



Report of the Conference:

**Evidence-Based Practices in Children's Mental Health:
Building Capacities for Implementation and Research
August 24-26, 2003**

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Executive Summary

Conference Purpose and Objectives

In response to earlier meetings of multiple stakeholders, the conference was planned as a forum for state child mental health directors, federal agencies, families, and researchers to discuss opportunities, challenges, and strategies related to the development and implementation of evidence-based practices (EBPs) in children's mental health service systems. Conference sessions comprised panel presentations and large group discussions. This executive summary presents the highlights of the conference in relation to the following main objectives of the conference:

- To stimulate interactive learning among stakeholders through sharing information, assumptions, and expectations about the opportunities and challenges of implementing EBPs.
- To clarify issues related to the states' capacities to implement EBPs, and the capacity of EBPs to meet states' needs – especially the needs of children and families with multiple problems.
- To clarify cultural and family perspectives on EBP research and development.
- To share information on how to be informed consumers of EBP (given the range and limitations); and how to integrate EBP into policy and practice within systems of care.
- To develop a research/action agenda to influence the development and implementation of evidence-based practices for the greatest benefit of children and families.

Objective 1. To stimulate interactive learning among stakeholders through sharing information, assumptions, and expectations about the opportunities and challenges of implementing EBPs.

The conference was structured in a way to address this objective throughout all of the sessions. However, two sessions in particular focused on sharing knowledge, assumptions, and expectations. In the session titled, *Setting the Context for Children's Evidence-Based Practices*, Dr. Kimberly Hoagwood provided a definition of evidence-based practices, described the criteria that are generally considered to be evidence for supporting the effectiveness of a given intervention, provided a historical overview of the use of the term "EBP", summarized major research findings on the effectiveness of interventions in children's mental health, and discussed the complexity of the factors that need to be considered in transporting interventions from clinical trials to real world settings.

In a following session titled, *The Science: What We Know and Don't Know about Evidence-Based Practices for Children and Families*, panelists shared information on a wide range of topics including:

- Goals and funding mechanisms of the National Institute of Mental Health (NIMH) that are intended to promote a new science of dissemination and implementation of EBPs.
- Existing initiatives of SAMHSA's Center for Mental Health Services (CMHS) to promote the implementation and dissemination of EBPs for adults; and current needs and opportunities to develop special strategies for advancing implementation in children's mental health.
- A framework for nesting EBPs within systems of care and states' quality improvement processes.
- The expertise and advocacy power of families that can be tapped as resources in facilitating technology transfer, creating climates for implementation, and in developing strategies for training and supervision.
- Methods used in two states to apply the research on effectiveness of interventions to practice. Ohio's "Coordinating Center of Excellence" approach provides regional infrastructures for training and technical assistance around several EBP topics, including implementation of Multisystemic Therapy (MST). Hawaii's extensive review of the research literature led to more usable ways of describing the evidence base of interventions, and to the development of user-friendly matrices to assist practitioners in selecting interventions for specific disorders.

Discussions of our knowledge and experience base quickly surfaced issues related to how EBPs are defined and classified operationally and politically, which in turn can determine how services are funded in the future. Reservations were also expressed concerning moving too quickly to embrace EBP and fears that EBPs will replace systems of care. Repeatedly, there was a call for inclusiveness in determining the course of EBP development, implementation, and dissemination. It was noted that as a field we are making great strides in institutionalizing family involvement, but that more outreach needs to be done to institutionalize multi-ethnic and multi-cultural involvement at all of these types of forums.

To address concerns conference participants endorsed an approach to advancing EBPs that: 1) is careful and thoughtful; 2) gives communities and families responsibility for selecting EBPs that fit with needs, context, culture, and values of their neighborhoods; and 3) imbeds EBPs in local service arrays within family-driven, quality-improvement oriented systems of care.

Objective 2. Clarify issues related to states' capacities to implement EBPs, and the capacity of EBPs to meet states' needs, especially the needs of children and families with multiple problems.

A session titled, *Challenges and Strategies of Implementing Children's Evidence Based Practices In State Systems*, provided the opportunity for three State Child Mental Health Directors to share their strategies and lessons in the early stages of implementing EBPs. The current state budget crises are obviously limiting states' capacities to start up major initiatives or to reach the actual number of children and families in need. However, one helpful strategy used by states to move the EBP agenda forward was to align EBP implementation with other state initiatives. For example, in Michigan, EBP is aligned with quality improvement activities; in New Hampshire, EBP implementation is being conceptualized as part of the on-going system of care development; and in Texas, implementation of EBPs is being nested into a major state initiative to create a new benefit design system.

States are employing various strategies to develop consensus and to promote stakeholder involvement in projects leading to EBP implementation. In Texas, a consensus conference was held; in Michigan, incentives were provided to mental health centers to participate in innovative projects; and in New Hampshire, the Federation of Families plays a lead role in quality assurance and training functions for the state system of care development.

The special needs of children and adolescents in the states came up during this and several other sessions. Families reminded the forum not to lose sight of children who do not fit existing EBPs or defined service packages, such as those with dual diagnoses, developmental disabilities, autism or Asperger's syndrome, very young children, and families forced to relinquish custody to get treatment for their children. Discussion focused on the need to adapt EBPs to meet not only the special needs of children, but also the characteristics, needs, and wishes of specific communities and cultures.

Objective 3. Clarify cultural and family perspectives on EBP research and development.

The conference opened with a session titled, *Perspectives on the Challenges and Opportunities of Implementing Evidence-Based Practices*, which included four panelists representing organizations that advocate for families and cultural groups. Several points related to cultural and family involvement in EBP research and development emerged in panel presentations and large group discussions. These included:

- When research and implementation of EBP becomes truly family driven, there will be major contributions made in the diversity of research questions asked, in broadening study design and analysis methods, and in creating more opportunities for utilization of findings and dissemination.

- Family involvement in the design, planning, evaluation, and implementation of EBPs and promising practices will increase the viability of research for populations in need; families and youth from racially, culturally, and geographically diverse communities, and the communities themselves.
- Active family involvement in evaluation processes will assist in monitoring fidelity and outcomes with vigilance.
- Data systems should incorporate more direct consumer feedback to providers versus relying solely on the contractual process between funders and providers. Information and data on service costs needs to be better disseminated so that families can use the information for system improvement and advocacy.
- Research and development activities should be directed to adapting EBPs for different racial, ethnic, and cultural groups; and for different locales.
- We need to study services that families value as promising practices (e.g., support services delivered by paraprofessionals).
- Service utilization research should examine disparities in service delivery across racial, ethnic, and cultural groups, especially as they relate to the mental health service needs of children entering the service system through juvenile justice and child welfare.

Objective 4. Share information on how to be informed consumers of EBP; and how to integrate EBP into policy and practice, within systems of care.

Two of the sessions directly addressed infrastructure, system, and organizational issues that must be addressed in order to select, implement, and sustain EBPs. One was titled, *Building State Capacities for an Evidence-Based Orientation*; the other was *SAMHSA's National Registry of Effective Programs*. Information was presented on two current large-scale SAMHSA and CMHS initiatives — one designed to promote the use of EBPs in developing systems of care within communities or states (Comprehensive Community Mental Health Program for Children and their Families), and the other to define and classify existing program interventions by level of evidence (NREP). Other panelists spoke on topics related to stages of implementation that extend from planning and preparation to sustainability, financing and administrative structures and processes that could be used to build capacity, and the advantages and disadvantages of relying on Medicaid in view of the barriers and limits that shrink the population that can be served through this funding source.

This session and others provoked much discussion of related infrastructure topics:

- Building partnerships between states, community mental health centers, and providers
- The importance of leadership and organizational climates that nurture innovation
- The need for collaboration across service sectors at federal, state, and local levels to remove barriers to EBP and system of care development
- The critical need to develop the workforce to increase states' capacity for EBP implementation
- Funding issues

Objective 5. Develop a research/action agenda to influence the development and implementation of evidence-based practices for the greatest benefit of children and families.

Throughout the conference, recommendations were made to address relevant issues, remove barriers, and facilitate implementation of EBPs, and to conduct research that will truly inform efforts. The following list of recommended actions were synthesized from the presentations of Dr. Larke Huang and Dr. Jane Adams, who directly addressed this topic in their talks, and summaries of conference discussions and highlights from Dr. Ken Martinez. Agenda items are grouped into categories that reflect the main conference goals of building capacity for implementation and research.

Action Steps for Building Capacity for Implementation of EBPs

- In consensus-building and planning forums, continuously assess stakeholder participation to ensure appropriate and adequate representation of ethnic, racial, and cultural groups
- Compile and disseminate a review of state strategies for disseminating, implementing, and bringing EBPs to scale
- Compile and disseminate lessons learned from reviewing state strategies, and from Adult EBP Toolkit project
- Develop Memoranda of Understanding or Agreement among child mental health, child welfare, juvenile justice, and education to better coordinate and integrate EBP implementation in states
- Develop state cross-system planning teams including families, leaders from diverse communities, and universities and technical colleges (for training infrastructure and research)
- Compile, disseminate, or develop, as needed, financing models for EBPs
- Develop state strategic plans for implementing EBPs
- Integrate EBPs in ongoing system of care development efforts
- Incorporate EBPs into performance-based contracts
- Develop EBP websites to share current thinking, curricula/training programs, funding strategies, implementation strategies, etc.
- Explore and assess the possibility of developing “Toolkits” for children’s EBPs, and other methods for increasing dissemination of EBPs in communities and states
- Build initiatives on recommendations made in the Report of the Presidents’ New Freedom Commission on Mental Health:
 - Rec. 2.4: Create comprehensive state mental health plans to coordinate services and improve outcomes and accountability.
 - Rec.5.2: Advance evidence-based practices using dissemination and demonstration projects and create public-private partnership to guide implementation.
 - Rec. 5.3: Improve and expand the workforce providing evidence-based mental health services and supports.
 - Rec. 5.4: Develop knowledge base in the area of mental health disparities in order to accelerate delivery of excellent mental health care.

Action Steps for Building a Research Agenda

- Develop relationships with local universities and researchers
- In partnerships composed of states, cmhc’s, providers, families, and researchers — identify and prioritize potential areas of study that fit with local questions and needs. As suggested in conference discussions, possible areas of research are:
 - Impact of adapting EBPs for different racial, ethnic, and cultural groups, and for different locales.
 - Implementation and effectiveness of therapeutic processes (e.g., engagement)
 - Implementation and effectiveness of services that families value (e.g., support services delivered by paraprofessionals)
 - Implementation and effectiveness of early childhood interventions
 - Implementation and effectiveness of emerging promising practices
 - Dissemination and implementation research
 - Disparities in service delivery across racial, ethnic, and cultural groups
 - Research on improving practice
 - Research on changing behavior
 - Measurement of partnership and leadership as factors that facilitate implementation of EBPs
- Plan strategies for implementing the research agenda, applying for funding, etc. (See example from Michigan in this report, Session V.)

Introduction

The conference was planned as a forum for state child mental health directors, federal agencies, advocacy organizations, families, and researchers to discuss opportunities, challenges, and strategies related to the development and implementation of evidence-based practices (EBP) in children's mental health.

The stated objectives of the conference were to:

- Stimulate interactive learning among stakeholders through sharing information, assumptions, and expectations about the opportunities and challenges of implementing EBPs.
- Clarify issues related to the states' capacities to implement EBPs, and the capacity of EBPs to meet states' needs (especially the needs of children and families with multiple problems).
- Clarify cultural and family perspectives on EBP research and development.
- Share information on how to be informed consumers of EBP (given the range and limitations); and how to integrate EBP into policy and practice.
- Generate strategies for integrating the implementation of EBPs within systems of care.
- Develop a research/action agenda to influence the development and implementation of evidence-based practices for the greatest benefit of children and families.
- Develop a paper that synthesizes learnings and recommendations.

Steve Mayberg, Ph.D., Director of the California Department of Mental Health and President of the NRI Board, welcomed conference participants and invited robust dialogue on the complex issues surrounding EBPs. Within the political context of the recent President's New Freedom Commission Report, a central issue involves the need to breakdown barriers and problem-solve through partnerships — between families and providers, providers and mental health authorities, mental health and other service systems, and between states and the federal government. Key to the partnerships is becoming culturally competent in order to recognize, respect, and value differences among people and their languages. Sometimes overlooked is the need to become culturally competent with regard to organizations and systems. Through the involvement of multiple stakeholders at the conference, the forum provides an opportunity for exploring and identifying points of leverage where pressure can lead to greater system reform.

Vijay Ganju, Ph.D., Director of the NRI Center on Mental Health Quality and Accountability, provided a historical context for the meeting. In December of 2002, a small group of researchers, providers, advocates, and representatives of family organizations met to discuss issues to be considered in moving EBPs in children's mental health forward. A series of recommendations came out of this meeting, which included:

- Systematically gather data on states' activities with regard to EBP implementation.
- Develop a definition of evidence-based practice with clarification of levels of evidence.
- Manage and disseminate information on EBPs.
- Develop a framework for children's quality and accountability with EBPs as a component of the framework along with System of Care principles and values, and a theory of change.
- Promote evidence-based practices (not just specific programs or interventions) that are nested within system and organizational structures that facilitate implementation, such as financing and organizational context that readily accepts and adapts to innovation.
- Collaborate and coordinate vertically and horizontally.
- Develop training infrastructure for in-service professional development and pre-service preparation (colleges and universities) for future workforce.
- Consider readiness of the field for a Toolkit-like project in children's mental health similar to the initiative in adult mental health services.

This conference is a direct follow-up to the earlier meeting. Modeling a partnership approach, the conference was planned, sponsored, or funded by the NASMHPD Research Institute, the National Technical Assistance Center for Children's Mental Health of Georgetown University, the National Technical Assistance Center for State Mental Health Planning and the NTAC Targeted Technical Assistance Project, the Annie E. Casey Foundation, and the Research and Training Center for Children's Mental Health Research of the Florida Mental Health Institute. Substantial input, which directed the course of the meeting, was also provided by the NASMHPD Division of Children, Youth, and Families, the Federation of Families, the National Mental Health Association, and the Child and Adolescent Action Center of the National Alliance of Mentally Ill.

Conference funding supported travel expenses for 34 commissioners and state child mental health directors (representing 31 states), 4 representatives of family member organizations, 6 family members, and 22 panel members.

Organization of the Report

This report follows the organization of the conference in the following sections:

- Perspectives on the Challenges and Opportunities of Implementing Evidence-Based Practices
- Setting the Context for Children's Evidence-Based Practices
- The Science: What We Know/Don't Know about Evidence-Based Practices for Children and Families
- SAMHSA's National Registry of Effective Programs
- The Challenges And Strategies Of Implementing Children's Evidence Based Practices In State Systems
- Building State Capacities for an Evidence-Based Orientation
- Summary and Next Steps

Each session was composed of 4-6 panel presentations, which were designed to provide background material. Panels were followed by substantial periods of discussion among participants and panels. The conference was audio-taped, and the tapes were transcribed. Powerpoint files and the conference transcripts were used to summarize the presentations of panel members for the report. To preserve the integrity of important material and content, in some cases the entire text of presentations was included with only edits. Discussions of issues and strategies that emerged across the sessions were summarized in topical areas, and are presented following the session summaries. The report concludes with a synthesis of recommended actions to build the capacity for implementation and research on evidence-based practices in children' mental health.

SESSION I.

Perspectives on the Challenges and Opportunities of Implementing Evidence-Based Practices

The first session was designed to highlight the perspectives of stakeholder groups in a discussion of the challenges and opportunities of implementing a “continuum” of evidence-based practices, and views on how the research/action agenda can be advanced.

Synopsis of Panel Presentations

A. Family Perspectives on Evidence-based Practices for Children’s Mental Health

The Role of Families - Trina Osher, M.A. (*Federation of Families*) opened the session with a three-member panel presentation of family perspectives on EBPs for children’s mental health. Though the notion of consumer-driven services is not new, how this is to be operationalized has not been clearly articulated. The presentation illustrated how research and implementation of EBP would be influenced by family-driven practice in comparison to researcher/provider-driven practice, in terms of the purpose and sources of research questions, relationships and roles of families in the process, objective vs. subjective orientation, study design and analysis, access to data, dissemination, and utilization of findings. For example, in terms of dissemination, researcher/provider driven practice would disseminate to research journals and professional meetings using technical language, whereas the vehicles for disseminating family driven practice research findings would be newsletters, magazine articles, videos, conferences, public forums, legislative hearings, in common vocabulary, and multiple languages and formats. Similarly, outcomes and indicators in a family-driven system would reflect families’ interests and concerns with high involvement, cultural competence, varied and valid data sources, and collective responsibility for implementation fidelity and outcomes.

Diversity and Cultural Competence - Darcy Gruttadaro, J.D. (*National Alliance of the Mentally Ill*) emphasized issues of diversity and cultural competence in an introduction contrasting the high proportion of unmet needs among minority youth populations, and the corresponding low proportion of culturally diverse youth and families represented in studies evaluating the impact of treatment interventions. Such a condition limits our ability to generalize to diverse communities. To increase the viability of research for populations in need, families and youth from racially, culturally, and geographically diverse communities, and the communities themselves, must be involved in the design, planning, evaluation, and implementation of EBPs. Further, it is critical to look toward these diverse communities to identify promising practices and partners to further develop the research base of practices valued by families. The onus is on the professional community to bridge communication and understanding gaps, and to learn and respect the interplay of culture and outcomes.

Policy Message to States and System Issues - Luanne Southern, MSSW (*National Mental Health Association*) reminded the audience of recurring policy themes that relate to EBPs as well as traditional and promising practices. For example, while at the same time we are introducing new EBPs, we have to continue to aim for adequate coverage (in terms of accessibility and availability) of traditional and promising practices within systems of care. The focus on outcomes of EBPs must be vigilant through monitoring fidelity and compliance to standards of practice, and implementing a range of quality assurance methods, including active family and advocate involvement in evaluation processes. EBPs must be integrated into systems of care and into individual plans of care. Insurance must cover EBPs as well as necessary paraprofessional services.

B. Challenges in Implementing Evidence-Based Practices for Communities of Color -

DJ Ida, Ph.D. (National American Asian and Pacific Islander Mental Health Association) reviewed the statistics on disparities in mental health services for diverse communities. Barriers that interfere with appropriate care include: shame and stigma; mistrust and fear of treatment and the mental health system; varying cultural ideas about health and illness; differences in health-seeking behavior, language, and communication patterns; racism and insensitivity of service providers; and lack of culturally and linguistically appropriate services. To address barriers arising from the provider system, a consensus statement was developed by a diverse group of researchers and advocates that summarizes the state of the knowledge and recommends actions for services research, development, and delivery. (NOTE: Refer to “How to Get Report” from FMHI or NRI website.)

C. Perspectives on System Reform and Evidence-Based Practice - *Patrick McCarthy, Ph.D. (Annie E. Casey Foundation)*

represented the perspective of a private foundation in expressing that “dysfunctional public policy and public systems trump good programs and EBPs.” System dysfunction was defined as: a system that has serious problems with basic operations (i.e., intake, risk assessment, service planning, case management, supervision and management); that is unwilling or unable to actively engage families; that has misaligned financial incentives; and that has a demoralized, untrained, and unsupported workforce. Among several recommendations made by the speaker, system reform was highlighted as key to bringing EBPs to scale, ensuring their fidelity, and sustaining them. Other recommendations included ensuring access and choice, promoting a culture of accountability, committing state and national resources to EBP implementation and to moving it to scale, extending and testing intervention models, and integrating EBPs into systems of care.

D. The States’ Perspectives - *Ken Martinez Psy.D. (New Mexico Children, Youth, and Families Department)*

as Chair of the NASMHPD Division of Children, Youth, and Families, placed his remarks within a vision of “defining, identifying, and implementing the most effective, family responsive, and culturally competent mental health strategies and practices to assist children and families.” He stressed that practice should be organized around a public mental health model, which focuses on the developmental nature of children and aims toward resilience. The definition of EBP was reviewed as a body of scientific knowledge about services and the impacts of treatments or preventive interventions on child or adolescent outcomes. A definition of “practice-based evidence” was proposed to capture services which are valued by families or cultural groups, but which as yet have no recognized body of empirical evidence. To advance implementation of evidence-based practices and practice-based evidence, traditional categorical funding from federal and state sources need to be replaced with funding streams that can be blended, braided, and used flexibly across agencies and within states. To facilitate the transition to new practices, training and technical assistance are needed to retool in areas of human resources, financing, and data monitoring and evaluation. The speaker repeated the call for more research to develop interventions that are culturally proficient and responsive to diverse populations.

SESSION II.

Setting the Context for Children's Evidence-Based Practices

This hour-long session was designed to frame the issues and special concerns related to the development and implementation of evidence-based practices in children's mental health.

Kimberly Hoagwood, Ph.D. (New York State Office of Mental Health and Columbia University) opened her presentation by describing the criteria (e.g., type and number of studies, number of different investigators, use of treatment manuals, etc.) that are generally considered to be evidence for supporting the effectiveness of a given intervention. She provided a historical overview of the use of the term "EBP," which came into widespread use after 1995. The body of research is large and growing, as evidenced by 12 major reviews of evidence-based interventions for children, covering 1500 published clinical trials on outcomes of psychotherapies, 300 on the safety and efficacy of psychotropic medications, 50 on the effects of community-based interventions, and numerous school-based and preventive interventions. Examples were shown of interventions that can be differentially classified as "well-established" or "probably efficacious" depending on the nature and amount of evidence, and medications for childhood disorders that have strong, moderate, or weak evidence of effectiveness. In addition, studies have revealed interventions that are not effective, such as boot camps and the Project Dare curriculum for fifth and sixth graders.

To illustrate the complexity of the factors that need to be considered in transporting interventions from clinical trials to real world settings, Dr. Hoagwood presented a conceptual framework that is being used in a multi-site study funded by the MacArthur Foundation. The study will examine the relationships among the multiple inputs and factors that can influence outcomes of EBPs, including: systems that are composed of organizations and financing structures, provider organizations (i.e., culture, climate, leadership, readiness), practitioners (i.e., attitudes, beliefs, expectancies), aspects of the treatment and service context (training, support, auxiliary services), and characteristics of the child and family (i.e., symptoms, functioning, age, ethnicity, sex, family context, expectations).

Most of the same factors above play a role in implementing an EBP in a community setting. Acknowledging the many challenges faced in implementation, Dr. Hoagwood suggested they can be bundled into the following categories: fiscal issues (funding and financing), fidelity, intervention development, training, technical support and supervision, stakeholder consensus, leadership support, and system partnerships. Two case studies of Texas and New York illustrated how key aspects of implementation can be accomplished through comprehensive planning approaches.

SESSION III.

The Science: What We Know and Don't Know About Evidence-Based Practices for Children and Families

In this session, panelists provided an overview of the knowledge and experience base on bridging the gap between science and service in children's mental health, the special issues related to defining "evidence" while also considering family preferences and diverse cultural values and beliefs about healing, approaches that have been used to develop and implement EBPs within systems of care in partnership with families and cultural groups, and lessons learned from large-scale dissemination efforts at state and national levels.

Synopsis of Panel Presentations

A. Improving Children's Mental Health Care and Outcomes: NIMH Services Research - Junius Gonzales, M.D. (NIMH) highlighted the gaps, not only between research and practice, but also between research and policy that can, in part, be bridged by advancing the science of dissemination and implementation. The areas that need knowledge development to advance use of EBPs are (as KH said) family access and engagement, provider knowledge and behavior, organizational structure and climate, and factors in the external environment, such as stigma and financing. The aim of NIMH is to have scientific rigor and relevance in real time, through new funding mechanisms (center and individual mechanisms) focused on developmental research and rapid review. NIMH is looking to advance knowledge in two directions: toward dissemination and implementation research, and toward rehabilitation and community integration.

B. Direction for the Future: Developing Data-based and Value-based Systems of Care that Incorporate Evidence-based Practice – Robert Friedman, Ph.D. (FMHI, USF) opened with three basic questions: How can we improve access to care, quality and effectiveness of care, and the mental health status and well-being of all children? He contextualized EBPs within systems of care that are anchored to continuous quality improvement strategies. A quality improvement process requires, first, assessing how a system performs in implementing its vision, adhering to its values, and achieving the intended outcomes as a prerequisite to changing the system. However, in reality often programs are adopted without evaluating their fit with the system. Even worse, some communities may not be able to assess this fit because they do not know what their priority populations of concern are, or what their goals are for those populations. So we should be very careful in trying to impose more scientifically based approaches, with all the expectations that EBPs bring, (i.e., measuring fidelity and outcomes), on communities that are still learning self evaluation. An alternative approach is to start with having the community articulate a theory of change, and to develop strategies for measuring progress and achieving goals related to their theory of change. Discussion was made about the need to focus on evidence-based *processes*, as opposed to distinct practice protocols, which may have inherent problems, such as their proprietary natures.

C. What We Know and Don't Know: From the Perspective of Families – Elaine Slaton RN, MSA (Federation of Families). Experience has taught us "deep anger, distrust, fear and historical trauma preempt family interactions with researchers and research." Families bring expertise about their culture and about raising children with mental health problems, and they have power to advocate for policy change and program implementation. We need to create an evidence base for effective family involvement. We need to examine our roles and prepare to assist with change processes, technology transfer, creating climates for implementation, training and supervising use of EBPs.

D. Connecting the Evidence Base to Practice: What it Takes To Get There – Bruce Chorpita Ph.D. (University of Hawaii at Manoa) traced the history of their children’s mental health system through court consent decrees, development of a system of care, increasing access, refining the system to rely less on out-of-state and out-of-home placements, and responding to legislator demands for greater accountability. Rather than use existing reviews of the literature to identify a range of evidence-based practices, they reviewed the literature with a 5-level efficacy rating scale. They adapted the scale from APA criteria to make it more usable, and added criteria related to acceptability (number that participated), attrition, trainability (manuals and training materials available), generalizability (client demographics, therapist qualifications, setting, frequency, and duration), and cost benefit. The resulting report was condensed to matrices that summarize types of EBP by disorder and level of evidence (best support, good support, some support, no support, known risks). In addition, they are analyzing components of various interventions reported in the literature, and are building a decision tree to assist in matching client needs to treatment under varying conditions.

E. Integrating evidence-based practices with Systems of Care - Patrick Canary, M.Ed. (Center for Innovative Practices, Ohio) showed how Ohio integrates practice and research through the mechanism of Coordinating Centers of Excellence (CCOEs). This is a state-level strategy to promote the Department of Mental Health’s quality agenda of EBP dissemination. Eventual funding self-sufficiency is desired. CCOEs are hosted within entities such as MH/ADAMH Boards and universities. CCOEs have varying purposes: substance abuse and mental illness, criminal justice and mental health, learning excellence, illness management and recovery, and medication algorithm. Objectives of the Center for Innovative Practices are to:

- Partner with organizations that promote the use of EBPs and promising practices,
- Integrate EBPs and system of care development,
- Provide TA with regard to policy, financing, evaluation, and program issues at state and local levels
- Identify a range of EBPs for potential development in state
- Complement and support other CCOE’s that promote EBPs and promising practices.

The presentation also provided information about specific CIP initiatives; financial, systemic, and clinical challenges in implementation; and lessons learned.

F. The Case for Toolkits – Crystal Blyler, Ph.D. (SAMHSA Center for Mental Health Services)– As the Program Officer of the SAMHSA-funded National Implementing Evidence-Based Practices Project, Dr. Blyler humorously told a story about the development of the Adult EBP Toolkit Project, which is examining the implementation of six evidence-based practices (family psycho-education, supported employment, assertive community treatment, integrated treatment for mental illness and substance abuse, illness management and recovery, and medication algorithms) in eight states. The Toolkits are composed of information, videos, and training materials that are used in conjunction with formal training programs and an evaluation protocol. Dr. Blyler gave examples of how the project has impacted the implementation and dissemination of EBPs in adult mental health services. She suggested that it is time to start discussing and planning how to initiate a children’s Toolkit project, and encouraged the field to move forward despite the research needs, issues to be resolved, and implementation barriers. SAMHSA is waiting to hear what Toolkits to develop. This session effectively started the dialogue within the child mental health community.

SESSION IV:

SAMHSA's National Registry of Effective Programs (NREP)

This luncheon session was designed to familiarize participants with an existing federal infrastructure for reviewing and classifying the evidence base of prevention and intervention programs in substance abuse and mental health services.

Kevin Hennessy, Ph.D. (SAMHSA, NREP) explained that the National Registry of Effective Programs (NREP) is a resource for reviewing and identifying evidence-based programs. NREP had its origin in reviewing substance abuse programs, but is now expanding to cover mental health programs. NREP casts a wide net in that candidate programs are solicited from the existing scientific literature, other EBP review sources, final reports from SAMHSA grantees, and from the field. The screening and selection process results in four categories: model programs, effective programs, promising programs, and those with insufficient current support. Although formal expansion to review mental health prevention and treatment programs is not scheduled until 2005, 29 of 45 model programs reviewed in 2003 also decrease risk and or increase protective factors related to mental health. Examples are:

- The Incredible Years (Webster-Stratton)
- Multisystemic Therapy (Henggeler)
- Nurse Family Partnership (Olds)
- Olweus Bullying Prevention program (Olweus)
- CBT for Child and Adolescent Traumatic Stress (Cohen & Manarino).

The context for the NREP expansion is to coordinate with SAMHSA's Science to Services Initiative, which is an effort to strengthen and accelerate the widespread application of effective mental health and substance abuse prevention and intervention programs. The Science to Services Initiative will fund four types of grants:

- Services - implementation of services with a strong evidence base, a substantial evaluation component, with average awards up to \$500,000 per year.
- Best Practices Planning and Implementation – to help communities identify EBPs and develop strategic plans for implementing, adapting, and piloting interventions.
- Infrastructure- to increase systems' capacities to support effective programs and services.
- Science to Service – funding of innovative practices that are in early phases of evaluation.

SESSION V:

The Challenges and Strategies Of Implementing Children’s Evidence-Based Practices in State Systems

This session highlighted the challenges and opportunities faced by child directors in three states and lessons learned that can be transferred to other states. Close to the full text of panelists’ presentations were included here to enrich understanding of the state context of implementation.

Panel Presentations

A. Strategies for NH’s Mental Health Authority to Incorporate Evidence-based Practices into Children’s Services – Joe Perry, A.C.S.W. (New Hampshire).

The state of New Hampshire is already participating in the Adult Toolkit Project and has made a commitment to move ahead with evidence-based practices for children and adolescents. There will be a tremendous challenge in getting a new initiative off the ground in the midst of on-going system of care development, recruitment and retention issues, waiting lists, budget cuts, low morale, fiscal crises of mental health centers, and being unable even now to meet the needs of the community or system partners. There is a commitment to an agenda and a strategy that will be owned by all the partners, and that will be the result of a long-term plan. The SMHA already partners with Dartmouth Psychiatric Research Center and has learned from their experience in the Adult EBP Toolkit Project that consensus building has to be more inclusive and continuous. They have not yet gone to scale in the three centers that are implementing these Toolkits.

Current children’s mental health initiatives include Positive Behavioral Interventions and Supports (PBIS)--a data driven model to improve student behavior and climate in the schools. Through the state’s system of care effort the Department of Education has joined in a statewide expansion, which DOE is supporting through funding and training. Project Renew was developed a number of years ago as a research-based process to look at how to facilitate the transition to adulthood for youth who have serious emotional disturbance. It is based on self-determination, employment, and education, and has been a great success. Dialectical behavioral therapy (DBT) was developed a number of years ago through a training agenda at the behavioral health division. The approach to training and dissemination included initial training, boosters, and on-going support and supervision. Positive feedback is being received from families on the competency of clinicians. Through the state’s system of care development effort, there is a state-level planning and management team call the Children’s Care Management Collaborative. Statewide, there are 14 early childhood planning teams. Development capacity, service capacity, and partnership become very important parts of the infrastructure in advancing the agenda of evidence-based practices.

Since 2002, quarterly meetings with children’s directors have provided a forum for active knowledge dissemination and development processes around evidence-based practices. This brings up questions related to roles and responsibilities of state vs. local areas: Where should this work be focused? How much of it is local? What are the responsibilities of the directors in a local community mental health center for their children’s program? And, how do they measure up in terms of developing consensus, developing practices, and assuring that children and their family have access to care? The CAFAS instrument is used for eligibility determination for services, and to assess and track children’s needs. Ensuring that all of the data is received and fully utilized is challenging. They continue to work on conceptualizing how evidence-based practices fit into the larger context of system of care, development and contracting with the mental health centers, and to struggle in developing shared language and shared definitions.

NAMI New Hampshire and the Federation of Families are leading the quality assurance and utilization management process for the NH system of care development and also managing the finances for a training agenda. In terms of quality assurance, the first choice of families was to do family focus groups. From these, they identified some strengths and weaknesses, which was strong enough evidence to provide immediate feedback to improve service delivery.

Without a lot of money, they are: trying to align current and new initiatives; examining the management infrastructure at the Division of Behavioral Health; assessing procedures of contracting with the mental health centers; and examining their partnerships. They are building on the contract with the Psychiatric Research Center to help them move ahead with evidence-based practices in the children's arena, which will include consensus development, data base development, research agenda development; training, sustaining fidelity, and grant writing. The Division is now starting to write requirements for evidence-based practices into rules for the public mental health system. In performance-based contracts, they will be using measurable indicators on individual and family outcomes and linking these to the use of evidence-based practices.

New Hampshire has made a commitment to the mental health planning council for children and adolescents, and to the stakeholders participating in the system of care that they need to know: whom we are serving; what we are delivering; and what the outcomes and costs are. They are currently in the process of developing annual reports, both for the system of care project and for the larger public mental health system. In partnerships, they hope to have a long-term process that will be flexible and measurable.

B. “Hold Harmless” Outcome Feedback to Providers Develops Support for Evidence-based Treatments - *Sherida Falvy (Michigan)*:

The road to outcome-based services for children and families in Michigan began with the Level of Functioning project developed by Jim Wotring (Department of Community Health) and Dr. Kay Hodges, developer of the CAFAS, in partnership with the 47 community mental health centers. The project started at Livingston County Community Mental Health, where they were blending funds and serving cross-system children. They explored patterns and trends in CAFAS scores, and how these related to the services provided to children. This showed that Livingston was doing fairly well and getting some good outcomes. As that information became more available, other community mental health agencies showed interest and ultimately 22 of the community mental health agencies became involved in the project. The project involved centers attending the CAFAS reliability training, routinely gathering CAFAS data (intake, 3 months, and exit), submitting the data to Dr. Hodges, and attending meetings three or four times a year with Jim Watrine and Dr. Hodges to consult about their data. Those sites that were participating received outcome and compliance reports on a monthly basis. The sites were also able to export the data and use it in other ways (reporting, etc).

A large effort was made to carry out the project as a partnership — not to expose the centers for their weaknesses, but rather as a way to improve their practice. The reports had to be relevant for the work of the centers. Comparisons were made with statewide averages and not to each other. The project has also been used to study level of severity of the children that are being served in community mental health. The “Hold Harmless” approach was helpful in encouraging CMHCs to self evaluate, and to demonstrate that aggregated data could be used to learn more about the adequacy of services in a non-threatening way. Generating benchmarks can assist in gaining more consistency across the state. Would a person living in the Detroit area benefit from the same services in the Upper Peninsula — a very rural area? Some of the questions that we think need to be answered by the CMHCs as they use this data are: What are the characteristics of the children that we serve? What are their outcomes? What are the factors associated with poor outcomes? Do outcomes differ for different children with different characteristics, and do resource allocations match children's needs?

They have learned that there are areas to target for evidence-based practice training. For example, training to provide cognitive behavioral therapy and family management is done in a targeted way because of the resource issue. CMHCs were invited to apply for the training. An NIMH grant was recently received to study the impact of the training.

C. The Benefit Design Initiative - *Deborah Berndt, M.Ed. (Texas)*

In the midst of a major restructuring of state health and human agencies, the public mental health system is also undergoing a large systems reform initiative known as the “Benefit Design Initiative.” Benefit Design basically is an effort to better systematize who is served, what services will be provided, service costs and payment methods, utilization management, and outcomes at the individual and at the systems level. A major focus is using evidence-based treatments within the conceptual design. Through a consensus building conference and with participation from national experts, family members and community representative and providers, covered services were identified. Some controversy grew out of that; some decisions were made about services that would no longer be covered (e.g., day treatment). They are requiring, rather than encouraging, the use of the EBPs in this initiative.

Eligibility determination for benefit design is based on two major criteria: the diagnostic profile and an instrument that was developed called the Texas Recommended Authorization Guidelines (TRAG). There is an adult TRAG and a child TRAG. The child and adolescent TRAG assess ten domains. For eligibility determination and assignment to a level of care, the diagnosis determines the service type and the functional impairment determines the level of intensity of service. There are three broad diagnostic clusters: externalizing disorders (ADHD, conduct disorder, oppositional defiant); internalizing disorders (depressive and anxiety disorders) and major diagnoses (bipolar disorders, schizophrenia, any other psychotic disorders). These clusters cover the vast majority of children served. Children with other diagnoses are served through a utilization management process.

There are four levels of care in Benefit Design and also crisis services. These are Brief outpatient, Intensive outpatient, Treatment foster care, and Aftercare services. Within levels of care One and Two, there are several service clusters that are based on diagnosis because diagnoses drive the services to be delivered. Wrap-around planning is required in levels Two and Three, the intensive levels of services. Outcome measures include individual level outcomes such as clinical change, juvenile justice recidivism, school behavior, child and parent satisfaction, and system level outcomes such as cost access and out-of-home placement. They will also be able to assess outcomes and unmet needs by level of care.

With regard to EBPs, cognitive behavioral therapy, child and parent skills training (e.g., behavior management training), Multi-Systemic Therapy, Treatment Foster Care, Intensive Case Management, Family Partners (parent peer mentors), wraparound planning and flexible family supports will be utilized. Specific models of CBT and skills training curricula have been chosen. Training will be provided and will use technology such as video-conferencing, web-based training, and CDs. Fidelity measures have been developed and technical assistance provided to assure fidelity. Four sites will start on September 1st. Although this is considered to be a test year, there are expectations to go statewide in '05. Medication algorithms for depression and ADHD for children will also be implemented statewide in the '05 benefit design.

This is quite obviously a lean model, but there are also other ongoing strategies, such as school-based mental health services and an infant and early childhood mental health initiative.

Some of the other issues that affect implementation of EBPs in Texas pertain to the availability of qualified staff, especially in large rural areas; bi-lingual staff; the availability of culturally appropriate instruments, models, and curricula that are in the public domain; and accessible and affordable training.

SESSION VI:

Building State Capacities For An Evidence-Based Orientation

This session focused on defining the elements of infrastructure needed to grow and sustain evidence-based services (e.g., conducting studies of the effectiveness of promising practices, financing, contracting, information systems development, and methods for maintaining quality and fidelity) and on the implications of integrating these elements into state service systems (i.e., feasibility, needs).

Synopsis of Panel Presentations

A. Building the Infrastructure for Evidence-based Practices - *Rolando Santiago, Ph.D. (Child, Adolescent Services Branch, CMHS, SAMHSA)* introduced the section with a detailed overview of the Comprehensive Community Mental Health Services Program for Children and their Families by outlining the assumptions of the program, actions for building an evidence-based infrastructure within systems of care, current treatment effectiveness studies of the initiative, and future directions. The basic assumptions include:

- An evidence-based orientation increases the capacity of a service system to deliver effective services.
- The effectiveness of a service system depends on the effectiveness of clinical interventions, functional interventions, organizational practices, and system of care implementation.
- Systems of care provide the infrastructure necessary for the delivery of specific evidence-based interventions within a public health model.

Building the infrastructure involves assessing community readiness for evidence-based interventions and community need, establishing relationships and buy-in, establishing evidence-based intervention options, and assuring that appropriate resources are available. Through a special nomination and selection process, CMHS has identified 11 evidence-based interventions as options. These include: Multidimensional Treatment Foster Care, Brief Strategic Family Therapy, Intensive Case Management, Parent Child Interaction Therapy, Parent Connections, Common Sense Parenting, Parent Training, Family Group Conferencing, Violence Offenders Rehabilitation, Training, Service System Integration, and Crawford County Truancy Diversion. Treatment effectiveness studies are currently being conducted to assess whether children who receive an evidence-based intervention within a system of care have better outcomes than system of care alone. The interventions being studied are Parent-Child Interaction Therapy and Common Sense Parenting. Another initiative being implemented involves a provider survey to examine how providers define evidence-based interventions (EBI), what they know about EBI, extent to which EBIs are used in practice, and support received from agencies related to use of EBI.

B. Building State Capacities for EBPs: Implementation Framework – *Dean Fixsen, Ph.D. and Karen Blase, Ph.D. (FMHI)* concentrated in more depth on implementation by providing a framework for understanding the stages of implementation that include: system of care planning and preparation, clarifying the EBP interface and adoption decision, installing the program, initial and advanced program implementation, innovation, and sustainability. They illustrated how implementation that is weak in either infrastructure, fidelity, readiness on the part of the provider, or lack of practitioner training can effect the ultimate effect size of the EBP. A paper tracing the literature on implementation, and summarizing the implementation framework, was included in the participants' manual.

C. Building the Infrastructure for an Evidence-based Orientation – *Sheila Pires, M.P.A. (Human Services Collaborative)* brought the discussion back to infrastructure and noted that there are infrastructure issues at multiple levels: federal, state/local level purchasers, managed care organizations, community providers, family/youth consumers, researchers, and facilitators. To support the elements of EBP (e.g., leadership, buy-in, trained and supervised clinicians, funding, etc.), a range of structures are needed including: data management, quality monitoring, training, clinical supports, financing and purchasing, billing and claims processing, and rate structures. To motivate the multiple levels of

infrastructure, incentives are needed. States or counties need to have EBPs linked with larger system goals, capacity building grants, and technical assistance. Managed care organizations need to see that EBPs can lead to rational clinical decision-making protocols and alternatives to expensive services. Providers need incentives such as easier service authorization processes, realistic rates and timely billing and claims processing. At the consumer level, families and youth might be driven by the promise of better quality of care, improved outcomes, and greater partnership in decision-making. Several tools for promoting infrastructure were highlighted, including: using Medicaid rehabilitation services option, bundled rates or case rates, cross-system financing, managed care technologies such as utilization management, Title-IV-E training dollars, capacity building grants, practice guidelines, toolkits, cost/benefit data, and implementation guidelines.

D. Medicaid and Mental Health : The Love and/or Hate Relationship – *Steve Mayberg, Ph.D. (CA Dept. of Mental Health)* discussed states’ increasing reliance on Medicaid for mental health services, in the face of the inherent barriers that limit its use to adults with SPMI and youth with SED, such as the varying state to state eligibility rules that are driven by low income. He emphasized the dynamic tensions that are created with regard to who is served, who provides service, where services are provided, what services are available, who coordinates services, and who is the authority — Medicaid or Mental Health. Every state also has different approaches to implementing CHIP. He closed by pointing out that the President’s New Freedom Commission Report on Mental Health has cast light on the complexity of the system and the need to use Medicaid as a part of funding packages that can be used flexibly with other funding streams.

SESSION VII:

Summary and Next Steps

Key issues and challenges identified during the meeting were summarized and the next steps in developing an agenda for research and practice were discussed.

Synopsis of Panel Presentations

A. Virginia Commission on Youth Study of Effective Treatment Modalities for Children with Mental Health Disorders – Leah Hamaker (VA Commission on Youth) presented an example of how the State of Virginia is encouraging the use of EBPs, through a legislated mandate to review, identify, and disseminate information on EBPs. The mandate was prompted by the need to ensure that children were receiving effective treatments and services for the public dollars expended. The methodology incorporated a multi-agency advisory group with providers and consumers; and a smaller clinical review group. The study resulted in a report that described EBPs by categories of disorders. Built in to the recommendations were methods for disseminating and periodically updating the information, as well as plans for encouraging the use of EBPs by the Secretary of Health and Human Services, and by the Departments of Juvenile Justice and Education.

B. Summary and Next Steps: Mission Possible? - Larke Nahme Huang, Ph.D. (Georgetown) summarized issues that surfaced during the first two days of the conference. One set of recurring themes concerned the need to be cautious in the process of adopting EBPs — to take care in not letting the urgency of the need to incorporate effective interventions push out important principles related to building systems of care, to be careful not to de-fund services that we may find are effective in the future, to consider the partnerships with families and the developmental nature of children, and to be mindful of vulnerable populations such as children in foster care and children of color. Dr. Huang summarized the hopes expressed in moving toward greater quality and accountability—the opportunity to find out what really works, for whom, and under what conditions; the need to put human and financial resources into practices with an evidence base; the need to link cost and outcomes; and the move to make research more accountable. With regard to advancing the research agenda for EBPs, multiple research agendas emerged: to add to the small base of EBPs; to study practice-based evidence; to study evidence-based processes; to examine organizational climates and other structures associated with improved outcomes; to develop dissemination and implementation research; to further investigate research on changing behavior; and to focus on research to “improve” practice. The new research paradigm should be more in line with participatory action research with stakeholder voices in the questions, design, implementation, and interpretation. The context in which EBPs will be implemented continued to emerge as a key theme, as well as community and organizational readiness, workforce issues, strategies for selection and implementation, and financing strategies, especially in view of the current economic climate. Dr. Huang emphasized the importance of looking at strategies at state and federal levels that are being enacted for facilitating infrastructure, such as the Ohio Centers of Excellence, initiatives in Washington and California, the federal system of care grants, and EBP efforts in other child service sectors (child welfare, juvenile justice, and education), and the President’s New Freedom Commission Report that converges with both EBP and system of care values and principles. Dr. Huang summarized the action items that emerged from the conference as follows:

- Compile state strategies for disseminating, implementing and bringing EBPs to scale;
- Compile lessons learned;
- Develop state strategic plans for implementing EBPs;
- Develop state cross-system teams including families and leaders from diverse communities;
- Develop financing models for EBPs;
- Integrate EBPs in ongoing system efforts;
- Assess pros and cons of Toolkits for children’s EBPs;
- Build on Presidents’ Commission on Mental Health recommendations;

C. Summary and Next Steps – Jane Adams, Ph.D. (*Keys for Networking*) summarized the conference highlights from her perspective as a leader in Kansas’ system reform efforts, and addressed next steps from this vantage point. Her next steps would involve sharing information about the conference with families and encouraging them to:

- Promote discussion about EBP and what it means in Kansas;
- Ask for evidence about the treatment recommended for their children and who will provide the services;
- Get to know their legislators and talking about evidence and outcomes of services;
- Organize and use family network structure to voice concerns and/or support for services, and to influence which practices are adopted as models;
- Advocate for individualized service plans with EBPs adapted for the family;
- Tell their stories; and
- Fight custody relinquishment practices.

With other family organizations, she would urge that the next steps include:

- Developing a monograph about EBP and strategies for families to be involved in all phases adoption, delivery, and evaluation;
- Training families to interpret data;
- Convening focus groups of family members to set the research agenda; and
- Networking across states to share strategies.

With researchers the recommended next steps would be to:

- Insist on intensive training for staff in family involvement ethics, principles, and practices;
- Insist on intensive training for families to ensure they have fully informed involvement;
- Insist families involved match the demographics of the target population.

Researchers and providers were urged to make service performance data available to consumers and get their feedback on what the data mean, engage families in identifying characteristics of the workforce that is needed, and train direct line staff in the need for EBP. Finally she recommended that the EBP agenda be linked to the educational “No Child Left Behind” agenda which has common goals around accountability. She closed by summarizing research findings that support the links between community and family involvement, and improved service delivery and outcomes.

D. Closing Remarks – Gary Macbeth, M.S.W., M.Ed. (*Georgetown*) transitioned the conference to the discussion of Next Steps with some lessons learned from our efforts to build systems of care. We emphasized that we have to start from a new basis this time — that of building from families — what they want and what they know works. EBPs have to fit with the context of real communities and system of care values and principles. The audience was reminded that we have in the past, and can again, overcome the daunting task of changing systems through leadership — at federal, state, organizational, community, advocacy, and family levels. We have to use this leadership to become the champions for building the kind of infrastructure which has the financing, supervision, training, family choice, etc., that is needed. Evidence-based practice is not a panacea but a tool that enhances wraparound approaches and enriches our values and our principles.

Large Group Discussions of Issues and Strategies

Substantial conference time was dedicated to encouraging dialogue among stakeholders. The volume of background material presented by panelists provoked much discussion within each session. Often, the same issues came up in different sessions. Therefore, the summary of the large group discussions is organized by themes that emerged across sessions in the following areas:

- Definition and Classification Issues
- Paradigm/Approaches
- Representation at the Conference
- Special Needs of Children and Adolescents
- Data Issues and Research Needs
- Partnerships between States, Community Mental Health Centers, and Providers
- Leadership and Organizational Climate
- Collaboration Across Service Sectors
- Work Force Development
- Funding Issues

Definition and Classification Issues

Although there is some clarity now around the definition of evidence-based practice (EBP), there is still some confusion in the use of terminology such as “promising” practices, “best” practices, and “practice-based evidence.” Furthermore, there is not a common understanding about what specific treatments, services, or programs are considered to be evidence-based, promising, etc. Reports from the States of Hawaii and Virginia have moved us forward in this area by synthesizing the scientific literature and categorizing the level of evidence for a wide range of community-based and clinical interventions. Hawaii has tried to make the information user friendly in the form of easy to read tables that match child/family demographics and needs with effective interventions. They are now in the process of trying to simplify this further by identifying key therapeutic processes across interventions.

A critical point concerning definition is the perceived threat, or reality in some cases, that if certain interventions are not included in a particular service class (based on definitions), it may not be funded or available. If we become too exclusive in narrowly defining what is evidence-based and therefore funded, we might lose innovation, interventions that families or particular cultures value and believe to be beneficial, and interventions that practitioners believe are effective based on their experience. So there is a strong voice advocating that promising practices should be considered just as important as those for which we have more scientific evidence, and that practice-based evidence (based on tradition, culture, values, experience) should be considered as valid as empirically based evidence.

The classification issue came up again as a concern for families in response to the presentation of Texas’ new Benefit Design. The system is a new initiative to align clients needs, service planning, and budgeting through matching client needs to levels of care, with associated services. There was fear that children would be assigned to a level of care that did not have services that families desired, or that certain children would not fit into the designated categories. Families expressed the need to have some type of safeguard built in so that parents could appeal the process.

Paradigm/Approaches

A great amount of ambivalence about EBPs was voiced throughout the conference. There is enthusiastic support for the use of interventions that have been demonstrated to be effective, yet there are concerns that families and children will have less choice in treatment and service options, that EBPs are antithetical to system of care values because fidelity requirements will not mix with flexible and individualized service delivery, and finally that the EBP trend will somehow replace the ongoing development of

systems of care. Issues were raised about the wisdom of moving too quickly in embracing EBP. To some, the trend to implement EBPs reminded them of the start of the systems of care movement 20 years ago when the enthusiasm for a “magical solution” blurred our view of the barriers to be overcome and the realistic outcomes that could be achieved. A question was raised about the utility of introducing evidence-based practices in a community that does not already monitor performance and outcomes and have a clear sense of how it measures up in terms of quality. The ecological and cultural context of the community should dictate what EBPs to deliver. To address concerns conference participants endorsed an approach to advancing EBPs that: 1) is careful and thoughtful; 2) gives communities and families responsibility for selecting EBPs that fit with needs, context, culture, and values of their neighborhoods; and 3) imbeds EBPs in local service arrays within family-driven, quality-improvement oriented systems of care.

Representation at the Conference

“When and where are we going to bring in the people that have the track record for making change in communities of color, but also in poor Caucasian communities?”

Although special efforts were taken to make the conference truly inclusive in inviting state mental health agencies, families, family organizations, researchers, and other advocates, early in the conference it was pointed out that there should have been greater representation by the critical change agents who are community leaders and researchers working in communities of color. It was noted that as a field we are making great strides in institutionalizing family involvement, but that considerably more outreach needs to be done to institutionalize multi-ethnic and multi-cultural involvement at all of these types of forums. A way to encourage diverse communities to keep returning to these type of forums is for researchers to return resources to communities.

Special Needs of Children and Adolescents

While participants argued for broader, more inclusive definitions of EBPs, families consistently reminded the forum not to lose sight of children who do not fit existing EBPs or defined service packages, such as those with dual diagnoses of emotional/behavioral disorders and developmental disabilities and children with autism or Asperger’s syndrome. The plight of parents forced to relinquish custody to get treatment for their children was poignantly illustrated by family members attending the conference who have had to make this onerous decision. In relation to EBPs, the challenge is to ensure the existence and availability of EBPs targeted to prevent out of home placements or to provide alternatives to residential treatment. Another area of special need is early childhood prevention and intervention for which there are some known EBPs, but few implementation initiatives in mental health. Children who are commercially insured cannot be overlooked either because they also do not have access to EBPs. Finally, discussion turned to the need to adapt EBPs to meet the special needs of children and specific locales and cultures; and the accompanying need for research and evaluation to test the effectiveness of adapted EBPs.

Data Issues and Research Needs

Quality, data, research, and evidence-based practices were linked in most discussions. Participants repeatedly called for “good data” to identify needs, to track unmet needs, to facilitate planning and service development, and to monitor progress and outcomes via ongoing evaluation for quality and accountability. We need to start with the data that we have and use it more effectively or improve our data systems, as many states have done, to answer questions regarding the needs of various segments of our populations. Which interventions work better for which groups? But this needs to start with knowing the demographics and needs of families and children. However, this demand for good data was paired with reservations about the limitations of data and how it can also present a threat if not used

transparently and reasonably in partnership with stakeholders. Data systems should incorporate more direct consumer feedback to providers versus relying solely on the contractual process between funders and providers. Information and data on service costs needs to be better disseminated from management information offices so that a broader group of stakeholders, such as state child mental health directors, providers, and families can use the information for system improvement and advocacy.

Across the various discussion sections, several areas of research needs were articulated. With regard to practices, there should be more studies examining the evidence for:

- adapting EBPs for different racial, ethnic, and cultural groups; and for different locales;
- therapeutic processes (e.g., engagement);
- services that families value (e.g., support services delivered by paraprofessionals);
- early childhood interventions; and
- emerging promising practices.

We need to study disparities in service delivery across racial, ethnic, and cultural groups, especially as they relate to the mental health service needs of children entering the service system through juvenile justice and child welfare. Partnership and leadership are continually mentioned as factors that facilitate implementation of EBPs, but we need to study these factors in greater depth. We also need to examine the natural experiments that are going on across the states and study the impacts of these approaches. Finally there was a persistent question that came up regarding how to build stronger partnerships with researchers to respond to these expressed needs.

Partnerships between States, Community Mental Health Centers, and Providers

The relationships that State Mental Health Authorities (SMHA) have with community mental health centers and providers, and states' abilities to influence the implementation of evidence-based practices, is determined by the various system, organizational, and funding structures within each state. The extent of influence is dependent upon whether the state directly operates regional or county-based mental health centers, or contracts for service provision through mental health centers. Some states have powerful provider professional associations that influence the direction of mental health initiatives. Regardless of structure, the quality of interorganizational relationships that states have with centers and with providers plays an important role in implementing any important system changes. Gains have been made in collaborative approaches in which the state consults with mental health centers and maximizes their decision-making, provides incentives and options for participating in EBP initiatives, and where successful demonstration projects encourage other centers to participate. To move the service system from relying on residential treatment to community based services, some states have elected to exert a strong influence in withdrawing funding of residential treatment. However, even in some states where there is strong control of funding, residential provider guilds have organized resistance to closing residential units. Though difficult for states, class action suits have contributed to growing system capacity for providing a wider array of community based services.

The SAMHSA-funded System of Care grants have made major contributions in providing incentives for developing community-based systems. There was still some frustration that after years of implementing wraparound approaches, it has still not become institutionalized. The expansion and shrinking of state budgets over the years have had a detrimental effect on institutionalizing system of care approaches, implementing EBPs, and the sustaining of partnerships between states, centers, and providers.

Leadership and Organizational Climate

The discussion of leadership surfaced in nearly every session and for every stakeholder group. Among family organizations and families, the call was to assume a leadership role in every aspect of implementation and evaluation to ensure accountability at the levels of individual families and communities. Part of this leadership role involves advocating for full accountability systems. For

families to assume leadership roles they need access to the same information as professionals and researchers. We need to find more effective ways of disseminating information besides the internet because many families do not have access to this source of information.

SMHAs have to take the leadership to mobilize centers and providers, to identify the EBPs which fit their locales and regions, to know the state's various funding streams and to identify and advocate for new funding programs that will support EBPs, and to develop training infrastructures within their states through partnerships with educational institutions. Leadership within community mental health centers needs to be encouraged to increase their investment in EBPs. Federal leadership is needed to remove barriers that stand in the way of states integrating, braiding, or creating funding streams; and to assist with states' efforts to develop training infrastructures. Finally the joint leadership of mental health, child welfare, juvenile justice, and education was encouraged in order to facilitate whole systems change versus piecemeal efforts.

To be better leaders, we need to make sure that our organizational climates are primed for organizational and system learning. The research of Charles Glisson and others has shown that organizational climate is linked to quality of service delivery and outcomes. Similarly, existing knowledge bases need to be tapped. For example we need to take advantage of the learning of the Adult EBP Toolkit Project and find out how to circumvent problems they faced. We have to document the strategies that are being used across states now to address system problems. Finally we must ensure that future leaders are being mentored by the leaders of today so that twenty years from now real change will be evident.

Collaboration Across Service Sectors

The system of care movement that began 20 years ago in mental health brought issues of system fragmentation and the need for system reform to national attention. Now the demand on service systems to add EBPs puts a renewed emphasis on working with child welfare, juvenile justice, and education to accomplish new system goals. The trend to use EBPs is happening in every sector. Some of the same interventions are identified as EBPs across sectors. For example Multisystemic Therapy (MST), Treatment Foster Care, and Functional Family Therapy are identified as EBPs in mental health, juvenile justice, and child welfare. However, there is a trend to adopt these practices for specific target populations in categorical ways that are determined by each sectors' funding. Each sector is individually dealing with implementation issues, rather than joining forces to address them collectively. A Toolkit-like project in child welfare brought all of the same issues discussed in this conference to the table. Although collaboration is often successful, it was remarked that sometimes juvenile justice and child welfare agencies become frustrated with funding or philosophical constraints posed by mental health agencies, so opt to design their own systems of care. There are conflicts over residential treatment with mental health discouraging its use, but juvenile justice and child welfare agencies using it because of available funding and mandates to protect children or society. As stated above, it was recommended that federal leadership is needed to iron out funding and structural issues that work against collaboration. It was noted that this is beginning to happen at the federal level with Sybil Goldman representing children's mental health. Even without federal guidance at this point it was emphasized that SMHAs need to provide opportunities for other sectors to learn about our EBP initiatives and to work with them to the extent possible. The absence of representatives at this conference from the fields of Education and Healthcare was noted. It was explained that this was not an oversight, but actually planned more as a conference for the field of mental health to do a self-assessment prior to engaging other sectors in the dialogue.

Work Force Development

The need for both professional and paraprofessional workforce development was stressed. Work force training is necessary for capacity building. Training staff to deliver EBPs is essential for initial and

ongoing fidelity. Sustaining training initiatives over time will promote ongoing skill development. Cross-training with other sectors would create another collaborative link and resource sharing. SMHAs are resource poor with regard to training infrastructures. However, a major bridge to workforce development lies in partnering with technical colleges and universities to adapt their curricula to respond to these needs. One example of an existing project is in the state of New York where the Department of Mental Health has developed partnerships with five schools of social work to develop curricula for EBPs and to place student interns in agencies where EBPs are being implemented.

Funding Issues

“We keep trying to fund mental health services with dated funding streams that were developed for other times and other purposes. We need to develop new financing strategies that fit our time and purposes.”

This comment from one participant captured the essence of funding issues. For example in many states Medicaid is covering residential treatment, but not many other community-based services. Concerns were particularly expressed over the current budget crisis and the challenges in trying to expand into EBPs in a time of drastic reductions. In Texas the CHIP program is at imminent risk of losing mental health coverage for large numbers of children of the working poor. Families who do not financially qualify for any public programs are threatened with loss of custody when their children need residential treatment. There was much discussion regarding how to get Medicaid and other health insurance providers to cover EBPs; and how to be blend or “braid” Title IVE, IDEA, and juvenile justice funding streams.

Strategies were also offered by states that are experimenting with new funding programs. For example, the Katy Beckett Medicaid option changes eligibility criteria dealing with family income for certain classes of children. Several states also have different types of waiver programs that allow for payment of community-based services. Jane Adams informed us that she has learned that it is the states that narrow Medicaid coverage. In Kansas, their Medicaid waiver covers respite, parent training and support, and independent living; and the waiver has been used to sustain and expand SAMHSA system of care projects. The first step is to be informed and to know the funding streams in one’s state. Another tip was to get to know the Medicaid staff in your state. Different participants said that once they developed relationships with Medicaid personnel, they were quite friendly and helpful.

More helpful information from other participants was that federal agencies, such as SAMHSA, CMS, and the new DHHS Office of Disability are open to exploring ways to implement new funding mechanisms. In addition, the Pew Commission is looking at financing for child welfare including Title IVE and IVB programs. The President’s New Freedom Commission Report, released in 2003, has provided a new impetus for action in the area of funding service delivery.

Recommended Actions

Throughout the conference recommendations were made to address relevant issues, remove barriers, and facilitate implementation of EBPs; and to conduct research that will truly inform efforts. The following list of recommended actions were pulled from the presentations of Dr. Larke Huang and Dr. Jane Adams who directly addressed this topic in their talks, and summaries of conference discussions. Actions are grouped into categories that reflect the conference goals to build capacity for implementation and research.

Action Steps for Building Capacity for Implementation of EBPs

- In consensus-building and planning forums, continuously assess stakeholder participation to ensure appropriate and adequate representation of ethnic, racial, and cultural groups
- Compile and disseminate a review of state strategies for disseminating, implementing and bringing EBPs to scale
- Compile and disseminate lessons learned from reviewing state strategies above, and from Adult EBP Toolkit Project
- Develop Memoranda of Understanding or Agreement among child mental health, child welfare, juvenile justice to better coordinate and integrate EBP implementation in states
- Develop state cross-system planning teams including families, leaders from diverse communities, and universities and technical colleges (for training infrastructure and research)
- Compile, disseminate, or develop, as needed, financing models for EBPs
- Develop state strategic plans for implementing EBPs
- Integrate EBPs in ongoing system of care development efforts
- Incorporate EBPs into performance-based contracts
- Develop EBP websites to share current thinking, curricula/training programs, funding strategies, implementation strategies, etc.
- Explore and assess the possibility of developing “Toolkits” for children’s EBPs, and other methods for increasing dissemination of EBPs in communities and states
- Build initiatives on recommendations made in the Report of the Presidents’ New Freedom Commission on Mental Health:
 - Rec. 2.4: Create comprehensive state mental health plans to coordinate services and improve outcomes and accountability.
 - Rec.5.2: Advance evidence-based practices using dissemination and demonstration projects and create public-private partnership to guide implementation.
 - Rec. 5.3: Improve and expand the workforce providing evidence-based mental health services and supports
 - Rec. 5.4: Develop knowledge base in the area of mental health disparities in order to accelerate delivery of excellent mental health care.

Action Steps for Building a Research Agenda

- Develop relationships with local universities and researchers (Schools of Social Work and Public Health tend to be open to community-academic partnerships)
- In partnerships composed of states, cmhc’s, providers, families, and researchers--identify and prioritize potential areas of study that fit with local questions and needs. As suggested in conference discussions, possible areas of research are:
 - Impact of adapting EBPs for different racial, ethnic, and cultural groups; and for different locales.
 - Implementation and effectiveness of therapeutic processes (e.g., engagement)

- Implementation and effectiveness of services that families value (e.g., support services delivered by paraprofessionals)
 - Implementation and effectiveness of early childhood interventions
 - Implementation and effectiveness of emerging promising practices
 - Dissemination and implementation research
 - Disparities in service delivery across racial, ethnic, and cultural groups
 - Research on improving practice
 - Research on changing behavior
 - Measurement of partnership and leadership as factors that facilitate implementation of EBPs
- Plan strategies for implementing the research agenda, applying for funding, etc. (See example from Michigan in this report, Session V.)

CONFERENCE AGENDA

Evidence-Based Practices In Children's Mental Health: Building Capacities For Implementation And Research

Fort Lauderdale, Florida
August 24-26, 2003

Purpose

The conference will serve being planned as a forum for state child mental health directors, federal agencies, advocacy organizations, families, and researchers to discuss opportunities, challenges, and strategies related to the development and implementation of evidence-based practices (EBP) in children's mental health.

Format

The conference is structured to maximize interaction among participants. At the beginning of most sessions, the perspectives of various stakeholder groups will be represented with brief presentations of about 15 minutes each. The presentations are designed to provide background material and to stimulate discussion among participants for the remainder of each session.

Objectives

Preliminary objectives of the conference are to:

- Stimulate interactive learning among stakeholders through sharing information, assumptions, and expectations about the opportunities and challenges of implementing EBPs.
- Clarify issues related to the states' capacities to implement EBPs, and the capacity of EBPs to meet states' needs (especially the needs of children and families with multiple problems).
- Clarify cultural and family perspectives on EBP research and development.
- Share information on how to be informed consumers of EBP (given the range and limitations); and how to integrate EBP into policy and practice.
- Generate strategies for integrating the implementation of EBPs within systems of care.
- Develop a research/action agenda to influence the development and implementation of evidence-based practices for the greatest benefit of children and families.
- Develop a paper that synthesizes learning and recommendations.

Sunday, August 24

3:00 p.m. – 5:00 p.m. REGISTRATION AND NETWORKING RECEPTION

5:00 p.m. – 5:30 p.m. WELCOME/OVERVIEW

5:30 p.m. – 7:30 p.m. **PERSPECTIVES ON THE CHALLENGES AND OPPORTUNITIES
OF IMPLEMENTING EVIDENCE-BASED PRACTICES**

Presenters:

Trina Osher (Federation of Families)
Darcy Gruttadaro (National Alliance of the Mentally Ill)
Luanne Southern (National Mental Health Association)
DJ Ida (National American Asian and Pacific Islander MH Association)
Patrick McCarthy (Annie E. Casey Foundation)
Ken Martinez (New Mexico and NASMHPD CYF Division)

The perspectives of stakeholder groups will be highlighted in a discussion of the challenges and opportunities of implementing a “continuum” of evidence-based practices, and views on how the research/action agenda can be advanced.

Monday, August 25

7:30 a.m. – 8:30 a.m. REGISTRATION AND CONTINENTAL BREAKFAST

8:30 a.m. – 9:30 a.m. **SETTING THE CONTEXT FOR CHILDREN’S EVIDENCE-BASED PRACTICES**

Presenter: Kimberly Hoagwood (New York State OMH and Psychiatric Institute)

This session will frame the issues and special concerns related to the development and implementation of children’s evidence-based practices. These issues include the wide variation in characteristics, problems, and needs of children; characteristics of children, families, and systems that differentiate evidence-based services for children from evidence-based services for adults; the nature of EBPs and “system of care” principles and values; and the state of the science and knowledge related to barriers and challenges that need to be addressed. The session will provide a broad overview of the topics and areas to be covered in subsequent sessions.

9:30 a.m. –12:30 p.m. **THE SCIENCE: WHAT WE KNOW AND DON’T KNOW ABOUT EVIDENCE-BASED PRACTICES FOR CHILDREN AND FAMILIES**

Presenters: Junius Gonzales (National Institute of Mental Health)
Robert Friedman (FMHI – University of South Florida)
Elaine Slaton (Federation of Families)
Bruce Chorpita (University of Hawaii)
Patrick Kanary (Ohio)
Crystal Blyler (Center for Mental Health Services)

This session will provide an overview of the knowledge and experience base in bridging the gap between science and service in children’s mental health, the special issues related to defining “evidence” while also considering family preferences and diverse cultural values and beliefs about healing, approaches that have been used to develop and implement EBPs within systems of care in partnership with families and cultural groups, and lessons learned from large-scale dissemination efforts at state and national levels.

12:30 p.m. – 2 p.m. NETWORKING LUNCHEON
Kevin Hennessy (SAMHSA National Registry of Effective Programs)

2 p.m. – 5 p.m. **THE CHALLENGES AND STRATEGIES OF IMPLEMENTING CHILDREN’S EVIDENCE-BASED PRACTICES IN STATE SYSTEMS**

Presenters: Joseph Perry (New Hampshire)
Sherida Falvay (Michigan)
Deborah Berndt (Texas)

This session will highlight the challenges and opportunities faced by child directors in four states. A facilitated discussion will follow focusing on issues, needs, and perspectives of states engaged in implementing EBPs. Emphasis will be placed on strategies for implementing EBPs in the real context

of child and family needs, current service delivery structures and processes, staff without specific training in EBPs, budget shortfalls, etc. What lessons have been learned that can be transferred to other states?

Tuesday, August 26

8 a.m. – 9 a.m. CONTINENTAL BREAKFAST

9 a.m. – 12 p.m. **BUILDING STATE CAPACITIES FOR AN EVIDENCE-BASED ORIENTATION**

Presenters: Rolando Santiago (Center for Mental Health Services)
Karen Blase and Dean Fixsen (FMHI – University of South Florida)
Terre Garner (Federation of Families)
Sheila Pires (Human Service Collaborative)
Stephen Mayberg (California)

Based on the content and discussion in the previous two sessions and identified state realities, this session will focus on how to move EBP research and practice forward. Presentations will focus on defining the elements of infrastructure needed to grow and sustain evidence-based services (e.g., conducting studies of the effectiveness of promising practices, financing, contracting, information systems development, and methods for maintaining quality and fidelity). To lead into the final session, discussion will center on the implications of integrating these elements into state service systems (i.e., feasibility, needs).

12 p.m. – 1 p.m. LUNCH

1 p.m. – 4:30 p.m. **SUMMARY AND NEXT STEPS**

Presenters: Leah Hamaker (Virginia Commission on Youth)
Larke Huang (Georgetown TA Center, President’s Commission)
Jane Adams (Keys for Networking, President’s Commission)
Gary MacBeth (Georgetown TA Center)

This session will be devoted to summarizing key issues and challenges identified during the meeting and defining the next steps in developing an agenda for research and practice. Emphasis will be placed on how to promote greater involvement of youths and families in research and development activities, and ways to shape policy and funding to fit the contexts and special issues identified. The session is intended also to be a bridge to the next meeting (the “policy academy”) being planned for multi-sector collaborative approaches related to EBP implementation.

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