

Promoting an Evidence-Based Culture in Children's Mental Health: A Resource Guide



The development of the Resource Guide for Promoting an Evidence-Based Culture was funded by the Child, Adolescent and Family Branch of the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services. It was developed through a partnership among the Child, Adolescent and Family Branch; the National Association of State Mental Health Program Directors Research Institute; the Federation of Families for Children's Mental Health; the National Alliance of Multicultural Behavioral Health Associations; and with the valuable input and feedback of families and youth.

Acknowledgements

Development of the Resource Guide

The idea of the *Resource Guide for Promoting an Evidence-Based Culture* grew out of three meetings convened from 2003 to 2005 by the NASMHPD Research Institute, Inc. and SAMHSA's Center for Mental Health Services. An important message emerging from these meetings was that for evidence-based and promising practices to grow and be sustained, a much stronger emphasis needed to be placed on the context in which EBPs are imbedded. The recommendation was to pull together many of the resources and tools that already existed on the subject of how to support EBPs as tools for continuous quality improvement.

The Resource Guide was prepared by staff of the NASMHPD Research Institute, Inc.:

Jeanne C. Rivard, Ph.D.
G. Michael Lane, Jr., M.P.H.
Kristin Roberts
Vijay Ganju, Ph.D.

The guide was developed through a partnership with ORC Macro, Inc. and Walter R. MacDonald & Associates, Inc.

Acknowledgements

The development of the Resource Guide would not have been possible without the generous support and feedback from many. Specifically, we are grateful for Sylvia Fisher, Ph.D., of the SAMHSA Center for Mental Health Services (CMHS), who helped direct the project and dedicated many generous hours of her time to editing; Gary Blau, Ph.D., Chief of the Child, Adolescent and Family Branch of CMHS, who made the development of this guide possible; and Kristin Williams, CMHS intern, who enhanced this project with her valuable hours of reviewing and editing.

We would like to thank the Federation of Families for Children's Mental Health for their continuous partnership and invaluable feedback. Elaine Slaton of the Federation contributed greatly through writing and editing key sections of the Resource Guide, and through organizing feedback from family and youth reviewers. We thank Sandra Spencer, Executive Director of the Federation, for her leadership and guidance in making sure that family and youth voices were heard and captured in this guide. There are several family and youth reviewers that we would like to thank specifically:

Kim Williams
Pat Hunt
Alan Rabideau
Adam Blais
Andrew Snowman
John Ouelette
Jocelyn Conrad
Mike Prior

Mareasa Isaacs, PhD, Executive Director of the National Alliance of Multi-Ethnic Behavioral Health Associations offered her expertise in writing and editing sections specific to cultural competence. We thank her for her guidance in highlighting all cultures and belief systems.

We would also like to acknowledge the contributions made by members of the Outcomes Roundtable for Children's Mental Health, who reviewed the entire Resource Guide on very short notice and offered important recommendations for content.

We thank Kristin Roberts of NRI for her administrative and editorial skills, and overall dedication to the project. Without Kristin's attention to detail, this project could not have been accomplished.

Finally, to those youth, families, consumer advocates, researchers, practitioners, and administrators who work every day to improve the resources and services offered in children's mental health, we thank you! We hope this guide can offer support and direction in navigating and advocating for evidence-based treatment.

Please note that the photographs used in the Resource Guide are for illustrative purposes only; and that any person depicted in the Licensed Material is a model.

Contact Information

Jeanne Rivard, Ph.D.
NASMHPD Research Institute, Inc.
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
703-682-9468
jeanne.rivard@nri-inc.org

Sylvia Fisher, Ph.D.
SAMHSA's Center for Mental Health Services
Child, Adolescent, and Family Branch
Room 6-1047
Rockville, MD 20857
240-276-1923
sylvia.fisher@samhsa.hhs.gov

Section I:

Home

About the Guide

This Resource Guide was created out of a need to integrate evidence-based practices into mental health service systems. This need was highlighted in the 1999 Surgeon General's Report on Mental Health that emphasizes the gap between science and practice, and calls for an increase in the use of evidence-based practices in mental health. The 2003 President's New Freedom Commission Report reinforces this call to bring practices with documented positive outcomes to the field, thus aiding in the transformation of the entire mental health system.

According to the [Institute of Medicine](#) (2001), "evidence-based practice is the integration of the best research evidence with clinical expertise and patient values." However, efforts to integrate EBPs into service systems have shown that we need supportive system and organizational cultures in which evidence-based and promising practices can grow and be sustained.

The term evidence-based culture is defined here as characteristics or features of organizations and systems that support the use of EBPs. The purpose of this resource guide is to provide families and youth, practitioners, and administrators with information and resources that can lead to continuous quality improvement within an evidence-based culture in children's mental health service systems and organizations.

References

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press. (<http://www.iom.edu/CMS/8089/5432.aspx>)

President's New Freedom Commission (2003). *Report of the President's New Freedom Commission on Mental Health*. Rockville, MD: U.S. DHHS.

U.S. Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. DHHS.

How to Use this Guide

This Resource Guide is designed for:

- Families and Youth
- Practitioners
- Administrators of state and local service systems and agencies

For each of these three user groups, you will find specific information and links to other resources about:

- Selecting interventions for your child, your agency, your community, or your state; and
- Strategies for success in building organizational and system cultures that support the implementation of evidence-based and promising practices to promote continuous quality improvement.

The remainder of the *Home* section provides information about navigating the Resource Guide, defines basic terms used throughout the Resource Guide, and describes the larger system context in which children's mental health services are delivered.

Navigating the Resource Guide

This Resource Guide is organized according to the following outline. Click on any topic below to go to that section of this Resource Guide. You can also visit other sections by clicking on the section icons to the left or the top of the screen. The Glossary of Key Terms also provides definitions of terms used throughout the Resource Guide. You may visit the Glossary of Key Terms by clicking on highlighted words throughout the Resource Guide.

Resource Guide Outline

I. Home

- i. How to Use this Guide
- ii. Background and Need
- iii. What is Evidence?
- iv. What is an Evidence-Based Practice?
- v. Cultural Competence and Evidence-Based Practices
- vi. What is an Evidence-Based Culture?
- vii. Larger Systems Context of Children's Mental Health

II. What are the Specific Evidence-Based Practices?

III. Families and Youth

- i. Process of Selecting Interventions
 1. Family and Youth Roles in Selecting Interventions
 2. Selecting your Provider
 3. Assessment Experience for Youth and Their Families
 4. Questions to Ask Providers
 5. Learning about Interventions
- ii. Making it Work: Strategies for Success
 1. Family-Driven and Youth-Guided Systems
 2. Families and Youth as Providers and Evaluators
 3. Families and Youth Advocacy

IV. **Practitioners**

- i. Process of Selecting Interventions
 - 1. Partnering with Youth and Families
 - 2. Assessing Youth and Family Needs
 - 3. Matching EBPs to the Needs of Youth and Families
- ii. Making it Work: Strategies for Success
 - 1. Professional Development
 - 2. Training in Specific EBPs
 - 3. Supervision and Coaching
 - 4. Monitoring Fidelity and Outcomes

V. **Administrators**

- i. Process of Planning for and Selecting Interventions
 - 1. Assessing Population Needs
 - 2. Assessing the Environment
 - 3. Assessing Cultural Competence
 - 4. Assessing Organizational Readiness
 - 5. Assessing Financial Readiness
 - 6. Criteria for Decision-Making
- ii. Making it Work: Strategies for Success
 - 1. Leadership and Managing Change
 - 2. Strategies for Building an Operational Infrastructure
 - Aiming at Transformation
 - Financing
 - Training and Technical Assistance
 - Using Data for Continuous Quality Improvement
 - Fidelity
 - 3. Strategies for Sustaining Efforts

VI. **Glossary of Key Terms**

Background & Need

Since the mid-1980s, states and communities have been striving to build coordinated Systems of Care in children's mental health. A basic premise of the Systems of Care model is that multiple child-serving sectors including mental health, substance abuse, juvenile justice, child welfare, and education work together to plan and deliver a comprehensive array of effective services and treatments to meet the individual needs of children, adolescents and their families. While the Systems of Care approach has been widely adopted, the field is still working diligently/intensively to develop comprehensive arrays of effective services and treatments that will help support families to achieve the goals and outcomes they desire.

The term evidence-based practice (EBPs) refers to treatments and services that have been found to be effective in helping children and families reach desirable outcomes. Accordingly, EBPs are being added to the service arrays of states and communities across the nation. In selecting EBPs, consideration is given to how the new practices:

- Fit with the needs, context, culture, and values of families, communities, and neighborhoods
- Will be incorporated in local service arrays within family-driven, quality-improvement oriented systems of care

Implementing new EBPs can be challenging, frequently requiring practitioners and supervisors to receive special training, new financial structures, and new ways to measure how the service is being delivered and how children and families are improving as a result. New ways of thinking about change, and shared values regarding how to use evaluation and research data, are needed. Experience indicates that challenges need to be anticipated up-front, and that a context or culture needs to be built that supports evidence-based and promising practices.

Navigation Hints:

The next few sections of the Resource Guide answer questions you may have about terms used throughout the Resource Guide, including:

- What is evidence?
- What is an evidence-based practice?
- What is an evidence-based culture?

Links that describe a wide range of specific evidence-based and promising practices are also available throughout the Guide.

What is Evidence?

The American Heritage Dictionary defines evidence as: “the data on which a judgment can be based or proof established.” Scientific evidence is the accumulation of data through evaluation and research that carefully examines how an intervention is delivered and what improvements result. Data is another word for numbers, as in the number of children that improve their functioning on a standardized measure, like the Child and Adolescent Functional Assessment Scale (CAFAS) or the number of families able to stay together and prevent out of home placement. Data can also be “qualitative,” as in narrative descriptions of families’ experiences in a particular program. It is important to use mental health treatments and therapies that have scientific evidence to prove they actually result in desired improvements and outcomes (e.g., a child’s aggression is reduced; child attends school regularly).

Researchers use many different types of designs and methods to study the effectiveness of interventions (does it work in helping my child and family?). A researcher can compare children who receive a new intervention with those that receive treatment as usual (called a comparison group). If children who receive the new intervention improve, the results are stronger because a comparison group was used. The results may also be stronger if the children were randomly assigned (by chance, as in flipping a coin) to receive either the new intervention or usual services. (For a description of different types of research designs see Understanding Research Designs.

If other researchers find the same positive results, this helps build a knowledge base about the effectiveness of certain interventions. Research results across many studies are typically reviewed and evaluated to determine whether the findings are strongly supported. This information helps us make decisions about which EBPs to add to our service systems.

However, other types of evidence are used to decide which treatments and services to use in our services systems. Families’ and practitioners’ observations of whether a particular intervention is working for them are also extremely important.

Helpful Links:

- The State of Oregon’s definition of evidence
- Hawaii’s Evidence-Based Practices Committee provides examples of how research studies are rated to assess EBPs in children’s mental health
- [SAMHSA’s National Registry of Effective Programs and Practices](#) rates programs on several criteria, including methods used in research studies that have tested interventions, whether instruction manuals are available detailing how the intervention should be delivered, whether they assess fidelity (e.g., how well the intervention was delivered compared to the instruction manual), and other criteria.

What is an Evidence-Based Practice?

The term Evidence-Based Practice is defined in many different ways. The preferred definition merges key aspects of science, clinical expertise, and personal values. The [Institute of Medicine](#) (2001) defines evidence-based practice as, “the integration of the best research evidence with clinical expertise and patient values.” Two other related terms of equal importance are promising practices and practice-based evidence.

Promising practices refers to interventions that have some research evidence to indicate that they produce positive outcomes for children and adolescents. Promising practices require additional supporting research evidence to be considered evidence-based practices.

Practice-based evidence is another term frequently used in discussions of evidence-based practices. Isaacs, Huang, Hernandez, and Echo-Hawk (2005) define practice-based evidence “as a range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions.”

Cultural competence should be required in developing evidence-based practices, and interventions with practice-based evidence should be further developed and distributed (Isaacs, et al., 2005).

Evidence-Based practices, promising practices, and practice-based evidence are distinct, but essential to the advancement of service delivery based upon comprehensive continuous quality improvement efforts.

References:

Institute of Medicine. (2001). Crossing the quality chasm: A new health system for the 21st century. Washington, DC: National Academy Press

Isaacs, M.R., Huang, L.N., and Echo-Hawk, H. (In press). The road to evidence: The intersection of evidence-based practices and cultural competence in children’s mental health. National Alliance of Multi-Ethnic Behavioral Health Association.

Cultural Competence and Evidence-Based Practices

Cultural and linguistic competence is a critical factor in the successful implementation of evidence-based practices. As Davis (1997) defines cultural competence, it is “the integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match the individual’s culture and increase the quality and appropriateness of mental health care and outcomes.”

This definition indicates that evidence-based practices must be congruent with the cultures, values, and help-seeking behaviors of those that would be recipients of such practices – and, in many instances, that would include large numbers of children and families of color. Therefore, cultural competence is about adapting mental health practices and interventions to meet the needs of children, youth and families from many diverse cultures. Cultural competence must be incorporated into the expansion of evidence-based practices.

Currently, many recognized evidence-based practices have not included large numbers of children and families of color in their research studies. Although these practices have proven to be effective in clinical trials and control groups, many do not have evidence that they are effective with different cultural groups or groups with differing cultural values and worldviews. Therefore, it is imperative to address “cultural fit” when identifying evidence-based practices for families and children of color.

It is important to assess whether these interventions include adequate samples of diverse cultural groups or account for differing ways that these groups view and utilize mental health services. Research suggests that some evidence-based practices can be effective for diverse populations when the provider adapts the delivery of services to reflect the child and family’s culture.

Isaacs, Huang, Hernandez & Echo-Hawk (2005) suggest two approaches for ensuring culturally competent evidence-based practices for children and families of color

- Cultural adaptations of existing evidence-based practices
- Utilization of culturally-specific interventions, i.e., practice-based evidence models

Cultural adaptations of evidence-based practices involve changes in the approach to service delivery, the nature of the therapeutic relationship, or the components of the intervention itself to accommodate the cultural beliefs, attitudes, and behaviors of the population of interest (Whaley, 2006). Currently, it is unclear how much cultural adaptation can be accommodated by evidence-based practices before the fidelity of the model is compromised. Cultural adaptations of existing evidence-based practices require further study.

On the other hand, there are many practices and interventions in communities of color that are well-developed and well-utilized and respected by diverse populations. However, inequities in access to funding and differing views about what constitutes “evidence” has led to a lack of recognition of many of these practices or their acceptance as evidence-based practices.

Thus, “practice-based evidence” models should be more widely studied and included in practices that might be culturally appropriate for a population group. Isaacs, Huang, Hernandez & Echo-Hawk (2005) define practice-based evidence models as “treatment approaches and supports that are derived from, the positive cultural attributes of the local society and traditions. Practice-based evidence services are accepted as effective by the local community, through community consensus, and address the therapeutic and healing needs of individuals and families from a culturally-specific framework” (p.16).

At the core of evidence-based practices is the need to improve the quality of care and to provide greater accountability for services that are delivered. These two outcomes are also important to children and families of color, as data suggests that they are far more likely to encounter problems in access to mental health services and to receive lower quality services when they do receive care. Thus, quality services that are culturally appropriate must be a key ingredient in evidence-based practices.

References

Davis, King. (1997). Race, health status and managed care. In Epstein, Len and Brisbane, Francis, eds. Cultural competence series. Rockville, MD: Center for Substance Abuse Prevention.

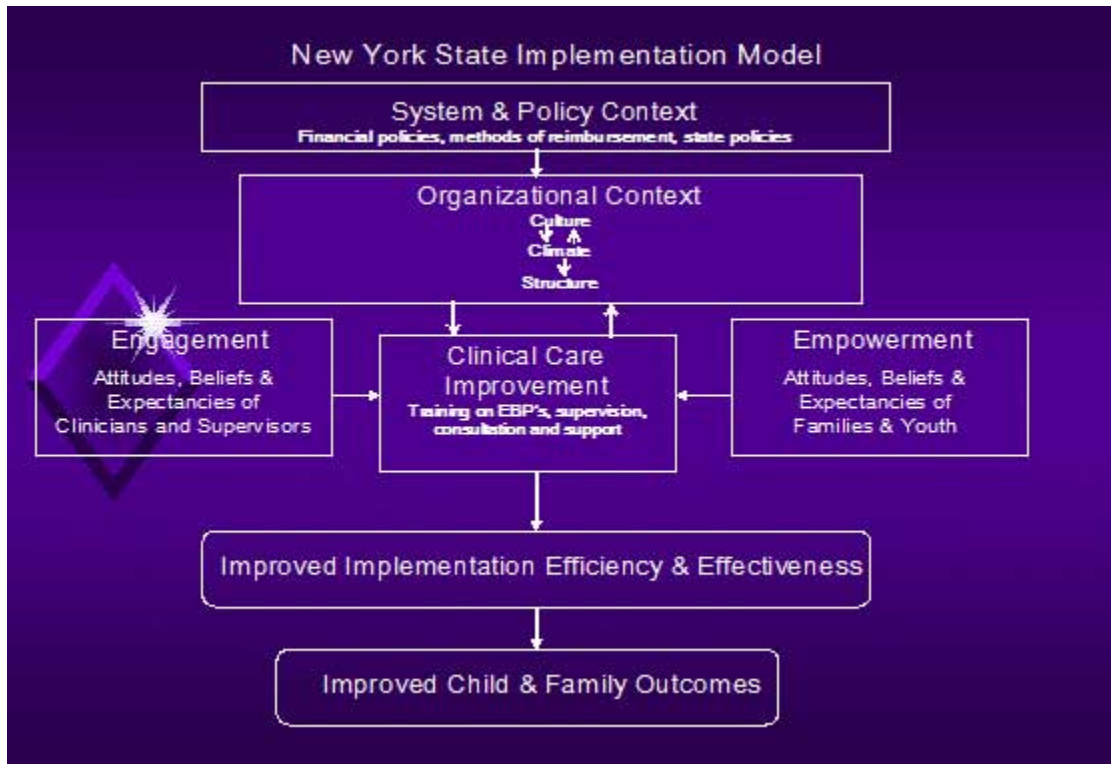
Isaacs, M.R., Huang, L.N., Hernandez, M., and Echo-Hawk, H. (2005). The road to evidence: The intersection of evidence-based practices and cultural competence in children's mental health. Washington, DC: The National Alliance of Multi-Ethnic Behavioral Health Associations.

U.S. Department of Health and Human Services. (2001). Mental health: Culture, race and ethnicity. A supplement to mental health: A report of the Surgeon General. Rockville, MD: DHHS, U.S. Public Health Services, Office of the Surgeon General.

Whaley, A. (2006). Request for proposals on cultural adaptation: Providing evidence-based mental health treatment for populations of color initiative. Austin, TX: Hogg Foundation for Mental Health.

What is an Evidence-Based Culture?

States and communities that use evidence-based practices emphasize the need for an infrastructure that supports their implementation efforts. An Implementation Model from New York's mental health system illustrates how system, policy, and organizational factors can influence the process and outcomes of mental health care (Hoagwood, 2006).



We use the term evidence-based culture (Dixon , 2003) to refer to the features of organizations and systems which support the use of evidence-based and promising practices, to promote continuous quality improvement. A system or agency with an evidence-based culture would have characteristics such as:

- Open, constructive communication to resolve problems and make new discoveries among families, practitioners/supervisors, administrators, and researchers
- A "change management" approach (i.e., an organization that is open to change and innovation, and willing to adapt policies and procedures to accommodate change that will improve programs and outcomes)
- Leadership that facilitates transformation to an evidence-based culture
- Shared values and understanding about how the use of evidence leads to service planning and development, service delivery, outcomes, and continuous quality improvement
- Skills and tools for using evidence to identify the needs of children, families, and communities
- Systematic approaches for reviewing available evidence from research and evaluation to decide which treatments and services address the identified needs
- Collaborative processes to select promising and evidence-based practices that address specific needs and fit the ethnic, racial, and geographic cultures of local communities
- Structure and financing to provide practitioners with necessary training, coaching, and technical assistance to learn service and treatment delivery methods
- Funding and reimbursement structures that support promising and evidence-based practices and ongoing evaluation supports

- Funding and reimbursement structures that support training for family and youth involvement in all phases of selection, implementation, and evaluation of interventions
- Structure and methods that measure how well new treatments and services are being implemented, and which assess whether new services are having the expected impact on children and families.

This Resource Guide provides information about how these characteristics or features can be built into service systems so that evidence-based and promising practices will be adopted and sustained.

References

Dixon , G.D. (2003). *Evidence-Based practices. Part III. Moving science into service: Steps to implementing evidence-based practices*. Tallahassee , FL: Southern Coast Beacon (a publication of the Southern Coast Addictions Technology Transfer Center). [Available online at http://www.scattc.org/pdf_upload/Beacon003.pdf]

Hoagwood, K.E. (2006, August). *Issues in implementing EBPs for children in New York State: Reverse engineering*. Paper presented at the meeting of the NASMHPD Research Institute on Lessons Learned: Implementing EBPs in Statewide Transformation, Arlington , VA.

Larger Systems Context of Children's Mental Health

Evidence-Based practices are being used by children's mental health and other child-serving sectors including Juvenile Justice, Child Welfare, Substance Abuse, and Education. There are websites and other resources in each field that identify and describe evidence-based and promising practices for emotional and behavioral disorders that affect children's functioning. The large number of evidence-based practices that are common across each sectors' list emphasize that children's needs are very similar across the various service sectors. The shared goals among all of the service sectors for greater effectiveness in service delivery through the use of evidence-based practices will likely increase opportunities for collaboration in service planning and delivery between these agencies.

Helpful Links:

Resources on evidence-based practices available in other child-serving sectors include:

- [Juvenile Justice - Blueprints for Violence Prevention](#)
- Child Welfare - Evidence-Based Practices in Mental Health Services for Foster Youth
- [Substance Abuse and Mental Health - National Registry of Effective Programs and Practices \(NREPP\)](#)
- Education and Mental Health - School-Based Mental Health: An Empirical Guide for Decision Makers

Section II:

What are the Specific Evidence-Based Practices?

What are the Specific Evidence-Based Practices?

Many intervention approaches have been found to be effective in treating different mental health, behavioral, and emotional problems. Typically, information on evidence-based practices is organized by type of problem. Sometimes problems are listed under general categories, such as "internalizing" and "externalizing" disorders. Youth experiencing internalizing disorders may have anxiety, depression, and/or post-traumatic stress disorder. Youth experiencing externalizing disorders may have problems with behavior, hyperactivity, and/or aggression.

To learn more about mental health, behavioral, and emotional problems, see: [American Academy of Child and Adolescent Psychiatry: Facts for Families](#)

Although a great deal of information is available to families describing specific evidence-based and promising practices that address different problems and disorders, it can be difficult finding this information. The [Society for Child and Adolescent Psychology](#) is a good place to start to learn about the many evidence-based practices available for several child and adolescent mental health problems.

Example: To identify evidence-based or promising practices for a youth who is having serious behavior problems in school and in the community:

- On the [Society for Child and Adolescent Psychology](#) website, click on "Conduct/Oppositional Problems"
- On that new page, click on "Conduct Disorders"
- On that new page you can read a description of conduct disorder and a profile of a youth that has a conduct disorder
- On that same page, in the box at the top click on "Evidence-Based Treatment Options"
- On that page you will see a list and descriptions of the various evidence-based and promising practices that have been found to be effective with youth that have conduct disorders.

Helpful Links:

The links below contain much of the same information, but were developed for different purposes:

- [SAMHSA's National Registry of Effective Programs and Practices](#)
- The Office of Juvenile Justice and Delinquency Prevention's [Model Programs Guide](#)
- [Ohio's Center for Learning Excellence](#)
- The NASMHPD Research Institute's Matrix of Children's Evidence-Based Interventions
- The Helping America's Youth [Program Tool](#)

Section III:

Families and Youth

Families and Youth

In this section, Families and Youth, you will be provided with helpful tips and links to resources you can use to help build an evidence-based culture. This information will help you learn how to advocate for scientifically-proven practices that match your goals for treatment.

Family-driven and youth-guided treatment principles are highlighted throughout the following sections. The importance of including families and youth in treatment decisions and mental health policy is emphasized throughout this Resource Guide. All parties, including families, practitioners and administrators (local, state), must work together to drive change and truly transform children's mental health.

Process of Selecting Interventions

Families and youth are driving system change to require that mental health services:

- Are culturally sensitive;
- Allow for shared decision-making;
- Incorporate strength-based principles; and
- Respect each individual family member's voice.

Family-driven and youth-guided principles must be included in mental health transformation.

Families are broadly defined here to meet the circumstances of individual youth and their primary caregiver(s) (Examples: mother/father and children, grandmother and child, foster care family, etc.). Youths, when developmentally ready, are considered active team members, and must be consulted about treatment. The selection of evidence-based interventions may be dependent on several factors, such as:

- Presenting problems or diagnosis;
- Access;
- Availability;
- Personal choice; and
- Cost

Difficulty accessing services and limited availability of services affect the experience of families and youth in mental health systems. Insurance, finances, and travel present more barriers.

Resources and guidance are provided in the next several sections for families and youth seeking and selecting treatment services. Links to information and materials that families and youth can use to navigate the mental health system are included.

Helpful Links:

- Taking Charge is a new monograph for families and youth on how to choose the most effective mental health services.
- [Mental Health America](#) provides families and youth with helpful information for beginning the process of selecting mental health treatments.
- The [Federation of Families for Children's Mental Health](#) provides more information about the principles of family- and youth-guided care.
- The [Pacer Center in Minnesota](#) offers helpful resources for parents, specific to emotional and behavioral disorders, as well as educational rights.

Family and Youth Roles in Selecting Interventions

We have all walked into a doctor's office seeking treatment because we feel sick. Sometimes we don't know how to talk to the doctor about how we feel or even what we need to feel better. Being told that "this is going around, just take this (medication) for a few days and you should be fine and come back to see me" may make you feel that you have wasted your time, or more importantly that you were not heard. This situation can happen when looking for mental health services for your child.

Families and youth should take on the role of experts when working with providers because only they know what they are experiencing. The *Child and Family Team* (Huffine, 2002), which is a key aspect of Wraparound Services, provides a model for family partnership and family-driven care. Key elements of the Child and Family Team are:

- The family has the primary role in determining care for their child or adolescent
- The team identifies the child's specific strengths and needs
- The team determines the nature of care to be offered and purchases this care, in consultation with professional as needed
- Membership on the team is determined by the family and should be composed of no more than 50% professionals. The rest of the team should be other family members, friends, family advocates, neighbors, workmates, ministers, coaches, or other community supports

The "Child and Family Team" model may not be used in your community, but there is no reason that families and youth can not advocate for this type of full partnership in determining the care that their child or youth is to receive.

Helpful Links

If you need support, seek out your local [Federation of Families](#) or [NAMI](#) chapter for peer-to-peer services. There are also supportive services available for youth through the [Youth Group Development, Youth MOVE](#).

References

Huffine, C. (2002). *Child and adolescent psychiatry: Current trends in the community treatment of seriously emotionally disturbed youth*. *Psychiatric Services*, 53, 809- 811.

Selecting Your Provider

The selection of a provider of mental health services for youth is a very important task.

You should make sure the provider you select:

- Will hear your concerns;
- Incorporate your goals into the treatment planning; and
- Value your opinions versus just telling you which treatment is needed.

Advocating in the mental health system is a helpful skill to have to ensure that your child receives the appropriate care. Dr. David Fassler provides [25 Tips for Advocating for Your Child in the Mental Health System](#).

Depending on which "child-serving sector door" (mental health, child welfare, juvenile justice, schools) you enter, you are likely to have contact with a variety of types of mental health providers, including psychologists, psychiatrists, social workers, case managers, professional counselors, school psychologists, child welfare workers, and juvenile justice counselors.

All providers are unlikely to have the expert skills necessary to provide evidence-based treatment. Families can visit their local community mental health agencies or contact their state mental health agencies to generate a list of private providers. Additionally, families with private insurance can contact their insurance company to see what services are covered within their plan. Be aware that evidence-based mental health treatment may not be provided equally in each state.

Helpful Links:

- To learn where local mental health agencies are in your state, you can link to a list of [State Mental Health Agencies](#) provided by the National Association of State Mental Health Program Directors (NASMHPD).
- A helpful guide is provided by the [Washington State Department of Social and Health Services](#) on [Tips from and for Parents on Building Early Intervention Partnerships with your Child's Doctor](#). Although this document deals specifically with Early Intervention Principles, these principles can be very useful in selecting and partnering with providers in the mental health community.

Assessment Experience for Youth and Their Families

Sometimes it is challenging to know when treatment may be needed. The [American Academy of Child and Adolescent Psychiatry](#) has some [helpful tips](#) for families on knowing when to seek out services.

After determining the need for treatment and selecting a provider, youth and families will go through an assessment phase to determine the most appropriate treatment needed. In an evidence-based environment, youth and their families should experience a strength-based assessment with valued input from youth, family members, teachers, and other child supports. Assumptions of strength-based assessment include the following (Harniss & Epstein 2005):

- All children have strengths
- Assessing a child's strengths, in addition to his or her deficits may result in enhanced motivation and improved performance for the child.
- Deficits should be viewed as opportunities to learn rather than as fixed or stable.
- Families and children are more likely to positively engage in treatment when service plans include a focus on strengths.

There are many standardized assessment instruments and protocols that practitioners use to assist in developing a treatment plan. Most likely, the assessment will involve a lengthy question and answer process to find out about the child/youth's history such as developmental milestones (i.e. walking, talking), school performance, social functioning, strengths, and reasons for referring the child to treatment. Throughout the assessment process, it is important for youth and families to ask questions about the process and to get an understanding of the next steps.

The section "Questions to Ask Providers" provides a list of helpful questions to offer youth and families guidance on gathering information about treatment and providing their input.

Helpful Links:

- [Bright Futures](#) has created some helpful tools for youth and families to learn about the normal developmental process and knowing when youth's development is off. Please visit this link to download the appropriate PDFs for each particular age group,
- To learn more about what a thorough psychiatric assessment may look like, visit the [American Academy of Child and Adolescent Psychiatry](#) section on [Comprehensive Psychiatric Evaluation](#).
- Please visit the [Pacer Center's](#) website for support and informational materials regarding children's mental health. In particular, the section on [Emotional or Behavioral Disorders](#) has some great information about understanding and determining if your child has an emotional, social, or behavioral impairment.

References:

Harniss, M. K., & Epstein, M. H. (2005). Strength-based assessment in children's mental health. In M. H. Epstein, K. Kutash, & A. J. Duchnowski (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices (2nd Ed.)*(pp. 125-141). Austin, Texas : Pro-Ed.

Questions to Ask Providers

As the mental health field moves toward an evidence-based culture, you as a client, have the right to request scientifically proven/evidence-based treatments. Youth and families must be provided the information to allow for a better-informed treatment selection process. Youth and families can ask questions like these when visiting mental health providers at different stages:

- Prior to the Start of Treatment
 - Does the provider have the educational background, training, and specific expertise to work with my child's special needs?
 - Will there be coverage when my child's provider is unavailable (i.e. is the provider part of a group, clinic-based, or independent practice?)
 - What is the provider's back-up plan in case of a psychiatric emergency?
 - Is the provider connected to local community interventions, such as crisis family services?
 - What are the costs associated with the care provided? Are the costs covered by my health insurance? What costs will fall to the family?
 - What languages does the provider speak? Does the provider have experience in treating people of different cultures?
 - Are informational materials presented in more than one language?
 - What culturally appropriate materials can the provider offer the family regarding mental health treatment?
 - What kind of treatment services are offered by the provider? Are the treatments evidence-based? If so, what expert training has the provider received?
 - Have these treatments been tried on other families like mine? With what results?
 - What is the length of the various treatment options?
 - What are the factors affecting my child's emotions or behaviors?
 - What are the primary problems you will target to decide which EBP will be most effective?
 - How will treatment help my child's emotional or behavioral problems?
 - How can I participate in treatment?
 - How do I communicate with you and other treatment providers about my child's progress?
 - What, if any, are the risks of treatment? What are the possible benefits?

- During Treatment:
 - How do we know if we are meeting our treatment goals?
 - My child's behavior is getting worse, is this supposed to happen?
 - My child refuses to go to treatment, what should I do?
 - We have not met the goals as outlined in the treatment plan; don't we need to change treatment?
 - When can we stop treatment, as my child is getting better?
 - This treatment is getting difficult for our family, can we change it?

- End of Treatment:
 - What supports are available to my child now that treatment is over?
 - Can we come back if my child experiences difficulties?
 - What support systems are available to my family and child after treatment? What will it cost?

Bring a notebook to write down your thoughts and answers to your questions. This will be useful in making decisions about treatment for your child, in developing treatment goals, and in making sure the desired outcomes are achieved.

Helpful Link:

[Michigan's Association of Children's Mental Health](#) (2004) [Guide for Families](#) regarding EBPs is a helpful resource for families and youth preparing for meetings with providers.

Learning about Interventions

Many resources are available for youth and their families to learn about evidence-based interventions and promising practices. The section entitled “What are the Evidence-Based Practices” provides helpful links and resources you can use to begin learning about treatments. Because there are many interventions available, it can take some time to go through these resources.

However, not all interventions are appropriate for all children. Some are targeted to particular diagnoses which may be more relevant to your child than others. Working with practitioners informs youth and their families with greater insights to narrow their search and choose from a select few.

As youth and their families review and visit references to learn about evidence-based interventions and promising practices, many new terms may be presented. Some of the terms that youth and families may come across are, diagnosis, prognosis, psychopharmacology, *length of treatment*, *expected outcomes*, and reimbursement. Please visit the Glossary of Terms in the Resource Guide to learn more about these terms and others.

Making it Work: Strategies for Success

The *Making it Work* section of the Resource Guide provides several strategies that help families and youth make an Evidence-Based Culture a reality that works for them in their community and according to their cultures. Some questions that families may desire the answers to before they begin their journey towards an Evidence-Based Culture are included below.

- ***Families and youth want services and supports that work for them, but how do we know what works?*** Treatments for children's mental, emotional, and/or behavioral disorders that are proven to work through scientific research are often called Evidence-Based Practices (EBP).

To become an Evidence-Based Practice, a treatment usually has to have three things:

- Evidence (proof) that it works through scientific research
- At least one Comparison Group Study (e.g., a study in which a group of people receiving the treatment are compared with a group of people not receiving the treatment)
- A Treatment Manual that says how the treatment is done

In addition, EBPs often require intensive training of providers so they can deliver the treatment exactly as it has been designed.

- ***If an EBP "works," does it create the results families want for their children or that youth want for themselves?*** There are many points of view about what treatment goals (e.g., outcomes) are right for any one child or youth with mental, emotional, or behavioral disorders and his or her family. For example, if an EBP reduces juvenile justice encounters and improves school attendance, it may not be the right thing for a family more concerned with keeping their child alive and reducing suicidal ideations. Families usually know their children better than anyone else. Youth know themselves. Therefore, the goals set by families or youth should take priority over the goals of available EBPs.
- ***So, if an EBP works to create the same goals a family or youth are seeking, how do they know it will work for them specifically?*** An EBP that has been proven to work in a clinical research setting may or may not work in a community setting. The children or youth may be different, the providers may differ in skills or abilities, and the setting in which the practice is delivered may be different from the original setting for the EBP. (For more information, see *Family-Driven and Youth Guided*.)
- ***Adaptations can be made when needed if there is ongoing evaluation to track results.*** When Evidence-Based Practices first emerged in the early 1990's, there was concern that an EBP would be a "*treatment in a car*" (i.e., no flexibility in application). There was great concern that values held by families, youth, and their advocates, such as individualized services and supports and cultural competence, would be lost. Today, we are learning what adaptations (changes) can be made to an EBP before it is no longer an EBP. For example, an Evidence-Based Practice developed and tested on young men in an urban setting may require some adaptations before it can be implemented in a rural area. Or if an EBP originally proven to work on depression is going to be applied to young people with depression and substance abuse, changes or adaptations may be required.

An important role for families and youth is advocating for and participating in continued evaluation of the treatment to be sure it does, in fact, work as implemented.

In the following sections, you can learn more about how to make sure the outcomes you want are, in fact, the goals of services, supports, or treatments that are provided:

- Family-Driven and Youth Guided Systems
- Families and Youth as Providers and Evaluators
- Family and Youth Advocacy

These sections also provide more ideas about how you, as a family member or youth, can make your community embrace a family-driven and youth guided approach to Evidence-Based Practices.

Family-Driven and Youth-Guided Systems

Family-driven, as defined by the [Federation of Families for Children's Mental Health](#), means families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation.

Youth guided as defined by [SAMHSA's Systems of Care](#), means that young people have the right to be empowered, educated, and given a decision-making role in the care of their own lives as well as the policies and procedures governing the care of all youth in the community, state, and nation.

Working definitions of *family-driven* and *youth guided* can be found at both the Federation of Families for Children's Mental Health and SAMHSA's Systems of Care websites. These definitions include ideas or guidelines that call for families and youth to be given complete information and included in all decision-making about their care.

TIPS to ensure that the services you receive are family-driven and youth guided:

- Know what you want to achieve. Know what outcomes you want.
- Keep your provider focused on the outcomes you want.
- Share stories about your child's healthy state of being, as well as his or her problems, to give the provider a full picture of your child. Youth, tell your provider what you are like when you feel your best (i.e., when you are not depressed.)
- Know what is included in the Evidence-Based Practice you and/or your child is/are receiving and what is supposed to change as a result. Visit the section on Learning about Interventions to learn more.
- Know what adaptations can be made within that EBP and ask for them if you need them.
- Keep a written record of what services you or your child is/are receiving. That is, make sure you are receiving the treatment or service you are supposed to be receiving. This refers to an important concept known as *fidelity to the model* (the service is delivered according to its proven design.)
- Keep a written record of how your or your child's symptoms or behaviors improve, get worse, or stay the same.
- Seek support and advocacy when you need it. To learn more, visit the Families and Youth Advocacy section of this Resource Guide.

EBPs should be delivered exactly as designed and tested. But when adaptations are needed, ongoing evaluation is essential.

TIPS for helping your community develop an Evidence-Based Culture

- Promote and practice family-driven and youth guided principles.
- Educate yourself and ask for information when you need it. Speak up when you have questions.
- Stay open to learning new things and supporting others to do the same.
- Ask for and participate in evaluation skills training. The [Federation of Families for Children's Mental Health](#) provides helpful information on [Family Leadership in Systems Evaluation](#).
- Learn to use *data* (information gathered in a scientific way) when making decisions. (For example, instead of saying you are never able to sleep at night, keep a journal and count the actual number of nights you were not able to sleep more than 6 hours over the past month.)
- When meeting with program administrators and policy makers, insist they use data to guide their decisions. (For example, rather than deciding that our county cannot afford to provide a certain service, document the cost of not providing the service and/or ask for evidence of the real cost to a neighboring county for comparison.)
- When considering an EBP, ask questions to ensure:
 - The children and youth involved in proving this practice works were like the children or youth it is being recommended for in your community. (e.g., race, age, ethnicity, socioeconomic backgrounds, single or multiple diagnoses)

- The providers involved in proving this practice works were like the providers intending to use it in your community. (e.g., race and ethnicity, educational backgrounds, training, years of experience)
 - The conditions under which this practice was proven to work are similar to the conditions of your community (e.g., urban or rural; school, clinical or home based, etc.)
- When there are differences between children and youth, providers, or practice delivery conditions than in those where the EBP was proven originally, participate in decisions about adaptations to the EBP and how those adaptations will be continuously evaluated to ensure they continue to work.
- Promote and engage in Continuous Quality Improvement (CQI). (e.g., ask advisory councils to report on the quality improvement data and resulting changes to improve services and supports.) The section on Families and Youth as Providers and Evaluators provides helpful information in this area.

Families and Youth as Providers and Evaluators

In many communities, families and family-run organizations have become providers of services and supports, a trend that benefits a workforce too small to meet the needs of our children and youth. They have also helped fill gaps in services and supports.

An additional benefit is that families and family-run organizations often know what works for the children and youth in their community - even if it has not been scientifically proven to work. Families and family-run organizations can develop capacities to gather data and partner with researchers to put evidence behind their practices.

Families and youth have also been very effective in program evaluation related activities through various ways such as:

- Families and youth asking important questions about the research supporting an EBP
- Families and youth helping to develop and advocate for access to Practice-Based Evidence
- Families and youth participating in and advocating for ongoing quality assurance strategies (especially tracking adaptations made to EBPs)
- Families and youth helping to develop and pilot measurement instruments
- Families and youth helping to design evaluations, collect data, interpret results, and suggest the best ways to use evaluation results for continuous quality improvement

Family and youth capacity to participate effectively in evaluation activities is a critical component of an Evidence-Based Culture.

The development of Practice-Based Evidence is crucial to the transformation of mental health services for children, youth, and their families. *Practice-Based Evidence* is critical to ensuring that all children and youth and their families have access to services and supports that will work for them. The national Federation of Families for Children's Mental Health defines Practice-Based Evidence as the *range of treatment services and supports that are accessible, culturally appropriate and known to be effective by the families, youth and providers*. Policy and funding for mental health services for diverse people cannot be limited to a finite list of EBPs developed through one single method, namely, scientific clinical trials.

For more information, visit the [Federation of Families for Children's Mental Health](#).

Families and Youth Advocacy

As the children's mental health field moves toward an evidence-based culture, it is essential that families and youth stay informed, ask questions, and keep the goals of individualized and culturally competent services and supports a priority throughout the process. Specific ideas about how to actively advocate for yourself, your family, and your community may be found in the Family-Driven and Youth Guided and Families and Youth as Providers and Evaluators sections of this Resource Guide.

Family and youth advocacy can be thought of in several ways:

- A peer-to-peer supportive activity, such as providing information and encouragement from one youth or family member to another
- A family-run organization sending a trained advocate to an Individualized Education Planning (IEP) meeting to ensure the rights of a family are protected
- Encouraging policy and funding decisions be made according to what families and youth know is best for families and youth in their community, tribe, territory, or state

All families and youth in an Evidence-Based Culture should have access to advocates and should be able to ask for help and support when they need it.

See www.ffcmh.org for resources on finding or starting a family-run information, support and advocacy organization for children and youth with mental, emotional, or behavioral problems and their families.

Visit the United Advocates for Children of California's report on "The Role of Family Organizations in the Evidence-Based Practice Movement" to learn more about the important and valuable roles families play in shaping the evidence-based practice movement.

Section IV:

Practitioners

Practitioners

Practitioners in children's mental health may practice in many different settings and play many different roles:

- Case manager
- Therapist
- Child welfare worker
- Juvenile justice counselor
- Psychiatrist
- Psychiatric nurse

Child-serving systems such as mental health, child welfare, juvenile-justice, substance-abuse, and schools, are often not aligned in their service delivery and coordination mechanisms. This climate makes it challenging to provide comprehensive one-stop approaches to care.

Moving toward an evidence-based culture focuses the children's mental health system on achieving desired outcomes for children and families with the use of standardized and manualized treatment protocols that have been shown to be effective. To build an evidence-based culture in a community, agency, and/or organization, practitioners must be actively involved in learning about evidence-based interventions, becoming trained in these interventions, and using data to drive their clinical practice.

This section includes helpful tools, links, informational materials, and references for practitioners to learn more about evidence-based care. This Resource Guide offers a framework for considering how practitioners and mental health systems can adapt their practice to promote evidence-based cultures.

The Practitioners' section addresses the following topics:

- Process of Selecting Interventions
 - Partnering with Youth and Families
 - Assessing Youth and Family Needs
 - Matching EBPs to the Needs of Youth and Families
- Making it Work
 - Professional Development
 - Training in Specific EBPs
 - Coaching and Supervision
 - Monitoring Fidelity and Outcomes

Process of Selecting Interventions

All practitioners, regardless of child-serving sector or mental health discipline, must play an active role in transforming children's mental health so that it can become resiliency-focused, family-driven, and youth-guided. When practitioners promote and encourage a data and outcome-driven framework, they facilitate the adoption of evidence-based interventions. By advancing evidence-based care, one can continue to enhance and improve outcomes for children.

Choosing the "right" treatment can challenge even the most skilled clinician as no single approach to mental, emotional, and behavioral health problems will work with every client. A variety of standardized screening and assessment tools are available to assist practitioners in selecting the most appropriate treatment.

An essential component of screening, assessment, and treatment planning is ensuring cultural competence.

The Practitioner Section includes helpful tips and resources on partnering with youth and families, assessing their needs, and aligning EBPs with the needs of youth and families.

Helpful Links:

- To learn more about what it means to be an evidence-based practitioner and to know what questions to ask when selecting an evidence-based intervention, visit the Center for Evidence-Based Practice: Young Children with Challenging Behaviors
- The [State of Hawaii](#) has an excellent resource, entitled the Blue Menu, which helps practitioners select the most appropriate evidence-based treatment

Partnering with Youth and Families

The [Institute of Medicine's](#) (IOM) 2001 Report on the *Quality of Health Care in America* outlines the importance of partnering with families to provide person-centered care. This report calls for bringing youth and families into the decision-making process, and for valuing and soliciting their input. As noted in the IOM's 2006 report on *Improving the Quality of Care for Mental and Substance-Use Conditions*, "decision making is less relevant if the only choice presented is that between one treatment or no treatment," (p. 105).

For an evidence-based culture to take root in one's practice, community, and/or agency, practitioners, youth, and families must actively build a collaborative relationship to identify the best treatment options available. Limited time to spend with clients, inadequate resources, and agency productivity quotas make it challenging to meet the needs of youth and their families.

Learning how to partner more effectively with youth and families is essential to developing a trusting relationship where youth and families can be heard and their wishes incorporated into treatment planning.

Practitioners can ask the following helpful questions during initial visits with youth and families:

- How can I be of help to you and your family?
- How do you define your problem?
- Who is your family?
- How do you identify culturally/racially/ethnically?
- How can I be sensitive to your cultural needs?
- What do you hope to accomplish from your experience, treatment, services?
- Provide a list of some of your strengths
- What are your hopes and dreams for the future?

**(adapted from Adams & Grieder, 2005, p.8)*

Helpful Links:

- The [Federation of Families for Children's Mental Health](#), a national advocacy group with local offices in several states, offers information on partnering with families.
- [The National Directory of Family-Run and Youth Guided Organizations for Children's Mental Health](#) provides an extensive listing of family-run and youth-run organizations in the United States, US Territories, and Tribal Nations.

References

Adams, N., & Grieder, D.M. (2005). *Treatment Planning for Person-Centered Care: The road to mental health and addiction recovery*. Burlington, MA : Elsevier Academic Press

McKay, M., Hibbert, R., Hoagwood, K., Rodriguez, J., Murray, L., Legereski, & Fernandez, D. (2004). Integrating evidence-based engagement interventions into "real world" child mental health settings. *Brief treatment and crisis intervention*, 4(2), 177-176.

Assessing Youth and Family Needs

Although the Diagnostic and Statistical Manual-Fourth Edition-Text Revised (*DSM-IV*) is considered the standard for making clinical diagnoses, assessment procedures should also be conducted to better understand a child's needs and issues. Practitioners should conduct a strengths-based assessment before matching youth with specific evidence-based interventions. To develop the most comprehensive picture of a child's presenting problems, it will be valuable to collect input from the child's parents/guardians, teachers, and other service providers who have worked with the child.

Evidence-Based assessment is just beginning to receive attention in the field. To ensure a good match between the youth's condition and treatment, you should include evidence-based assessment as part of your practice guidelines. Using practice friendly assessment strategies (self-administered, efficient problem-solving scales), and promoting consensus between youth, family and the provider will improve the likelihood of a good match between an evidence-based treatment and a youth's diagnosed condition (Weisz, 2006).

Vandiver (2002) identified seven essential steps to follow when applying evidence-based practices with clients:

- Conduct a biopsychosocial assessment
- Arrive at a diagnosis and select specific diagnostic guidelines
- Identify problems
- Develop goals and targeted areas to change
- Create an intervention plan
- Establish outcome measures
- Evaluate

You should be prepared to provide concrete examples of how the treatment process begins and what it will be like, as well as informing youth and families about how they will know when there is improvement. Reviewing the list of questions within the Youth and Families section on Questions to Ask Providers will assist the family in preparing for treatment, continuation of treatment, and end of treatment.

Helpful Links:

- The [Office of Juvenile Justice and Delinquency Prevention within the US Department of Justice](#) has a Resource Guide for practitioners who conduct assessments and screening, which is useful for practitioners interested in different screening and assessment instruments.
- The *Child and Adolescent Needs and Strengths* is a useful assessment tool to assess and guide service delivery for children. This tool can be administered repeatedly to assess how the youth is progressing during treatment.
- Refer to the Florida Mental Health Institute's publication, "Using the CAFAS to Promote and Evaluate Evidence-Based Interventions and Implement Systems of Care for Youth with SED" to learn more about assessment using the Child and Adolescent Functional and Assessment Scale.
- For more information on evidence-based assessment, see the special issue of the *Journal of Clinical Child and Adolescent Psychology*, which contains information about assessment instruments and protocols to use with a range of disorders: [The Journal of Clinical Child and Adolescent Psychology \(2005\) Volume 34, Number 3](#). (Please note that you will have to purchase individual articles or the entire issue from the publisher.)

References:

Springer, D. W. (2004). Treating juvenile delinquents with conduct disorder, attention-deficit/ hyperactivity disorder, and oppositional disorder. In A. R. Roberts & K. R. Yeager (Eds.). *Evidence-Based practice manual: Research and outcome measures in health and human services* (pp. 263-273).

Vandiver, V. L. (2002). Step-by-step practice guidelines for using evidence-based practices and expert consensus in mental health settings. In A. R. Roberts & G. J. Greene (Eds.). *Social workers' desk reference* (pp. 731-738). New York : Oxford University Press.

Weisz, J. (2006, September). *Evidence-Based practices in child and adolescent mental health: Recent news and my ESP on EBPs*. Paper presented at the meeting of the Children's Array of Psychiatric Programs, Portland Oregon.

Matching EBPs to the Needs of Youth and Families

No one evidence-based practice can meet all of the varied cultural, racial, ethnic, personal, financial, geographic, and diagnostic needs of each youth and his/her family. However, practitioners, with youth and families, can determine the most appropriate EBP to be implemented.

To help you match children's EBPs to their specific needs, consider:

- First and foremost - Work **with**, not **to** youth and families.
- Is the EBP appropriate for all cultures, setting, age group, and gender? If not what are some *practice elements* of EBPs to implement? Visit the [State of Hawaii's Evidence-Based Practice Profiles](#) to learn more.
- Can modifications be made to meet certain cultural concerns without comprising fidelity?
- What kind of time commitments work for the youth and family?
- What components of evidence-based treatments are most useful and desirable by the family (parent-management and child training, cognitive-behavioral approach, social-learning principles)?
- What outcomes are most important to the family (e.g. increase compliance, decrease explosivity, increase in coping mechanisms, and/or increase in school performance)?
- Are there costs to the family associated with a particular EBP?
- Does the EBP work within only one child mental system (juvenile justice, child welfare, school-based)?
- Can the EBP meet the needs of more than one diagnosed condition (i.e. aggression and post-traumatic stress problems?)

Helpful Links:

- A helpful resource guide developed by Columbia University, *Guidelines for Child & Adolescent Mental Health Referral*, offers practitioners a breakdown of different evidence-based treatments for different diagnoses and problems.
- The section entitled "What are the Evidence-Based Practices?" provides several resources that list evidence-based treatment options for youth and their families.

Making it Work: Strategies for Success

Sustaining an evidence-based culture requires the support and facilitation of practitioners, supervisors, administrators, and families and youth.

Many mental health practitioners describe their therapeutic approach as “eclectic” (i.e., using a mix of theoretical principals and therapeutic techniques). Hesitation and resistance to using manualized approaches stem from the perception that EBPs are overly prescriptive, not sufficiently individualized, and do not allow for practitioner expertise and flexibility. Accordingly, practitioners may choose not to adopt evidence-based practices. Although using eclectic approaches can improve outcomes for youth and families, evidence-based approaches and treatments increase the likelihood of achieving proven outcomes. Hayes (2005) points out that provider attitudes toward EBPs have more to do with uptake of EBPs than the strength of the evidence. Gregory Aarons’ study on provider attitudes regarding the implementation of evidence-based practices has shown that factors include: appeal of an EBP, requirement to use an EBP, openness of provider to new practices, and the perceived difference between usual practices and an EBP.

This section of the Resource Guide contains information, resources, and links that illustrate the pivotal role of practitioners in promoting an evidence-based culture:

- Professional Development
- Training in Specific EBPs
- Coaching and Supervision
- Monitoring Fidelity and Outcomes

References:

Hayes, R. A. (2005). *Introduction to evidence-based practices*. In C. E. Stout & R. A. Hayes (Eds.). *The evidence-based practice: Methods, models, and tools for mental health professionals* (pp. 1-9). Hoboken, New Jersey: John Wiley & Sons.

Professional Development

Memberships in professional associations help practitioners stay up to date with state of the art practices. Several professional associations are addressing the importance of providing evidence-based treatment and bridging the gap from research to service. Practitioners in social work and psychology can learn more about evidence-based care:

- The [American Psychological Association](#) has distributed a statement regarding the use and definitions of evidence-based treatment.
- The [National Association of Social Workers](#) has created a [Practice Research Network](#) to increase the knowledge base on social work practice and to advance education and policy.

Another important and valuable way that practitioners advance their own professional development is by seeking out local family-run organizations. Practitioners who reach out to the community can learn about what is important to those youth and families who have been immersed in their local mental health system.

Helpful Links:

- For psychologists interested in learning more about new treatments and seeking opportunities to collaborate, visit [Scientist-Practitioner.com](#) that provides online professional development for psychologists.
- For continuing education for several mental health disciplines, visit the [National Council for Community Behavioral Healthcare's National Council E-Learning Site](#) which provides accredited continuing education courses online.
- To learn how to become part of a learning community of practitioners and researchers, visit the [Society for Prevention Research](#).

Training in Specific EBPs

Practitioners need specific training in order to provide EBPs. Some states are moving forward to ensure that training and treatment in evidence-based practices are more widely available. Many social work schools in New York are offering more expert training on specific EBPs. In addition, statewide legislation in the State of Oregon will institute evidence-based treatment for children as the standard for all children's mental health by 2009, thus increasing the need for practitioner training in EBPs. As pre-service education and in-service training on evidence-based treatment in children's mental health becomes the standard, practitioners will have more opportunities to obtain training in these approaches.

According to Mullen (2004), practitioners must be prepared to engage in evidence-based practices for the benefit of their clients, even when working in non-supportive environments. In many cases, practitioners may need to advocate for themselves by encouraging the agency leadership to provide training opportunities and to provide time-off for these activities.

Helpful Links:

- To learn about the state of workforce development in behavioral healthcare and the areas that need addressing to assist in the training of practitioners, see <http://www.annapoliscoalition.org/index.php>
- Helpful websites and resources with detailed information about EBPs and available training may be found in the section on "What are the Evidence-Based Practices"

References:

Mullen, E. J. (2004). Facilitating practitioner use of evidence-based practice. In A. R. Roberts & K. R. Yeager (Eds.), *Evidence-Based practice manual: Research and outcome measures in health and human services* (pp. 205-210). New York City, NY: Oxford University Press.

Supervision and Coaching

Although evidence-based treatment is provided directly by practitioners, other supports must be in place for implementation efforts to be successful and sustained, such as supervision and coaching. Supervisors or mentors can be employed by the agency itself or supervision may be provided directly by purveyors of evidence-based treatment(s). Practitioners that receive more support and guidance in using EBPs will be more likely to implement practices true to the model. Supervisors can measure and assess specific goals and outcomes and provide expert feedback to practitioners to ensure they achieve desired outcomes.

Some children's EBPs, such as Multidimensional Treatment Foster Care, Family Functional Therapy, and Incredible Years provide a built-in training infrastructure for practitioners and expert training for supervisors.

The University of South Florida provides helpful information on coaching as a core component of successful EBP implementation.

Helpful Links:

- The Southern Coast Addiction Technology Transfer Center (ATTC) has created a tips page for clinical supervisors in the substance abuse field that is useful for all supervisors.
- The resource guide, *Turning Knowledge into Practice*, is available to assist practitioners, supervisors, and administrators in learning how to implement and disseminate evidence-based practices.

Monitoring Fidelity and Outcomes

Outcomes

A fundamental principle of an evidence-based culture is continuous quality improvement to strive for the best outcomes for children, youth and families.

John Weisz, Ph.D. summarized the following methods that practitioners can use to assess and monitor treatment when measuring outcomes:

- Parent Ratings
- Child Reports
- Teacher Reports
- Trained Observer Ratings
- Peer Observer Ratings
- Peer Sociometric Choices
- Child Performance/Task/Test
- Diagnostic Interview – P/C
- Global Assessment Ratings/Mental Health

Standardized instruments that match these topical areas include the Child Behavior Checklist with a parent, teacher, or trained observer rating; and the Youth Satisfaction Survey for Families as reported by parents and children. For a list of specific instruments that can be used to assess outcomes, see the OJJDP Resource Guide in the Practitioners' section on Assessing Youth and Family Needs.

Miller, Duncan, & Hubble (2005) have proposed the following 3-step process for practitioners to become "outcome-informed" in their practice (see reference for full text article):

1. Select instruments (finding measures of process and outcomes that are valid, reliable, and feasible)
2. Pilot the tools chosen, gather data
3. Develop a feedback process (scoring and discussing results with clients at each session).

John Lyons has proposed that a "[Total Clinical Outcomes Management Framework](#)" be adopted to monitor your practice. This framework encourages practitioners to capture the progress that a youth and family are making and use this information to manage ongoing treatment.

Fidelity

As evidence-based practices are selected and implemented with shared decision-making, practitioners must be trained and aware of how to implement "true to the intervention." Adhering to the actual model or treatment protocol increases the likelihood of obtaining the outcomes that are expected.

Fidelity measures and scales are available for some, but not all, evidence-based practices. Although fidelity scales do not exist for some children's EBPs, practitioners are still encouraged to use these interventions.

Gorman-Smith (2006, working paper), proposes that practitioners and supervisors can use one of several methods to measure adherence to an intervention protocol:

- Practitioners complete checklist targeted to the main content areas; recipients of intervention also complete the same checklists
- Direct observation of the implemented intervention (supervisor's review)
- Videotaped observation of intervention session (reviewed and coded later) (pg. 8).

The strategic use of repeated evaluations of programs using fidelity scales, either for an individual program or on a statewide level, is based on the general principle that whatever is attended to is more likely to be improved.

Helpful Links:

- To become better informed around outcomes, see Saggese's (2006) article, "Maximizing Treatment Effectiveness in Clinical Practice: An Outcome-Informed, Collaborative Approach."
- For information about issues related to [assessing the fidelity of Wraparound services using the Wraparound Fidelity Index](#), see the article in *Focus*, entitled "Ensuring Fidelity to the Wraparound Process" from the Portland State University's Research and Training Center on Family Support and Children's Mental Health.
- For information about assessing the fidelity of the Incredible Years program and to see some of the measurement instruments, visit the [Incredible Years website](#).

References:

Miller, S. D., Duncan, B. L., & Hubble, M. A. (2004). Beyond integration: The triumph of outcome over process in clinical practice. *Psychotherapy in Australia*, *10*(2), 2-19.
<http://www.talkingcure.com/documents/BeyondIntegration.pdf>

Section V:

Administrators

Administrators

Administrators of state and local service systems and organizations play a crucial role in creating an evidence-based culture that will support the implementation and broader dissemination of evidence-based practices as a mechanism for continuous quality improvement. As key change agents, administrators can:

- Foster an environment where open, constructive inquiry leads to problem resolution and new discoveries
- Promote an atmosphere of shared values and understanding about how to use data and evidence to enhance the quality of service planning, development, and delivery; and to attain the desired outcomes for children and families
- Encourage openness to change and innovation, and a willingness to adapt policies and procedures to accommodate change that will improve programs and outcomes.

The next two sections of the Resource Guide provide information and resources for administrators about the processes involved in selecting evidence-based and promising practices that will enhance service systems and strategies for ensuring that the new approaches will be sustained. The following topics are covered:

Process of Selecting Interventions

- Assessing population needs
- Assessing the environment
- Assessing cultural competence
- Assessing organizational readiness
- Assessing financial readiness
- Criteria for decision-making

Making it Work - Strategies for Success

- Leadership and managing change
- Strategies for building an operational infrastructure
 - Aiming at transformation
 - Financing
 - Training and technical assistance
 - Using data for continuous quality improvement
- Strategies for sustaining efforts

The Process of Planning for and Selecting Interventions

This section provides information for [administrators](#) both at the local and state level in planning and selecting [evidence-based practices](#) to be incorporated into a [service provider organization](#) or into a service system. In planning to incorporate evidence-based treatments into a [service system](#), there are several important considerations; prior demonstrations have shown that:

- The first step is to determine the needs of the target population and to identify potential evidence-based and [promising practices](#) that might address these needs;
- Second, the environment must be assessed for community willingness and consensus, capability of the workforce (i.e., training level of potential [practitioners](#) in the community), and the capability of the provider system to implement and sustain EBPs (i.e., type and number of providers);
- Third, an [organizational readiness assessment](#) of service provider organizations will identify key characteristics that are necessary for implementing an evidence-based practice with new requirements for training, supervision, and measuring [fidelity](#) and [outcomes](#);
- Fourth, the [financial readiness](#) of both the system and the service provider organizations should be assessed to identify funding and [reimbursement](#) mechanisms;
- Finally, decision-making criteria should be developed to assist with the selection of evidence-based practices to be implemented.

The sections contained here present the main points that should be considered in each area and provide resources and tools that can be accessed for additional information.

Assessing Population Needs and System Capacity

The needs of the target population are the first criteria to consider in selecting which [evidence-based practices](#) to add to a service array. Important elements that comprise a [needs assessment](#) include:

- Prevalence estimates of child and youth mental, emotional, and behavioral disorders in the target populations (i.e., children and youth within your organization, local area, region, and state)
- Number of children receiving services by disorder, by type of service, and by service sector
- Average frequency and duration of services
- Service capacity review and identification of unmet need
- Service [outcomes](#) review
- Cost of current service utilization
- Cost effectiveness of services

The State of Michigan uses the Child and Adolescent Functional Assessment Scale (CAFAS) in partnership with providers to assess needs and monitor outcomes; this process led to the implementation of evidence-based [cognitive behavioral therapy](#) for [depression](#) and parent training. This [example](#) illustrates how the use of data promotes an [evidence-based culture](#) in children's [mental health](#) in Michigan.

Helpful Links:

- An example of using existing national and state data to determine needs is available in the document entitled [Children's Mental Health in Washington State \(2006\): A Public Health Perspective Needs Assessment](#)
- An example of surveying providers to assess needs for clinical services and system capacity is available in the document entitled [Children's Mental Health Needs Assessment in the Bronx \(2003\)](#)

Assessing the Environment

Some of the areas to be considered in assessing the extent to which the system and community environment will support [evidence-based practices](#) include:

- Community willingness and consensus to implement new interventions
- Capacity of the provider system to implement and sustain evidence-based practices (i.e., type and number of providers)
- Interagency collaboration needed to support the implementation of evidence-based practices

Some of these questions can be addressed while conducting [needs assessments](#), as shown in some of the examples in the prior section. However, the following is an example of a model that incorporates assessment of the larger environmental context and population needs.

The Partnerships for Success Model

The Partnerships for Success (PFS) Model is a statewide approach in Ohio for building [community capacity](#) to prevent and respond to child and adolescent problem behaviors while promoting positive youth development. The PFS website provides extensive information about the model and tools for building community capacity to improve [outcomes](#), including:

- Community involvement
- Strategic planning for a broad array of prevention and intervention services
- Needs assessment
- Resource assessment (service capacity)
- Data-based decision making
- Training and consultation
- Selecting and implementing evidence-based practices
- Monitoring progress

Interagency Collaboration

Because of the multi-sector nature of children's services, effectively responding to the needs of children and adolescents requires interagency collaboration. Projects demonstrating the implementation of evidence-based practices repeatedly point out that interagency collaboration is a critical component to appropriately identify needs of children and adolescents across agency boundaries, to develop consensus for a wider system approach, to explore joint financing, to coordinate service delivery, to cross-train staff, and to deliver [mental health](#) evidence-based and [promising practices](#) within schools, [juvenile justice](#), and [child welfare](#) settings.

A measurement instrument used to assess interagency collaboration, which is relatively easy to administer, has been developed and tested at the Florida Mental Health Institute. It can be obtained by writing to the author, Paul Greenbaum, Ph.D.

Assessing Cultural Competence

As stated in the introductory section of the Resource Guide on Cultural Competence and Evidence-Based Practices, cultural and linguistic competence is a critical factor in the successful implementation of evidence-based practices. It is instrumental in increasing service access and utilization, enhancing quality of care, and increasing the likelihood of better outcomes for children and families.

One of the most comprehensive sources of information on assessing cultural competence can be found on the [Georgetown University National Center for Cultural Competence website](#). This website contains information about a wide range of self-assessment measures for both agencies and individuals working in health and mental health care, including:

- Processes and methods for self assessment
- Information describing the specific measures.

Another resource on assessing cultural competence is the [State Mental Health Cultural Competence Activities Assessment Instrument](#). This was developed by the National Technical Assistance Center for State Mental Health Planning (NTAC, 2004).

Assessing Organizational Readiness

Organizational readiness assessments assist to identify organizations that are more readily able to undertake implementation, to measure change during implementation, and to identify areas where consultation, technical assistance, or other organizational/system support may be needed.

Lehman and colleagues (2002) developed the Organizational Readiness for Change Survey for use in substance abuse treatment organizations to assess the readiness of an organization to implement evidence-based practices. The key areas assessed include:

- Motivational readiness (perceived need for improvement, training needs, pressure for change)
- Institutional resources (office, staffing, training, resources, computer access, electronic communication)
- Staff attributes (value placed on professional growth, efficacy, willingness and ability to influence co-workers, and adaptability)
- Organizational climate (clarity of mission and goals, staff cohesiveness, staff autonomy, openness of communication, level of stress, openness to change)

Organizational readiness instruments that can be applied to a wide range of evidence-based practices in children's mental health are currently in development. However, many developers of individual evidence-based practices have developed readiness assessments specific to their intervention. As an example, procedures are in place for sites considering Multisystemic Therapy to identify the target population and their needs, and to assess organizational readiness of provider agencies and financing options.

Reference

Lehman, W.E.K., Greener, J.M., & Simpson, D.D. (2002). Assessing organizational readiness for change. *Journal of Substance Abuse Treatment, 22* (4), 197-210.

Assessing Financial Readiness

While reviewing your organization's financial readiness, Hayes (2005) stresses that the decision to use evidence-based practices is one that requires staff time and costs to:

- Identify the most appropriate evidence-based practices to meet needs of target populations
- Design and implement the use of those practices within the agency
- Collect, aggregate, and report the fidelity and outcomes of those practices
- Interpret the results to redesign or enhance the use of protocols
- Evaluate the direct costs of the use of the practices
- Evaluate the continued commitment to use the practices based on their outcomes and costs

Such commitment of staff time and funds necessitates that the practice produce the desired outcomes for children and families and be cost effective. Sound planning is at the base of incorporating and sustaining evidence-based and promising practices within the larger system of care.

Helpful Links:

Recent publications provide guidance for administrators in this area:

- A Self Assessment and Planning Guide: Developing a Comprehensive Financing Plan

This guide was developed as part of a larger study to increase understanding of financing structures and strategies to support effective systems of care. The self assessment and planning guide was designed to guide service systems and individual sites in assessing their current financing structures and strategies, and to prioritize a strategic financing plan for moving forward. It provides a means for projecting possible outcomes that are to be achieved and strategies for achieving those outcomes.
- Public Financing of Home and Community Services for Children and Youth with Serious Emotional Disturbance: Selected State Strategies

This monograph provides information about sources of federal funding for child mental health services and profiles state approaches to financing home and community based services, including:
 - Medicaid Home and Community Based waivers
 - Medicaid Rehabilitation Option
 - Case rates used by designated case management entities for high risk populations
 - The TEFRA option
- The Washington State Institute for Public Policy 2004 report on the cost effectiveness of several evidence-based practices for prevention and intervention

References

Armstrong, M.I., Pires S.A., McCarthy, J., Stroul, B.A., Wood, G.M., & Pizzigati, K. (2006). *A self-assessment and planning guide: Developing a comprehensive financing plan (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. #235-01)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health.

Hayes, R.A. (2005). Evaluating readiness to implement evidence-based practice. In C.E. Stout & R.A. Hayes (Eds.), *The evidence-based practice: Methods, models, and tools for mental health professionals* (pp. 255 - 279). Hoboken, NJ: John Wiley & Sons.

Ireys, H.T., Pires, S., & Lee, M. (2006). *Public financing of home and community services for children and youth with serious emotional disturbances: Selected state strategies*. (2006). Washington, DC: Office of Disability, Aging and Long Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Criteria for Decision Making

Addressing the following questions may provide criteria to guide decision-making about how to best incorporate evidence-based practices, promising practices, and practice-based evidence into agencies and service systems:

- What are the needs of the target population and subsets of that population?
- What are the cultural needs and wishes of the target population and subsets?
- Which specific interventions address the needs of the target population and subsets?
- Are all stakeholders at the planning and decision-making table (including families, youth, practitioners, agency and community representatives, funders)?
- What specific outcomes are desired?
- How broad or how limited are the prevention or intervention goals (universal, selected, or targeted)?
- What is the context and what are the values in which the intervention will be imbedded (family/child centered, system of care, cultural, etc.)?
- What is required of all involved users (provider agencies, practitioners, families, funders)?
- How practical, acceptable, and feasible are the intervention options?
- What are the financing and reimbursement options for training, coaching, on-going technical assistance, assessing fidelity and outcomes, and delivering the intervention?
- What is the capacity and readiness of the system, agencies, and workforce to incorporate the new intervention options?

Making it Work: Strategies for Success

The previous section, Process of Planning for and Selecting Interventions, focuses on selecting interventions to incorporate evidence-based and promising practices into service systems or organizations. Once evidence-based and promising practices are selected, it is time to consider and plan strategies that will support the implementation and broader dissemination of the new evidence-based and promising practices that are being incorporated into the system. Reviews of the research on implementation (Fixsen et al., 2005; Rohrbach et al., 2006) have shown that the evidence base on strategies for effective implementation is far behind the science on developing interventions, but that factors linked with successful implementation have:

- Strong administrative leadership and support for the innovation
- Power sharing and participatory decision-making
- Open and clear communication patterns
- Stable resources and personnel
- Shared vision and goals
- A willingness to initiate change
- A positive organizational climate

In this Resource Guide we include these empirically identified factors as some of the features of an evidence-based culture. The term, *evidence-based culture*, was borrowed from the Southern Coast Addictions Technology Transfer Center (Dixon, 2003) which uses the term to describe the multiple factors that are needed to support the implementation of evidence-based practices. The term is also being used in children's mental health in Michigan to describe their efforts to advance continuous quality improvement through the active utilization of data. (Wotring & Hodges, 2006).

This section of the Resource Guide provides more information and resources in the following topics:

- Leadership and Managing Change
- Strategies for Building an Operational Infrastructure
 - Aiming at transformation
 - Financing
 - Training and technical assistance
 - Using data for continuous quality improvement
- Strategies for Sustaining Efforts

References

Dixon, G.D. (2003). *Evidence-Based practices. Part III. Moving science into service: Steps to implementing evidence-based practices*. Tallahassee, FL: Southern Coast Beacon (a publication of the Southern Coast Addictions Technology Transfer Center). [Available online at http://www.scattc.org/pdf_upload/Beacon003.pdf]

Fixsen, D., Naoom, S.F., Blase, K., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Rohrbach, L.A., Grana, R., Sussman, S. & Valente T.W. (2006). Type II translation: Transporting prevention interventions from research to real-world settings. *Evaluation and the Health Professions*, 29 (3), 302-333.

Wotring, J. & Hodges, K. (2006). *Creating the culture to support the implementation of evidence-based practices*. Paper presented at the 2006 Training Institutes of the National Technical Assistance Center for Children's Mental Health at Georgetown University. Orlando, FL.

Leadership and Managing Change

Two recent studies of [mental health](#) provider organizations showed that transformational leadership that inspires and motivates people is associated with higher team functioning (Corrigan et al., 2002) and positive attitudes towards adopting [evidence-based practices](#) (Aarons, 2006). Integrating historical and contemporary theories on leadership and organizational research on leadership characteristics, Jordan (2006) developed a framework for the Seven Hills Foundation that models key aspects of leadership characteristics, leadership skills and competencies, and leadership behaviors and actions. Click in the box to the right to see an abridged version of the framework and to find out how to obtain the full report.

Helpful Links:

To learn more about training and resources on leadership:

- [The Center for Community Leadership](#) convenes Leadership Institutes with topics such as: creating a shared vision, anatomy of change, risk and courage, leadership styles and choices, formal and informal leadership, ethics in leadership, information as power, and thriving in chaos.
- [The Center for Creative Leadership](#) offers a series of five-day courses on individual leadership development; on leading groups, teams, and organizations; and on specialized topics, such as: navigating Complex Challenges, The Women's leadership Program, and Coaching for Development.
- [The National Council for Community Behavioral Healthcare's Leadership Academy](#) for the Behavioral Health Industry offers three-day training events on leadership topics such as: key leadership practices, dealing with difficult people and assertiveness, coaching for commitment, performance management and accountability, and resource management. Training and follow-up can include individualized assessment, goal-setting, coaching, and facilitating sessions with staff.

NCCBH also provides a [Middle Management Academy](#) for managers aspiring towards top leadership position.

References

Aarons, G.A. (2006). Transformational and transactional leadership: Association with attitudes toward evidence-based practice. *Psychiatric Services, 57* (8), 1162-1169.

Corrigan, P.W., Diwan, S., Campion, J., & Rashid, F. (2002). Transformational leadership and the mental health team. *Administration and Policy in Mental Health, 30* (2), 97-108.

Jordan, D.A. (2006). *A framework of leadership for Seven Hills Foundation*. Seven Hills Foundation.

[Van de Ven, A.H., Polley, D.E., Garud, R., Venkataraman, S. \(1999\). *The innovation journey*. New York, NY: Oxford University Press.](#)

Seven Hills Foundation Leadership Framework (Jordan, 2006)

Leadership Characteristics
Emotional Intelligence
Determined resolve
"Other" -interest
Desire to nurture/develop others
Passion of ideals
Vision
Systems thinker

Leadership Skills and Competencies
Coaching and mentoring
Ability to manage change
Effective communicator
Conceptual skills
Analytical skills
Ability to motivate others
Self-reflection

Leadership Behaviors and Actions
Leads by example
Exhibits moral and ethical behavior
Acts with humility
Maintains a positive attitude
Honest with self and others
Empowers others

Strategies for Building an Operational Infrastructure

Operational infrastructure refers to the administrative functions and foundation that support innovation and continuous quality improvement in children's mental health.

Building an operational infrastructure involves:

- Aiming at transformation--to be proactive in raising the standard of care from "treatment as usual" to the highest quality of care.
- Creative financing strategies--to encourage sustainability of evidence-based practices, and to allow more youth and families access to effective care.
- Comprehensive training and technical assistance--to reinforce implementation efforts and increase the likelihood of better outcomes.
- Continuous quality improvement processes that utilize data for:
 - identifying the most pressing needs of children and families
 - selecting evidence-based and promising practices to address such needs
 - monitoring fidelity to ensure that evidence-based practices are being implemented as intended
 - monitoring quality of care provided and outcomes
 - indicating areas where improvement is needed

The following sections point to examples of how leadership can set the stage for change, and provide information and resources related to financing, training, and using data for quality improvement.

Strategies for Building an Operational Infrastructure: Aiming at Transformation

The President's New Freedom Commission Report calls for transforming the mental health system into "one in which:

- Americans understand that mental health is essential to overall health;
- Mental health care is consumer and family-driven;
- Disparities in mental health services are eliminated;
- Appropriate and early mental health screening, assessment, and referral to services occurs;
- Excellent mental health care is delivered and research is accelerated; and
- Technology is used to access mental health care and information." (SAMHSA, 2005, p. 4).

The State of Oklahoma is actively engaged in transformation as one of the states awarded the SAMHSA Transformation Infrastructure grants. Following a comprehensive needs assessment process, their plan to transform the state has now been developed. For each recommendation of the President's Commission the plan lays out findings of needs assessments, strategic developments in the state, workgroup recommendations, and action plans.

For example, one of their action steps to address the Commission's recommendation to implement early screening, assessment, and referral to substance abuse treatment and mental health is to "propose a plan to include a basic continuum of behavioral health services for school-aged children receiving primary care services, child welfare services, and services through juvenile justice." (p. 37).

Also demonstrating their cross-system transformation focus, under the Commission's recommendation that excellent care is delivered, one of Oklahoma's action steps is to "Develop a cross-agency framework for professional learning including standards for training, technology-infused learning, experiential learning, distance learning, support systems, and peer coaching." (p.49)

For more information, see:

- [Oklahoma's Substance Abuse and Mental Health Services Comprehensive Plan.](#)
- [Mental Health Transformation in Texas](#)

Strategies for Building an Operational Infrastructure: Financing

The Administrator's section on Assessing Financial Readiness refers to a report on [*Public Financing of Home and Community Services for Children and Youth with Serious Emotional Disturbance: Selected State Strategies*](#) (Ireys et al., 2006). This monograph provides information about sources of federal funding for child mental health services and profiles state approaches to financing home and community based services, which could include evidence-based practices. States are profiled by type of reform being implemented (broad statewide financing reforms or incremental reform), policy context and program characteristics, financing issues, and lessons learned. This is a valuable resource describing strategies and advantages and disadvantages of particular strategies, which could be considered by other states. Some of the financing strategies include:

- Pooling or braiding funds from mental health and other state agencies for the state's Medicaid match to expand federal dollars
- Use of the Medicaid rehabilitation services option to expand coverage for mobile response and stabilization, in home services, and intensive case management
- Behavioral health care administered by a single purchasing collaborative
- Medicaid home and community-based waiver for specific target populations
- Combined Medicaid home and community based waiver and rehabilitation service option

Much has also been published on the approaches used to finance the local [*Milwaukee Wraparound Program*](#), which uses managed care and blended funds from mental health, child welfare, and juvenile justice; and has diverted large numbers of children from institutional care.

Another helpful resource on financing was developed by the Bazelon Center for Mental Health Law (2003). It is called *Teaming Up: Using the IDEA and Medicaid to Secure Comprehensive Mental Health Services for Children and Youth*. For mental health administrators that may not know how IDEA can support therapeutic services and support, this report is very informative in describing the benefits and limitations of IDEA as a school-based entitlement and in providing examples of litigation involving IDEA and Medicaid.

Strategies for Building an Operational Infrastructure: Training and Technical Assistance

From the extensive [review of the implementation literature](#) by Fixsen and colleagues (2005) we learned that training without follow-up technical assistance is ineffective in promoting uptake of evidence-based practices by practitioners. The review also shows that some of the most critical “drivers of implementation” are:

- Pre-service training,
- In-service training,
- On-going consultation, and
- Staff evaluation

The concept of a consultant/coach is novel in mental health, though the term is being used now in management training and even to help people manage their lives to reach their goals (“life” coaching). Whereas the formal training program imparts the necessary theory, philosophy, and knowledge of the skill components and rationales; consultant/coaches are instrumental in operationalizing those principals in the work setting with clients—in client engagement, treatment planning, practicing therapeutic skills, and in exercising clinical judgment (Fixsen et al., 2005).

If administrators now must look beyond formal training as the primary in-service strategy for preparing practitioners to assume their jobs, how can administrators ensure this essential support is provided?

A number of states have built productive public-academic collaboratives for translating science to practice and for providing more of a “training and coaching” approach. For example:

- **Connecticut** has nested implementation of EBPs for children and youth within 27 local systems of care called community collaboratives, and partners with the University of Connecticut and Yale to operate the Connecticut Center for Effective Practices to support the collaboratives. Some of the functions of the center are: identifying, implementing and evaluating effective treatment models appropriate for the state’s system of care initiative; developing and implementing statewide training for mental health care coordinators; and developing tools and resources to empower families with children who have mental health conditions and/or are involved in the juvenile justice system. (More information is available at the [Child Health and Development Institute of Connecticut](#).)
- **Ohio** has gained much recognition for instituting several “[Coordinating Centers of Excellence](#)” (CCOE). The CCOEs were built on preexisting relationships with universities to train mental health professionals in the fields of psychiatry, psychology, and social works. However, the CCOEs emphasize technology transfer through training current practitioners in EBPs. The centers each have a distinct focus. Two specialize in meeting children’s needs through disseminating technology on multisystemic therapy, diversion from juvenile justice, and mental health services in schools. To learn more about Ohio’s CCOEs, read *Tools for Transformation: A Guide to Ohio’s Coordinating Centers of Excellence and Networks*.
- **New York** is on the cutting edge in moving academia towards including evidence-based practices in their curricula. The State has a unique arrangement with several Schools of Social Work in the State to develop curriculum for EBPs and to place interns in agencies providing EBPs.

Strategies for Building an Operational Infrastructure: Using Data for Continuous Quality Improvement

Researchers at the Vanderbilt University Center for Evaluation and Program Improvement have developed a system for collecting, tracking, and analyzing program and outcome data for continuous quality improvement (Bickman et al., 2006). It is called Contextualized Feedback Interventions and Training (CFIT), and has four major components, including:

- Methods for assessing organizational needs, readiness for change, and implementation processes
- Methods for measuring treatment process and outcomes
- Methods for formative feedback via on-line reports of aggregated data (by clinic, treatment type, etc.)
- Methods for training administrators and clinicians in the CFIT approach, effective therapeutic techniques, and evidence-based interventions

A power point presentation on the system with more information on the system can be found at:
http://peabody.vanderbilt.edu/documents/pdf/cepi/heart_and_soul_of_change_bickman_june_2006.pdf

In an article aptly titled, *From Data to Wisdom: Quality Improvement Strategies Supporting Large-scale Implementation of Evidence-Based Practices*, Daleidan and Chorpita (2005) described strategies used by the state mental health agency in Hawaii to increase the utilization of three types of data that come from: a) services and intervention research, b) case histories, and 3) aggregated practice-based evidence. Below are some of the strategies for using these types of evidence:

Strategies for Using Services Research Information

- Use of an information tool called the "Blue Menu", a one page matrix of target problem, description of treatment packages, and efficacy level
- Incorporate into interagency performance standards and practice guidelines that are attached to service contracts
- Use of a practice development office that is responsible for providing interagency training, mentoring, and consultation to promote ongoing skill development and dissemination of service research information
- Funding structures in place to support EBPs
- Utilization management procedures to monitor whether relevant populations are receiving evidence-based levels of care and whether service use is consistent with practice guidelines

Strategies for Using Data from Individual Case Histories

- Use of diagnoses to consider complexity of symptomatology
- Service plans to organize treatment targets and intervention data
- Quarterly standardized assessments to monitor symptoms, functioning, and service needs
- Treatment providers complete monthly summary of interventions provided
- Case-based and administrative reviews with small random samples from each region and provider

Strategies for Using Aggregated Data (Practice-based Evidence)

- Dissemination of information via user friendly graphic reports
- System performance measures

Hawaii's approach exemplifies the process of valuing many sources of data and institutionalizing or "acculturating" data-based approaches into everyday decision-making, which is considered to be one of the

main features of an evidence-based culture. Their quality improvement framework, databases, and processes are being replicated in other states.

References

Bickman, L., Riemer, M. Breda, C., & Kelley, S.D. (2006). CFIT: A system to provide a continuous quality improvement infrastructure through organizational responsiveness, measurement training, and feedback. *Emotional and Behavioral Disorders in Youth*, 6 (4), 86-94.

Daleidan, E.L., & Chorpita, B.F. (2005). From data to wisdom: Quality improvement strategies supporting large-scale implementation of evidence-based services. *Child and Adolescent Psychiatric Clinics of North America*, 14, 329-349.

Strategies for Building an Operational Infrastructure: Fidelity

Fidelity is a term used to describe the extent to which an evidence-based intervention is delivered in line with the original model that was found to be effective. If the intervention is not being delivered with fidelity, it may not be realistic to expect the same types of outcomes found in the original research. We do not know yet which components of evidence-based practices are actually the main ingredients that produce the positive change, and therefore which ones can be weakened or dropped to still have the same intervention. This is a new frontier of research that is of particular interest to administrators that often need to adapt interventions for particular groups or geographic areas without the benefit of research to support such adaptations.

Fixsen and colleagues (2005) again have an excellent discussion on fidelity resulting from their review of the literature on implementation (p.47). They point out that measures fall into three categories: contextual, compliance, and competence; provide examples of the various types of measures; and describe the processes of measuring fidelity.

References

Fixsen, D., Naoom, S.F., Blase, K., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL : University of South Florida , Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Strategies for Sustaining Efforts

From the NRI survey of strategies used by states to implement evidence-based practices (2005), it was learned that states, which had clear goals of “going to scale” with their evidence-based and promising practices included many of the following strategies:

- Strong consensus development processes up front to get buy-in from all stakeholders
- Inclusive advisory boards
- Collaboration with other agencies and Medicaid to establish funding mechanisms
- Contractual relationships between the state and providers to use evidence-based and promising practices
- Establishment of collaborative relationships with universities to develop Centers of Excellence for on-going training and technical assistance

Although research on the effectiveness of specific strategies for implementing and disseminating evidence-based interventions is scant, Rohrbach and colleagues (2006, p. 315-319) recently summarized factors considered to be important in taking evidence-based programs “to scale,” these include:

- **Packaging program materials so that they are attractive and user friendly**
 - Program implementation manuals should be easy to follow, explicit about the requirements for implementation, and presented in a language and format that is familiar to implementers
 - Materials to be presented to program participants should be attractively packaged, appropriate for all cultural groups that will use them, and reproducible on a large scale, yet not too costly
- **Establishing a diffusion system**
 - The system for disseminating program information should have the capacity needed to respond to inquiries about the program, distribute materials widely, provide training and technical assistance, and link program users to developers for questions about implementation, adaptation, and evaluation.
 - Many developers of evidence-based practices have developed their own diffusion system with the requisite capacity. Most of the websites listed in the section “What are the Evidence-Based Practices?” contain information on developers or purveyors which can be contacted to find out whether they have existing dissemination systems.
- **Helping sites build their organizational capacity**
 - Ensure that adopting sites have established a clear need for the evidence-based practice and that it fits with the agencies’ mission
 - Establish initial and sustainable funding, strong administrative support, a local program champion, adequate supply of receptive and skilled program implementers, and strong levels of community support
 - The capacity building process requires a detailed implementation plan
 - Expect that the capacity-building process may take up to 9 months, may require on-site visits and telephone contacts with developers or dissemination organizations
- **Providing training and technical assistance to program implementers**
 - Mechanisms must be put in place for the developer or dissemination organizations to do the training and on-going technical assistance
 - Some large-scale prevention programs have used self -instruction modalities such as websites, and teleconferencing. For an example, visit the Medical University of South Carolina’s Website dedicated to [Trauma-Focused Cognitive Behavior Therapy](#).
 - Requests for technical assistance may include peer support, coaching, consultation, trouble-shooting implementation problems, and ongoing efforts to help the agencies build capacity for sustainability

- **Establishing a system for collecting and reporting data on program delivery**
 - Routine reporting data on fidelity and outcomes can guide program efforts to improve on-going implementation and can foster sustainability
 - Some diffusion systems have centralized information systems with built-in measurement instruments, reporting schedules, and feedback loops.
 - Technical assistance can be used to develop program specific evaluation plans and methods

References

Rohrbach, L.A., Grana, R., Sussman, S. & Valente T.W. (2006). Type II translation: Transporting prevention interventions from research to real-world settings. *Evaluation and the Health Professions*, 29 (3), 302-333.

NASMHPD Research Institute, Inc.. (2005, August). *Results of a Survey of State Directors of Adult and Child Mental Health Services on Implementation of Evidence-Based Practices*. Alexandria, VA: Author.

Glossary of Key Terms

- **Administrators:** Individuals that manage agency functions related to service delivery, training, human resources, financing, management information systems, and quality improvement.
- **Aggression:** Words and action that are deemed to be threatening to others.
- **Anxiety:** Exaggerated or inappropriate responses to the perception of internal or external dangers. Includes panic disorders, phobias, obsessive-compulsive disorders, post-traumatic stress, and generalized anxiety disorders.¹
- **Assessment:** A professional review of child and family needs that is done when services are first sought or periodically to assess progress. The assessment of the child includes a review of physical and mental health, intelligence, school performance, family situation, and behavior in the community. The assessment identifies the strengths of the child and family. Together, the provider and family decide what kind of treatment and supports, if any, are needed.²
- **Assessment protocol:** a set of guidelines that an agency or individual follows when conducting assessments.
- **Assessment tools:** A variety of standardized instruments that are used to gather information about a person's functioning and/or level of need.
- **Attribute:** An inherent quality or characteristic.³
- **Behavioral healthcare:** Continuum of services for individuals at risk of, or suffering from, mental, addictive, or other behavioral health disorders.²
- **Behavioral therapy:** As the name implies, behavioral therapy focuses on changing unwanted behaviors through rewards, reinforcements, and desensitization. Behavioral therapy often involves the cooperation of others, especially family and close friends, to reinforce a desired behavior.⁴
- **Best practices:** Most often is used to describe guidelines or practices driven more by clinical wisdom, guild organizations, or other consensus approaches that do not necessarily include systematic use of available research evidence.⁵
- **Biopsychosocial assessment:** The evaluation of a person's biological, psychological, and social factors to develop a comprehensive picture from which to base treatment.
- **Case manager:** An individual who organizes and coordinates services and supports for children with mental health problems and their families. (Alternate terms: service coordinator, advocate, and facilitator.)²
- **Capacity building:** Involves enhancing the ability of individuals, groups, organizations, and systems to mobilize and develop resources, skills and commitments needed to accomplish shared goals.³
- **Child and Adolescent Functional Assessment Scale (CAFAS):** is a rating scale, which assesses a youth's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems.²
- **Child welfare:** Child service sector that focuses on child protection, foster care, and the overall care of children's health and living conditions.
- **Cognitive therapy:** Aims to identify and correct distorted thinking patterns that can lead to feelings and behaviors that may be troublesome, self-defeating, or even self-destructive. The goal is to replace such thinking with a more balanced view that, in turn, leads to more fulfilling and productive behavior.⁴
- **Cognitive behavioral therapy:** A combination of cognitive and behavioral therapies which helps people change negative thought patterns, beliefs, and behaviors so they can manage symptoms and enjoy more productive, less stressful lives.⁴
- **Community capacity:** Refers to the ability of community members to use the assets of its residents, associations and institutions to improve quality of life. Each community's collection of assets will be unique, for it will reflect the specific characteristics of its population, its political structures and geography.⁶
- **Conduct Problems:** Behaviors that are characterized by acting out, ranging from annoying, minor oppositional behavior (yelling, temper tantrums) to more serious types of antisocial behavior (aggression, physical destruction, stealing).⁸
- **Consumer:** Any individual who does or could receive health care or services. Includes other more specialized terms, such as beneficiary, client, customer, eligible member, recipient, or patient.²

- **Continuous Quality Improvement:** A strategy of continuously assessing the process and outcomes of service delivery to learn how to improve those processes to reach better outcomes and higher quality of mental health care.²²
- **Cultural Competence:** Understanding and appreciating the differences in individuals, families, and communities, which can include: thoughts, speech, actions, customary beliefs, social forms and material traits of a racial, religious or social group. It also affects age, national origin, gender, sexual orientation or physical disability.⁹
- **Depression:** A type of mood disorder characterized by low or irritable mood or loss of interest or pleasure in almost all activities over a period of time.¹
- **Diagnosis/Diagnostic Formulation:** The process of determining by examination the nature and circumstances of a mental health condition and the decision reached by such examination.¹⁰
- **Early Intervention:** A process for recognizing warning signs that individuals are at risk for mental health problems and taking early action against factors that put them at risk. Early intervention can help children get better more quickly and prevent problems from becoming worse.¹¹
- **Emerging Practices:** Are new innovations in clinical or administrative practice that address critical needs of a particular program, population or system, but do not yet have scientific or broad expert consensus support.⁵
- **Emotional Health:** The well-being and appropriate expressions of one's emotions.
- **Evidence:** Refers to data resulting from scientific controlled trials and research, expert or user consensus, evaluation, or anecdotal information.⁵
- **Evidence-Based Assessment:** Methods and processes that are based on empirical evidence, in terms of both reliability and validity as well as their clinical usefulness for prescribed populations and purposes.¹²
- **Evidence-Based Care:** The application of the best evidence available to treat in the health care community to improve the overall quality of care.
- **Evidence-Based Culture:** Characteristics or features of organizations and systems that support the use of EBPs.
- **Evidence-Based Environment:** An environment in health care that is represented by the practice and implementation of evidence-based interventions.
- **Evidence-Based Practices:** Practices that integrate the best research evidence with clinical expertise and patient values.¹³
- **Externalizing Disorder:** Disorders that are expressed overtly and can be characterized by aggression, behavioral acting-out, hyperactivity, and conduct disorder.
- **Family-Centered Services:** Help designed to meet the specific needs of each individual child and family.²
- **Family-Driven:** Families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation.¹⁴
- **Family-Run Organizations:** Advocacy and support organizations that are led by family members with expertise/experience in the field of mental health.
- **Fidelity:** Adherence to the key elements of an evidence-based practice shown to be critical to achieving the positive results found in a controlled trial. Studies indicate that the quality of implementation strongly influences outcomes.⁵
- **Fidelity Scale:** Measurement instrument for assessing the extent to which information is delivered with fidelity.
- **Financial Readiness:** The assessment of an organization, agency, or individual practice to determine the financial standing and ability to provide evidence-based practices.
- **Hyperactivity:** A disorder in which children are overactive and impulsive (acts without thinking).
- **Internalizing Disorders:** Disorders expressed within the individual and focused on clinically problematic affective and emotional state, such as anxiety or depression.
- **Juvenile Justice:** An area of law that applies to children who have not reached the legal age of adulthood/maturity, normally eighteen years of age. The goal of juvenile justice is rehabilitation, not punishment. Also refers to the service sector that is responsible for serving children judged to have committed unlawful acts.
- **Juvenile Justice Counselor:** Juvenile Counselors provide custody, supervision, direct care, and counseling to juveniles. Responsibilities include teaching socially desired habits and behaviors, provide recreational activities, and assist with crisis intervention programs.¹⁵

- **Licensed Clinical Social Worker:** A social worker who helps individuals deal with a variety of mental health and daily living problems to improve overall functioning. A social worker usually has a master's degree in social work and has studied sociology, growth and development, mental health theory and practice, human behavior/social environment, psychology, research methods.¹⁶
- **Linguistic Competence:** capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. This may include the use of bilingual staff, interpretation services, assistive technology, etc.¹⁷
- **Manualized Treatment Protocols:** Approaches to mental health treatment that offer a prescriptive approach through the use of manuals and specialized training. These manuals should be followed as stated.
- **Medicaid:** A federal program administered by states that is intended to provide funding for health care and health-related services to low-income individuals or other special groups.
- **Mental Health:** How people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore choices. This includes handling stress, relating to other people, and making decisions.²
- **Motivational readiness:** The perceived need for improvement or pressure for change.
- **Multisystemic Therapy:** An intensive family- and community-based evidence-based treatment for youths with antisocial behaviors.
- **Needs Assessment:** Systematic approach for gathering data on the needs of a population to be served.
- **Organizational Readiness Assessment:**Assesses key characteristics that are necessary for implementing an evidence-based practice with new requirements for training, supervision, and measuring fidelity and outcomes.
- **Outcome-Driven Framework:** A guiding set of principles that individuals who are offering mental health services follow when making decisions about treatment. The focus is on the outcomes that need to be achieved.
- **Outcomes:** The results of a specific mental health care service, usually phrased in terms of child and family gains (e.g., improved school performance, improved family communication).²
- **Person-Centered Care:** The recipient of care is the driving force behind making decisions about their treatment.
- **Post-Traumatic Stress Disorder:** A psychiatric illness that can occur following a traumatic event in which there was threat of injury or death to you or someone else.¹⁸
- **Practice-Based Evidence:** A range of treatment approaches and supports that are derived from, and supportive of, the positive cultural of the local society and traditions.¹⁹
- **Practitioner:** Anyone who provides direct services for children or their families. A practitioner may be a licensed independently practicing clinician, a supervised clinical staff member, a certified direct service provider, a person who is trained and meets the criteria to provide direct services or a peer helper.⁵
- **Professional Counselor:** A person with an advanced degree in mental health or other social services charged with assessment and treatment.
- **Prognosis:** Prediction by a health professional regarding a person's diagnosed condition and chances for recovery.
- **Promising Practices:** Clinical practices for which there is considerable evidence or expert consensus and which show promise in improving client outcomes, but which are not yet proven by the highest or strongest scientific evidence.⁵
- **Psychiatrist:** A professional who completed both medical school and training in psychiatry and is a specialist in diagnosing and treating mental illness.²
- **Psychologist:** A professional with a doctoral degree in psychology who specializes in assessment and therapy.²
- **Psychopharmacology:** The practice of using medicine to treat individuals with psychological and psychiatric conditions through the use of medications.
- **Psychotherapist:** An individual with an advanced degree in social services charged with assessment and treatment (see *professional counselor*)
- **Reimbursement:** Refunds for out-of-pocket expenses by an individual or company.

- **Resiliency:** The quality that allows an individual or group to function well despite the odds against them. Two fundamental concepts are associated with resiliency: risk and protective factors. Mental health promotion concepts focus on minimizing the impact of risk factors (such as stressful life events) and enhancing the protective factors such as social support that increase people's ability to deal with life's challenges.⁵
- **School psychologist:** An individual with an advanced degree in psychology who assesses children for the presence of learning problems, as well as emotional problems, diagnoses, and treats children in the school system. Roles of school psychologists will vary by location.
- **Scientific Evidence:** Results from a study or research project that has a rigorous controlled design (including a clearly articulated hypothesis and rigorous methodology along with controlled conditions and random assignments to various comparison conditions) that includes sufficient subjects to overcome the possibility that the result could have occurred by chance, and is repeated with the same result in multiple sites with different researchers and different experimental and control groups.⁵
- **Screening instruments:** Typically a brief measure to determine a client's level of need for treatment.
- **Service provider organizations:** Mental health or other social service agencies that offer treatment or other services to children and families.
- **Service system:** Refers to multiple agencies in different sectors (mental health, child welfare, juvenile justice, substance abuse, education, and healthcare) that provide services and treatments for the varying needs of children and families.
- **Social health:** Social health refers to how well you get along with others. When you are socially healthy, you have loving relationships, respect the rights of others, and give and accept help. Building healthy relationships with family members, making and keeping friends, and communicating your needs to others are all important for social health.²⁰
- **Stakeholders:** Those people who are interested, involved, and invested in the project or initiative in some way. In mental health, groups of people who might be identified as stakeholders may be: children and families, family organizations, advocates, community groups, funders, mental health and social service providers, or university or college-based research teams.⁴
- **System of Care:** A system of care is a method of addressing children's mental health needs. It is developed on the premise that the mental health needs of children, adolescents, and their families can be met within their home, school, and community environments. These systems are also developed around the principles of being child-centered, family-driven, strength-based, and culturally competent; and involving interagency collaboration.²
- **Wraparound Services:** a collaborative team-based approach to offering services for children with emotional and behavioral problems and their families. Team members, who are identified by the child and family and other service providers meet regularly to design, implement, and monitor their individualized treatment plans.²¹
- **Youth guided:** Youth are experts and considered equal partners in creating system change at the individual, state, and national level.²

¹ Westchester Community Network. (2005). *Alphabet Soup*. Retrieved October 23, 2006, from http://www.westchestercommunitynetwork.com/Family_Ties/Facts_Information/Alphabet_Soup/alphabet_soup.html

² SAMHSA's National Mental Health Information Center: Center for Mental Health Services. (n.d.) *Mental Health Dictionary*. Retrieved October 23, 2006 from <http://mentalhealth.samhsa.gov/resources/dictionary.aspx>

³ English-Test.net. (n.d.) *Definition of Attribute*. Retrieved October 23, 2006 from <http://www.english-test.net/toefl/vocabulary/words/009/toefl-definitions.php>

⁴ Online Therapy, Counselling & Mental Health Resources. (n.d.). *Glossary of terms commonly used in mental health*. Retrieved October 23, 2006 from <http://www.counsellingresource.com/types/glossary/c.html>.

5. Hyde, P.S., Falls, K., Morris, J.A., Schoenwald, S.K., (2001). *Turning knowledge into practice: a manual for behavioral health administrators and practitioners about understanding and implementing evidence-based practices*. Boston: Technical Assistance Collaborative.
6. Mental Health Promotion Toolkit: A practical resource for community initiatives. (n.d.) *Glossary of terms*. Retrieved October 23, 2006 from http://www.cmha.ca/mh_toolkit/intro/glossary.htm.
7. CAFAS. (n.d.) *CAFAS*. Retrieved October 23, 2006 from <http://www.cafas.com>
8. McMahon, R.J., Wells, K.C., & Kotler, J.S. (2005). Conduct problems. In E.J. Mash, & Barkley, R.A. (Eds.) *Treatments of childhood disorders: Third edition*. (pp. 137-268). New York: Guilford Press.
9. Children's Board of Hillsborough County. (n.d.) *THINK Key Terms, Acronyms and Abbreviations*. Retrieved October 23, 2006 from <http://www.childrensboard.org/familyresources/documents/KeyTermsandAcronyms.pdf>
10. Dictionary.com. (n.d.) *Definitions from Dictionary.com*. Retrieved October 24, 2006 from <http://www.dictionary.com>.
11. Family Guide: Keeping Youth Mentally Healthy and Drug Free. (n.d.) *Mental Health Dictionary*. Retrieved October 23, 2006 from <http://www.family.samhsa.gov/main/mhdictionary/e.aspx#1>.
12. Mash, E.J., & Hunsely, J. (2005). Evidence-Based assessment of child and adolescent disorders: issues and challenges. *Journal of Clinical Psychology, 34*(3), 362-379.
13. Institute of Medicine. (2001). *Crossing the quality chasm: a new health system for the 21st Century*. Washington, D.C., National Academies Press.
14. Federation of Families for Children's Mental Health. (n.d.) Retrieved October 24, 2006 from <http://www.ffcmh.org>
15. New York City Department of Juvenile Justice. (n.d.) *A career as a juvenile counselor*. Retrieved October 23, 2006 from <http://www.nyc.gov/html/djj/html/counselor.html>
16. MedicineNet.com: We Bring Doctors' Knowledge to You. (n.d.) *Licensed clinical social worker definition*. Retrieved October 23, 2006 from <http://www.medterms.com/script/main/art.asp?articlekey=15160>.
17. Pires, S.A. (2002). *Building systems of care: a primer*. Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University for Child and Human Development.
18. United States National Library of Medicine: National Institutes of Health. (n.d.) *Medline Plus Medical Encyclopedia*. Retrieved October 23, 2006 from <http://www.nlm.nih.gov/medlineplus/ency/article/000925.htm>
19. Isaacs, M.R., Huang, L.N., and Echo-Hawk, H. (In press). *The road to evidence: The intersection of evidence-based practices and cultural competence in children's mental health*. National Alliance of Multi-Ethnic Behavioral Health Association.
20. Milken Community High School. (n.d.) *9th grade health and human development social health unit*. Retrieved October 24, 2006 from <http://www.mchschoool.org/academics/departments/hs/health9/social.htm>
21. National Wraparound Initiative. (n.d.) *National Wraparound Initiative: About the NWI*. Retrieved October 25, 2006 from <http://www.rtc.pdx.edu/nwi/NWIAbout.htm>.

²² Kahan, B. & Goodstadt, M. (1999). Continuous quality improvement and health promotion: can CQI lead to better outcomes? *Health Promotion International*, 14(1), 83-91.