Statewide Implementation of Child and Family Evidence-Based Practices: Challenges and Promising Practices

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February 2012
Introduction
Adopting and scaling up practices that are empirically proven to be effective in one or more service settings has been a prominent goal across many human service settings. In recent years there has been a growing demand for programs and practitioners to use proven effective practices or “evidenced-based practices” (EBPs). EBPs are defined by the integration of the best research evidence with clinical expertise in the context of patient values, characteristics, culture, and preferences (American Psychological Association, 2005; Institute of Medicine, 2001). The increased focus on using EBPs is in part a result of political demand for human service programs to be accountable—that investment in particular services will result in positive outcomes for youth and children (Cooney, 2007; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

Several Federal agencies have responded to the request as a result of the increased call by policymakers that programs and services increase their ability to be accountable for their practice and show results; these agencies include the Department of Education, Department of Health and Human Services, and the National Science Foundation. They have funded hundreds of scientific research studies designed to develop and test the effectiveness of various human services interventions, programs, and practices producing empirically supported lists of evidence-based practices. In addition, there has been great investment in new Federal requirements, special initiatives, and the provision of technical assistance to States selecting, promoting, and using EBPs in treatment settings (Kazak et al., 2010). For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute of Mental Health (NIMH) both have focused on the integration of EBPs into mental health service systems. They have supported studies, grant programs, and technical assistance on EBPs (Laws & D’Ambrosio, 2007; National Association of State Mental Health Program Directors [NASMHPD], 2005). Many States also have passed legislation that requires the use of EBPs in various human service practice areas, such as education, substance abuse, child welfare, juvenile justice, and mental health (e.g., Lieberman et al., 2009 Lipsey, Howell, Kelly, Chapman, & Carver, 2010.). Consequently, the movement to use EBPs is not only on a local level, but also on a statewide basis. For example, in 2004, 46 States were attempting to implement mental health EBPs for adults and/or children (NASMHPD, 2005) and at least a dozen States are implementing EBPs specifically for children’s mental health (Bruns & Hoagwood, 2008; Bruns et al., 2008).

Successful use of the right EBPs can address a range of social and health-related problems and enhance the well-being of individuals, families, and communities (Cooney, 2007). However, the challenges of successfully using and implementing EBPs as originally prescribed by the research that developed and proved their efficacy (and effectiveness at times), is a shared problem in the human service field (Henggeler & Schoenwald, 2011; Hoagwood et al., 2001; Greenwood, 2008; Gotham et al., 2008; Kazak et al., 2010; Laws & D’Ambrosio, 2007; Plant & Panzarella, 2010; Simpson, 2002). In this brief, we discuss the implementation of EBPs for children and youth on a statewide basis, including the importance, the challenges, and the successes across different fields in human services. We also share two State case examples, Connecticut and Ohio, illuminating the challenges and best practices in implementing EBPs on a statewide basis.
This brief concludes with key points for States to remember as they approach implementation of EBPs on a statewide basis and a list of resources that state administrators might find useful in their efforts.

**Implementation of EBPs: Its importance and challenges**

EBPs emerge from research that empirically supports that a specific program, or practices within a program, will make an impact on a specified outcome, typically using scientific vigorous randomized group experiments and clinical trials. However, most scientific studies are done on a small scale (e.g., within a single program, with a small number of participants, or within a single community), in pilot situations, or in a university lab setting (Hoagwood et al., 2001; Institute of Medicine, 2001), and with samples of individuals who do not experience the co-occurrence of disorders that often are experienced in the field. The conditions under which EBP research is implemented are different than the way EBPs are delivered outside of the research setting or study (Hoagwood et al., 2001). In other words, there is a difference in the **efficacy** of an EBP (how well a program or practice works in an ideal, controlled setting, such as a random controlled trial) and its **effectiveness** (how well it works under real-world conditions—in typical clients, treated by the average practitioner, under ordinary clinical conditions) (Weisz & Jensen, 2001). Thus, implementation is a crucial component of moving the science of EBPs to practice (Fixsen, Blase, Naoom, Wallace, & Panzano, 2005).

There are many challenges taking what we know works well in the human service field under scientific conditions and/or on a small scale and transferring/replicating those practices to other populations and communities. There is a gap between what we know about effective human service practices (our scientific knowledge), and what we know about how to provide those effective practices (our implementation knowledge) on a large scale in the real world (Hoagwood & Johnson, 2003; Institute of Medicine, 2001; Fixsen et al., 2005; Weisz, Sandler, Durlak, & Anton, 2005). Conducting more and better research on the impact of a specific practice is not sufficient to lead to more successful implementation of the practice itself (Fixsen et al., 2005). Implementation is an entirely different enterprise.

Implementation is defined as a specified set of activities designed to put into practice an activity or program of known dimensions (p. 5, Fixsen et al., 2005). Implementation of EBPs is not automatic, and often takes several years to achieve (e.g., Fixsen et al., 2009; Hoagwood et al., 2001; Laws & D’Ambrosio, 2007). It is a multi-step interactive process with several stages and components, including exploration and adoption, installation, initial implementation, full operation, innovation, and sustainability. Several articles have described the activities and challenges faced by providers, practitioners, consumers, and families engaged in implementing EBPs (Bachman & Duckworth, 2003; Dixon et al., 2001; Drake et al., 2001; Hoagwood et al., 2001; McFarlane et al., 2001; Magnabosco, 2006; Hoagwood et al., 2001; Torrey et al., 2001, 2002). Hoagwood et al. (2001) state that the science of EBPs does not often deal with “nuisance

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1 See Fixsen et al., 2005, pp. 15-17 for a full description of their implementation stages and conceptual framework, and Aarons, Hurlburt, & Horwitz, 2011 for another full model framing the key components of EBP implementation.
variables” that are important for implementation in the real world (e.g., State policies, reimbursement structures, staff qualifications, and program availability), and the development and validation of EBPs rarely attend to such variables. The end result is that the selected EBPs are often not adopted with good implementation (i.e., specified and supported activities to put the EBPs in place), and thus do not have the intended effects as expected from the research evidence (Fixsen et al., 2006).

The number of factors and mechanisms that need to be considered, planned for, and then implemented for EBPs to be transferred and successfully implemented statewide has been well documented (e.g., Aarons, 2007; Aarons, Hurlburt, & Horwitz, 2011; Blase & Fixsen, 2003; Chorpita, 2010; Finello, Hampton, & Poulsen, 2011; Fixsen, Blase, Naom, & Wallace, 2009; Franks, Schroeder, Connell, & Tebes, 2008; Ganju, 2003; George et al., 2008; Henggeler & Schoenwald, 2011; Hoagwood et al., 2001; Huey & Polo, 2010; Kazak et al., 2010; Laws & D’Ambrosio, 2007; Liddle et al., 2006; Lieberman et al., 2009; Massatti, Sweeney, Panzano, & Roth, 2007; Martino, 2010; National Alliance on Mental Health, 2007; Panzano et al., 2007; Panzano & Roth, 2006; Panzano & Roth, 2009; Simpson, 2002; Stuart, Sanders, Gurevich, & Fulton, 2011; Wandesman, 2010; Whitaker, et al., 2006; Yannacci, Rivard, & Ganju, 2005). In summary, the literature details these important factors:

- **Governance and Administrative Structures.** This includes developing partnerships and building consensus across an array of individuals, groups, and/or across agencies; the level of State agency influence over State, regions, or county-level programs; whether provider agencies are public or private; State agency regulations and policies; and the capacity and quality of information technology infrastructures to capture data and monitor progress.

- **Organizational Readiness.** This includes State and local level organizational readiness to change and adopt new practices; organizational tolerance for the risk involved in adopting new practices; having clear goals and objectives; having high levels of trust and cooperation among staff; having clear communication about the goals, outcomes, and process of the EBPs; and building a support system to help State and local entities (e.g., schools, coalitions, community-based organizations) to build capacity for effective implementation.

- **Leadership.** This includes recognizing the catalyst(s) for implementing EBPs; ability to share the EBP vision for changing practice equally across agencies and programs; and opportunities for providers and clients to participate and offer input and feedback.

- **Finances and Resources.** This includes having sustainable financing and resources to purchase initial EBP training and supplies; evaluate/monitor fidelity and implementation outcomes; offer ongoing training and incentives to providers; provide time to staff to learn about EBPs and honor contract obligations; and establishing payment parity and/or a reimbursement system to implement new treatments.

- **Practitioners and Supervisors.** This includes recruiting high-skilled and receptive EBP practitioners and supervisors, retaining staff and maintaining low staff turnover, providing consistent and reinforced staff training and coaching, and supporting practitioners with
different backgrounds situated in various organizations. This also includes the ability to include supervision as a tool for helping practitioners apply what they have learned in training.

- **Cultural and Linguistic Appropriateness.** This includes considering a range of circumstances that the people served by the EBPs live within or are affected by. Much of the research that supported the emergence of EBPs may have focused on a specific population, but transferring that knowledge to work consistently and in the same way with other populations is another challenge. Communities struggle to implement EBPs because they are not always applicable or the system is not responsive to the unique cultural needs of various minority populations of children, youth, and families they are serving.

- **Limited Involvement of Youth and Families.** Related to the challenge of cultural relevance, is that families and youth who have been the recipients of EBPs have not been a part of the development of EBPs. Therefore many EBPs are not matched to a family or youth’s specific needs and services are individualized. Service recipients may be concerned that the EBPs may not be relevant to their personal situation, circumstances, and not buy-in or believe the positive aspects of the EBPs, making successful implementation by the practitioner difficult. Most EBPs have not been developed with a balanced approach that includes the perspectives and preferences of children, youth, and families.

**Implementation of EBPs: State Examples**

The move toward statewide EBP implementation is still relatively new, but several States have taken varying approaches to these implementation challenges with initial success (Lieberman et al., 2009). It is apparent, even among States that have had the best success implementing EBPs, that implementation occurs at a slow, diffused, and often inconsistent pace (Laws & D’Ambrosio, 2007; Henggeler & Schoenwald, 2011). Many States explore or attempt to implement EBPs in human services, particularly for children, on a statewide basis, but very few are able to successfully install an EBP to full operation and sustainability. Two States that have implemented EBPs on a statewide basis, made progress towards long-term sustainability, and consistently documented their implementation process are Connecticut and Ohio.

**Connecticut**

Connecticut used a centralized approach to the implementation of Multisystemic Therapy (MST), an EBP developed for children and youth at risk with substance abuse and behavioral problems. In 1997, the State started with a series of small pilot projects, which included local evaluations, to implement MST with youth offenders released from out-of-home placements. The pilots were supported by the central agency responsible for serving juveniles in State custody, the Department of Children and Families (DCF). Since these early evaluations indicated positive youth outcomes, there were State leaders who wanted to expand MST to reach a greater number of high-risk youth across the entire State. Expanding to a statewide scale required a change in State infrastructure and procurement policies, as well as a new system for monitoring MST implementation and quality assurance. Thus, Connecticut built collaborative systems and created coordination bodies between DCF and the Judicial Branch Court Support Services. The Judicial Branch Court Support Services purpose is to support the Judicial Branch by
collaborating with other agencies in enhancing public safety, and assist individuals and families through effective interventions (Court Support Services Division, 2011). These two agencies jointly funded the expansion of this EBP by directly reimbursing contract providers’ organizations for delivering MST. In addition, they funded a single private organization to provide the ongoing staff training, coordination, and quality assurance monitoring to make sure the MST and other EBPs were being provided as intended (i.e., the Connecticut Center for Effective Practice, a division of the Child Health and Development Institute of Connecticut), and to develop the structure called the Learning Collaborative which provides training, evaluation, and quality improvement supports. This organization helped build buy-in from practitioners and increase their willingness to learn new practice approaches.

Connecticut’s approach addressed implementation challenges such as provider readiness, cross-agency collaboration, new system infrastructures, funding, provider training, staff turnover, evaluation, and ongoing monitoring of the implementation process. For example, they learned the need to provide incentives to reduce practitioner turnover and focus the recruiting therapist on key clinical skills and the willingness to learn new approaches. But the State also learned that many implementation challenges are ongoing, such as investing in the development of the provider workforce and providing training of their mental health professionals. They had to make some hard choices on the road to statewide implementation. For example, in terms of sustainable funding, different State agencies had to be willing to let go of control of some of their dedicated funds. Connecticut was willing to take a highly collaborative approach in order to find a successful way both to blend and braid funds from mental health, substance abuse, juvenile justice, and child welfare. They also were willing to re-direct existing funding programs that did not utilize or successfully implement the EBP.

The State of Connecticut realized that implementing an EBP statewide is complex, takes a great deal of time and resources, and requires multiple structures, dedicated supports, and a willingness to change and accept a new way of doing business among all stakeholders. The State also learned that the implementation process of an EBP is ongoing and never complete; collaboration with State organizations, provider agencies, practitioners, and clients is an ongoing relationship that needs attention, support, and patience. But, despite the complexity, the hard work of properly implementing an EBP is worth it.²

Ohio
Ohio approached the implementation of EBPs via a quasi-decentralized approach. Originally, a Governor’s office initiative began by improving and evaluating services for juvenile offenders. It further supported and expanded the initiative with the State’s establishment of the Ohio Department of Mental Health’s Coordinating Centers of Excellence (CCOEs). Ohio then implemented four EBPs statewide (i.e., Multisystemic Therapy for youth, Cluster-Based Planning, Integrated Dual Disorder Treatment for individuals with mental illness and substance abuse, and the Ohio Medication Algorithms Project). The CCOEs were developed in order to

² For more information on Connecticut’s implementation of MST see Franks et al., 2008; Lang, Franks, & Bory, 2011; Henggeler & Schoenwald, 2011; Panzarella, 2011.
create a governance structure that would facilitate the uptake and coordination of EBPs across State departments (i.e., health, child welfare, juvenile justice, mental health, and education). The State provided the initial infrastructure resources to support each center across the State (i.e., time, money, and personnel for information dissemination and technical assistance), but ongoing support is done via contract agreement with local providers. Services are mainly financed through the State’s Medicaid benefit and local mental health board dollar matches. Boards are responsible for matching dollars and administering monies to contracted providers, but they have taxing powers and are able to generate real estate taxes and levy local resources to provide the ongoing support needed. The Center for Innovative Practices also collaborates with a variety of local mental health providers (e.g., mental health boards, universities, clinical practices) to provide quality assurance and improvement systems to the implementation of the State’s four EBPs, as well as general information on effective practices, training, coaching, resilience frameworks, suicide prevention, and evaluation. Ohio’s implementation process includes a research and evaluation project dedicated to examining the EBP implementation process in the State (Innovation Diffusion and Adoption Research Project).

As of 2009, 71 mental health providing organizations have adopted or considered adopting one of four evidence-based practices of which 19 adopted two or more EBPs. Ohio has learned that successful implementation relates to organizations having a tolerance for risk, paying detailed attention to multiple levels during the implementation, including close monitoring of the EBP practice and providing technical assistance, and having ongoing support from top management over the long term. (For more information, see Henggeler & Schoenwald, 2011; Panzano & Roth, 2009; Roth et al., 2005).

Key Points to Remember for States Implementing EBPs
Based on the lessons learned from Connecticut, Ohio, and several other States attempting to implement EBPs statewide (e.g., California, Oregon, Hawaii, Illinois, and Washington), and on research on implementing EBPs, there are five key points for States to keep in mind as they move forward in implementing EBPs.

1. **Be systematic in selecting an EBP.** It is important to take the time to be systematic and thoughtful in selecting an EBP that a) will address the problem that needs most attention, and b) has a high success of being adopted and implemented. Selecting an EBP is a multi-step process that includes the following: developing a comprehensive list of possible EBPs to address the clinical/behavioral issue; evaluating EBPs’ cultural appropriateness and relevance across diverse, statewide populations; determining if the EBP can be logistically applied across various geographic areas; ensuring it is sufficiently operationalized, with key components clearly laid out; establishing methods for ensuring and measuring fidelity; evaluating the EBP on an ongoing basis for good implementation and clinical outcomes; and confirming its usability by staff with a wide diversity of backgrounds (Iowa Practice Improvement Collaborative Project, 2003; Samuels, Schudrich, & Altschul, 2009). It is also important to note that one EBP may not be an answer to all problems; Thus, an array of EBPs, along with additional patience and support, may be necessary to implement appropriately (Lynde, 2006).
2. **Invest in multi-level collaboration.** Be prepared to collaborate horizontally (i.e., across State agencies) and vertically (i.e., from State, to communities, to programs, to practitioners). Successful implementation of EBPs will not work using a top down approach without working systematically with programs and practitioners in the field. Buy-in across various stakeholders at the management level, at the State agency or local program, is crucial for successful implementation. Also, remember to include non-traditional partners, such as higher education institutions, which educate practitioners. In order for practice to change, collaboration and support is necessary for changing organizational infrastructure, shifting organizational climates, and improving organizational readiness.

3. **Implement ongoing workforce development and training.** Practitioners will need to be trained and certified in the EBP. Training and certification is not a one-time event, but an ongoing process that needs to include pre-service, in-service, and certification training in order to achieve change in actual practice. Also, before implementing an EBP, it is important that the available workforce has the essential experience, training, and supervision needed to learn and implement an EBP across a range of populations and geographic regions that represent the State.

4. **Create monitoring and data systems with feedback loops.** It is crucial to have a solid infrastructure in place for ongoing monitoring, evaluation, and measurement about implementation of an EBP that can provide feedback to practitioners, programs, State agencies, and policy makers. This includes data about the fidelity of implementing the EBP, related client outcomes, workforce training and certification, and cost-benefit analysis examining the return-on-investment of an EBP.³

5. **Plan for initial and sustainable financing.** Successfully implementing an EBP requires sustainable financial resources. EBPs are loaded with various costs related to training, supervision, certification, fidelity monitoring, data collection, etc. States will need to think creatively about utilizing various funding strategies, share resources, and be willing to sacrifice. There are three major areas to plan funding: (1) start-up activities to explore the need, feasibility, and installation of the EBP; (2) the direct service provided to consumers by the EBP, including training and incentives for providers to adopt the EBP; and (3) the infrastructure needed to successfully implement and then sustain the quality of the EBP.⁴

**Conclusions**
Laws & D’Ambrosio (2007) wrote that the successful diffusion and adoption of evidence-based programs and practices statewide requires a collaborative effort among State and county agencies, treatment providers, technical assistance providers, researchers and evaluators, and private insurers. Implementation of evidence-based programs and practices necessitates cooperation and support among all entities to facilitate ample financing, organizational readiness, leadership, training and technical assistance, and ongoing evaluation and tracking of client outcomes. A key take-away message when it comes to implementing EBPs on a statewide basis is that a successful initiative will include a multi-faceted approach, be able to overcome

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³ See Aos (2010) for more information about cost-benefit analysis models for EBPs.
⁴ See George et al., 2008 for more information on EBP funding strategies.
multiple challenges, and recognize that the EBP implementation process may not be linear or straightforward. Patience, collaboration, time, and resources are central to implementation success (Fixsen et al., 2005; Henggeler & Schoenwald, 2011; Roth et al., 2005).
Resources

Connecticut’s Community-based Behavioral Health Services
The intent of this service within the Department of Children and Families is to provide the clinical intervention and support necessary to successfully maintain each child in his or her home or community. The goal is to provide a degree of clinical care and supervision in the home and community setting that is appropriate to children discharged from a more restrictive setting (e.g., residential, psychiatric hospitalization), or as an alternative to a more restrictive setting. Practices include: Family Support Teams (FST); Functional Family Therapy (FFT); Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS); Multidimensional Family Therapy (MDFT); and Multisystemic Therapy (MST).

Connecticut’s Child Health and Development Institute (CHDI)
http://www.chdi.org
CHDI is home to the Connecticut Center for Effective Practice (CCEP), a unique partnership of State agencies and academic institutions working to improve the effectiveness of treatment provided to all children with serious and complex emotional, behavioral, and addictive disorders. The overall mission of CCEP is to develop, train, disseminate, evaluate, and expand effective models of practice in children’s mental health and juvenile justice. CHDI also provides resources about implementing EBPs.

Find Youth Info
http://www.findyouthinfo.gov
The Interagency Working Group on Youth Programs provides information, strategies, tools, and resources for youth, families, schools, and community organizations related to a variety of cross-cutting topics that affect youth.

Promising Practices Network (PPN)
http://www.promisingpractices.net
The PPN site features summaries of programs and practices that are proven to improve outcomes for children. All programs have been screened for quality to ensure that they have evidence of positive effects.

National Implementation Research Network (NIRN)
http://www.fpg.unc.edu/~nirn/resources/
The mission of NIRN is to close the gap between science and service by improving the science and practice of implementation in relation to evidence-based programs and practices. They provide resources and technical assistance for the implementation of evidence-based programs and practices in communities and States.
The purpose of the NCWWI is to build the capacity of the Nation’s child welfare workforce and improve outcomes for children, youth, and families. This resource provides links to various tools to help assess an organization’s readiness to explore and implement EBPs in child welfare, substance abuse, and mental health.

The NASMHPD Research Institute (NRI), Inc.  
NRI is a non-profit corporation devoted to issues in the public mental health system. Established in 1987 as a national organization resource to provide leadership and support in the areas of analysis, evaluation, and research, NRI facilitates the application of research findings to the management of State mental health programs. This links to information and reports on EBPs.

Ohio’s Center for Innovative Practices (CIP)  
http://msass.case.edu/begun/CIP/index.html
CIP is a coordinating center of excellence supported by the Case Western Reserve University at the Begun Center for Violence Prevention Research and Education. CIP continues to provide the dissemination of Multisystemic Therapy, one of the leading EBPs for youth with violent and anti-social behaviors and at risk for out of home placement. For more information please contact Patrick Kanary at patrick.kanary@case.edu or 216-368-0160.

Ohio’s Coordinating Centers of Excellence (CCEOs)  
http://www.mh.state.oh.us/what-we-do/promote/coordinating-centers-of-excellence.shtml
CCEOs were established by the Ohio Department of Mental Health to promote the implementation of EPBs and clinical best practices that address critical needs of adults and children affected by serious emotional disturbances and/or mental illness.

Ohio’s Innovation Diffusion and Adoption Research Project (IDARP)  
http://60c839e46aa2b05f44a0545042a9813f1819b245.gripelements.com/what-we-do/plan-and-implement/innovation-diffusion-and-adoption.php
IDARP is a collaborative endeavor involving the Ohio Department of Mental Health's Decision Support Services and the Ohio State University's Fisher College of Business that contributes practical and theoretical knowledge to the field regarding the implementation of evidence-based and other innovative practices by mental health agencies.

Social Programs that Work, Coalition for Evidenced-Based Policy  
http://www.evidencebasedprograms.org/
This site summarizes the findings from rigorous evaluations of programs targeting issues such as employment, substance use, teen pregnancy, and education. Some of the programs have substantial evidence of their effectiveness, while others have evaluation results suggesting their ineffectiveness.
Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-Based Programs and Practices (NREPP)

http://nrepp.samhsa.gov/

NREPP is a searchable online registry of more than 200 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment.

Washington State Institute for Public Policy

http://www.wsipp.wa.gov/topic.asp?cat=19&subcat=0&dteSlct=0

The Washington Legislature created the Washington State Institute for Public Policy in 1983. The Institute’s mission is to carry out practical, non-partisan research—at legislative direction—on issues of importance to Washington State. Current areas of expertise include education, criminal justice, welfare, children and adult services, health, utilities, and general government. They have conducted research and produced several publications on evidenced-based programs including cost-effectiveness and cost-benefit studies.

National Alliance on Mental Illness (NAMI) booklet, A Family Guide: Choosing the Right Treatment: What Families Need to Know About Evidence-Based Practices

http://www.nami.org/Content/ContentGroups/CAAC/ChoosingRightTreatment.pdf

This guide was developed to advise families about EBPs in children’s mental health and to share information on a range of treatment and support options.
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Acknowledgments
We would like to thank Karen Blase (FPG Child Development Institute, National Implementation Research Network); Michael Dennis (Chestnut Health Systems); Robert Franks (Child Health and Development Institute of Connecticut, Inc.); Susan Godley (Chestnut Health Systems); Scott Henggeler (Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina); Emmy Marshall (Prevent Child Abuse North Carolina); Allison Metz (Frank Porter Graham Child Development Institute, National Implementation Research Network); Peter Panzarella (Connecticut Department of Children and Families); and Lilas Rajaee-Moore (Colorado State Judicial Branch) for their suggestions and information needed to put together this paper.

We also would like to thank Ken Martinez and David Osher for their thoughtful reviews.

This brief was developed by the Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) through partial support from the Center for Mental Health Services’ (CMHS) Child, Adolescent and Family Branch within the Substance Abuse and Mental Health Services Administration (SAMHSA). We acknowledge that the information, opinion and commentary in this guide are those of the TA Partnership and do not necessarily reflect those of CMHS or SAMHSA. We gratefully appreciate their generous support for making this brief possible.