The data summarized in this section on evaluation come from CiMH evaluation reports known as “Aggregate Program Performance Dashboard Reports,” or “dashboards” for short. Dashboard data will be presented for the following programs: 1) Trauma-Focused Cognitive Behavioral Therapy, 2) Aggression Replacement Training, 3) Functional Family Therapy, and 4) Multidimensional Treatment Foster Care.

Overview of Treatment Outcome Measures

Information on evaluation is available only for those evidence-based programs supported by CiMH. The staffs responsible for dissemination of NFP, PCIT, SafeCare, Triple P and MST were asked for evaluation data; however, in no case were they able to provide it as they aggregate across programs and could not produce California-specific outcomes.

A *number* of different treatment outcome measures were used to quantify the effectiveness of these EBPs.

One pair of measures – the Youth Outcome Questionnaires (YOQ and YOQ-SR) – will be described here, because they were utilized in *several* dashboards. These two YOQ measures are both *broad* measures of improvement – measures of child’s/youth’s *global* mental health functioning. The items in the YOQ and YOQ-SR cover an array of mental health areas – e.g., interpersonal relations, social problems, such as aggression and delinquency, and emotional distress. The YOQ is a report by a *parent/caregiver* (for children ages 4-17); the YOQ-SR is a youth *self-report* (for ages 12-18).

In addition to the *broad* YOQ measures, many of the dashboards also reported data on a more *focal* outcome measure – i.e., on a measure that sensitively assesses the *specific* outcome that was the *focus* of the treatment. For example, Trauma-Focused Cognitive Behavioral Therapy concentrates on reducing Post-traumatic Stress Disorder (PTSD) symptoms; hence, a measure of PTSD symptom reduction was reported in the dashboard.

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) aims to reduce the PTSD symptoms of traumatized child clients. It is an individual, rather than group, treatment. The dashboard for TF-CBT was based on outcome data submitted to CiMH from eight counties and 17 private-provider agencies. There were 23 organizations that submitted these data.

The dashboard was based on data from the 677 children referred to these TF-CBT programs. These TF-CBT clients had an average age of 11.3 years, and were more often female (about 60%) than male (about 40%).

TF-CBT resulted in extremely good treatment outcomes for clients.

First, consider the *focal* measure – the measure of improvement in PTSD symptoms. The Post-traumatic Stress Disorder Reaction Index (PTSD-RI) is a 20-item measure that assesses the frequency of post-traumatic stress disorder symptoms. This measure was completed by *both* the client (the child/youth) and a parent/caregiver *both prior* to the start of treatment (pre-score) and after the completion of treatment (post-score).

The child/youth data showed a 38.9% improvement from pre-score to post-score – this is a *very large* improvement in PTSD symptoms. The parent/caregiver data also showed a very large improvement – a 33.1% pre- to post-improvement.

Now, consider the two *broader* measures of improvement –the YOQ and YOQ-SR. Again, TF-CBT resulted in a very large improvement. On the *parent/caregiver* version of the YOQ, there was a 33.1% improvement from pre- to post. On the youth *self-report* version, there was a 38.9% pre- to post-improvement.

In brief, the dashboard data show that TF-CBT results in *major improvement* in the *focal* outcome – trauma symptoms – and in *global* mental health.

Aggression Replacement Training

Aggression Replacement Training (ART©) is a treatment delivered in groups of youth with aggression and delinquency problems. ART© has – in essence – three focal aims: 1) increase *social skills* in challenging situations, 2) teach *anger control*, and 3) improve *moral reasoning* in morally challenging situations.

The dashboard for ART© is based on data from eleven counties.

The dashboard is based on data from 4,159 ART© clients who had an average age of 16.5 years, and were more often male (about 3/4ths) than female (about 1/4th).

The Skill Streaming Checklist measured the amount of improvement in the specific *social skills* that were taught in the treatment groups. The checklist showed a good treatment outcome for ART©. When the checklist was completed by *teacher/staff*, there was a 20% improvement from pre-score to post-score. When the checklist was completed by the *client*, there was a 12% pre- to post-improvement.

The Aggression Questionnaire (AQ) measures improvement in *anger control* as rated by the client. The AQ showed a 9% pre- to post-improvement.

The How I Think Questionnaire (HIT) measures improvement in *moral reasoning* as rated by the client. The HIT showed an 8% improvement from pre to post.

Consider now the more global YOQ-SR measure. Again, ART© showed good improvement. There was a 9% pre- to post-improvement.

On one of the YOQ-SR's *subscales* – the Social Problems Scale, which assesses improvement in problems that are socially related, including aggression and delinquency – there was a 14% pre- to post-improvement. This is impressive, as the items comprising the Social Problems Scale tend to be slow to change.

In sum, the dashboard data show that treatment groups utilizing ART© result in good improvements in the *focal* outcomes – namely, the *social skills* targeted, *anger control*, and *moral reasoning* – and in *global* mental health.

Functional Family Therapy

Functional Family Therapy (FFT) aims to help a troubled youth by improving the functioning of his/her family.

The dashboard data comes from 29 Functional Family Therapy (FFT) teams throughout the state of California. The clients treated with FFT had an average age of 11.3 years, and were more often male (about 3/5ths) than female (nearly 2/5ths). Treatment outcome was measured using the YOQ-SR and using the YOQ as completed by the mother and/or father. Outcome data is reported for the 1,231 youth who were FFT completers.

These YOQ data show very good treatment outcomes. When the mother filled out the YOQ, there was a 26.8% improvement from pre-score to post-score. When the father completed the YOQ, there was a 17.4.8% pre- to post-improvement. The YOQ-SR revealed a 21.3% pre- to post-improvement.

Clearly, youths who completed FFT showed substantial improvements in global mental health.

Multidimensional Treatment Foster Care

Multidimensional Treatment Foster Care (MTFC) is a multifaceted treatment approach for youths with very substantial delinquency problems.

Dashboard data were collected for 131 youths served in four counties. The percent of males and percent of females was about equal.

Only one county reported outcome data. The measure used was the Brief Impairment Scale (BIS), a clinician-rated assessment of youth's current level of functioning in three domains: Interpersonal Relations, School/Work Functioning, and Self-care/Self-Fulfillment. The 13 successful MTFC graduates showed a great deal of benefit on the BIS; there was a 56% pre to post improvement. No pre or post BIS data were reported for the youths who did *not* successfully graduate from MTFC.

A larger amount of outcome data would be desirable, but the data so far paint a positive picture of MTFC. It should be noted that MTFC was the first EBP we implemented and, since that time, we require everyone to submit data.

Evidence-Based Programs and Culturally Diverse Populations

One of the overarching goals of the MHSA is to decrease disparities in mental health care by improving access for California's culturally underserved populations. Studies of unmet mental health need consistently demonstrate that rates of unmet mental health need are highest among Latino, African American, and poor and uninsured children; up to 75 percent of children in the child welfare system have unmet need.

The factors contributing to underutilization of services are complex, but families most commonly cite a lack of knowledge about available services, lack of transportation, stigma related to mental health disorders and lack of understanding about the purpose and mechanisms of treatment. Additionally, 40 to 60 percent of families that begin treatment terminate prematurely, with many of them reporting similar barriers as a reason for termination.

Elimination of barriers to care and improved access to high-quality care are thought to increase service utilization and improve outcomes for cultural groups. Access to care can be improved by locating services in areas convenient to cultural groups, improving language access for people with limited English proficiency, and improving efforts to overcome shame, stigma, and discrimination. Additionally, efforts must be made to engage consumers, families, and communities in developing services that are congruent with cultural norms, promote evidence-based programs, and understand and respect the world views and experiences of consumers of all cultural groups.

The EBPs highlighted in this report are without exception, being successfully delivered to culturally diverse populations throughout the state of California. Access and utilization have increased and positive outcomes are being achieved. In most cases, positive results have been achieved for the following reasons: (1) services are being delivered in non-stigmatizing locations, such as homes, schools, family support centers, public health centers, faith-based organizations; (2) ethnic-specific service agencies are increasingly participating in the provision of EBPs; (3) language access is being improved for consumers with limited English proficiency; and (4) EBPs are being accommodated to fit the cultural groups being served.

A few examples serve to illustrate these points.

MTFC – Fresno

Fresno County children's services supports two MTFC teams, one of which is dedicated to serving Latino families. All of the MTFC staff are bilingual/bicultural, all of the foster parents are Latino and bilingual, and 100% of the youth and families (biological or relatives) served are Latino. The family therapy component of MTFC has been accommodated to serve the needs of Latino families. Specifically, in addition to having parents learn the points and level system, another evidence-based family program is offered: Bicultural Family Effectiveness. Also the MTFC team provides case management to the parents so that youths are not serving as interpreters for situations in which parents are not able to communicate in English. It should be noted that the cultural accommodations to MTFC were made with the "blessing" of the developer.

Nurse Family Partnership (NFP) – Sacramento

The NFP program in Sacramento County has focused on the needs of young, poor, first-time African American mothers owing to very poor birth outcomes for their children and poor economic outcomes for mothers. NFP is a home visiting program delivered through the public health department, which increases access and decreases stigma. Additionally, NFP is tailored to the cultural values of the young women being served, and nurses pay particular attention to the role that past and current discrimination plays in impacting self-efficacy of mothers. Among the notable achievements of NFP in Sacramento is the 50% reduction in premature births for first-time African American mothers.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) – Statewide

TF-CBT is being delivered to a significant number of Latino children and families throughout the state. Michael de Arellano and Carla Danielson from the medical

center at the University of South Carolina have developed a culturally modified version of TF-CBT for Latino children and families. The culturally modified program addresses the following aspects of culture: spirituality, gender roles, *familismo*, *personalismo*, *resperto*, *sympatia*, *fatalismo*, and folk beliefs. Treatment is offered in non-traditional settings such as homes, schools, churches and other community sites parents find convenient. The importance of cultural concepts to the child and family is addressed and treatment is tailored to address those cultural issues. This helps to increase both the perceived relevance of the intervention and engagement in treatment. In addition, treatment is offered in Spanish, and consultation to therapists is provided in Spanish.

Conclusion

The field of mental health is rapidly moving towards providing services by utilizing intervention strategies that have been assessed for safety and effectiveness, based on empirical criteria, often referred to as evidence-based programs. It is widely accepted that the use of EBPs will improve the quality of mental health services. Since they have been subject to rigorous scientific testing, EBPs should provide consistent outcomes for consumers when they are implemented as designed.

This report and the accompanying policy report demonstrate that California has made significant strides in the provision of EBPs, and that good outcomes are being achieved for children and families in the child welfare and juvenile justice systems, as well as those from diverse cultural groups.