

Evidence-Based Practices, Systems of Care, & Individualized Care

Robert M. Friedman & David A. Drews

February, 2005



The Research and Training Center
for Children's Mental Health
Department of Child and Family Studies
Louis de la Parte Florida Mental Health Institute
University of South Florida

Contents

Background.....	3
Method	4
Findings	7
Facilitators of integration.....	8
Barriers to integration	8
Evidence of Effective Integration	10
Summary and Recommendations.....	11
References	13
Appendix A. Participants in the Interviews	14
Appendix B. Some Perspectives on “Getting There”	15

This is a publication of the Research and Training Center for Children’s Mental Health, which is jointly funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the National Institute on Disability and Rehabilitation Research of the U.S Department of Education, under grant # H133B90022. The opinions contained in this publication are those of the grantee and do not necessarily reflect those of the U.S. Department of Education or the Center for Mental Health Services, SAMHSA.



Evidence-Based Practices, Systems of Care, and Individualized Care

Background

For the past 20 years, a major focus of children's mental health policy in the United States has been on improving outcomes for children with serious emotional disturbances and their families through the implementation of data-based and value-based systems of care (Stroul & Friedman, 1986; Huang et al., in press). Within recent years the focus has changed somewhat. There has been an enormously increased emphasis on improving outcomes for children with mental health challenges and their families through the use of evidence-based practices at the child and family level. Although there is no single set of criteria for defining an intervention as an evidence-based practice or program, the common feature of such programs is that they have met some specified research criteria of effectiveness (Hoagwood, Burns, Kiser, Ringeisen, Schoenwald, 2001).

Developers and implementers of systems of care have been among those showing interest in evidence-based practices. A hallmark of such systems of care has been the development of individualized treatment plans. These plans are often developed through a participatory planning process called "wraparound," (Burns & Goldman, 1999; VanDenBerg & Grealish, 1996) that brings family, youth (where appropriate), members of the natural support system, and members of the formal service system together to develop plans that reflect a comprehensive focus on strengths and needs of families in multiple life domains. Such treatment plans frequently involve family choice of services and of providers, are designed to be culturally competent, are coordinated by a case manager/care coordinator, and involve multiple components.

This paper describes an exploratory study on the relationship between systems of care with their individualized care component, and evidence-based practices. The focus of the paper is on the direct delivery of services to children and families. It is recognized that systems of care place an important emphasis on developing system-level infrastructures, and on changing system-level practice in important ways, and involve much more than direct service interventions. This paper, however, is focused specifically on the delivery of services to children and families.

The impetus for the paper was the observation by the authors that while evidence-based practices, systems of care, and individualized care appear to be conceptually compatible with each other, and have something to offer each other, there seems to be relatively little integration of them in actual practice. The purpose of this paper is to report on the results of an exploratory study designed to identify models for effective integration of these approaches, and to identify both facilitators and barriers to such integration. The paper includes recommendations for enhancing the effective integration of these complementary approaches.

It should be noted at the outset that the wraparound process may be considered to be an evidence-based process by itself. In recent years there has been considerable progress in defining the key elements of the wraparound process, in developing instruments to measure fidelity to these key elements, in relating fidelity to child and family outcomes, and in comparing outcomes for children and families who receive services through a high fidelity wraparound process with those who do not (Bruns, Rast, Walker, Bosworth & Peterson, in press; Peterson & Rast, 2004; VanDenBerg,

This paper describes an exploratory study on the relationship between systems of care with their individualized care component, and evidence-based practices.

Although evidence-based practices, systems of care, and individualized care appear to be conceptually compatible with each other, there seems to be relatively little integration of them in actual practice.

This paper focuses on how specific evidence-based programs developed outside of the system of care/wraparound movement can be integrated with systems of care and wraparound to enhance outcomes for children with serious mental health challenges and their families.

2005). While the progress in defining, measuring, and studying the wraparound process has been encouraging, this paper focuses on how specific evidence-based programs developed outside of the system of care/wraparound movement can be integrated with systems of care and wraparound to enhance outcomes for children with serious mental health challenges and their families.

Method

This was an exploratory study designed to gather examples of communities in which systems of care, individualized care, and evidence-based practices were being used, and to learn from individuals about the facilitators and barriers that affect the integration of these approaches. A series of telephone interviews were conducted with key informants from around the country, and literature on evidence-based practices and systems of care was reviewed. Key informants were identified initially by a nomination process from leaders in the systems of care and evidence-based practice field. A special attempt was made to interview individuals from communities that seemed to be successful in achieving integration of these different approaches. As the study progressed, additional individuals were identified, and interviewed. Interviews were conducted with developers and purveyors of evidence-based practices as well as with individuals involved in the development of systems of care, and with family members.

In total, 27 interviews were conducted with 41 individuals representing 11 states and 4 evidence-based programs (see Appendix A). In some cases, more than one individual from a particular site or program was interviewed. Interviews were conducted by the authors, and notes were taken and summarized for each interview. A further analysis of respondents shows them to belong to the following sub-categories:

- Individuals from communities that were implementing systems of care ($n = 15$);
- State-level policymakers in children's mental health ($n = 7$);
- Individuals who, while outside of the local community, were working with the community to help improve services for children with serious mental health challenges and their families ($n = 6$);
- Family Advocates ($n = 5$);
- Representatives of evidence-based programs ($n = 8$)

The interview instrument was developed by the authors and consisted of a series of open-ended questions covering the following general areas:

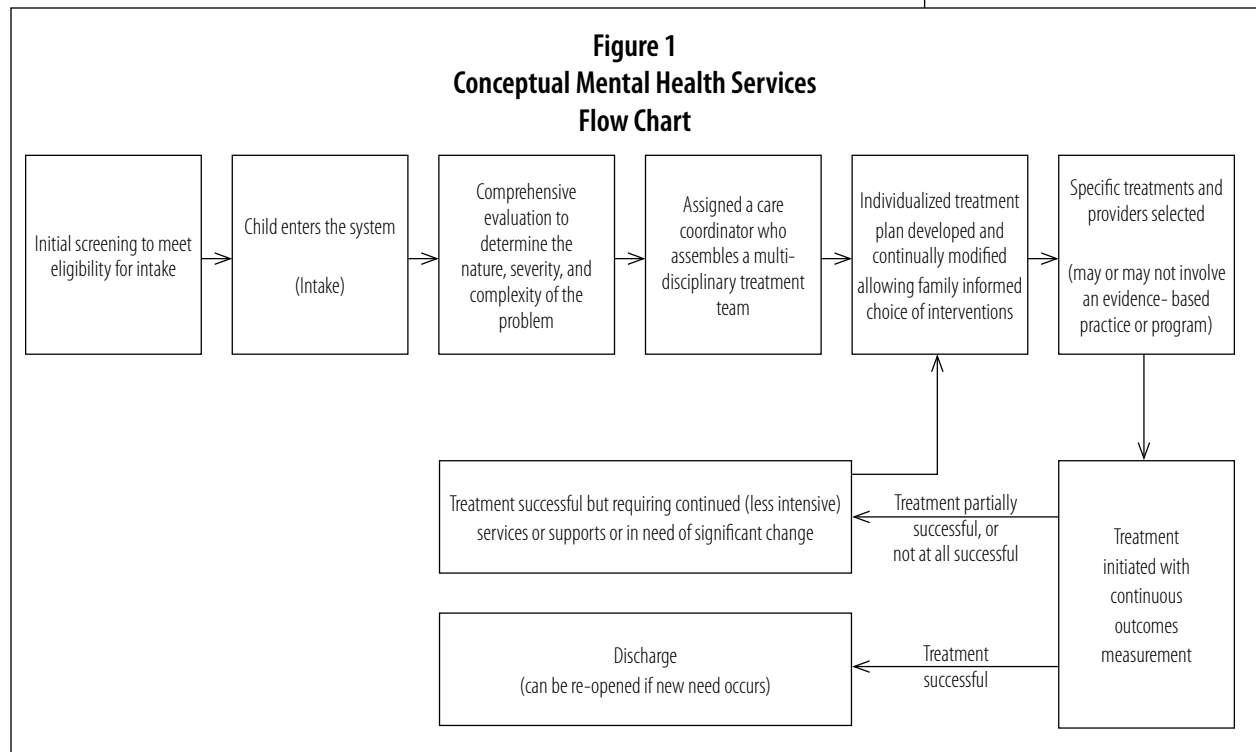
1. Description of the program or system
2. Identification of stakeholders and funders
3. Description of populations served
4. Description of the service array
5. The use of evidence-based practices
6. The role of families
7. Description of efforts in performance measurement and quality improvement
8. Degree of individualization of services

9. Description of treatment planning
10. Facilitators/barriers to integration of systems of care, individualized care, and evidence-based practices efforts toward integration
12. Suggestions of other programs of sites that may be doing a good job in this area

Semi-structured interviews were then conducted via telephone by both authors participating on speakerphone with the key informants. Open-ended questions and probes regarding the 12 topics yielded in-depth responses about people's experiences, perceptions, opinions, feelings, and knowledge.

The total set of interviews was reviewed by the researchers and a small group of advisors to identify promising examples of integration of evidence-based practice, systems of care, and individualized care, and to identify general themes related to facilitators and barriers.

The interviews began with an orientation to the authors' vision of integration of systems of care, individualized care processes, and evidence-based practice. The vision that was presented to interviewees is illustrated in Figure 1.



The authors explained that within such a system, children with serious mental health challenges and their families are provided with a care coordinator and often a family support person. The families, together with their care coordinator and family support person, identify a team of people to come together to develop an individualized treatment plan based on the needs, strengths, goals, and preferences of the family. The team consists of family members, other members of the family's natural support system, and representatives of agencies, organizations, or schools that are involved with the family. At the team meeting, a culturally

There were relatively few instances identified where there had been a systematic effort to integrate evidence-based practices with individualized care and systems of care.

competent and strength-based approach is used to assess needs and options in multiple life domains. During this process, families are provided with information about various service options, and these options may include as many evidence-based practices and programs as possible. Information about services would include research findings about short-term and long-term effectiveness in achieving particular goals for particular groups of children and families, and about the providers available to offer the services. The family would also receive current information on the performance of various services within the local community. Families would be assisted in making choices, and their choice may involve several types of services and supports, including evidence-based programs.

It was this type of application of system of care values and principles, individualized care approaches, and evidence-based practices that this exploratory study sought to identify, and defined as integration. It is recognized that there are communities in which evidence-based programs are offered by individual providers but are not integrated into the overall team-based treatment planning process for children with the most serious challenges. This is a type of parallel effort that may demonstrate varying degrees of effectiveness but differs substantially from the integrated approach described above.

Findings

There were relatively few instances identified where there had been a systematic effort to integrate evidence-based practices with individualized care and systems of care. In most cases, the policy emphasis in a local community was either on promoting the development of systems of care and individualized care, or on promoting the use of evidence-based practices. In some cases this was because there were strong proponents for one or the other approach. In other cases, policymakers expressed interest in an integrated approach but felt constrained by available resources to focus primary energy in one or the other area.

The good news is, however, that there were *some* very positive examples of such an integrated approach. Where such an integrated approach was found, there tended to be one of two types of precursors. In the first case, based on data from their performance measurement system, administrators in a system of care, expressed dissatisfaction with the outcomes they were achieving at the child and family level either for a particular sub-group of children and families, or for a broader population. This led to a search for strategies that might improve those outcomes, including evidence-based practices. This was most typically a targeted effort, directed at a particular sub-population of children. In some instances, where performance measurement data were not available, policymakers expressed general frustration with the lack of information about the type of services that were being provided, or the lack of control over quality, and moved toward evidence-based practices to increase knowledge of what was being offered.

The second way in which systems of care began to work with evidence-based programs was when a sector in the service system other than mental health (e.g., juvenile justice) would bring a particular program into a community. In such cases, system of care administrators sought to develop collaboration across sectors as a mechanism to try to create as integrated an approach as possible.

Particularly in those instances where mental health policymakers and administrators had initiated efforts to introduce evidence-based programs, the general belief was that the combination of individualized care with an evidence-based

program produced better results than either approach by itself. It was believed, for example, that if Multisystemic Therapy was available as one option for a family to select as part of a wraparound process, then the ultimate result was often better than if Multisystemic Therapy was done by itself, or if the individualized treatment plan was implemented without Multisystemic Therapy. This perception of an “enhanced” effect from an integration of approaches is encouraging, but at this point it is only a perception. There is some research in both Nebraska and Hawaii that is beginning to look at this important issue of the impact of the combination of approaches. Interestingly, however, there has been little research in the individualized care/wraparound arena or evidence-based practice field that has looked at the effect of a combined approach.

Facilitators of integration

The primary facilitators of an integrated approach identified were the existence of a functioning system of care with a strong set of values and principles, a clear direction and set of goals, and a strong performance measurement system. One interviewee who worked in several states reported that such a functioning system of care was a necessary foundation before an integrated approach could be implemented. Several respondents reported that existence of a data-based culture with a strong performance measurement system allowed policymakers to identify populations of children for whom positive results were being obtained, and populations for whom such results were not being obtained. This approach was evident in several communities or states. For example, in Central Nebraska the data indicated that results were unsatisfactory for children with anti-social behavior; so an attempt was made to identify an evidence-based program that might improve results for this population of children. In Milwaukee, data showed that adolescent sex offenders presented a special challenge, and an effort was made to identify and later develop an effective intervention consistent with system of care values for this population. In Michigan, a statewide performance measurement system identified a need to improve outcomes for children for whom depression was part of a constellation of problems, and this led to a search for effective interventions to improve outcomes for this population of concern.

Barriers to integration

Although policymakers expressed the general view that results were better with an integrated approach than without it, several barriers to effective integration were identified. One barrier reported in several communities was the requirement of an evidence-based program that once it became involved in providing services, the care coordinator and other service providers should cease to be involved with the family. This requirement seems to originate from several places. First, in the early development stages of program development, it is easier to test an intervention if everything is held constant except for that intervention. Second, it also becomes easier to secure external funding for research on the program if all other factors are held constant. Third, program developers often feel a strong sense of accountability for outcomes, and believe that such accountability can best be managed if they are the sole providers of service. Fourth, program staff, for understandable reasons, want to prevent the possibility of there being any interventions that take an approach that conflicts with the approach of the evidence-based program. However, policymakers, providers, and families involved in systems of care and individualized care rather consistently and sometimes very strongly

The primary facilitators of an integrated approach were the existence of a functioning system of care with a strong set of values and principles, a clear direction and set of goals, and a strong performance measurement system.

Policymakers in systems of care who seek to enhance their outcomes through the application of evidence-based programs have very little to choose from in terms of programs that have been demonstrated to be effective with children who often require long-term interventions.

objected to this policy because they felt that families benefit from, and should have, continuity of care. In several instances, local policymakers indicated that when they asserted very strongly that they would only work with the evidence-based program if a true “team” approach was used, more flexibility was shown and an arrangement agreeable to all participants was worked out. This is another encouraging finding of the study—what initially appeared to be a barrier to an integrated approach could be overcome.

A related barrier is that some evidence-based programs provide services on a time-limited basis while proponents of an individualized care approach prefer services that are provided for as long as they are needed and progress is being made. Multisystemic Therapy (MST; Henggeler, 1999) and Functional Family Therapy (FFT; Sexton & Alexander, 1999) are examples of programs that are provided essentially on a time-limited basis. For example, in Central Nebraska, when children with serious mental health challenges and their families were served through MST on a time-limited basis, it was found that many youngsters required services beyond the time period for which MST provided services. This meant that other providers who had ceased to be involved while MST was involved had to get re-involved. This interfered with continuity of care and was unacceptable to the systems of care policymakers. However, a positive resolution was achieved; MST staff now serve on the wraparound team and work collaboratively with other providers throughout their involvement.

One of the reasons that some evidence-based programs served children for briefer periods of time is that they were originally designed for populations of children for whom shorter-term intervention was well-suited, such as children with serious delinquency problems, or children at risk of being removed from their home because of abuse or neglect issues. MST program staff emphasize that they are an evidence-based program for children with serious delinquency, and not yet for children with serious mental health challenges (Schoenwald, personal communication; Swenson & Strother, personal communication) They indicate that they would like to become evidence-based for this additional group of children but recognize that it would take additional developmental work and modifications in the program model, such as providing service for longer periods of time.

In general, the largest barrier to the integration of evidence-based programs with systems of care and individualized care for children with serious mental health challenges may be that the discrete programs most frequently identified as being evidence-based, such as MST, FFT, and Multi-Dimensional Therapeutic Foster Care, (Fisher & Chamberlain, 2000), have primarily served populations other than children with serious mental health challenges and their families. In essence, policymakers in systems of care who seek to enhance their outcomes through the application of evidence-based programs have very little to choose from in terms of programs that have been demonstrated to be effective with children with serious mental health challenges and their families who often require long-term interventions.

Two other barriers were identified. The first is financial; the implementation of evidence-based programs requires significant start-up funding, often including a consultation and training fee for program developers. Sometimes these fees continue over an extended period of time. The issue is not whether these fees are justified—it is understandable that program developers are not able to provide the needed training, consultation, and coaching without charging a fee—however, securing the funds needed for start-up serves as a barrier to implementation.

The final barrier identified was a more subtle attitudinal barrier. Proponents of particular approaches, be it a system of care or an evidence-based program, tend to be passionate advocates for their approach. According to several interviewees, such passionate advocacy can sometimes cross the line into overt criticism and disrespect for the approach taken by others. Within this project, an attempt has been made to frame the issue of how systems of care, individualized care, and evidence-based practices and programs can work together in an integrated way to *enhance* services and outcomes. Often times, however, according to interviewees, the issue appeared to be framed in a competitive way to determine which approach is better than the other, rather than how they can work together in a complementary way.

Evidence of Effective Integration

Despite these barriers, there are examples of effective integration. In Hawaii, a very comprehensive effort has been made to incorporate not only evidence-based programs, but practices that have been identified as contributing to success with children with varying diagnoses and needs. Such practices as social skill development, anger management training, and cognitive behavior therapy were identified through systematic review of existing research to find practices consistently present in effective interventions for particular problems. (Hawaii DOH, 2004)

Hawaii has developed a network of providers who are trained in these particular practices, and has developed an approach that integrates system-of-care values and principles, individualized care, a performance measurement system, and strong family involvement and voice in selecting treatments and providers. In this instance the professionals, with support from researchers, view one of their principal roles as providing information to families and other treatment team members about what the research indicates about the effectiveness of various interventions for particular problems. This equips families with information that they can use to make informed choices of services. Hawaii's integrated approach was assisted by a strong partnership between state policymakers and the University of Hawaii as well as external consultants, and built on the opportunity created by a class action lawsuit. It seems to be the most comprehensive state-wide effort in the country to integrate so many features into a genuinely data-based and value-based system of care, and initial outcomes are very promising.

Other positive examples of integration have been found in communities in Nebraska, New York, Ohio, and California. These examples typically involve a single evidence-based program (e.g., MST or FFT), working within systems of care rather than the comprehensive approach taken in Hawaii. However, they do serve as illustrations that while it is still the exception and not the rule, systems of care, individualized care, and evidence-based programs can work together.

One of the principal roles of professionals is providing information to families and other treatment team members about what the research indicates about the effectiveness of various interventions for particular problems.

It is possible to develop an approach that integrates system of care values and principles, individualized care, and evidence-based programs.

It is important to have a solid plan for implementation of a new intervention, and for ongoing assessment of its effectiveness.

Summary and Recommendations

Perhaps the most important summary statement is that the results of this exploratory study indicate that it is possible to develop an approach that integrates system of care values and principles, individualized care, and evidence-based programs. Further, in those communities where this has happened, it was clearly viewed positively by the respondents to this study, and is believed to enhance positive outcomes for children and families.

The most important conditions for the development of an effective approach appear to be:

- The existence of a strong system of care with a clear set of values and goals, a well-established treatment planning process that is family-driven and culturally competent, and a practical performance measurement system that provides data on how well the system is serving children with various types of mental health challenges and their families;
- The existence of one or more evidence-based programs or practices that have the potential for improving outcomes for those specific sub-populations of children for whom improvement is most needed;
- System of care administrators and evidence-based program developers who have mutual respect for each other's efforts and are willing to work in a flexible and collaborative manner, systematically gathering data on child and family outcomes as the process proceeds.

Important first steps toward the development of effective, integrated approaches may be the development within systems of care of strong treatment planning processes, and performance measurement procedures. Hence, the stage may best be set for the entry of evidence-based programs within a community system that is based on strong values, but relies on both process and outcome data to inform decision-making.

After the stage is set, it becomes important to have a solid plan for implementation of the new intervention, and for ongoing assessment of its effectiveness. Without careful attention to implementation, intervention effectiveness is going to diminish (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). It is essential that there are proper training, consultation, coaching, and feedback procedures in place, and that there be ongoing monitoring of program fidelity, implementation, and outcome (see Appendix B).

At the same time that work goes on within individual systems of care, there needs to be support for further work on the development of evidence-based programs and practices, and/or their modification to work with new populations. This work must emphasize the development and testing of interventions in real-world settings. These interventions must be designed to serve culturally diverse populations of children, and children and families with a range of varying needs and conditions.

Results suggest that intervention research needs to move beyond testing new approaches in comparison to "normal" business. New approaches need to be tested in complex, real world settings, and particularly as an integrated part of an individualized treatment plan. The issue is not so much whether "Treatment A" is better than "Standard Practice B." Rather, the issue may concern what the potential combined impact of "Treatment A" and a system of care is, compared

to either one alone. Such an approach is consistent with a general view that evidence-based practices and programs potentially constitute an important enhancement to systems of care, and not an alternative to them.

Also, such research must determine how to incorporate the practice of family choice into the design. Given the importance of family choice as a value, and as a potential evidence-based process in and of itself, research designs that do not incorporate family choice will be of less value than those that do (Friedman, 2004).

The President's New Freedom Commission on Mental Health (New Freedom Commission, 2003) emphasizes both the importance of individualized plans of care, and the application of evidence-based practices. This is very significant because long-term meaningful improvement in outcomes for children with serious mental health challenges and their families will depend on a coming together of these two important approaches. The New Freedom Commission also emphasizes that providing families and consumers with choice of services and providers represents in and of itself a major transformation to our current system.

It is recognized that this study was exploratory in nature, was restricted in terms of the number of sites that participated, and did not include actual site visits. It is further recognized that there is an absence of data on the impact of the delivery of services to children and families within an integrated system of care, individualized care, and evidence-based practice approach.

Despite these limitations, however, it is encouraging that there are models of effective integration, and that several communities have been able to overcome what appeared to be significant barriers to integration. The opportunity is now there to bring together each of these important approaches in a mutually respectful way based on a clear set of values and principles, data on the functioning of the system, good strategic thinking about approaches to enhance system performance, and the application of sound implementation practice.

References

- Bruns, E. J., Rast, J., Walker, J., Bosworth, J., & Peterson, C. (in press). Spreadsheets, service providers and the statehouse: Using data and the wraparound process to reform systems for children and families. *American Journal of Community Psychology*.
- Burns, B. J., & Goldman, S. K. (1999). *Systems of care: Promising practices in wraparound for children with serious emotional disturbance and their families*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Fisher, P. A., & Chamberlain, P. (2000). Multidimensional Treatment Foster Care: A program for intensive parenting, family support, and skill building. *Journal of Emotional and Behavioral Disorders*, 8, 155-164.
- Fixsen, D. L., Naoom, S. F., Blase, K. B., 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, National Implementation Research Network.
- Friedman, R. M. (2004). *Creating informed choice for families: The link between individualized care, data-based and value-based systems of care, and evidence-based practice*. Paper presented at the 11th Annual Building on Family Strengths Conference, Portland, OR.

Research must determine how to incorporate the practice of family choice into the design.

- Hawaii Department of Health, Child and Adolescent Mental Health Division, Evidence Based Services Committee. (2004). *Biennial Report, 2004*. Retrieved from: <http://www.hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs011.pdf>
- Henggeler, S., Rowland, M., Randall, J., Ward, D.M., Pickrel, S.G., Cunningham, P.B., Zealberg J.J., et al. (1999). Home-based Multisystemic Therapy as an alternative to the hospitalization of youths in psychiatric crisis: Clinical outcomes," *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(11), 1331-1339.
- Hoagwood, K., Burns, B.J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence-Based Practice in Child and Adolescent Mental Health Services. *Psychiatric Services* 52, 1179-1189.
- Huang, L., Stroul, B., Friedman, R., Mrazek, P., Friesen, B., Pires, S., & Mayberg, S. (in press). Transforming mental health care for children and their families. *American Psychologist*.
- New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America. Final Report*, [Pub. No. SMA-0303832] Rockville, MD: U.S. Department of Health and Human Services.
- Peterson, C., & Rast, J. (2004, February-March). *Wraparound effectiveness: Comparing traditional services to wraparound in Nevada*. Paper presented at the 17th Annual Conference, A System of Care for Children's Mental Health: Expanding the Research Base, Tampa, FL.
- Sexton, T. L. & Alexander, J. F. (1999). *Functional Family Therapy: Principles of clinical intervention, assessment, and implementation*. Henderson, NV: RCH Enterprises.
- Stroul, B. A., & Friedman, R. M. (1986). *A system of care for severely emotionally disturbed children and youth*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
- VanDenBerg, J. E. (2005, April). *Research and high fidelity wraparound*. Paper presented at the first national conference on wraparound, Toronto, Ontario, Canada.
- VanDenBerg, J. E. & Grealish, E. M. (1996). Individualized services and supports through the wraparound process: Philosophy and procedures. *Journal of Child and Family Studies*, 5, 7-22.

Appendix A Participants in the Interviews

State, County, Local, and Provider Leadership

Nebraska	Nebraska Family Central	1. Beth Baxter
Kentucky	ORC-MACRO (re: Impact/Bridges Programs)	2. Lisa Marcum
Hawaii	Child and Adolescent Mental Health Division/University of Hawaii	3. Tina Donkervoet/Bruce Chorpita
California	California Institute for Mental Health	4. Bill Carter/Todd Sosna/Lynne Marsenich
	San Diego Center for Children/Therapeutic Services, Inc.	5. Marty Giffin/Barbara “Cricket” Mitchell
	Humboldt County Mental Health	6. Lance Morton/Phil Crandall
	Orange County Health Care Agency	7. Denise Churchill/Holly Magna
Minnesota	Children’s Mental Health Division	8. Glenace Edwall
Arizona	St. Luke’s Health Initiative	9. Elizabeth McNamee
	Value Options	10. Amy Henning/Kristy Bartusek
Wisconsin	Wraparound Milwaukee	11. Bruce Kamradt
New York	New York State Office of Mental Health	12. Mike Zuber/Jim MacIntyre
	Kids Oneida	13. Mike Daly
	Westchester County	14. Myra Alfreds
Ohio	Center for Innovative Practice	15. Patrick Canary
	Office of Children’s Services and Prevention	16. Sharon Aungst/Kay Rietz
Indiana	Dawn Project, Marion County	17. Knute Rotto

Family Advocacy

United Advocates for Children of California	18. Pam Hawkins
Georgia Parent Support Network	19. Sue Smith
Hawaii Families as Allies	20. Susan Cooper/Linda Machado/Charlie Duraban

Evidence-Based Programs

Homebuilders	21. Shelley Leavitt/Charlotte Booth
Multisystemic Therapy	22. Sonja Schoenwald
	23. Marshall Swenson/Keller Strother
Functional Family Therapy	24. Thomas Sexton/James Alexander
Multidimensional Treatment Foster Care	25. Patricia Chamberlain

National Experts/Consultants

Bazelon Center for Mental Health Law	26. Ira Burnim
Human Systems and Outcomes, Inc.	27. Ivor Groves

Appendix B

Some Perspectives on “Getting There”

Karen A. Blase and Dean L. Fixsen, National Implementation Research Network, Louis de la Parte Florida Mental Health Institute, University of South Florida

Note: Dr. Blase and Dr. Fixsen, experts on evidence-based programs and implementation issues, served as consultants to this project. They offer here some perspectives on what it takes to bring about effective system change that brings evidence-based practices and systems of care together.

The utilization of evidence-based programs and practices (EBP) holds great promise for children with serious emotional disturbances and their families. But as we know, these children exist in a complex system of family, community, multi-jurisdictional services and settings (e.g. Mental Health, Education, Child Welfare). And systems variables can unfortunately ‘trump’ program effectiveness. How, why and when “systems” at the practice, program and policy level make decisions is therefore highly relevant to successful transformation efforts and the implementation of Systems of Care (SOC)

Therefore, it may be helpful to think about the setting conditions that facilitate the development of any effective human service initiative. With respect to the integration of EBP’s with SOC’s, it may be very useful to help SOC initiatives first develop and then learn to rely on a performance-based measurement system and databased decision-making (process and outcome). The development and utilization of decision-support systems based on data provides a solid foundation for the integration of an evidence-based program or practice with SOC efforts.

Systems of Care may benefit from decision-support and databased tools and processes to help:

- Clarify the community’s questions related to current service configuration and access (e.g. access for specific populations, outcomes, cultural competence)
- Define the outcomes they expect with respect to the areas of need and populations of concern.
- Determine if improving collaboration, access, integration, staff development and accountability structures would be a logical next step (the strategy)
- Determine if implementing an evidence-based program or practice would be helpful (as a strategy)
- Analyze the fit of the values of the particular evidence-based practice with the system of care value base
- Determine the costs and benefits that might be required and realized
- Analyze the accessibility of the expertise to adopt the EBP
- Determine the infrastructure needed for high fidelity implementation and sustainability including requirements and costs.
- Develop the ongoing process and performance measures to guide the process and evolution of the SOC and the adoption and implementation of the EBP.

In general, helping SOC initiatives create and utilize a clear theory of change and a practical, useful performance-based measurement system may create the community context needed to increase the likelihood that a mutually beneficial relationship with an EBP could be developed that would benefit children and families.

Different Points of View Regarding Implementation:

- Evidence-based program point of view—to achieve fidelity we have to do it this way because we are highly accountable for processes and outcomes—stand back and let us do our stuff, it’s hard enough as it is
- Systems of care point of view—to achieve long-term benefits for a whole range of children and families we need well coordinated services where we all share responsibility for joint processes and overall outcomes—have to coordinate services and assure continuity for children and families and there is no room for loose canons
- State government point of view—need to stay within budgets, policy and regulatory guidelines, maximize revenues, and provide maximum benefits to the population of children and families in the state

Key components of successful program implementation and/or development:

- Clear theory of change / clear goals and defined strategies
- Data collection with frequent / tight feedback loops within and across levels (e.g. practice, program, system)
- Penchant for operationalizing “what works”—do it, write it down, follow the written guideline, analyze results, revise it, do it again (Plan, Do, Study, Act)
- Focus on innovation with consistent attention to creating change to improve benefits. The catch phrase here is “Quality insistence not the path of least resistance”. Innovation can sometime be disguised as not working through the challenges of high fidelity implementation and is really program drift without attention to outcomes.
- Move up the scale of usefulness by eliminating harmful / ineffective practices and doing more of what works/evidence-based practices and programs

Questions to ask “purveyors” or proponents regarding the evidence base for a program:

- What are the characteristics of the populations in the data used to develop the database for an evidence-based program? How do those characteristics compare to the specific strengths and needs of the public-sector population to be served in the system of care?
- What are the characteristics of the comparison / control groups used to develop the database for an evidence-based program? Are those normative interventions typical of those in the current public sector environment of the system of care?
- What are the characteristics of the service environment in which the database for the evidence-based program was developed? Is it resource rich? How do those service environments compare with the public sector environment in which the system of care is developing?
- Has the program been successfully implemented in typical service settings?
- Does the practice or program clearly define its ‘theory of change’ and the ‘active ingredients’ that need to be in place in order to create positive change for children and their families?
- As the EBP is implemented with fidelity, how can the SOC site learn to discriminate the functions of the active ingredients and vary the form to better fit the population, culture and setting? Will the program developers work with the SOC to do this?
- Will the SOC have ready access to the process and outcome data associated with implementation efforts? Will the SOC be willing to share their data with the EBP “purveyors” and developers and vice versa?

In summary, performance-based measurement systems can create the opportunity for decision-support systems that are based on sound process and outcome data. With this navigation tool in place, SOC sites and evidence-based programs can work together compatibly, creatively, and respectfully to better meet the mental health needs of children and their families.

The Research and Training Center for Children's Mental Health
Department of Child and Family Studies
Louis de la Parte Florida Mental Health Institute



University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3807
(813) 974-4661 Fax: (813) 974-6257
<http://rtckids.fmhi.usf.edu>

