

Community Mental Health Settings as a Context for Evidence-Based Practice

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Abstract and Keywords

One avenue for improving access to quality mental health care for children, adolescents, and their families is to provide services in the communities where they live. There has been growing support for the implementation of evidence-based practice in community mental health settings to address the complex needs of diverse young clients. Evidence-based practice encompasses psychometrically sound assessments and empirically supported treatments with appreciation of the culture of communities in which they are provided. This chapter reviews the background of the community mental health movement, describes community mental health settings and the current status of youth evidence-based practices in community care contexts, and explores barriers to and prospects for bringing tested practices for youths into community-based care.

Keywords: community mental health, children, adolescents, youths, evidence-based practice, empirically supported treatment, assessment

Introduction

Over the decades, countless efforts have focused on supporting and improving the mental health of children and adolescents (herein “youths”). One view that has steadily gained traction is that quality youth mental health care is often best provided in the communities where young people live (e.g., as opposed to inpatient psychiatric hospitals, residential treatment facilities, etc.). Here, we briefly review the background of this concept within the community mental health movement, and we characterize some of the current community mental health settings for youth mental health care. We then provide a snapshot of the status of evidence-based youth mental health practices in community settings, followed by a discussion of prospects for more fully integrating evidence-based practice (EBP) and community-based care.

Brief Background on Community Mental Health

Following World War II, there was an expansion of the human rights movement with increased attention to blatant violations of basic human rights, including the rights of those with mental disorders (World Health Organization, 2003). As global awareness of the inadequate living conditions and treatment of individuals in mental asylums grew, the process of deinstitutionalization began. This involved reducing the number of people living long term in state mental hospitals and downsizing and closing some hospitals with the intention of replacing hospital-based mental health services with community-based care. However, in both developed and developing countries, alternative treatment provided in communities was not uniformly immediately available or readily accessible (World Health Organization, 2003).

(p. 624) As an illustration of the shift toward community mental health care for youths in particular, we focus mainly on the process in the United States, the region we know best. Pleas for reform in youth mental health services gained momentum in the United States in the 1960s. In 1963, President John F. Kennedy signed into law the Community Mental Health Act, which authorized federal grants to support the establishment of community mental health centers throughout the country as an alternative to residential care. Following the passage of that law and related historic events (e.g., instantiation of Medicaid, closure of state public mental hospitals) that led to mass deinstitutionalization, consistent themes across calls for action for improvements in youth mental health care emerged. These themes focused on the limited use of mental health services by those in need and concerns about the availability and effectiveness of services provided (Joint Commission on the Mental Health of Children, 1969; President's Commission on Mental Health, 1978; US Congress Office of Technology Assessment, 1986). Several federal initiatives, including the Comprehensive Community Mental Health Services for Children and Their Families Program (started in 1992 and constituting the largest federal initiative focused on youth and family mental health to date), paved the way for services delivered in community settings and laid the groundwork for private philanthropic organizations and state governments to make substantial contributions. Indeed, a recent report indicated that numerous states signed bills in 2014 supporting programs and efforts to serve youth, especially those who are underserved and uninsured, within their communities (National Alliance on Mental Illness, 2014). In addition, there have been numerous class action lawsuits in the United States requiring states to provide community-based mental health care for youths, which have resulted in expansion of services (e.g., Kuhlthau et al., 2011).

There remains a strong international emphasis on the importance of quality community-based mental health care. This is reflected in the World Health Organization's (2001) recommendations to provide care in the community, as opposed to only in institutions such as mental hospitals, to involve communities in the development and decision-making regarding service provision and to monitor community mental health care. Scholarly dis-

cussions of how to enrich community mental health services around the globe continue to take place (e.g., Thornicroft, Deb, & Henderson, 2016).

Community Mental Health Settings

Mental health services delivered in community settings have increased dramatically, particularly since the early 2000s (Wells, Morrissey, Lee, & Radford, 2010). For example, 2.6 of the 2.9 million 12- to 17-year-olds who received any specialty mental health services in 2009 received outpatient care (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Community-based mental health care is provided within government and county-run organizations and private nonprofit and for-profit agencies and clinics, with funding coming from diverse sources (e.g., Medicaid, private insurance, self-pay, as well as city, county, state, federal, and philanthropic programming; SAMHSA, 2012).

There is no centralized, national database on community mental health services in the United States, but the Research Network on Youth Mental Health (also known as Child STEPs [Child System and Treatment Enhancement Projects]), funded by the MacArthur Foundation, collected data for a particularly representative picture (Glisson et al., 2008; Schoenwald, Chapman, et al., 2008). Child STEPs investigators found that most outpatient settings were private, nonprofit organizations affiliated with larger institutions. Treatment modalities included individual, family, and group psychotherapy along with case management. Services were delivered by clinicians from a range of disciplines, including psychology, psychiatry, social work, counseling, marital and family therapy, and psychiatric nursing. Most providers were female (76%) and Caucasian (71%) with a mean age of 38 ($SD = 11$, age range 21–74); 67% held a master's degree and fewer than 10% a doctoral degree, and 60% were licensed.

Youths and families receiving care in community mental health settings are diverse in terms of age, gender, race/ethnicity, culture, diagnosis, comorbidity status, risk and protective factors, and family composition (e.g., Brookman-Frazee, Haine, Baker-Ericzén, Zoffness, & Garland, 2010). The most common presenting problems for outpatient care include disruptive behavior, attention, and mood problems (e.g., Merikangas et al., 2010). Because community mental health centers in the United States are often funded significantly by government programs such as Medicaid, they tend to serve youths and families of lower socioeconomic status than do private agencies (Warren, Nelson, Mondragon, Baldwin, & Burlingame, 2010).

(p. 625) Evidence-Based Practice in Community Mental Health Settings

Evidence-based practice refers to clinical practice and decision-making provided within a context that values the role of the treating clinician and the characteristics, needs, and perspective of clients (see also APA Presidential Task Force on Evidence-Based Practice,

Community Mental Health Settings as a Context for Evidence-Based Practice

2006). As such, EBP has been conceptualized as a “three-legged stool,” integrating research evidence, clinical judgment, and client characteristics (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). While EBP encompasses psychometrically sound assessments and empirically supported treatments (ESTs) (Kazak et al., 2010), concerns have been raised around the vagueness of the “EBP” label and whether the research evidence leg of this three-legged stool is afforded sufficient weight (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013). (For a review of these issues and the debates over both evidentiary criteria and the emphasis on ESTs versus evidence-based principles of change, see APA Presidential Task Force on Evidence-Based Practice, 2006; Forman, Gaudiano, & Herbert, 2016).

Although many support the application of tested practices in youth mental health care (President’s New Freedom Commission on Mental Health, 2003; US Public Health Service, 2000), surprisingly little is known about the actual use of EBP in community mental health settings (Garland, Bickman, & Chorpita, 2010; Garland et al., 2013). However, the limited research on this topic suggests that EBP is not being provided with much intensity or consistency (e.g., Brookman-Frazee et al., 2010; Jensen-Doss & Hawley, 2010; Mitchell, 2011). This may be unfortunate, given findings suggesting that EBP elements are associated with positive effects when used at high intensity by therapists in community outpatient clinics (e.g., Garland et al., 2014).

Various federal, state, and charitable organizations have implemented initiatives to support integration of youth ESTs into everyday clinical services (Chambers, Ringeisen, & Hickman, 2005; Hoagwood et al., 2017). Manualized treatment protocols seem promising for enhancing EST use in community care contexts, particularly when these treatments are delivered using a child-centered, individualized approach with active involvement of clients (Kendall, Gosch, Furr, & Sood, 2008). The focus on effectiveness and implementation research for youth ESTs in community mental health is growing, and numerous studies support their transport to these practice settings.

For example, randomized controlled trials (RCTs) of treatments for youths with disruptive behavior, including *The Incredible Years* (e.g., Menting, Orobio de Castro, & Matthys, 2013) and multidimensional family therapy (e.g., Liddle, 2016), have demonstrated positive effects when implemented in community clinics. Trauma-focused cognitive behavioral therapy (TF-CBT) has also shown beneficial impact in community settings (e.g., Jensen et al., 2014), as has multisystemic therapy for child abuse and neglect (e.g., Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010). In addition, computer-assisted CBT has been associated with positive clinical outcomes for youths with anxiety in the community (Storch et al., 2015). Despite promising results, meta-analytic findings indicated that ESTs originally developed and tested in efficacy trials may show reduced effects when implemented in community mental health settings (Weisz, Kuppens, et al., 2013). In addition, benchmarking studies comparing effectiveness and usual care evaluations with efficacy trials often demonstrated lower effect sizes in community treatment of youths (e.g., Jónsson, Thastum, Arendt, & Juul-Sørensen, 2015; Weersing & Weisz, 2002).

Community Mental Health Settings as a Context for Evidence-Based Practice

The ESTs are meant to be guided by the integration of data from psychometrically sound, culturally sensitive assessment instruments. Ideally, evidence-based assessment is conducted prior to therapy to inform treatment planning, followed by periodic assessments to steer supervision, guide necessary adjustments to therapeutic strategies, and determine whether the treatment being implemented is in fact beneficial (Achenbach, 2017; Weisz, Chu, & Polo, 2004). Assessment can also be used to decide jointly with a family when to end an episode of care, and post-treatment and follow-up assessment can reveal longer term impact and whether booster sessions are needed (Kazak et al., 2010). Systematically incorporating evidence-based assessments into everyday practice settings still seems to be lagging (Jensen-Doss, 2015). Many clinicians do not implement evidence-based assessments because of barriers ranging from practicality (e.g., client burden, inadequate reimbursement) to perceived irrelevance to clients (Jensen-Doss & Hawley, 2010). In fact, reports suggested that most clinicians rely solely on unstructured interviews, which can be prone to bias and may not be as accurate as evidence-based structured interviews (Jensen-Doss, 2011). (p. 626)



Figure 41.1 Examples of barriers to the successful implementation of evidence-based practice in community mental health settings. EBP = evidence-based practice; ESTs = empirically supported treatments.

Barriers

To understand what appears to be rather limited EBP within community settings, it may be helpful to consider barriers that may stand in the way. These barriers include what may be less-than-perfect fit of some evidence-based procedures to the realities of everyday clinical settings. Other barriers can be found in the conditions under which ESTs are typically created and evaluated, plus potential problems of fit with client characteristics, clinician characteristics, setting characteristics, and funding practices (see Figure 41.1).

Goodness-of-Fit of Evidence-Based Practice

Over the past five decades, there has been a proliferation of ESTs along with the development of psychometrically sound assessment tools. Most ESTs, created by many talented individuals and research teams, have been focal—that is, designed to treat a single disorder.

Community Mental Health Settings as a Context for Evidence-Based Practice

der or homogeneous cluster (e.g., conduct problems or a subset of anxiety disorders) and employing a linear design (discrete number of sessions delivered in a more or less fixed order). Focal treatment manuals offer several advantages, including (a) clarity of focus; (b) manageable scope for therapists; (c) precise mapping of treatment procedures onto the characteristics and symptoms of a specific disorder; (c) support for linkage between treatments and the standard diagnostic manual; and (d) manageable scope for therapists' training and implementation of a treatment.

Despite these advantages, the limited uptake of focal treatment manuals by front-line practitioners may reflect, in part, a mismatch between manuals and the realities of mental health care in community settings. Specifically, clinicians tend to work with youths across a range of disorders and problems, but typically lack the time or resources to learn a separate treatment manual for each disorder or problem area in their caseload. Unlike clinicians in traditional RCTs, clinicians in real-world clinical settings do not have the luxury of developing inclusion and exclusion criteria for their caseload to help guide them in choosing clients they want to treat. In addition, most clinically referred youths present with multiple disorders and problems (Angold, Costello, & Erkanli, 1999), so that even if a clinician were to master many focal treatment manuals, there would be no evidence-based guidelines for how to navigate among the manuals to address comorbidity. Furthermore, a youth's problems necessitating attention may shift during a treatment episode, and manuals with a linear design may lack the flexibility to address this flux. This is not to mention the various problems that may arise as part of the broader "mental health ecosystem" (Weisz, Ugueto, Cheron, & Herren, 2013), such as major life events, financial and housing hardship, family illness, and other (p. 627) nontarget issues, which manualized treatments do not comprehensively address. Thus, the design, structure, and content of many ESTs may not be an ideal fit to the clinical practice context. In fact, after a focal treatment trial or training initiative, clinicians tend to use specific components of the learned manual flexibly and when applicable, as opposed to implementing the full treatment manual in the prescribed sequence (Chu et al., 2015).

As noted previously, ESTs are intended to be guided by data from regularly administered evidence-based assessments. However, there are a variety of potential barriers to this practice in community mental health settings, including but not limited to cost constraints (e.g., it may be difficult for organizations to afford these tools); time constraints (e.g., it may be challenging for clinicians to have adequate time to identify, score, and interpret measures); language barriers (e.g., these tools may not be readily available in all languages); literacy issues (e.g., some caregivers may not be able to read assigned materials); other cultural barriers (e.g., lack of available norms for certain cultural groups); and limited training of clinicians (e.g., in the selection, scoring, and interpretation of appropriate instruments).

Research (Conditions)-to-Practice Gap

The conditions under which many ESTs have been created and tested often differ substantially from the conditions of real-world clinical practice (Weisz & Gray, 2008). In a recent evaluation of 461 youth psychotherapy RCTs from the 1960s through the 2000s, the vast majority of the 1,160 treatment and control groups included youth participants who had not been clinic referred, therapists who were not practicing clinicians, and therapy that was not delivered in actual practice settings (Weisz, Ng, & Bearman, 2014). There are benefits to the ways in which most child and adolescent psychotherapy research has been conducted (Weisz, Krumholz, Santucci, Thomassin, & Ng, 2015). For example, the conduct of these studies may allow the investigator to have greater control over the study sample (e.g., selection of participants who have the target disorder and limited or no comorbidity); therapist behavior (e.g., supervision by the treatment developer and sufficient time to prepare for sessions may increase adherence); and treatment setting (e.g., the treatment developer can closely monitor the day-to-day operations of the setting). While these elements yield greater precision in testing of interventions, and consequently heightened scientific rigor, they may have a downside. Without evaluating treatments amidst the complicating factors so often found in community mental health contexts, there may be missed opportunities to learn how to make treatments more effective in these real-world settings.

Client Characteristics

One of the major criticisms of research supporting youth ESTs is that research participants from these trials have often differed markedly from individuals seeking treatment in community mental health settings (Garland et al., 2013). For example, clinic-referred youths seeking treatment in community clinics tend to have higher rates of comorbidity and externalizing problems than youths seen in research clinics (e.g., Ehrenreich-May et al., 2011). Comorbidity is also frequently coupled with shifts in the most pressing problems during treatment episodes (Weisz, Ugueto, et al., 2013).

In addition, caregivers who bring a child to participate in a research trial usually know their child will be in a study focused on a particular disorder or problem area (Weisz, Ugueto, et al., 2013). By contrast, caregivers seeking treatment for their children in community clinics tend to be requesting help with problems of daily living (e.g., school refusal and sleep difficulties), rather than specific diagnoses. Furthermore, families requesting mental health services in communities tend to be more ethnically diverse, have lower income, and have more challenging family compositions (e.g., often single-parent households) than families requesting services in research clinics (Ehrenreich-May et al., 2011; Southam-Gerow, Weisz, & Kendall, 2003).

Importantly, youth and family minority status and low family income have been linked with premature treatment termination, decreased youth and family engagement in treatment (Hoagwood et al., 2010; McKay et al., 2004), and reduced treatment effects (e.g., Curry et al., 2006; L. M. Miller, Southam-Gerow, & Allin, 2008). Other stressors, such as

Community Mental Health Settings as a Context for Evidence-Based Practice

parental and sibling psychopathology, divorce, unemployment, and family member illness, which may be exacerbated by the confluence of multiple stressors, can interfere with implementation of more narrowly focused ESTs (Weisz, Ugueto, et al., 2013).

Clinician Characteristics

Clinician-related barriers to bringing EBP to community mental health settings also warrant attention. There are often discrepancies between (p. 628) clinicians in research studies and those working in community settings (Weisz, Southam-Gerow, Gordis, & Connor-Smith, 2003). For instance, therapists in research trials commonly work with or for the treatment developer or lead researcher and receive intensive training and close supervision from the treatment developer's team; carry small, focused caseloads; and do not have productivity requirements specifying number of hours that must be billed per week. In contrast, therapists in community mental health settings come from a variety of disciplines and educational backgrounds; work for a clinic or agency versus the researcher (who thus lacks the authority of an employer); carry large, heterogeneous caseloads; have productivity requirements involving reimbursable hours; and receive modest or no supervision (Southam-Gerow, Rodríguez, Chorpita, & Daleiden, 2012). Their clinical work may be guided by theoretical orientations that differ from EST manuals, and they may have limited exposure to and training in the implementation of ESTs (Weissman et al., 2006).

In addition, many clinicians working in community mental health clinics function within a different compensation system than research therapists, who are often paid to immerse themselves in learning, practicing, and receiving supervision for the treatment manual used in a study. Community mental health practitioners, in contrast, tend to be compensated through salaries with high productivity requirements (e.g., 70% of their total time at work must be billable) and increasingly through a fee-for-service employment model, with payment only provided for hours billed (Weisz, Ugueto, et al., 2013). With such financial structures and incentives in place, clinicians could risk significant loss of income and failure to meet productivity quota if they devoted the time needed to be fully trained and supervised in a new treatment model.

Another potential barrier to EBP is the perception that EST manuals are overly rigid and may not fit the needs and preferences of clients (e.g., Addis & Krasnow, 2000). In fact, this concern arises even among clinicians who seem to be open to EBP (Thomas, Zimmer-Gembeck, & Chaffin, 2014). Regarding assessment, time constraints and financial pressures coupled with potentially limited training in best practices in assessment procedures may impede the ability of community-based clinicians to regularly administer evidence-based assessments.

Setting Characteristics

Provider organization characteristics can also complicate efforts to implement EBP. One aspect is the shortage—current and projected—in the mental health workforce, particularly in, but not limited to, rural areas (SAMHSA, 2012). The number of clients and men-

Community Mental Health Settings as a Context for Evidence-Based Practice

tal health visits have increased more rapidly than the mental health workforce has expanded, yielding a striking increase in the client-to-staff ratio: 178 clients per practitioner in 1998 compared to 499 clients per practitioner in 2003 (Druss et al., 2008). In fact, the difference between the number of individuals in need of mental health services and the number of available clinicians is so drastic that even if there were twice as many clinicians, there would only be a slight improvement in availability of mental health care (Kazdin & Blase, 2011). Consequently, there are often extensive wait lists in many community practice settings (Hersh, Metz, & Weisz, 2016). Not only does this result in decreased access to care, but also it points to heightened demands for organizations to provide care to as many young clients as possible, which may detract from time and resources needed to support clinicians in learning to deliver ESTs and other aspects of EBP with fidelity. Such organizational pressures, coupled with large and complex youth and family caseloads and productivity pressures, may lead to therapist burnout (Raquepaw & Miller, 1989). In addition, other aspects of community mental health settings, including frequent therapist turnover (with skilled therapists leaving or being promoted to more administrative roles in their clinics) (Hersh et al., 2016), may interfere with the attainment of a highly skilled clinical service workforce.

Even if community mental health settings provided training and supervision to support clinicians in EBP, the high rates of staff attrition could interfere with the sustainability of these practices. Additionally related to sustainability, in-house clinic supervisors may not have adequate experience with newly learned ESTs to successfully supervise staff and monitor and promote fidelity, but outside expert supervision may require resources not available to agencies. Other contextual factors to consider involve organizational culture (norms and expectations about individuals' behavior within and the functioning of an organization) and climate (employees' perceptions of and responses to their workplace), which are thought to impact attitudes toward the adoption of innovative (p. 629) practices, including EBP, with more positive culture and climate associated with more positive attitudes (Aarons & Sawitzky, 2006).

Funding Issues

Youth mental health services are consistently underfunded on national, state, and agency levels, as is research to advance these services (Kazak et al., 2010). These funding limitations make it difficult to introduce, much less sustain, state-of-the-art assessment and intervention practices in community mental health settings. Enriching clinicians' EBP skill sets for youths spanning the spectrum of mental health problems and disorders requires a financial investment. Unsurprisingly, the exploration of innovative approaches is limited by budgetary restrictions (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004), which seem to permeate all levels of funding for youth mental health care.

State, county, and municipal budgets can vary drastically from one year to the next, and during financially challenging times cost-cutting can negatively impact community mental health agencies through factors such as lowered reimbursement rates and suspensions in hiring, which in turn can result in increased work for agency personnel (Weisz, Ugueto, et

Community Mental Health Settings as a Context for Evidence-Based Practice

al., 2013). In addition, policies and associated funding for mental health care in most states are propelled by insurance programs, with reimbursement often primarily based on categories of care delivered and time dedicated to care, without attention to whether the intervention or assessment used is backed by empirical support (Weisz, Ugueto, et al., 2013). Consequently, organizations face pressure to emphasize quantity over quality of services, and this could undermine both youth outcomes and therapist morale (Hamilton, Daleiden, & Dopson, 2011).

Community mental health agencies frequently face significant financial pressures based on their budgets. In a nationally representative sample across 36 states participating in the Child STEPs initiative, the average annual budget for agencies was approximately \$2.5 million, with a range of \$60,000 to \$27 million. Approximately one third of the directors with site-specific budget data indicated that their agency ran at a budget deficit for each of the 3 years prior to the survey, which resulted in layoffs, staff turnover, and increased productivity requirements (Schoenwald, Chapman, et al., 2008). Those in leadership positions in community clinics may be reluctant to take the financial risk of investing in EBP trainings and resources knowing staff may leave shortly thereafter (e.g., 66% turnover in 4 years; Weisz, Ugueto, et al., 2013) and because there are no fiscal incentives for EBP use in their settings. Clinics in rural areas and low- and middle-income countries may be even more reluctant to invest in EBP, given unique barriers in these settings, including a shortage of providers and significant financial constraints (Patel, Flisher, Nikapota, & Malhotra, 2008; Wagenfeld, 2003).

Prospects

While there are undoubtedly barriers to bringing youth EBP into community mental health settings, they are not necessarily insurmountable. This section focuses on prospects of bringing EBP into community contexts by describing ways to address the research-to-practice gap and increase access to EBP through policy/funding/advocacy as well as through attention to organizational and family-level factors.

Overcoming the Research-to-Practice Gap

With growing recognition that the research conditions under which many ESTs have been developed and tested often have not reflected the complexities of everyday community mental health practice or incorporated key stakeholders, we recommend two research approaches that could help improve the fit and practice readiness of treatments. The first is a service-oriented translational research framework focused on maximizing the relevance of research on EBP to real-world clinical practice. A prototype of this framework is the *deployment-focused model*, in which interventions are developed and tested, from an early stage, with the types of therapists and clients and in the types of settings for which the interventions are eventually intended (Weisz, 2004). In more traditional models, the goal is to develop and test interventions using conditions that maximize internal validity (e.g., homogeneous sample with strict exclusionary criteria and highly trained therapists often

Community Mental Health Settings as a Context for Evidence-Based Practice

supervised by the treatment developer). While this type of research permits strong causal inferences to be gleaned about the efficacy of interventions compared to control conditions, it does not provide a robust test of how interventions will work in real-world clinical care settings. For maximum efficiency, we advocate progressing as quickly as feasible from small pilot efficacy tests to real-world randomized effectiveness trials with diverse families in community mental health clinics in different locations (e.g., urban, rural, suburban). These real-world trials can provide opportunities to test interventions in the contexts (p. 630) for which they are ultimately intended and thus to learn what adjustments and refinements are needed to make the interventions effective in precisely those contexts. Trials of this kind can help make it possible to build the interventions that are really needed for those contexts, so that when they are eventually scaled up for wider implementation, they can do the good they were designed to do. Following the deployment-focused model can, in our view, facilitate building interventions that are ready for and effective in practice settings.

A second research approach is *community-based participatory research* (CBPR; see Hartwig, Calleson, & Williams, 2006). Situated at the nexus of research, practice, and policy, CBPR is a research paradigm in which empirically supported science is systematically adapted through active engagement of key stakeholders with the goal of reducing long-standing health disparities (Minkler, 2010; Wallerstein & Duran, 2010). CBPR involves a collaborative partnership between academic researchers and relevant community members, in which partners combine their expertise and unique strengths, while sharing responsibilities as they conduct translational research together (Israel, Schulz, Parker, & Becker, 1998). The foundational principles that direct and inform CBPR include facilitating an equitable, cooperative partnership; expanding on the strengths and resources within a community; and promoting co-learning and capacity building (Israel et al., 1998; Minkler & Wallerstein, 2008).

Increasing Access to Evidence-Based Practice

Policy, Funding, and Advocacy

Policy, funding, and advocacy are intricately intertwined, and efforts in these domains have the potential to support increased EBP within community mental health settings. The mental health service system is currently poised for what could be a significant transformation with the potential to become more integrated and data driven (Hoagwood, Atkins, & Ialongo, 2013). The 2010 Patient Protection and Affordable Care Act, which includes mental health services in addition to other health services, is generating incentives, payment methods, and a focus on quality, potentially paving the way for integrated mental health services guided by data on both quality and outcomes (Conway, Mostashari, & Clancy, 2013). There is significant funding to support legislation (e.g., the National Quality Strategy of the Affordable Care Act and Children's Health Insurance Program Reauthorization Act of 2009) and initiatives focused on using quality metrics and developing and refining quality measurement tools for youths (Hoagwood et al., 2013). The bottom line is that substantial health-care policy reform is leading to changes in

Community Mental Health Settings as a Context for Evidence-Based Practice

provider organizations and uncovering opportunities to design research to inform these changes (Hoagwood et al., 2013). It is important to note that in early 2017 the United States underwent political changes within Congress and with a newly elected president, making the stability of the Affordable Care Act and associated funding fragile and raising questions about the future of this relatively new legislation.

Although there is heightened attention to EBP by government agencies, funding is not yet consistently being allocated in ways that could smooth the trail for EBP in practice settings, such as by offering payment to cover training costs and providing enhanced reimbursement rates for EBP. Government agencies could assist by targeting funding in ways that incentivize EBP. This is particularly important for the many financially struggling, underfunded community mental health agencies. Considering that budget restrictions can thwart exploration of innovations, states can use additional strategies for boosting exploration and increased use of EBP. For instance, the Child Health and Development Institute of Connecticut, a nonprofit created in 1997 and funded by the Children's Fund of Connecticut, focuses on promoting effective health and mental health innovations and advances for youths through projects informing system-level change (Child Health and Development Institute of Connecticut, 2016).

Increased research funding prioritizing the development, dissemination, implementation, and supervision of EBP in community mental health settings, especially for youths who are underserved, is also crucial. Additional research and funding recommendations include improved communication about research findings, including null findings, as well as funders and journal editors urging researchers to specify limits of generalizability of their studies and submit translational research projects with EBP delivered to diverse youth populations (Kazak et al., 2010). Continuing to study ESTs with diverse young clients and their families can inform any necessary adaptations to the content and process of treatment.

To further promote policies and encourage funding priorities that are aligned with bringing EBP into community mental health settings, advocacy for effective child mental health services is (p. 631) vital. Models from healthcare (e.g., for diabetes) can be used to inform the development of mental health care advocacy groups that include multidisciplinary expertise and the important voices of diverse families (Kazak et al., 2010). Aarons, Hurlburt, and Horwitz (2011) have developed a conceptual model for implementing EBP in public service sectors, with informative discussions of sociopolitical issues, advocacy, and funding.

Organizational Level

Various organizational factors are likely to facilitate the implementation of EBP within community agencies. Research on organizational structure and climate, for instance, suggests that greater supports tend to be present in private versus public organizations, and larger organizations may have more resources than smaller ones to implement innovative approaches (Aarons et al., 2011). Indeed, public sector agencies may be less likely to engage in innovation or may try to force top-down change rather than engage in facilitative

Community Mental Health Settings as a Context for Evidence-Based Practice

and supportive change strategies, even though the latter promote more positive attitudes toward and use of EBP (Aarons et al., 2011). To help public sector organizations adjust their climate to bolster innovation, Glisson and Schoenwald (2005) created an organizational and community intervention model. In addition, enhanced organizational supports, flexible treatments, and transformational leadership style are associated with positive provider attitudes about ESTs and a greater likelihood of EST adoption (Aarons, 2006; Aarons, Sommerfeld, & Walrath-Greene, 2009; Nelson, Steele, & Mize, 2006). ESTs are more likely to be implemented and sustained when an EST is consistent with an organization's mission and values and when procedures for an EST are formalized and incorporated into an agency's policies and procedures (Glisson & Schoenwald, 2005). Last, implementation of a new EBP requires substantial resources (e.g., for initial startup costs of training providers and leaders). Initial implementation does not include resources needed for sustainability (including typical maintenance expenses, such as expert coaching and case consultation for clinicians who are just learning the treatment program, and booster trainings as new clinicians come online), which also require careful attention and planning (e.g., Aarons et al., 2011).

Family Level

While many of the current efforts to improve youth mental health care focus on dissemination and implementation of ESTs (National Advisory Mental Health Council, 2000), the potential benefits from these efforts can only be actualized if youths and their families are engaged (e.g., regularly attending and consistently participating) in mental health services (Garland, Haine-Schlagel, Accurso, Baker-Ericzén, & Brookman-Frazee, 2012). Low engagement and retention are recognized as a threat to ESTs (National Advisory Mental Health Council's Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001). Service accessibility is influenced not only by practical factors (e.g., availability, affordability, transportation, language barriers) but also by psychological and cultural influences on how accessible an offered service is actually experienced to be.

Fortunately, an array of treatment engagement and retention strategies has been developed (for systematic reviews, see Ingoldsby, 2010; Kim, Munson, & McKay, 2012; Nock & Ferriter, 2005). While some await scientific evaluation, many of these approaches may be useful in community mental health settings. Although there exist a multitude of ways to target family barriers (e.g., the inclusion of family peer advisors to help connect clinicians and families from different cultural backgrounds; Hoagwood et al., 2010), we focus herein on leveraging the results of RCTs that emphasize engagement to increase access to quality community mental health services for youth and offer one such example.

By leveraging the results of RCTs, the efficacy of engagement-focused interventions under carefully controlled conditions can be assessed and their effectiveness further tested in the public sector. Ingoldsby's (2010) review of RCTs examined strategies for increasing initial engagement and retention of families in parent and child mental health programs and drew several pertinent conclusions, including that helping families address practical obstacles (e.g., transportation, scheduling) increases engagement; that monetary incen-

Community Mental Health Settings as a Context for Evidence-Based Practice

tives increase initial enrollment, but not subsequent engagement; and that assisting caregivers with issues outside of the treatment itself (e.g., financial concerns or relationship conflicts) can be beneficial to increasing retention.

In a qualitative review of RCTs by Kim and colleagues (2012), the effectiveness of the engagement intervention was evaluated at the level of the individual (e.g., reminder calls, positive reinforcement from the provider for maintaining engagement), family, and service delivery (i.e., using an [\(p. 632\)](#) ecological perspective to identify treatment barriers at different system levels; McKay, Bennett, Stone, & Gonzales, 1995). Individual-level approaches improved attendance at early stages of treatment, family-level approaches improved attendance throughout but with relatively greater impact on initial attendance, while service delivery-level interventions were more effective at improving ongoing engagement—including treatment completion (Kim et al., 2012).

An example of an intervention that draws on several of the previously described effective strategies to target increased treatment engagement is the participation enhancement intervention (PEI; Nock & Kazdin, 2005). PEI is a brief, adjunctive intervention delivered by clinicians for 5–15 minutes during the first, fifth, and seventh therapy sessions. The goal is to enhance caregivers' motivation for treatment and to identify and overcome barriers to participation following approaches developed for adult motivational enhancement (W. R. Miller & Rollnick, 2002), such as providing caregivers information on the link between participation and treatment outcomes and using worksheets to elicit self-motivational statements and specific change plans. While this intervention was developed and tested in the context of parent management training for disruptive behavior, it can likely be modified for use with a range of presenting problems. In an RCT of PEI, results were encouraging, with increased attendance and treatment adherence for the group that received PEI, and caregiver motivation was a significant mediator (Nock & Kazdin, 2005).

Innovation in Community-Based Youth Mental Health Care

The sluggish adoption of EBP in community mental health settings has fueled efforts to overcome the barriers to adoption and spurred myriad innovative ideas and approaches. While there are numerous kinds of innovation worthy of application and evaluation in community mental health settings, this section highlights two broad types with potential to increase the use of EBP in these settings: (a) treatment delivery methods focused on compatibility with consumers and (b) treatment and assessment practices focused on compatibility with clinical practice settings, providers, and clients' presenting problems.

It is possible that modifications to the format of ESTs to better fit with consumers than traditional weekly therapy sessions may lead to increased appeal, interest, and treatment participation and thus to improved outcomes. Two examples include youth treatments in the form of computer-based interventions and camps. Computerized CBT (cCBT) delivers the elements of CBT in a computer- or web-based format with varying levels of provider support, including programs designed to be administered by a clinical provider (i.e., computer-assisted CBT). Manualized ESTs targeting child anxiety, for example, have been

Community Mental Health Settings as a Context for Evidence-Based Practice

adapted to cCBT formats. Wait-list-controlled trials have offered preliminary evidence for the efficacy of both BRAVE-Online (March, Spence, & Donovan, 2009; Spence, Holmes, March, & Lipp, 2006) and Cool Teens CD-ROM (Wuthrich et al., 2012) in reducing anxiety symptoms. cCBT programs, when offered in community mental health clinics, may be particularly appealing and engaging to child and adolescent clients, who are increasingly interacting with different forms of technology. In addition, novel camp-based interventions that are delivered in clinic settings have been developed; these can offer brief but intensive exposure and immersion in a naturalistic context to foster repertoire expansion and have shown promising initial results (e.g., Child Anxiety Multi-Day Program [CAMP]; Santucci & Ehrenreich-May, 2013). These are but two ways in which treatments can be adapted to increase consumer appeal. Kazdin and Blase (2011) have proposed numerous models of treatment delivery beyond traditional individual psychotherapy through, for example, self-help, media, smartphones, and Internet, which could expand treatment offerings in community mental health settings and enhance client consumer appeal and access to mental health care for youths and families.

Another innovation with potential to boost EBP involves designing treatments and assessments to more readily fit the realities of clinical practice. One example is the shift from focal treatments, which target single disorders or homogeneous problem clusters, to treatment protocols that are designed to address multiple disorders and problem areas, as well as changes in treatment needs during episodes of care. These treatment manuals that can address comorbid disorders and co-occurring problems, sometimes referred to as *transdiagnostic*, may address some of the barriers that have limited (p. 633) the dissemination of empirically supported focal treatments. Potential strengths of transdiagnostic approaches include

- increased efficiency (streamlined treatment strategies housed within one manual)
- enhanced cost-effectiveness (fewer EBP trainings needed)
- more practicality (closer mirroring of usual EBP clinical practice)
- enhanced ability to meet the complex and often shifting needs of youths during treatment
- improved treatment satisfaction and acceptability to clinicians and families (possible decrease in length of treatment and time needed for response to treatment)
- enhanced access to quality mental health care for youths and families (parsimonious EBP packaging potentially facilitating training and dissemination)

In line with best practice in youth mental health care, transdiagnostic approaches should be paired with evidence-based assessment, ideally assessment that is administered at regular intervals and is brief, low or no cost, and readily available for community clinicians.

An example of a transdiagnostic intervention and accompanying assessment approach for use in community mental health settings is the Child STEPs model, which was developed as part of the work of the Research Network on Youth Mental Health (Schoenwald, Kelle-

Community Mental Health Settings as a Context for Evidence-Based Practice

her, & Weisz, 2008). The Child STEPs approach includes two components: (a) a modular, transdiagnostic treatment protocol (i.e., Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems [MATCH]; Chorpita & Weisz, 2009) and (b) a web-based clinical monitoring and feedback system. MATCH was created to address some of the common barriers faced by clinicians when trying to implement ESTs in everyday clinical settings; it incorporates ways to address client comorbidity, breadth of clinician caseloads, and fluctuations in client problems needing attention during a treatment episode. In addition, MATCH is intended to ease training burden and costs for organizations, as this manual covers treatment content that addresses approximately 75% of an outpatient clinician's typical caseload in the United States. Designed for 6- to 15-year-olds, MATCH is essentially a menu of practice elements from ESTs for common youth mental health problems with brief modules (three- to four-page descriptions) encompassing 33 practice elements (Figure 41.2 provides a visual depiction of MATCH modules) and flowcharts to guide clinical decision-making and help therapists individualize treatment using a logical sequence. The MATCH manual includes treatment components that frequently appear in CBT for depression (e.g., behavioral activation); CBT for anxiety (e.g., graduated exposure); CBT for trauma (e.g., trauma narrative); and behavioral parent training for conduct problems (e.g., reward system).

The second component of Child STEPs, the web-based monitoring and feedback system, illustrates the use of assessment designed to fit into everyday practice. This involves two brief, psychometrically sound measures—the Brief Problem Checklist (BPC; Chorpita et al., 2010) and the Top Problems Assessment (TPA; Weisz et al., 2011)—each completed by youth and a caregiver on a weekly basis and together requiring no more than a minute or two to complete. The BPC is a standardized, 12-item measure that reveals severity of a youth's internalizing and externalizing symptoms. The TPA is an idiographic consumer-driven assessment, in which a youth and caregiver each identify and rate the one to three most important problems for which they are seeking treatment. Results from these assessments appear on a web-based dashboard (Figure 41.3) that can be accessed by clinicians and their supervisors to monitor therapeutic progress, inform supervision, and adjust treatment as needed.

MATCH has demonstrated positive results in numerous community mental health agencies in the United States. Specifically, in an initial randomized effectiveness trial, MATCH combined with the web-based monitoring tool outperformed focal treatment manuals (i.e., for anxiety, depression, and disruptive conduct) and usual care on clinical and functional outcomes when tested with diverse children and adolescents (Weisz et al., 2012), and the superiority of MATCH over usual care was replicated in a 2-year follow-up (Chorpita et al., 2013). In a more recent trial (Chorpita et al., 2017), MATCH and the measurement tool again outperformed usual care on clinical outcomes as well as on treatment duration, consistency of therapy sessions (8.51 days between sessions in MATCH condition), and use of (p. 634) other mental health services. Research on MATCH is continuing to be conducted in a variety of mental health settings, including internationally. MATCH is also being implemented in multiple community settings outside of the bounds of research trials. As one example, the first author is the codirector of a child and adolescent psychotherapy

Community Mental Health Settings as a Context for Evidence-Based Practice

clinic focused on delivering EBP, with MATCH as the primary intervention, to underserved populations in the outpatient psychiatry department of a community hospital in the northeastern United States

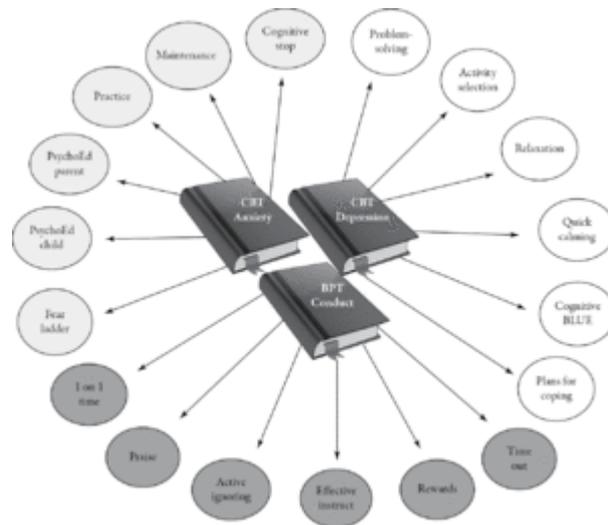


Figure 41.2 Selected modules illustrating the structure of the *Modular Approach to Therapy for Children With Anxiety, Depression, Trauma, or Conduct Problems* (Chorpita & Weisz, 2009). CBT = cognitive behavioral therapy; BPT = behavioral parent training. BLUE is an acronym representing four different patterns of depressogenic thinking: B, blaming myself; L, looking for bad news; U, unhappy guessing; and E, expecting bad things to happen. Figure adapted with permission from John R. Weisz and reprinted with permission from the *Annual Review of Clinical Psychology, Volume 11*.

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Conclusion

In sum, improving access to quality youth mental health care is imperative, and the provision of effective, culturally attuned mental health services in community mental health settings may be one way to accomplish this goal. A method for potentially enhancing the quality of these services involves more routinely incorporating EBP, including ESTs and evidence-based assessments, into care delivered in these settings. While barriers to bringing EBP into community contexts undeniably exist, understanding those barriers is an important first step toward finding ways to overcome them. Many are dedicated to this pursuit, and as a result of the diligence and determination of those currently involved and those who will be in the future, there is reason to be hopeful that EBP will continue to be adopted, refined, and increasingly accessible to young people and their families seeking mental health services through community channels. (p. 635)

Community Mental Health Settings as a Context for Evidence-Based Practice

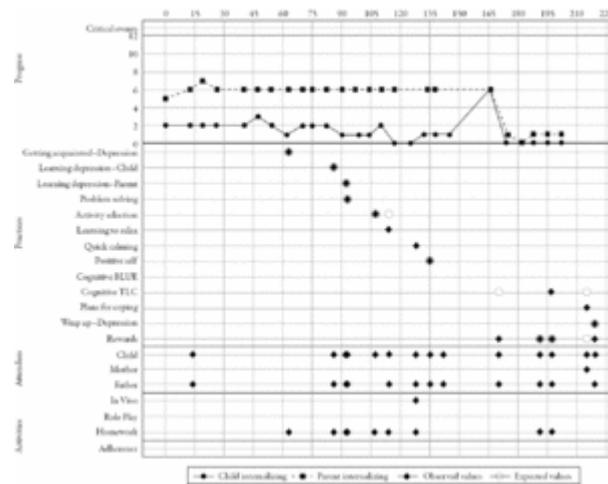


Figure 41.3 A sample course of MATCH treatment, displayed using one version of a monitoring and feedback system. In this version, the upper panel shows changes in youth problem ratings (here limited to parent and child internalizing problem scores) across 200+ days of treatment. The second panel from the top displays which MATCH modules were planned (circles) and actually implemented (dark fill) in each treatment session. The lower two panels show who attended each treatment session and when certain treatment methods (e.g., role plays, homework) were used. Figure reprinted with permission from John R. Weisz and the *Annual Review of Clinical Psychology, Volume 11*.

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