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Workforce

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ON FAMILY SUPPORT AND CHILDREN'S MENTAL HEALTH

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NIDRR National Institute on Disability and Rehabilitation Research

Caring for Every Child's Mental Health Systems of Care

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FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

Workforce: Staffing the Transformation of Children's Mental Healthcare Systems

Over the last 20 years, providers of services and supports for children's mental healthcare have come under increasing pressure to change the way they do business. This pressure has come from two different directions. On the one hand, there is the movement to build *systems of care*. The focus of systems of care is the provision of individualized, coordinated services and supports to meet the specific needs of particular children and their families. The system of care approach is further distinguished from traditional approaches by the emphasis placed on serving children in community settings and by the importance accorded to family and youth "voice." Whereas traditional service approaches tend to see professionals as the experts, the system of care approach recognizes families and youth as having the greatest amount of expertise about their own needs and the service and support strategies that are most likely to be helpful. Service and support strategies must therefore be highly flexible in order to fit the unique needs and preferences of each child and family served.

On the other hand, service and support providers have also come under pressure to increase their use of *evidence-based practices* and programs, or *EBP*s. EBPs are service and support strategies that have been rigorously researched and shown to be effective. EBPs tend to be highly structured, which makes sense, since the goal is to reproduce the outcomes that were obtained in the original research. Providers are expected to be able to demonstrate that they are adhering to these structures. Thus, EBP providers are typically required to collect very specific data in order to monitor *fidelity* (the extent to which their practice follows the expectations of the model).

While people have been advocating for both system of care and EBP within children's mental health for at least 20 years, the pressure for providers to undertake significant practice change really began to mount after the publication of the final report from the President's New Freedom Commission on Mental Health in 2003. The report was structured as a series of recommendations that placed a high priority on increasing the use of both system of care and EBP. Importantly, all federal agencies were directed to bring their mental healthcare-related policies—including their grant-making programs—into line with the report's recommendations. The report's stated goal was to help drive a complete transformation of the mental healthcare system in America.

Not surprisingly, many providers felt uncomfortable and confused when faced with this growing pressure to transform their services and supports. In the first place, it seemed that training staff to do things differently was not going to be easy. If what had been valued in "traditional" service provision was no longer considered appropriate, who was going to train and supervise the workforce to carry out these new approaches? What is more, it was not clear how providers were to get staff to a level of competence in system of care *and* EBP at the same time. After all, system of care prioritizes flexibility and individualization, while EBPs are more rigid and highly structured. And systems of care focus on reaching goals that are important to particular families and youth, while EBPs are designed to produce very specific outcomes that may not reflect youth or family priorities. How were providers to train staff that could work with each family flexibly *and also* adhere to a treatment manual with fidelity? Were these two approaches even compatible with each other, or was this vision of transformation based on an inherent contradiction?

This issue of *Focal Point* highlights a series of jobs and roles that have evolved to fit within transformed children's mental healthcare systems as envisioned in the report from the

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New Freedom Commission. Some of these roles have clearly been created or significantly adapted to support the requirements of working with EBPs. This issue focuses in detail on roles within two popular and well-regarded EBPs. One set of articles describes several roles that are part of an agency's implementation of *Incredible Years (IY)*, a series of programs to reduce conduct problems and promote social, academic and emotional competence in young children. A clinician, supervisor and evaluator describe their roles within *IY* and the training and supervision that ensures that they practice this EBP with fidelity. Another set of articles focuses on similar issues within *Multisystemic Therapy (MST)*, an EBP designed to treat youth who have mental health needs and are involved in the juvenile justice system.

Other roles described in this issue are more obviously consistent with efforts to implement key elements of the system of care philosophy. One set of articles focuses on the provision of *direct support services*—flexible, home- and community-based services that focus on helping the child and family live successfully in the community. Another article focuses on the role of *family partner*, a peer support and advocacy role used within systems of care and as part of the wraparound process. A central part of the family partner role is to help ensure that family voice drives care and treatment so that services and supports are individualized to meet their unique needs. Another article describes the role of *early childhood mental health consultant*. While this role is not entirely new, expectations associated with the role are changing to reflect the essential elements of system of care.

At the surface level, then, these articles would seem to reinforce the essential difference between the rigidity required for EBPs and the flexibility that is the hallmark of system of care approaches. Surprisingly, however, a more careful look reveals that a number of essential expectations for practice are quite similar, regardless of whether the role is more clearly associated with system of care or EBP. In particular, key commonalities that are shared across the roles described in this issue include:

- *Working within well-defined structures and expectations.* While this is obviously characteristic of EBPs, the direct support and family partner roles also carry specific practice expectations and require ongoing feedback from families as part of the process of quality assurance and maximization of the "fit" between family needs and the services/supports provided.
- *Focusing on families' and children's daily lives and contexts.* This characteristic is obvious in the system of care approaches; however, both

MST and *IY* focus heavily on making changes within the family, peer and/or community systems that represent the main day-to-day contexts in the lives of children and families.

- *Partnering with families and youth/ Providing a flexible response.* Again, while this might be taken for granted within system of care approaches, the EBP articles also reinforce the need for providers to partner with families and youth, and to tailor treatment and care based on what is learned as a result of respecting family/youth voice and expertise.
- *Teaming with colleagues.* In addition to partnering with families, each of these approaches requires teaming with colleagues—including those who might be considered superiors or subordinates—in ways that recognize each individual's expertise and contributions.
- *Building on strengths.* Each of these approaches highlights the need to build an appreciation for families' and children's assets and capabilities, to communicate this appreciation to the children and families, and to use these strengths as a foundation for service and support strategies.

While many of these practice essentials are not a part of traditional services, the articles also show that learning how to work in a transforming mental healthcare system does not require people to start from scratch. The articles describe how existing capacities—including group skills, communication skills, empathy, knowledge about specific challenges and disorders, and many specific clinical strategies—work well within these new roles. This said, it will be a considerable challenge to prepare the workforce so that the envisioned transformation is possible. Workers at all levels within systems—from direct care providers to supervisors, administrators and agency heads—tend to be ill-prepared for partnering with families, teaming with colleagues, building on strengths, or using data and feedback systematically to assure quality. Effective pre- and in-service training must be developed quickly to spread these essential capacities throughout the children's mental healthcare workforce. Workers who gain these capacities will be well-prepared to work in a variety of roles, though of course additional role-specific training will be required.

Preparing the workforce in this way should not be left to providers alone—educational institutions and public systems also need to develop creative ways to invest in and support workforce development. The concluding article in this issue describes Ohio's work to build statewide capacity to deliver EBPs. While this creative approach deserves recognition, much further effort and more creative workforce development strategies are needed. Without this, mental healthcare transformation will be limited to pockets of excellence.

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Direct Support Services in Children's Mental Health

The system of care approach has taken hold in the field of children's mental health in recent years, causing many communities around the nation to rethink and reorganize the services and supports they offer to children and their families. This shift is perhaps most obvious for children with complex needs, who might previously have been placed in residential treatment facilities or hospitals. The system of care approach focuses instead on developing care and support strategies that enable children to live in community settings and to participate fully in family and community life. Direct support services [see article on page 8] are compatible with—and in many cases essential for—making this approach work for children with complex needs and/or difficult behavior. Direct support services are flexible, home- and community-based services that build on and develop child and family strengths and capacities, and that focus on helping the child and family live successfully in the community. In the traditional medical model of mental health, experts identify a problem and apply treatment in order to fix the trouble. Within a system of care, on the other hand, treatment and care approaches are identified by partnering with families, first to discover their underlying needs and then to design a plan that uses their strengths, capacities, and resources to reach the goals they consider most important. Making this sort of approach work requires skills for partnering with youth and families, and such skills are often not part of the traditional mental health worker's repertoire. As a result, this approach often requires clinicians to work in new ways. This approach also requires new roles, like that of the direct support worker, so that in-home and in-community support can be provided in ways that are consistent with the child and family's plan.

Direct Support Services Differentiated

Direct support services are provided in the homes of families and in the community rather than in an office setting. They involve a philosophy of "treatment by participation," focusing on helping a child get involved in the community, develop a respected role and positive reputation, practice life skills, make choices, and experience enhanced quality of life. Less focus is placed on talking and more is placed on doing. Rather than dwelling on diagnoses and limitations, the philosophy of direct support encourages people to become busy with constructive activities and the positive aspects of life. This helps to center their attention on contributions they can make in their homes and communities.

Although relatively common in the fields of developmental disabilities and special education, direct support services are not typically as understood, appreciated or effectively utilized in children's mental health. Centering on positive activities rather than on trying to "fix" bad behavior, direct support services are different from a more-typical "behavior coaching" model, where attention is continually drawn to the undesired behavior in an effort to extinguish or replace it. Instead, direct support services work within the environment of the family's culture and use a positive approach to focus on what the person wants to do rather than simply what others want the person to stop doing.

This approach is particularly helpful for individuals and families for whom traditional mental health services have not been successful in the past, including those with very complex needs. A common misperception is to see direct support as a "lower level" of service that is put in place only as a precursor to traditional clinical services such as counseling and medication management. In reality, direct support services in and of themselves, or in combination with traditional clinical services, are often the interventions that are most successful for youth with challenging needs. This is due in large part to the good fit between community-based support services and the interests and needs of

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children and families. Additionally, direct support services are often a good match for children who are either too early in their development or too consumed with the challenges of life to benefit from therapeutic approaches that require cognitive processing of their behavior. And because direct support services provide practice in the immediate environment in which the child lives, positive outcomes are likely to be sustained. For all of these reasons, direct support is an excellent service option in children's mental health systems as a means of augmenting customary clinical treatment services.

The following examples illustrate some of the ways direct support services may be used in children's mental health to address the needs of families. (Names and identifying information have been removed or changed.)

- The family and their support team identified a need for family members to celebrate their spirituality together. Their goal was to attend church as a family. In the past, Brandon's anxiety in social situations had led to his being kicked out of church repeatedly. Direct support workers helped him plan and practice how to dress, talk and act while at the service. They showed him new skills such as tying a necktie and shaking hands with others so that he would feel comfortable at church. They accompanied him to church along with his family to help ensure his success.
- Two siblings needed to have positive relationships with peers. They frequently got into fights with others during any activity that they perceived to be competitive. Direct support workers helped initiate neighborhood flag football games to help the two young siblings make friends in their neighborhood and learn how to play in competitive situations. During the football games, the support workers modeled sportsmanship and fair play.
- Linda needed to have a positive identity. She had been cutting on her legs when she felt stressed and everyone in life had begun to identify her as a "cutter." Support staff helped her plan, prepare for and carry out a "perfect day" of her choice. They role modeled and participated in bike riding, paddle boating, and helping Linda make dinner for her family. Support workers helped Linda identify her own positive qualities based on the day's activities. These were important steps in helping Linda build a new life of purpose and meaning.

Some of our own agency's best direct support workers had little or no prior experience in the field of behavioral health, yet they have helped some of our community's most complex youth live successfully in their community and overcome significant challenges and risk factors.

Integration of Bachelor's Level and Paraprofessional Workforce

Unlike clinical service roles, most direct support service roles do not require a graduate degree in a behavioral health field. Instead, the workforce predominately consists of bachelor's-level employees (behavioral health technicians) and individuals with less formal education but with a talent for connecting with children (paraprofessionals). Such a workforce has both advantages and challenges. One of the advantages is the opportunity to create an agency culture based on the direct service philosophy described above. This is more difficult in an agency where most workers have had formal training and experience in professional cultures dominated by deficit-based approaches and medical models. Some of our own agency's best direct support workers had little or no prior experience in the field of behavioral health, yet they have helped some of our community's most complex youth live successfully in their community and overcome significant challenges and risk factors.

On the other hand, the lack of traditional formal training also presents challenges. For example, it is important that direct support workers understand basic theories of behavior, possess strong listening and communication skills, see the value of proper documentation, and recognize ethical obligations. However, many paraprofessionals and behavioral health technicians have little training and experience in these areas. What is more, direct support work usually occurs in homes and in the community rather than in an office, leaving the worker without immediate assistance or oversight. It thus is essential that agencies offer high-quality training and supervision to direct support workers, in order to ensure that they are properly prepared to meet the challenges that are inherent in their jobs.

Licensed Mental Health Professionals and Direct Support

Licensed mental health professionals play several critical roles in community-based direct support. First, although somewhat of an anomaly, a masters-level, licensed clinician can be one of the most effective direct support workers in a system of care, especially when paired with a community-based, support-driven approach to helping others. Such employees are often the products of established systems of care, where community-based work is an expected practice, or they emerge from schools of social work or community health, where a belief in working in homes and communities comes more naturally. Unfortunately, many fee-for-service

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reimbursement schedules are based on the type of service (counseling as opposed to skills training, for example) rather than on the qualifications of the person providing the service. This provides a disincentive to agencies to use masters-level professionals for many direct support roles. In systems where direct support thrives, agencies are paid nearly the same rate for services by a licensed masters-level worker, regardless of whether the unit of service involves therapy, respite or any other service. Configuring rates in this progressive manner allows willing clinicians to provide services in any manner most likely to help a family, including direct support when needed.

Separate from direct service provision, licensed clinicians may be a valuable part of direct support programs by contributing clinical supervision and guidance for the workforce. As mentioned previously, direct support services are often provided by individuals with little formal training and experience. These workers benefit tremendously from consistent and frequent supervision. In providing clinical supervision, it is imperative that the clinician understand and emulate the principles and values of community-based care and direct support services. Perhaps no other position has more influence on the work performed by frontline staff. A clinician who is not aligned with the values of community-based work may contradict and render ineffective even the finest training program. It is thus essential to carefully select, train, and supervise licensed clinicians who take on supervisory or administrative roles in a direct support program.

Positive Behavior Support

Positive Behavior Support (PBS) is a strengths-based, non-coercive approach to behavioral intervention that is the foundation of effective direct support work in children's mental health.[1] This positive approach is consistent with system of care values, but is very different from the deficit-based approaches that predominate in traditional mental healthcare. Many agencies offering home-based services and behavior coaching use deficit-based approaches as the default operating modality. As a community moves toward becoming a true system of care, a significant amount of workforce and supervisor retraining may thus be necessary.

Positive Behavior Support works well with individuals for whom more traditional behavioral interventions have not been successful. Youth and

even adults with complex behavioral needs often reach a point where approaches such as timeout, removing privileges, and punishment are not successful. In some instances, not only are these approaches ineffective, they may make matters worse. This often results in a temptation to give up on the individual or to label the person as being unresponsive to help.

PBS uses a different approach to challenging behavior. It removes the coercive and punitive interventions and focuses on positive opportunities and choices. It is not possible to control the actions of others, and for individuals with complex behavioral needs, attempts to do so sometimes backfire. The success of Positive Behavior Support for youth with very complex needs is well documented as an alternative approach to traditional interventions.[1]

PBS focuses on preserving the respect and dignity of the individual and family, giving people real choices, improving quality of life, and creating opportunities to help people practice (rather than just talk about) being contributing members of society. PBS discourages and avoids punishment, behavior level systems, ultimatums, coercion, criticism, and making opportunities to participate in the community contingent on good behavior.

Conclusion

While an abundance of research is available regarding the effectiveness of Positive Behavior Support for youth with complex needs, additional research is needed to explore how to optimize PBS-based direct support within systems of care. Important research questions include the following: What is the best way to balance and/or combine PBS-based direct support with traditional clinical services? Is there a particular benefit to using family members of children with behavioral health needs as providers of direct support services? Does family-led recruiting and hiring for direct support workers help improve the quality of the workforce?

Direct support services are a growing trend in the field of children's mental health, particularly in connection with the move toward Systems of Care. Direct support workers have an exciting opportunity to become involved in the growing trend of strength-focused, community-based work. This opportunity is available to individuals with little or no prior behavioral health experience and to licensed mental health professionals. Agencies that ground their direct support approach in the principles of Positive Behavior Support are more likely to experience successful outcomes for children and families with complex needs.

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Direct Support: How it Works

Brian is 14 years old and has been receiving mental health care since he was three. By the time he entered 5th grade, Brian had been to four different schools. Shortly thereafter, he was hospitalized and entered a residential treatment center. After seven months, the treatment center closed and Brian went home to live with his mother Ruth, his father, and his older brother. Because of funding provided through a grant, Brian and his family had the opportunity to get help in their home and in the community. That is when they met Scott, a direct support specialist who has been working with the family for about a year. Brian's story is based on a series of interviews.

Brian's Story

My name is Brian. My favorite things to do are play video games and have my friends come over. I really like it when we all play together. My hero is my older brother who just moved to California and lives near the beach. My favorite subject in school is science and I especially like it when we learn about animals. I am hoping to someday get a job at McDonalds.

I met Scott [Brian's Direct Support Specialist] at around Halloween last year. I have a lot of fun doing things with him. Usually we play games, go to the mall, and spend time together at my house. But we have also been to some concerts, the fair, and even Golf Land. Sometimes he stays for dinner and eats with me and my mom and dad. It's great to just hang out and do things together.

Since working with Scott, I have changed. I don't get as angry anymore. I used to get really angry and now not as much. I don't fight with people as much any more and I cuss less—I get along with people better. So because of that I have been going out a lot more and I can do a lot more different things than I used to. Like, we get to go to movies together at the theater. The last movie we saw was *The Simpsons Movie*. It was good and I had fun doing that. And lately my friends have been able to come over more. We play video games together and play on the computer. And my mom will be around and she will make cookies for us sometimes—I like it when she does that! It feels good to do all these things.

Ruth's Story

I knew from early infancy that something was unique in Brian. One night shortly before he turned three, he was crying in bed. I went in his room to comfort him and he hit me—a closed fist punch. The psychologist dismissed my concerns about Brian by saying, "He was having a nightmare and didn't know what he was doing." I took on a lot of guilt and began to doubt my parenting skills.

We sent Brian to preschool to give him more structure. We believed someone could do better with him. Right away we were getting calls from the school, and I said, "It's bad isn't it?" He had a hard time socializing; he was hitting other kids. Then, when he was in first grade, Brian was transferred to a self-contained classroom. He was totally comfortable there. He completely blossomed in that smaller classroom—the lights were dim, there wasn't too much stuff on the walls—it was the right environment. He was safe and the other kids were safe with him. But then, due to class size, Brian was sent to another school during second grade. By February he was

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no longer doing well. We took him to the doctor for more tests, and that is when he was diagnosed with bipolar. With new medications, he was OK for a few years. But things got worse in 5th grade and he was hospitalized and then admitted to a residential treatment center (RTC). After seven months, the RTC facility closed and Brian came home. Our case manager told us that thanks to a grant we would be able to get someone to help us work with Brian in our home. So, we met Scott, a direct support specialist. And that was it. He taught us how to deal with our son.

All along we needed someone to be in our home. We needed someone who really knew how to work with Brian. Scott is a great big teddy bear—a big guy with a soft heart. Early on, there was one day when Brian was upset. When that would happen before, I would lock myself in the bedroom. This time, Scott made eye contact with me that said "stay here." So I backed up, but stayed and watched. I saw how Scott was able to figure out how to work with Brian—that when Scott could take a step towards Brian that meant he could talk to my son. But even when Brian would hit Scott hard, Scott always knew when to step in and intervene; and he has done it like any loving parent would want it done. Because of Scott, I am no longer afraid of our son. I know how to give him time and space.

Scott showed us how to see when Brian is testing his boundaries to make sure things are safe. He showed us how to help Brian make choices by breaking down the options and helping him decide. And that is fun for Brian. He is learning responsibility for his actions. Now we are at the point where if he breaks something, he knows that he has to pay for it himself. He has come a long way.

I love having our son at home. I love tucking him in at night and saying prayers with him. Just doing regular stuff together. I am happy that I am able to teach him the lessons that a mother needs to teach her child.

Brian did not ask to be born with this. If he can learn to help himself, he can be a productive member of the community. Having Scott in our home saves taxpayers money. If it weren't for Scott, our son might not be in our home; chances are he would either be in a therapeutic group home, a residential treatment center, or juvenile detention. Having our son at home is best for us, and best for society—it's really the best for all of us.

Scott's Story

I have worked with Brian's family for one year. In the beginning I saw a mom who was crying due to fear and frustration. I saw a child who was out of control, occasionally violent, and not respectful towards his family's property.

The very first thing I did was build a working relationship with the family, including Brian. I helped the family decide together what goals we were going to work on. With Brian, I always valued his feelings and encouraged him to express them freely to me and to his Mom. I did this by teaching Brian to talk with his Mom in a calm and respectful manner. I helped Brian understand why teachers and family members were asking him to do certain things. This helped him make sense of things, which in turn helped him buy in to the plans and goals.

Every single day with Brian is different. I do some pre-planning, but I have to be ready to think outside of the box and change those plans according to Brian's mood. If I see that he's having a bad day, I can bring him to a better place by using humor and empathy. I help him take breaks and calm down, and get into a better frame of mind. I do that by prompting him to walk away and divert his attention to one of his interests. Lately, I've been asking him questions about Halloween because I know he's excited about that. That helps get him un-stuck and re-focused.

I get to Brian's house before he gets home from school to see what Ruth's plans are. She may want to run errands with Brian, for example. I help her plan the time by creating scenarios that could possibly arise during these outings. This helps Ruth by getting her to think about how she will communicate with Brian about being respectful and following rules. I think it gives her the confidence that she can do it even without my being there.

In the beginning, when things got escalated, Ruth would go into her room and lock the door out of fear. I encouraged her to stay and handle the situation and show no fear even if it was there. Over time she gained confidence in herself. It has been almost a year since Brian has shown any physical aggression towards his mother. However, I still bring the possibility up every day to increase her confidence about handling the most challenging situations in case they do happen.

Brian has gained more respect for the safety guidelines that have been set for him. He has learned how to use his coping skills with his anger. Things have become safer, and his parents have more of an understanding of what their child wants and needs.

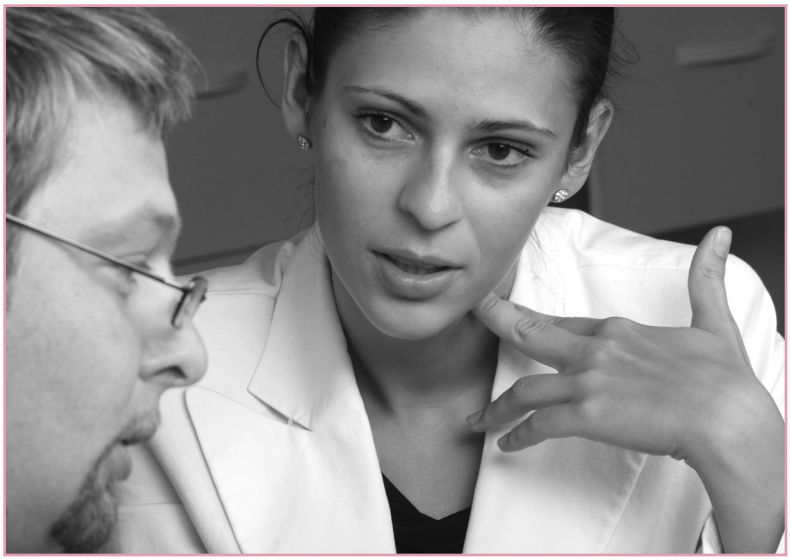
Authors*

Brian is an 8th grader living in Arizona.

Ruth is Brian's mother, and is a very active parent participant in Behavioral Health Systems of Care work in her community.

Scott is a direct support provider who has supported children with unique needs for several years.

**Actual names have been changed to protect the privacy of the authors.*



Implementing *Incredible Years*: Reflections on Changes in the Clinician's Role in an Evidence-Based Practice

In 2007, Morrison Child and Family Services received a Science to Service Award from the Substance Abuse and Mental Health Administration (SAMHSA). The award, in the "Mental Health Promotion" category, recognized Morrison's successful implementation of an evidence-based practice, Incredible Years Parent and Child Groups. *The Science to Service awards are part of SAMHSA's efforts to encourage the successful application of research at the practice level.*

The emergence and spread of new modes of practice in the field of children's mental health has had a significant impact on many clinicians' roles. Our agency, Morrison Child and Family Services, in Portland, Oregon chose to implement *Incredible Years*, an evidence-based practice (EBP), as part of a federal grant. *Incredible Years* (*IY*) is a series of programs designed to work together to reduce conduct problems and promote social, academic, and emotional competence in young children. Morrison has implemented the *IY* Parent and Child Training programs, and is in the process of implementing the *IY* Teacher Training program. Clinicians implementing *IY* programs at Morrison have had the opportunity for several years now to compare and contrast a more traditional outpatient mental health role with one that incorporates an EBP as a primary mode of practice.

Clinicians have a range of responses to the prospect of working within a manualized treatment program. Often, there is fear that use of an EBP will stifle the clinician's creativity, or that it will force them to abandon skills they already possess. Some worry that they will be "micro-managed," or that EBP will feel too rigid. By contrast, others often appreciate that an EBP has a body of evidence to support its efficacy and feel confident that they are using a model that will allow them to consistently replicate these positive outcomes with their clients. Many clinicians find they enjoy having a solid framework within which they can make comprehensive use of their knowledge and skills.

Shifting Roles for Clinicians

Implementing an EBP brings with it a series of requirements that have typically not been found in agency outpatient settings. In *IY*, clinicians collect both pre- and post-data on client behavior. These data are tracked and submitted for evaluation. In traditional practice, clinicians tend not to be this involved with obtaining data from clients on a systematic basis. However, thorough collection of client data is indispensable in determining effectiveness of the program. This knowledge is essential for internal program assessment and, frequently, for reporting to funders.

Another aspect of working within the *IY* framework that differs from more traditional clinical work is the process of practitioner certification. Practitioners are oriented to an *IY* program during a three-day training, but in order to be certified as group leaders, they must complete a videotaped supervision process wherein

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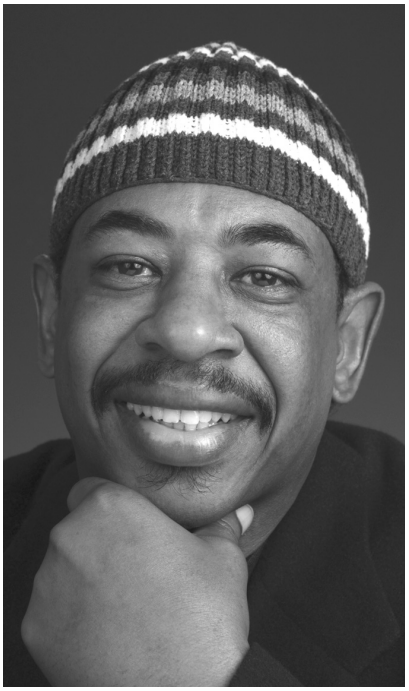

they receive feedback from the developer about their use of the model. This is likely a new experience for clinicians. Researchers affiliated with the developers of *IY* have analyzed data showing that agencies with practicing certified group leaders are most likely to have the best outcomes from the program.

Clinicians are also introduced to the idea of implementing EBP "with fidelity," meaning that they must demonstrate that their practice complies with the guidelines of the model. In the *IY* programs, clinicians complete a Group Leader Checklist each week, indicating whether or not they have presented each element of the curriculum for that week's session. Additionally, at the fourth and eighth weeks, co-leaders complete a Peer- and Self-Evaluation form, reviewing both their own and their partner's delivery of the curriculum. At Morrison, we have also instituted an *IY* peer review group, where clinicians meet in a supportive setting to share strategies, problem-solve challenges, and present videotape reviews of classes to gather specific feedback. These practices, in addition to ensuring fidelity to the model, can also lead to a more sustained and thoughtful reflection on one's own progression toward mastery of the curriculum.

Finally, because an EBP is usually a manualized treatment, clinicians may assume that it is simplistic—that "anyone can do this." In fact, what we have discovered with the *IY* programs is that this EBP requires both skill and creativity to implement. Clinicians must bring their existing group therapy skills, and parenting and child development knowledge to bear during their work with *IY*. They will also need to learn new skills, such as how to facilitate videotape reviews of new tools during class, how to conduct role plays to support clients' rehearsal of new behaviors, and how to problem-solve the challenges clients encounter with their weekly home activities. Group leaders will be managing these clinical tasks while also tracking the weekly checklists, phone calls, client feedback, and homework reviews required between classes. Integrating the entire repertoire of skills creates new learning challenges and growth opportunities for clinicians.

Clinician and Client Benefits

Benefits for both clients and clinicians are clearly emerging from Morrison's implementation of this particular EBP. Our client data show significant improvement after completion of the program. Parents consistently report a decrease in feelings of isolation and increases in support, skills, and feelings of community. This is illustrated by the story of one client family that was mandated to participate because of their involvement with child welfare services. While the family was participating in the *IY* program, the Morrison group leader called child welfare twice with concerns about child safety. The family, while aware of the calls, continued to participate in the entire 14-week series. In fact, the family called the group leader several times after the close of the series to report their progress with the child.

Clinicians also report success with and enjoyment of the *IY* curriculum. Many relate that, particularly after becoming certified group leaders, they are encouraged to consider how to tailor and enrich the program, within the essential framework, to further meet the individual needs of each client. The programs require as one of their central elements of practice that group leaders take a collaborative, non-expert-based stance toward clients. Many clinicians find that this dovetails with their own preferences for a client-centered or strengths-based approach to families. Finally, Morrison's implementation of the *IY* programs has created a shared language and practice. Using a common model generates an atmosphere of collective thought and work. In sum, it seems that we as clinicians have a parallel learning experience to the families with whom we work— supporting each other as a community in the use of new tools and skills for the benefit of those in our care.

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PARENT AND CLINICIAN COMMENTS

"… the things I learned in the Incredible Years *class helped me to create a more peaceful home. I am enjoying my children more because of it."*
—IY *parent*

"In using Incredible Years*, I can state with confidence to a parent that 'this has been researched and found effective as a way to treat the problems you are experiencing with your child.' In one sense, it backs me up."*
—Morrison IY *group leader*

"I had several families who took the class as a prevention class. Through the weeks, they became treatment-ready for outpatient family therapy. Each of the three families, whom I subsequently treated, reported fewer behavior problems and greater satisfaction with parenting their child. As a clinician, it was very satisfying to work with them."
—Morrison IY *group leader and family therapist*

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Implementing *Incredible Years*: Implications for Supervisors and Administrators Working with an Evidence-Based Practice

In our experience working with the *Incredible Years* (*IY*) programs at Morrison Child and Family Services, implementing an evidence-based practice (EBP) requires not only a shift in clinical practice, but also shifts in supervisory and administrative practices. For an EBP to be successful, it is crucial that the supervisory and administrative staff understand and support the implementation at multiple levels. First and foremost, this requires being informed about the clinical and logistical requirements of implementing the EBP with fidelity. For instance, it is common for staff roles to change, for initial and ongoing training to be required, and for time commitments for implementation to differ from past practice.

Recruiting and Hiring Clinical Staff

As we gained experience with *IY*, we honed our approach to recruiting staff. We found we could not depend on hiring staff with previous experience using *IY*, since experience using the model is still relatively rare. Instead, we identified the core skills required by clinicians to be successful with *IY*. For instance, because *IY* is a group model, applicants with solid group treatment skills or experience leading parenting groups are often strong candidates. Also, Morrison implements *IY* parent classes in community childcare centers. Group leaders market and recruit for the *IY* program from these centers. Therefore, hiring staff experienced in marketing and promoting groups has been a key to our success. Finally, staff members experienced in providing services in community settings (versus office-based services) are assets to the program.

When interviewing candidates, we found it vital to clearly describe the expectations of the EBP. The candidate must understand the training requirements, fidelity monitoring, and credentialing expectations. Candidates are often unprepared for this type of practice. Many candidates are accustomed to practicing in a manner that is driven only by clinician choice. While some candidates are enthusiastic about using an EBP model, others will not find this to be a good fit.

Training and Ongoing Consultation

Implementing *Incredible Years* has also meant that supervisors and managers at Morrison take an active role in planning initial EBP training for the staff, as well as arranging and assuring follow-up consultation. Since the initiation of *IY* implementation, Morrison has sponsored yearly trainings and consultation days. This accommodates the initial training needs of new Morrison staff and allows us to share training opportunities with community partners.

Following the initial training, Morrison provides expert consulta-

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tion at several levels. First, we have established an ongoing dialogue with the developer of *IY*, Carolyn Webster-Stratton. This dialogue occurs in a variety of ways, but has included phone consultation, on-site consultation by the developer's staff, e-mail exchanges, and attendance at consultation days sponsored by the developer. Additionally, *IY* offers a certification process for group leaders to receive direct supervision from Dr. Webster-Stratton or her staff through the review of video-taped group sessions. At the completion of the process, group leaders receive a certification that indicates that they are implementing the model as the developer intended and can expect to achieve similar results.

Consultation with the developer has been a useful strategy for solving questions about implementing with fidelity. Initially, this approach allowed the team to avoid disagreements about how to define fidelity to the model and what sorts of adaptations were allowable. The suggestion to "talk to Carolyn" was a common refrain when we encountered implementation puzzles. Typically, talking to Dr. Webster-Stratton allowed us to see possibilities for resolving the difficulties using the curriculum as it was written. If needed, she and her staff would assist us in making an adaptation.

In addition, *IY* offers an advanced certification called a "Mentor Certificate." This permits a mentor to train and support staff in the agency. A Morrison *IY* group leader has completed this process. Subsequently, Morrison created a position for the mentor role. The mentor will train staff and provide coaching for experienced and beginning *IY* group leaders. This will enhance tremendously Morrison's ability to maintain and further improve *IY* implementation locally.

Finally, Morrison employed a local expert on group therapy to consult regularly with the *IY* team. As a group model, *IY* assumes a level of group facilitation skill. Augmenting clinical skills with training from a group therapy expert has been valuable. In addition, this expert assisted us on other aspects of implementation, such as recruitment and retention of group members.

New Roles

In addition to the mentor position discussed above, the implementation of *IY* on a large scale also prompted Morrison to create new staff roles to manage logistics related to offering the groups. For example, in order to decrease barriers to attendance, Morrison holds many parenting classes in local childcare and education sites throughout the metropolitan area. Dinner and childcare are provided for each group. It was necessary to hire people to organize these essential, supportive components. The hiring, training, and supervision of a large childcare staff is an ongoing responsibility.

In summary, embracing an EBP has spurred the development of new roles and responsibilities for supervisors and administrators, as well as clinicians. Recruiting and hiring practices have shifted, and there has been an increased supervisory focus on assuring initial and ongoing training, monitoring fidelity, and promoting certification.

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CONFERENCE ANNOUNCEMENT

TRAINING INSTITUTES 2008:
July 16-20, 2008, Nashville, TN.

Developing Local Systems of Care for Children and Adolescents with Mental Health Needs and Their Families: New Directions to Improve Outcomes

Event Description

In-depth, practical information on how to develop and operate systems of care and how to provide high-quality, effective, clinical interventions and supports within them. Special focus on three "new directions" to strengthen systems of care and improve outcomes, each comprising a distinct track: Implementing a Public Health Approach, Partnering With Schools, and Partnering With Child Welfare.

Contact Information

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Implementing *Incredible Years*: An Evaluation Perspective on an Evidence-Based Practice

Morrison Child and Family Services' implementation of the *Incredible Years* (*IY*) programs has been supported by the agency's internal evaluation department, which conducts ongoing evaluations for all of Morrison's programs. When Morrison began implementing *IY* in 2004, we evaluators expected our roles to shift, with more emphasis on fidelity monitoring and less emphasis on outcomes reporting. In fact, as we gain experience with *IY*, we are finding that is not necessarily the case.

We are fortunate to have had federal and local grants that provided us with enough resources to evaluate the program thoroughly, by measuring both fidelity and client outcomes. Having these resources gave us the flexibility to experiment with how to distribute our time between fidelity monitoring and measuring outcomes. It also supported our evaluators' efforts to be more involved in the day-to-day tracking and collecting of data.

What is Fidelity for *Incredible Years*?

Fidelity for *IY* is assessed in the following ways:

Group Leader Checklist. Group leaders review and complete a checklist customized to track the content and process of each unique weekly session. These checklists track the number of video vignettes shown during sessions as well as what "Did I's" were completed (i.e., "Did I review parents' goals?" or "Did I role play the play skills?"). For the current Morrison evaluation, these checklists first are submitted to the program's clinical supervisor for review and then to support supervision, and finally submitted to the evaluator for analysis. Currently we have Group Leader Checklist data analyzed for ten *IY* basic groups, two *IY* advanced groups and three *Dina Dinosaur* groups. (*Dina Dinosaur* is a problem-solving and social skills group curriculum for young children experiencing behavior problems.). Overall, program staff are in compliance with 92% of the required checklist items.

Cargiver evaluations. Caregiver participants complete evaluations of every group session. This provides an opportunity for group leaders to receive ongoing feedback from participants about their experiences with the group process. Weekly and final evaluations are collected and monitored by both the clinical supervisor and program evaluator. Since *IY* groups were started in the spring of 2004, 98% of participants have reported that they are satisfied or very satisfied with the *IY* programs at Morrison.

Group leader certification. Staff can pursue certification from the program's developer. To become certified, staff must submit at least one video-taped session per group series, peer and self evaluations, and all of

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the fidelity paperwork listed above. Morrison currently has six staff certified in the *IY* basic parent series and two staff certified in the *Dina Dinosaur* child series. One staff member has become a certified mentor, which means she may offer authorized trainings to Morrison staff and provide mentoring for their groups.

What We Thought We'd Be Doing

As evaluators, we initially expected to monitor the collection of fidelity measures, but in fact, that role was taken on by the clinical supervisor. The clinical supervisor uses case-specific information from the fidelity measures to provide real-time course corrections to the therapists as they learn to implement a complicated package of protocols. Morrison is fortunate to have a program supervisor who understands how important the data collection and feedback loop are for the successful implementation of the model.

We also expected that we would be asked to calculate how well each group leader was performing on the fidelity measurement tools. Instead, the developer tracks the fidelity measure compliance percentage as part of each group leader's certification process. If there is a period of time when no group leader is working towards certification, this may require more fidelity compliance tracking by the evaluation team. In any case, the clinical supervisor will still be using fidelity forms as part of supervision and will continue to monitor fidelity so as to guard against drifting from the model.

What We Actually Did

This left the internal evaluation team time to evaluate outcomes, which is increasingly a requirement of funders. One of the advantages of implementing a program that had been thoroughly researched was that we could adopt a simple evaluation model using similar evaluation protocols. We knew what change to expect and what instruments to use to measure that change. For *IY* we specifically selected the Intensity Scale of the Eyberg Child Behavior Inventory (ECBI) to measure children's problematic behaviors and the ECBI Problem Scale to assess parents' ability to manage those behaviors, because the ECBI has been consistently used in evaluations and replication studies of the *IY* model. Data have been collected from group participants since the spring of 2004. Table 1 shows the mean pre- and post- scores for each scale as reported by parents and primary caregivers who completed an *IY* basic or advanced group series. Parents and caregivers reported significant improvements in both their parenting efficacy and their children's behavior.

TABLE 1: PARENT/CAREGIVER ECBI RATINGS

ECBI (N=147)	Pre-Intervention Mean	Post-Intervention Mean	Effect Size**
Intensity*	58.27	53.78	.61
Problem*	57.67	51.34	.64

*p<.001

** Effect size is a standardized measure of the magnitude of the difference between two samples, allowing comparison across different variables and sample sizes. Though interpretation of effect size requires consideration of several factors, general qualitative guidelines suggest that an effect size of .20 is small, .50 is medium, and .80 is large.

Conclusion

The expected drastic changes to our roles as evaluators did not in fact occur. While we anticipated that we would have to take on the responsibility of monitoring fidelity, we learned that fidelity monitoring was an essential program component that was mostly carried out by the clinical supervisor and the developer.

For the agency as a whole, there are increased costs associated with collecting fidelity data and using the data for supervision and certification. This leaves fewer resources for examining outcomes. However, we were able to take advantage of the previous research on *IY* to design a simple and cost-effective pre/post evaluation study. It is difficult to know exactly how we will adjust our evaluation strategies when grant funds are no longer available, but more and more of our contracts are requiring both outcomes measurement and fidelity monitoring.

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Family Partners in Systems of Care and Wraparound

Since the President's New Freedom Commission on Mental Health's declaration that mental health care will be consumer and family driven,[1] expectations that systems would be "family friendly" through the involvement of family members have been more emphatically framed. For example, communities awarded federal funds under the Comprehensive Community Mental Health Services for Children and Their Families Program (commonly known as "system of care grantees") are required to have "a strong family and youth voice in all aspects of governance of the system of care, service delivery, and evaluation;" to hire a full-time key family contact with responsibility for advocacy and outreach to other families and serving on governance bodies; to support a family-run organization; and to describe how care will be family driven.[2]

A similar vision of family involvement has been incorporated into the guiding principles for both systems of care and wraparound. As a result, opportunities for family involvement have expanded greatly as wraparound and systems of care have flourished throughout the country. Family members now hold influential positions in the mental health system to an unprecedented degree. They have gained a strong foothold as leaders within the governance, management, and evaluation of mental health systems and practice.

Wraparound is a collaborative team process for creating and implementing individualized, strengths-based plans of care for children and their families. At the practice level, wraparound's first principle of *family voice and choice* explicitly recognizes that the perspectives of family members must be prioritized throughout the wraparound process. The principle explicitly recognizes that families are not likely to have sufficient impact during wraparound planning unless intentional activity occurs to ensure that families' perspectives drive the process and exert primary influence during decision-making. However, experience in communities implementing wraparound has shown that not all teams are adequately prepared and supported to share power for decision-making with the families and youth. Likewise, not all family members are adept at the self-advocacy required to share in decision-making with their wraparound team.

Recognition of this common difficulty has led naturally to the development, within wraparound, of the role of the Family Partner, a peer support and advocate role. This article describes the evolution and current status of the role of the Family Partner within wraparound.

Family Partner Task Force

In the early years of wraparound, communities tried several strategies for using Family Partners to provide a supportive role to families on wraparound teams. In spite of good intentions, many of these efforts were not particularly successful. Lack of clarity about the role and a lack of training and coaching for Family Partners (as well as other wraparound team members) led to confusion and even conflict. Family Partners were not consistently valued as members of the wraparound team. Some, for example, were included only when a care coordinator invited them, others were limited to providing transportation or child care, or were prevented from advocating with the family during wraparound team meetings. Establishing some standardization about the responsibilities, expectations, limitations, and qualifications of Family Partners within the wraparound process became an urgent issue.

In response, the National Wraparound Initiative (NWI)[3] established the Family Partner Task Force in June 2006. Sixteen NWI advisors, predominately family members, agreed to work on creating a description of how Family Partners operate within the wraparound process. Within the first year, the Family Partner Task Force established a work plan, and membership grew to 54. The work plan and progress to date can be reviewed on the NWI website (www.rtc.pdx.edu/nwi).

First, the Family Partner Task Force surveyed its members about

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how they perceived and defined the role. "Family Partner" was eventually selected as the title for this role and key responsibilities and characteristics of the individual who is qualified to fill it were incorporated into a short role description (see sidebar).

Next, believing that the role of Family Partner needed to be firmly grounded in the wraparound principles as well as in the phases and activities of the wraparound process itself, the Family Partner Task Force began to examine how the Family Partner role was shaped by, and also contributed to, operationalizing each of the ten principles of the wraparound process. The resulting document, *The Application of the Ten Principles of the Wraparound Process to the Role of Family Partners on Wraparound Teams* is available on the NWI website (http://www.rtc.pdx.edu/nwi/pbNWI-FamilyPartner10Principles.pdf)

What it Takes

Wraparound Family Partners are parents or other primary caregivers who have raised children with emotional, behavioral, or mental health needs. Their personal experience interacting with various child-serving systems prepares and qualifies them to offer support and guidance to other families so that they can have true voice and choice on their own child's wraparound team. It is also the Family Partner's responsibility to engage with the professional community and, by working closely with these stakeholders, to model collaboration, shared decision-making, and non- adversarial advocacy. Through exposure to these relationships and modeling, the family and youth being served develop the skills to become self-empowered and their wraparound team's decision-making becomes truly family-driven and youth-guided.

A frequently asked question is "Does the person who fills this role have to be a family member first?" The answer is a definitive "Yes!" What distinguishes the Family Partner from other helping roles within wraparound is the emphasis on peer support. Families who have children with mental health needs often feel judged and diminished by a deficit-based system. The Family Partner is *the* wraparound team member who can approach the family as a colleague and peer. Contact with peers gives family members hope, understanding and respect, ample time to explore and reflect on options, and a personal guide along the complex path of getting effective and appropriate supports and services.

Sometimes called upon to offer support, a Family Partner must be a compassionate and empathic person who is an attentive listener. As coach or mentor, a Family Partner must be non-judgmental, reflective, and objective. As someone who educates families, a Family Partner is knowledgeable about policies, systems, and services. As a key player in the wraparound process, the Family Partner displays good verbal skills and accurately portrays the family point of view in many venues.

Ideally, Family Partners are individuals who feel that they have experienced some success navigating their way through the complicated and confusing assortment of requirements and procedures as they sought supports and services for their own child and family. Importantly, the status of a Family Partner's own child should not be a measure of how well an individual can perform in this role. Many Family Partners' children have done extremely well. However, this does not necessarily mean that every Family Partner's child and family have overcome all of their own challenges. Not all systems and circumstances are responsive to even the best advocacy. Unfortunately, some children have been lost to suicide, have landed in jail, or have joined gangs. The desire to help other families can be kindled by poor outcomes. Looking back on their own histories, many family members have keen insights about what is needed to transform services and systems so that outcomes can improve.

Infrastructure and Support

Family Partners cannot work in a vacuum. They require support and supervision just like any other person practicing wraparound. The parameters of the position must be clearly defined and the role must be understood by all the wraparound partners and families being served. A sustainable and appropriate infrastructure for Family Partners is necessary to prevent frustration and failure.

Family Partners' success requires ongoing training for stakeholders, so that there is a shared understanding about the benefits of partnership between families and professionals. New staff may not be familiar or comfortable with the concepts of family-driven care and practice. They will need orientation to this new way of doing business and support to learn how to perform well under these conditions.

There are some questions for which there can be no standard answer that fits every community. Among the most commonly asked are: What is the ratio of Family Partners to Care Coordinators? How many families will a Family Partner be serving? Should there be opportunities for Family Partners to stay involved at a less intense level when a family is no longer enrolled in the wraparound process? And, what is a fair rate of pay for a Family Partner? These and other questions must be

THE FAMILY PARTNER

The Family Partner is a formal member of the wraparound team whose role is to serve the family and help them engage and actively participate on the team and make informed decisions that drive the process. Family Partners have a strong connection to the community and are very knowledgeable about resources, services, and supports for families. The Family Partner's personal experience is critical to their earning the respect of families and establishing a trusting relationship that the family values.

The Family Partner can be a mediator, facilitator, or bridge between families and agencies. Family Partners ensure each family is heard and their individual needs are being addressed and met. The Family Partner should communicate and educate agency staff on wraparound principles and family voice and choice to ensure fidelity.

addressed by each local system. But they cannot be ignored! Importantly, the answers must be consistent with the ten principles of wraparound.

The position of Family Partner can be financed many ways. Contracting with a family organization or hiring families within a public or private agency are the two most common strategies. Regardless of the financing strategy, appropriate supervision must be provided so that Family Partners are able to perform the advocacy function of their role with integrity and without overstepping the boundaries of the wraparound process.

Other Roles for Families in Wraparound

While the role of Family Partner is central to wraparound, it is by no means the only role in which family members can and do function. For instance:

- In Rhode Island, the Family Service Coordinators who facilitate the wraparound process are family members of children who have emotional, behavioral or mental health needs.
- Some wraparound trainers are parents or caregivers of children who have been served through this planning process.
- In Maryland, Patricia Mosby, a statewide system of care trainer and coach, was first served by a Community Kids wraparound team, then became employed as a Family Partner, and subsequently worked as a care coordinator.
- Nanzetta Hatcher, whose child was served by a wraparound team through the care management organization Partners for Kids and Families, became that organization's Quality Assurance Director.
- A family organization in New Jersey requested that a parent be hired for the wraparound evaluation team. The agency in charge of evaluation was hesitant to hire someone whose chief credential was raising a child with mental health needs. Deborah Kennedy, a parent, was nonetheless hired part-time. She was so effective that a full-time position was created for her. When Deborah left to become statewide Family Ombudsman, a parent was hired to fill her evaluation position.

Next Steps

The work to date has provided a solid base from which information, materials, and tools to fully integrate this role into wraparound practice can evolve. Questions that remain to be answered and issues that need clarification or resolution include: How is the Family Partner's activity unique during the engagement phase of wraparound? What does the Family Partner actually do during planning meetings and throughout the planning process? As the plan is being implemented, what are the daily responsibilities of the Family Partner? How are Family Partners integrated into the transition phase? The Task Force's own work plan calls for:

- providing a description of the daily activities of Family Partners and how those activities fit within the four phases of the wraparound process;
- developing a data bank of resources about this role;
- developing mechanisms to link individuals serving in this role with each other to form a learning community;
- developing tools to assess the fidelity and the quality with which individuals are performing this role;
- developing a framework for setting salaries and defining work environment and employment issues;
- collaborating with researchers to formally study the use of this role and its impact.

As it works to address these needs, the Family Partner Task Force is at the forefront of building knowledge about what it takes to create systems of care and wraparound programs that truly deserve to be described as family-friendly.

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Changes at The Bridge: Promoting Family Voice in Residential Treatment Programs

At The Bridge of Central MA, Inc., we have 34 years of experience providing comprehensive human services. As part of our service array, we serve children and adolescents ages 8 to 20 in three residential programs. During the last several years, we have worked to restructure our residential treatment programs, with the goal of providing care that accurately reflects families' goals and concerns. Making these changes has required us to adopt a new perspective about our work, and to learn new practices and procedures.

In the past, our approach was very traditional. We had our set of rules and policies, and we would essentially tell the parents what we thought the treatment plan should be and how the goals should be accomplished. We would ask their opinions, but ultimately *we* would write the treatment plan. It was not really a collaborative effort. In general, we ran our programs based on our own ideas and perspectives, and developed program polices that reflected what we thought.

A New Philosophy

Starting approximately five years ago, we began to question that approach. We began to hear in trainings and at conferences about new ways of working with families. We also heard more about strengths-based approaches and about the importance of helping children develop and maintain connections to their communities, even if they needed out-of-home placement for a while.

It all sounded good, but at first it was just words to us. What really motivated us to start our own change process was when several of our staff members attended the System of Care Training Institutes in the summer of 2006. There, for a week, we were immersed in a new philosophy of care. What made the biggest impression was hearing from families—hearing their stories—and we began to truly see that there were better ways to do our work. During that week, we were surrounded by people who were working in new ways, who were really living their words, and we were inspired. We came home committed to making changes of our own.

There was another piece of motivation as well. Recently, there has been external pressure from state funding agencies, who are encouraging wraparound and family-friendly services. The environment in Massachusetts and our training experiences were exposing us more and more to this philosophy. Through these experiences, we began to fully recognize how difficult it is for a family to place their child outside the home. We began to appreciate the family's perspective more.

New Practices and Policies

In the last year and a half, we have made significant changes within our residential programs. One area where this is particularly obvious is in treatment planning. Our whole approach is different. We work over the course of several meetings to develop a plan

of care with the families. We start with finding out about their vision and goals. The whole plan is built around what family members feel are the outcomes that are most important for them. We also ask about child and family strengths; we talk about what's worked (or not) in the past; and we find out about the family's support system and the people who are there to help them. We do all this with a laptop and a projector, so the family can see the record of this conversation as we're having it.

When we get to the point of creating the plan, we examine areas of concern. Families and staff contribute, and we all talk about what we feel the priorities are. We think about how each one might relate to the family's vision. Everyone explains their thinking, but ultimately we defer to the parents if there is a disagreement.

We've changed policies and procedures in a number of areas, based on feedback we've received from families. Much of this feedback has come through focus groups with families and with the young people themselves. Some of the things we've changed have been simple, but important. For example, families wanted to know the staff members who are involved with their children and staff roles and responsibilities. So now we are very intentional about making sure that families are able to meet the entire staff team. We've also created a calendar of events to keep families better informed and give advance notice of different activities. We invite family members to go along on field trips and to attend special activities, and we've started a family movie night once a month. As a result of these changes, all family members (including siblings) have opportunities to participate in fun activities rather than having all interactions focused on therapy.

Some of the changes have been bigger from a program perspective. Previously, we had very specific ideas about what kinds of therapy a child would have while he or she was part of our program. We were somewhat rigid in our ideas about what therapy was like, who would be there, how often it would happen. Almost exclusively, therapy was provided by our own staff. Now, we think about it more on an individual level and what will meet a particular child and family's need. If a child and/or family has a therapist that they're working with, we support that, and they can continue to work with that therapist. Such relationships can be important for maintaining continuity of care and community-based support.

We've also made big changes in how we look at home visits. Passes for our young people to spend time at home with family used to be based on a points and level system. A child would have to earn a pass through good behavior. Now, families have much more say in that. We collaborate with them, and our focus is on "What can we do to be sure that the visit will be successful?" It is not about the points and level system any more.

Changing Roles

The responsibility for putting these changes into practice has really fallen on our program managers and clinicians. It is a challenge to learn how to work with families in a positive and collaborative way. The whole focus of these roles has changed. Rather than just dictating, the role now centers on stimulating ideas and options. On the whole, our clinical staff has adjusted well. There are definitely more demands and more meetings, but there is also a strong feeling that this approach makes their jobs more productive. We get better results when we are working collaboratively with families rather than just telling them what we think is best.

Some of the direct care staff struggle with working in a more collaborative way. Many of them are very young—just out of college—and often they don't have families of their own. Sometimes it is not easy for them to connect with families or be sympathetic to their perspective. We are persistent in reminding them that this is the way we work. We offer training and supervision, but if staff aren't willing to be open to this way of working, they are welcome to look for work elsewhere.

We are committed to this new philosophy of care, and we believe that it is working out better for everyone involved. Of course, there is plenty of room for improvement, and there are further changes we would like to implement, but for which we haven't been able to obtain funding. For example, we would like to hire family partners, but we don't currently have the resources. Despite the challenges, we are excited about what we have accomplished and are eager to continue. Though we don't yet have a lot of solid data, we have experienced reductions in restraints and length of stay. But what makes us most certain that we are moving in the right direction is the affirmation that we have received from our young people and families.

We invite family members to go along on field trips and to attend special activities... all family members (including siblings) have opportunities to participate in fun activities rather than having all interactions focused on therapy.

Based on an interview with Margaret Crowley and Nancy Bishop of The Bridge.

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Early Childhood Mental Health Consultation: A Developing Profession

As a career path, early childhood mental health consultation (EC-MHC) is an emerging and growing work force opportunity. In keeping with the vision of an effective and transformed service system expressed in the final report of the President's New Freedom Commission, states and communities are expanding their capacity to meet the mental health needs of young children and their caregivers through mental health consultation. ECMHC supports children in naturalistic community settings, avoids the excessively "expert" attitude,[9] and works through collaboration with families and other providers who care for them. In addition, there is growing experience and research evidence[6] to suggest that ECMHC is an effective service that, from a public health perspective, promotes social and emotional development and prevents or reduces the impact of mental health problems in young children.

The early childhood mental health consultation workforce is in transition from one of broad diversity in terms of training, experience, roles, responsibilities, and work expectations to one that has specific expertise in early childhood mental health and the specific skills required to take on the role of consultant. The purpose of this article is to support the development of a transformed workforce with the attitudes, knowledge, skills, and behaviors to work as early childhood mental health consultants in a changing children's mental health field.

Defining ECMHC

ECMHC includes culturally sensitive and *primarily indirect services* for children birth- through- six in group care and early education settings. Indirect services include building capacity among staff and family members, observing children and the caregiving environment, and designing interventions that involve changes in the behaviors of caregivers. ECMH consultants collaborate with administrators, staff, family members, and caregivers who intervene directly with children in group care, early education, and/or home settings. ECMHC is intended to promote social and emotional development in children and to transform children's challenging behaviors. Two types of consultation are: (1) child- or family-centered consultation to address factors that contribute to a child's (and/or family's) difficulties in functioning well in the early childhood setting, and; (2) programmatic consultation to improve the overall quality of the program or agency and/or assist the program to solve issues that affect more than one child, staff member, and/or family.[3]

Illustrative Scenario

Since moving to a new childcare classroom, Robert cries and disturbs other children during naptime. He does not eat very much and does not seem to enjoy classroom activities. At Robert's teacher's request, the mental health consultant visits the center to observe Robert at various times during the course of a day. The consultant also assesses the quality of the interactions in the classroom between Robert and the other children. The consultant then meets with Robert's parents and discovers that Robert's mother's new work schedule causes frequent disruptions in the family routine. The consultant helps both parents and child care staff to understand Robert's behavior and helps them develop new strategies at home and in the classroom so that Robert develops a sense of predictability. By observing and encouraging communication between staff and parents, the consultant helps Robert's caregivers implement strategies to help him adjust to change (child- or family-centered consultation). In addition, the staff improve how they transition the entire class from lunch to nap time and, as a team, respond to special needs of individual children (programmatic consultation).

What is the Need?

There are a number of compelling reasons for supporting, training, and utilizing consultants. Perhaps most prominent of these is the growing number of very young children who are exhibiting social-emotional problems and who are spending significant amounts of time in non-parental care in early childhood settings. Recent research suggests that expulsion rates for children in preschool far exceed expulsion rates for children in K-12.[5,7] In a national survey of pre-kindergarten programs, Gilliam[5] found that teachers who had access to an ECMH consultant were less likely to expel children than teachers who did not have a mental health professional available to them. ECMHC

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may also decrease child care provider stress and high rates of job turnover by enhancing caregivers' abilities to successfully manage difficult behaviors and promote positive social-emotional development.[1] Decreasing turnover also supports the continuity of care essential for children's social-emotional development. Further, it is important to note that ECMHC may help to identify and ameliorate challenging behaviors before serious problems emerge, thus reducing the need for more costly and specialized intervention services later in life. However, at this time, many early childhood educators do not have ready access to a mental health professional for information, resources, or support.[5]

Competencies and Preparation

At the core, consultants must have knowledge of child development, formal preparation in children's mental health, and experience working with young children and their families. In order to assist early care and education staff with identifying and addressing atypical behaviors in young children, consultants need to have knowledge of and experience with child developmental milestones, early childhood education and early intervention systems.[3,4] Consultants should have a strong foundation in early childhood mental health best practices, so they can: (1) support program directors and staff with developing a mental health program philosophy and a shared vision of mental health services, and; (2) help implement strategies to promote social and emotional development and reduce challenging or troubling behavior.[8] In addition, consultants should have knowledge of family systems and feel comfortable working with parents of children enrolled in early childhood settings.[3] Finally, consultants must have a deep understanding of how cultural and linguistic diversity contribute to perspectives on child development and child mental health.

In addition to these professional competencies, consultants must possess the skills that enable them to work in collaboration with families and early care and education staff. Thus, consultants should be able to:

- recognize and build upon the strengths of early childhood staff and families, thereby avoiding an "expert" stance;
- use facilitation skills to encourage communication and interaction among early care and education staff and families;
- employ coaching and modeling skills to encourage shared problem solving; and,
- become an integrated part of the early childhood program.

While consultants often enter the field of ECMHC with a strong foundation in mental health, some beginning consultants may lack knowledge and experience in early childhood and/or be unfamiliar with the consultative approach. Additional training, supervision, and support are needed to help them develop the range of skills and broad knowledge base that are necessary to be effective in the consultant role. A variety of approaches currently exist for training and supporting consultants. Some states investing in ECMHC, such as Colorado, Michigan, and Ohio, offer systematic in-service training to early childhood and mental health professionals to prepare them to be consultants. A few well-established ECMHC programs, such as Day Care Consultants in San Francisco, CA, have created intensive pre-service training modules for all beginning consultants. Several colleges and universities, including Portland State University and Wayne State University, have begun to develop certificate or credentialing programs in early childhood mental health that include training specific to consultation. Models for training consultants are in various stages of development, so research should focus on determining the necessary components of training, supervision, and support for developing and maintaining effective consultants.

How Effective is ECMHC?

The evidence base is building for the effectiveness of ECMHC. Searching for published and unpublished research and evaluation studies, reviewers found 28 studies that were reported in two recent research syntheses addressing outcomes for children and families,[10] and staff and programs.[2] One challenge of conducting these reviews was the absence of a clearly-defined consultation model in nearly all of the investigations.

Perry and her collaborators[10] found that children in classrooms receiving consultation generally showed more improvement in social and emotional development, and greater decreases in problem behavior, than did children in no-consultation comparison groups. However, these reviewers found that results for families were more mixed; while there was some evidence of improved parent-staff communication, greater access to mental health services, and more positive child-parent interactions with consultation services, no changes in parenting stress were detected.

Brennan and her review team[2] found generally positive outcomes for

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staff, with evidence that consultation improves their feelings of competency and effectiveness, and increases their attunement to the needs of children. Decreases in staff stress were found in several studies, but this finding was not replicated in a recent well-controlled study of consultation.[6] Finally, programs were found to benefit from ECMHC in multiple studies that reported lower staff turnover and fewer children expelled for behavior.

What Comes Next?

Professionals trained in early childhood mental health are in increasingly greater demand. Simultaneously, states are investing heavily in ECMHC as a promising intervention by creating funding initiatives using state general revenue dollars and through the creative use of federal funding streams such as Medicaid, TANF, special education, public health, maternal and child health, mental health, child welfare, and childcare block grants. An informal survey of states conducted by one of the authors found funding that ranged from $200,000 for several pilot sites to $5 million for a large, state-wide effort. While most states still struggle with the difficulty of paying for ECMHC without a designated "client," a patchwork approach to funding has worked for some.

ECMHC is at the brink of becoming an evidence-based practice, but further evaluation and research are needed. Data are essential to inform the decisions that states, communities and programs make about many aspects of ECMHC and workforce preparation. Such data can answer important questions such as:

- Who is best suited to be an effective consultant?
- What education, competencies, skills, and ongoing training and supervision are needed?
- What components of the model lead to the best outcomes?
- What level of intensity and duration of ECMHC is required to achieve positive outcomes?
- How do we measure the qualities that define a good relationship between the consultant and caregiver?
- Are there disparities among the children being identified for intervention?
- Do consultants have adequate cultural and linguistic competence to work in our diverse nation? And if not, how can we equip them with necessary knowledge and skills?

ECMHC is consistent with the transformation goals set by the New Freedom Commission and embraced by many state agencies. Reducing expulsion from preschool, enhancing the skills of the early care and education workforce, and helping families grapple with the challenges of raising a temperamentally difficult child are all in a day's work for early childhood mental health consultants. Let's learn more about what makes this important role most effective.

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION: AN EVALUATION TOOL KIT

For states, communities, agencies and programs investing in early childhood mental health consultation and committed to quality data

This web-based resource combines a brief review of the literature and current research addressing the effectiveness of early childhood mental health consultation with guidance for designing and implementing program evaluation. It will help states, communities, and programs increase their capacity for high-quality evaluation of early childhood mental health consultation in community-based settings. Researchers, policy makers, and program evaluation teams will find:

- A brief review of the evidence base, current issues, and questions;
- Defining characteristics of early childhood mental health consultation;
- Components of high quality evaluation and sample logic models;
- Evaluation tools to measure both process and outcome, including outcomes for children, families, staff, and programs; and
- Guidance for using evaluation data for improving programs and communicating outcomes.

The Toolkit is available at:

http://www.rtc.pdx.edu/pgECMHCToolKit.shtml

Developed collaboratively by:

Georgetown University, National Technical Assistance Center for Children's Mental Health
http://gucchd.georgetown.edu/programs/ta_center/index.html

Johns Hopkins University, Women's and Children's Health Policy Center
http://www.jhsph.edu/wchpc/

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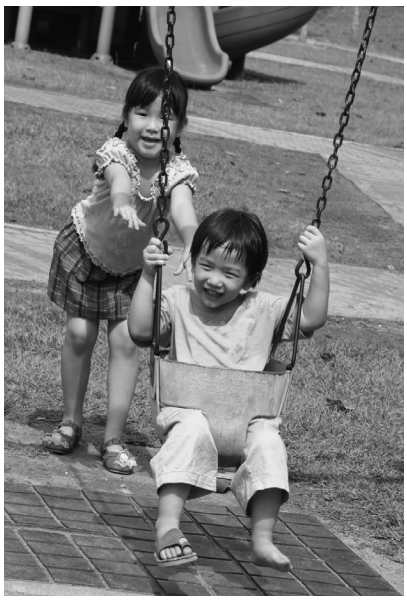

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It Takes a Village: *MST* from Multiple Perspectives

Evidence-based programs (EBPs) differ from traditional therapeutic approaches in several ways. For example: 1) Interventions used are grounded in sound empirical research that has demonstrated their effectiveness; 2) Therapists practicing the models are held accountable to practicing with high fidelity; and 3) Supervision of these models is often layered, involving a site supervisor as well as supervision from a model expert or consultant. Depending on the individual, working within an EBP can be viewed as either confining or freeing; it's all a matter of perspective and personal preference.

One of the EBPs that we work with is *Multisystemic Therapy* (*MST*), a model designed to treat youth who have mental health needs and are involved in the juvenile justice system. While the "typical" *MST* consumer is a youth exhibiting delinquent behaviors, it is accepted that many times these youth are suffering from mental health issues that also drive their acting out behaviors either directly or indirectly.

MST is an intensive family- and community-based treatment that views individuals as living within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. *MST* strives to promote behavior change in the youth's natural environment, using the strengths of each system to facilitate that change. *MST* is designed to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers. *MST* also works to empower youth to cope with family, peer, school, and neighborhood problems. Intervention strategies include strategic family therapy, structural family therapy, behavioral parent training and cognitive behavioral therapies.

One of the greatest benefits of working within the *MST* model is the cohesive and supportive team environment. An *MST* team consists of at least two and at most four therapists and one supervisor. Additionally, a consultant is often considered as part of the team. Weekly supervision and consultations are conducted in a team setting. This structure requires a trusting, challenging, and fun team environment in order to effectively encourage growth and retention of *MST* therapists.

Supervisor Perspective: The Importance of Fidelity

Within *MST*, like other EBPs, the standard activities involved in supervision and team building happen within the context of model fidelity. Each therapist receives detailed supervision and consultation on each case weekly in order to ensure adherence to the model. The intensity and directiveness of supervision, along with the high accountability for outcomes, makes the therapist's fit with the model paramount to its success. Progress is monitored using fidelity instruments, measures designed to determine the degree to which therapists are adhering to model principles on a session-by-session basis. It is the supervisor's responsibility, working closely with the consultant, to see the strengths of every therapist and to build on those strengths in order to maximize adherence. The most concrete way this happens is through the clinician development plan.

Effectiveness as an *MST* therapist is measured through multiple sources; it is the supervisor's responsibility to gather the data and present it to the therapist in a manner that minimizes defensiveness and maximizes buy-in to the goals of the development plan. Data are collected monthly from adherence measures, sessions that the supervisor has either observed or listened to on tape, observation during supervision and consultation, and from evidence of ability to engage families. The therapist and supervisor look at the data together, and based on it write goals for the month in order to increase adherence. This is a very similar process to what happens

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when therapists do weekly paperwork on their families. When done correctly, it provides the therapist with a wonderful opportunity to experience the *MST* process from the family's perspective.

Recent research on the *MST* Therapist Adherence Measure (*MST*-TAM) has demonstrated that adherence to the *MST* model impacts the outcomes experienced by families—higher therapist adherence leads to more positive outcomes for families.[1] For this reason, therapist performance on fidelity measures is an important consideration in each and every session and intervention. Fidelity measures traditionally measure what are considered to be indicators that the therapist is abiding by the model principles. For instance, average number of sessions per week/month, perceived compatibility of therapist and family goals, and implementation of interventions that match model principles are periodically measured through interviews with the families. These interviews yield data that provide supervisors and consultants with information regarding areas of strength and need for individual therapists as well as for whole teams. Scores yielded by these measures are often tied to eligibility for wage increases and are based on the perception of the family receiving the services, making the use of fidelity measures a source of either added stress or added security for therapists.

The supervisor follows a similar process with the help of the consultant. Every other month each therapist fills out a Supervisor Adherence Measure (SAM) and the resulting data along with team outcomes, turnover rates, team TAM scores, and recordings of supervisions are compiled. Together, the supervisor and consultant use the data to identify supervisory strengths and needs and write goals based on the assessment. While this process may feel overwhelming at the beginning, effective supervision and team culture reinforce that this process is intended to be supportive rather than punitive.

Professionals choose to be *MST* therapists because they want to work within a well-researched model and want to provide effective services to challenging families. The most successful way to avoid therapist burnout is supervision because it demonstrates to the therapists the effectiveness of their work. Feedback that uses outcomes and builds on the strong work ethic and the desire of success for their clients is used to motivate, challenge and reward therapists. When the team approach is consistently demonstrated to be supportive of and empowering to therapists, much of the resistance to supervision and consultation dissipates and therapists are left open to the guidance that will allow them to provide the most effective therapy of which they are capable.

MST FAMILY MEMBER PERSPECTIVE: "IT'S THE ENCOURAGEMENT THAT HELPS THE MOST"

The number one thing I thought was different with this treatment is that you weren't judgmental, and you didn't take sides. You didn't focus just on me or on Alison; you focused on the family. In other counseling they would just focus on the kids and I didn't get any help out of it in how to parent. They made me feel like I was a bad person. They would blame me for everything, but they wouldn't show me how to correct it. Parents need to know how to discipline their kids instead of doing things the wrong way like I was doing it. You came into my home, saw what I was doing, and showed me a different way that worked better. You taught me to discipline my kids as teenagers, not as little children.

I could call you or whoever was on call anytime I wanted. I called you for everything: my problems, the kids' problems, and problems with my husband—and you were willing to listen. You were a support not just for the children but for everything. When I was out of control saying, "I'm done. I'm done. I'm done," or the kids were out of control, I would call you. You'd calm me down first, then we would talk about the situation—how to handle it and what to say. You'd guide me on what to say while we were on the phone together. Then what really worked—you used to tell me, "Good job." You made me feel proud of myself and how I handled the situation. You didn't rush through it, like some counselors do. I think you like your job and you're not just here for the paycheck.

You've seen Alison—her lying, not coming home, and she and her sister throwing a big fit. You've seen me at my worst, but you kept me in check and I appreciated that. If you weren't in the house you wouldn't have seen the things that led to fights. What helped, too, is that you took time to make a list of all the free activities that were available in town for us to do as a family and even took the time to go with us to see how we interacted in places like that.

You ate my food when you didn't even know me—I thought that if you were willing to eat my food, I could trust you. You were always willing to go to probation meetings and to court and sit with us. You always told them how good Alison and I were when we were doing good. I think it's the encouragement that helps the most.

I remember one time you stayed four hours to calm us down. You made sure there wasn't going to be a fight after you left the house. And when you were not available, the therapist on call was very helpful. I knew I could count on her, too, because you all work as a team. I knew all the therapists meet in a group to discuss our situation and you've told me that you get together and brainstorm how you can help us. Just like they say, it takes a village to raise a kid. It takes a bunch of therapists to raise a kid, not just one.

-Melissa

Therapist Perspective: "Prepared, Supported, and Excited"

"We've been officially brainwashed," I remember a fellow Mulitsystemic Therapist saying as we made our way out of the 5-day *MST* initial training. I remember thinking, "That's funny, I feel really prepared, supported, and excited!" As with most any experience, the way we approach working within evidence-based models and practices is all a matter of perspective.

The transition from working within traditional therapy models to utiliz-

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ing evidence-based models is often rocky because it requires a 180-degree shift in thinking. Therapists making this shift usually feel inadequate for several months; it's a lot like going back to graduate school and wondering if your chosen profession is really a good fit for you because it's so difficult to grasp the necessary concepts and make it all flow in practice. The therapist is no longer conceptualizing cases and developing interventions independently; these processes are dictated by the model within which they have chosen to work. Each EBP has an analytic process that therapists utilize to determine appropriate next steps/interventions in treatment, and depending on the perspective of the therapist, this devotion to a model of treatment can either feel like a safety net or like a shackle. A common misperception of therapists considering work in an evidence-based model is that the therapy within these models is "prescribed." While a newer therapist might feel that *MST* is scripted and they are not allowed to think "outside the box," a more experienced *MST* therapist will undoubtedly argue that within the model you may use almost any intervention. It was helpful when I was first learning *MST* to think of the model as a guide, like a roadmap—a way to get from A to Z (current state to goal state), all while driving the car of my choice. I knew I had to get to Z and as long as I could demonstrate how I would use model principles to get there, my interventions would be approved and I could hop in my car and begin the journey!

MST works with difficult families. Often the challenges are too much for therapists to manage on their own. Thankfully, one of the greatest benefits of working with *MST* is the cohesive and supportive team environment. The accountability model, when managed effectively, can be one of the most effective methods of building a team. A large majority of therapists new to *MST* have never previously worked in a therapeutic model where they are responsible for outcomes. This gives supervisors an opportunity to frame the focus on outcomes and accountability in any way they choose. If, from the beginning, accountability is explained as the method of achieving the common goal of success for families, the whole process becomes significantly less threatening and shifts to being supportive. Each therapist has the responsibility of engaging the family.

When this is difficult there is a whole team to offer ideas, support, and experience in building on strengths even in the most challenging situation. It is for that reason that positive climate should be a part of regular team discussions and individual therapists should be accountable to their role in developing and maintaining it on their teams.

The most tangible support that both the supervisor and the team can offer fellow therapists is through the supervision process. Often, the families served in *MST* have very good reason to distrust the system and the greatest tools in engaging the family are the ideas offered by the rest of the team. Even after the therapist has effectively engaged the family, they will have blind spots. Just as parents experience blind spots with their own children that an objective therapist can help highlight, the therapist experiences blind spots with a family they are well engaged with. Supervision is the first safety net that ensures those blind spots do not become liabilities in the therapeutic encounter. The consultant is the second safety net to help support both the therapist and supervisor when the supervisor might have blind spots because of his or her engagement with the therapist. When the process is both explained and implemented this way, the majority of the therapist's defensiveness is reduced. Additionally, no one on the team is singled out. For new staff, watching a more experienced *MST* therapist receive feedback can provide both excellent role modeling and comfort, as they know that the feedback is an expected part of the process and does not indicate that they are doing anything wrong. An experienced therapist who can explain to a new staff person, "This is where I started and this is the process that helped get me where I am today," is perhaps the most effective way to decrease defensiveness and feelings of vulnerability on the part of the new staff.

When I began working in the *MST* model I had six years of post-Masters work under my belt as a traditional therapist in residential treatment settings with youth and their families. I was well trained in traditional therapy and I firmly believed in the notion that therapists are not responsible for their clients' lack of progress."People will change when they're ready," is what I was taught and what I believed. It's been a year and a half since my initial 5-day *MST* training; I am now the *MST* and *Functional Family Therapy* (*FFT*) Director at a community mental health center in rural Colorado, and I can't imagine going back to practicing traditional therapy.

Reference

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Melissa* and her family were referred to *MST* by a placement evaluator at Social Services. Permission has been granted by Melissa to share her experiences.

**Name has been changed to protect the privacy of the author.*

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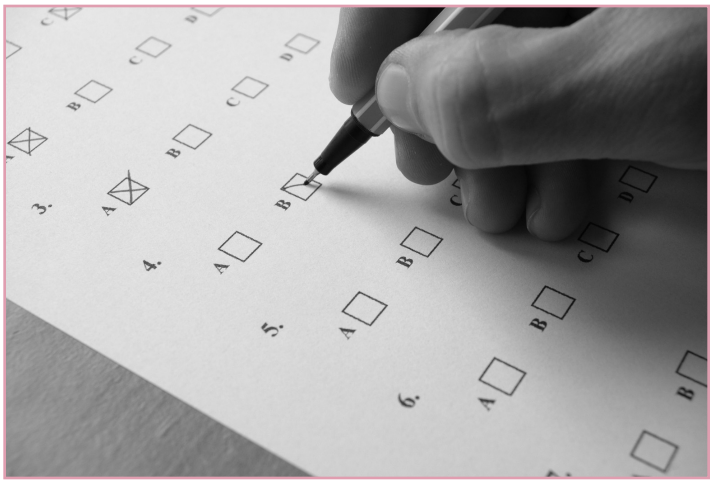

Outcomes: Starting at Home

It is clear that the youth and family behavioral health system is increasingly moving to an outcomes-based system of care. The terms of success have dramatically changed in recent years. In the past, program success was measured in terms of "productivity"—case load size, numbers of clients seen, and numbers of units delivered. Now, with the increased attention to evidence-based practices and practice-based evidence, the success of behavioral healthcare is measured in terms of improvement in quality of life and overall functioning within the context of the family, in the community, with peers, and in school.

This shift in the way that services and systems are assessed has created challenges for providers and funders of behavioral health services, who must now develop new capacity both to achieve and to measure desired outcomes. Research is providing more and more information about practices and approaches that can produce these kinds of outcomes. This leaves providers and funders with two central challenges. First, they must train, support, and sustain a workforce with expertise in the practices and approaches that have been shown most likely to produce desired outcomes. And second, they must develop and sustain processes and infrastructure for measuring outcomes, so that they can ensure that practices and programs that are implemented are in fact producing the desired results. The Ohio Department of Mental Health (ODMH) has developed state-level strategies for addressing each of these challenges.

Centers of Excellence

In 2001, the Ohio Department of Mental Health created a number of Coordinating Centers of Excellence (CCOE). The purpose of the Centers was to focus on a particular practice and/or underserved population, and to bring more to scale interventions found to be effective for improved outcomes. For example, the Center for Innovative Practices (CIP) was created to further facilitate the dissemination of *Multisystemic Therapy* (*MST*). The Center employs *MST* Consultants, who support *MST* teams in 14 communities around the state. Since the Center began its work, the number of *MST* teams in the state has nearly quadrupled.

Based on that initial success, CIP has worked with the state on a number of other home- and community-based initiatives, including the ODMH Resiliency Initiative, and the ongoing development and dissemination of the *Integrated Co-Occurring Treatment* model for youth with co-occurring disorders of mental health and substance abuse. CIP has also provided consultation on the implementation of wraparound, consultation on systems of care development, and the implementation of Ohio's newest service, *Intensive Home Based Treatment* (*IHBT*). Thus, the Center has become the hub for information and dissemination of effective and evidence-based practices within the youth and family behavioral health area of our system of care.

A New Level of Accountability

IHBT is a mental health service that is designed to meet the intensive needs of youth with serious emotional disturbance who are at risk of out-of-home placement or who are returning home from placement. The goal of *IHBT* is to provide the necessary mental health services and supports to enable the youth to live in his or her home in the least restrictive, most normative setting possible. *IHBT* services are provided in the home, school, and community

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TABLE 1.1. OUTCOMES MATRIX AND INDIVIDUAL CLIENT THRESHOLDS

Outcome (Defined)	Method of Collection	Source of Data	Time of Collection	Criteria	Threshold
1) Problem Severity	Ohio Scales	Parent report	Admission (every six months if *IHBT* case remains open) and discharge	10-point improvement on the Problem Severity Scale score (from admission to discharge)	80% of *IHBT* clients meet the criteria
2) Functioning	Ohio Scales	Parent report	Admission (every six months if *IHBT* case remains open) and discharge	8-point improvement on the Functioning Scale score (from admission to discharge)	80% of *IHBT* clients meet the criteria
3) Satisfaction with Services	Ohio Scales	Parent report	Admission (every six months if *IHBT* case remains open) and discharge	Achieve a "7" score on the Satisfaction Scale score at time of discharge	80% of *IHBT* clients meet the criteria
4) Hopefulness	Ohio Scales	Parent report	Admission (every six months if *IHBT* case remains open) and discharge	2-point improvement on the Hopefulness Scale score (from admission to discharge)	80% of *IHBT* clients meet the criteria
5) Whether the child lived in out-of-home placement for more than a total of 14 days during the measurement period.[1]	Supervisor tracking utilizing *IHBT* tracking sheet	Parent report	Admission and discharge	Youth not in out-of-home placement for more than a total of 14 days from time of admission to time of discharge.	70% of *IHBT* clients meet the criteria
6) Whether the child is attending school and getting passing grades in school	Ohio Scales	Parent report	Admission (every six months if *IHBT* case remains open) and discharge	A score of 2 or better on Ohio Scales item #12 from the Functioning Scale at time of discharge.	80% of *IHBT* clients meet the criteria
7) Whether child is living at home at time of discharge from *IHBT*	Supervisor tracking utilizing *IHBT* tracking sheet	Parent report	Discharge	Youth not in placement at time of discharge	70% of *IHBT* clients meet the criteria

[1] Admission measurement for out-of-home placement is for six months prior to admission. This serves as the baseline measurement for each client.

TABLE 1.2. CONSUMER OUTCOMES MEASURED AT SIX MONTHS POST DISCHARGE[2]

Outcome (Defined)	Method of Collection	Source of Data
Whether the child lived in out-of-home placement for more than a total of 14 days since *IHBT* discharge	Agency tracking utilizing *IHBT* tracking sheet	Parent report
Whether the child is attending school and getting passing grades in school since *IHBT* discharge	Agency tracking utilizing *IHBT* tracking sheet, as measured by question #12 from the Ohio Scales Functioning Scale.	Parent report

[2]Consumer outcomes measured at six months post-discharge do not have thresholds.

where the youth lives and functions, and focuses on ameliorating the presenting mental health issues that put that youth at risk of placement while promoting positive development and healthy family functioning. *IHBT* is a family-focused, strengths-based approach that emphasizes parent and professional partnership and collaboration with other agencies and child-serving systems. *IHBT* services strive to be culturally responsive and respectful, and build on the unique qualities and resources of each child and family and their extended support systems. *IHBT* integrates core mental health services (community psychiatric supportive treatment, behavioral health counseling and therapy service, mental health assessment, and crisis response) into one seamless service for consumers. Social services which support the basic needs and functioning of the youth and family may also be provided as needed.

Since 2004, the Ohio Department of Mental Health has been requiring that licensed providers use a tool called the Ohio Scales to measure outcomes and utilize them in treatment. With the new *IHBT* service rule, however, the state has required a further level of accountability.

Providers must collect and submit required outcome data, and must achieve designated outcome thresholds. In addition, *IHBT* providers are required to monitor their fidelity to the *IHBT* standards. Certified programs are asked to collect outcomes at regular intervals—at intake, every 6 months while open, upon discharge, and optionally at 6 months following discharge. Providers are required to meet certification standards and achieve seven specific outcome thresholds in order to continue to be certified to provide *IHBT* services (See Tables 1.1-1.2). Specifically, agencies have three years from the date of certification of *IHBT* to meet all seven thresholds in order to maintain certification. Clearly, this approach represents a quantum leap from merely counting contact hours or other outputs.

The focus on fidelity and outcomes requires agencies that offer *IHBT* to invest additional resources for infrastructure purposes. For instance, there are additional data management costs, additional fidelity and CQI monitoring costs, and additional training costs. This certification is unique since it shifts the focus from productivity to quality and outcomes.

In summary, Ohio has chosen to focus certification efforts on outcomes and standards of care in addition to its efforts to disseminate evidence-based practices for early adopters. This two-fold path supports both agencies who implement EBP's, and those agencies that can demonstrate they meet best practice standards and obtain outcomes over time. One of the intentions in moving toward a standard-based and outcome-driven system is to impact the level of workforce training and skill sets, and ultimately to affect the quality of care and outcomes for youth and families.

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