

**Prioritizing Evidence Based Practices in Children's Mental Health  
Evidence Based Subcommittee of the State of Maryland's Blueprint Committee**

**Background**

Maryland's public mental health services for children and adolescents have grown in number and scope during the past decade. Today, children under 18 comprise more than 40% of the individuals using the public mental health system. With this dramatic growth in numbers of children, services and expenditures, the need to have a Maryland Blueprint for Children's Mental Health is vital. In September 2002, Dr. Brian Hepburn, Director of the Mental Hygiene Administration, authorized the creation of the Maryland Committee for Children's Mental Health (MCCMH), charging the group with the responsibility of formulating a vision and strategies to address the mental health needs of children and their families in Maryland. MCCMH is comprised of a representative group of diversified stakeholders and experts including family members, researchers, providers, policy makers, administrators, agency representatives and advocates. In March 2003, the Committee's report, *Maryland's Blueprint for Children's Mental Health*, was published and made recommendations on how to improve and better integrate the current mental health system for children.

The MCCMH, also referred to as the Blueprint Committee (Blueprint), prioritized three strategies that it believes, if addressed, would significantly improve the Child and Adolescent Mental Health System in Maryland. One of these three main recommendations was to increase service delivery, support and treatment. The Service and System Evaluation Subcommittee of the Blueprint established detailed service definitions for the continuum of care for children's mental health in a 45 page document and further recommended the state investigate best and promising practices to retool and train clinicians in the field on implementing evidence based practices (EBPs). An Evidence Based Practice subcommittee was developed to provide the framework for a consensus-based process for evaluating EBPs. The charge of the committee was to gather, evaluate, and summarize information to guide statewide implementation of EBPs.

The State of Maryland has been a pioneer in the development of an infrastructure to implement processes that promote the implementation of EBPs for adults with serious mental illness. The adult public mental health system has supported statewide implementation of EBP models in supported employment, assertive community treatment, and family psycho-education. Implementation of these EBPs for adult consumers has received considerable attention and resources spurring child and adolescent stakeholders to action. The child and adolescent field is now sufficiently "mature", i.e., there is now a sufficient depth and breadth of pediatric EBPs, to support a similar effort in Maryland for children and adolescents. Prioritizing child EBPs for implementation is seen as an important first step.

**Methods**

The Evidence Based Practice Subcommittee, which was comprised of a diversified group of stakeholders in children's mental health (family members, researchers, providers, state policymakers, and mental health providers), selected the EBPs most

appropriate for the committee to address. The committee developed a stakeholder driven, consensus-based method for evaluating the appropriateness of EBPs for implementation. This process involved gathering background information on available EBPs (Appendix 1), reviewing and discussing this background information, and rating each EBP on the matrix presented in Appendix 2. Through this process, each EBP was considered and rated according to need, mental health focus, evidence, ease of implementation, and resources required for implementation and sustainability. Each practice was given a total score as an aggregate of the individual subscores. Appendix 3 lists the stakeholder(s) responsible for gathering the background information for each EBP reviewed.

### **Summary on EBPs Rated**

Table 1 summarizes each individual practice addressed by the EBP subcommittee. This summary is meant to be a reference for the committee's process for synthesizing and prioritizing the information that was gathered. The ratings guided the work of prioritizing and categorizing EBPs, PBE, and delivery frameworks. In addition the subscores pointed to the areas of need and ease of implementation for specific recommendations and priorities. Through the scoring process, it became apparent to the committee that certain practices fell in different subcategories:

- 1) Practices with solid empirical efficacy and recognized nationally as Evidence Based Practices;
- 2) Promising Practices and practices with Practice Based Evidence (PBEs) and;
- 3) Promising Service Delivery Frameworks.

Particular attention was paid to the discussion regarding the Promising Service Delivery Frameworks for delivering EBP's and Promising Practices. Frameworks such as Early Childhood Mental Health Systems of Care, School Based Mental Health and Wraparound all depend on an overall commitment to a service delivery system that promotes family engagement, cultural relevancy, and resiliency in youth. Within these frameworks the identification of need and subsequent appropriate referral for an EBP and/or Promising Practices is essential for successful intervention to occur.

### **Committee Recommendations and Next Steps**

The committee outlined the following recommendations and priorities for child and adolescent focused EBPs. The recommendations are the beginnings of a work plan for the new Maryland Child and Adolescent Mental Health Institute (The Institute) with continued guidance from Maryland's Blueprint Subcommittee on Evidence Base Practice.

Recommendations	Next Steps
1) Increase efforts implementing a trauma informed statewide system of care in children’s mental health.	<ul style="list-style-type: none"> <li>• Support MHA effort to create the <i>Center for the Study and Facilitation of Effective Treatment for Traumatized Youth- Child Welfare (SAFETTY-CW)</i> through SAMHSA</li> </ul>
2) Support the ongoing efforts in the state for implementing an effective EBP TFC model	<ul style="list-style-type: none"> <li>• Support TFC Research Roundtable and assist in the implementation of recommendations</li> </ul>
3) Support and draw on local efforts to increase the use of Evidence Based Family Therapy (MST, BSFT, and FFT)	<ul style="list-style-type: none"> <li>• Provide evidence based training, technical assistance, consultation and coaching consistent with these EBPs</li> <li>• Provide outcomes management processes within and across selected early adopter sites</li> </ul>
4) Improve practice based evidence in Respite and Psychiatric Rehabilitation Programs (PRPs)	<ul style="list-style-type: none"> <li>• Charge The Institute with the development of competencies and outcomes for these PBEs.</li> </ul>
5) Work in partnership with the Early Childhood Mental Health, School Based Mental Health Subcommittees to further analyze and disseminate the core competencies of the Promising Service Delivery Frameworks and ensure forward progress increasing EBP service delivery, support, and treatment in Maryland.	<ul style="list-style-type: none"> <li>• Support ongoing statewide efforts to implement Wraparound within a System of Care</li> <li>• Support the efforts to implement the Early Childhood Mental Health Certificate to train the workforce in core ECMH principles</li> </ul>

**Future Work of EBP Subcommittee**

Establish itself with The Institute as a hub for EBP, PBEs, and Promising Practices discussion, recommendations, and necessary implementation elements statewide. Keep abreast of current children’s EBP, PBEs, and Promising Practices in the field with an annual review of potential new practices or models for the committee to review for scoring.

**Appendix Outline**

Appendix 1: Background Questions for each EBP

Appendix 2: Matrix for Scoring EBPs

Appendix 3: Committee Members responsibility for EBPs

Appendix 4: Background Information for each EBP

**Table 1: Evidence Based Subcommittee of the State of Maryland's Blueprint Committee  
Summary of Findings**

<b>Evidence Based Practice</b>	<b>Need</b>	<b>Resource</b>	<b>Evidence</b>	<b>Implementation</b>	<b>MH focus</b>
<p><b>Trauma Focused Cognitive Behavioral Therapy (TFCBT)</b></p> <p>Individual trauma focused cognitive-behavioral therapy.</p>	<ul style="list-style-type: none"> <li>-Trauma exposure and related disorder often overworked</li> <li>-Provider perception very high</li> </ul>	<ul style="list-style-type: none"> <li>-Initial program costs medium (free training out there)</li> <li>-Ongoing system level costs become high</li> </ul>	<ul style="list-style-type: none"> <li>-Evidence high for TFCBT</li> <li>-Studies currently on efficacy, several effectiveness case studies</li> </ul>	<ul style="list-style-type: none"> <li>- SAMHSA grant funding</li> <li>- Local expertise</li> <li>- Training is online and free</li> </ul>	Primary
<p><b>Treatment Foster Care (TFC)</b></p> <p>Alternative to residential or group care where foster family receives extensive training and continued support. The foster family works closely with a case manager to tailor home and therapeutic environment to meet the individual youth's needs.</p>	<ul style="list-style-type: none"> <li>-Least Restrictive Environment for large population</li> <li>-Agency, provider perception high</li> </ul>	<ul style="list-style-type: none"> <li>-Well established provider base</li> <li>-Medicaid reimbursable</li> </ul>	<ul style="list-style-type: none"> <li>-Some (3) efficacy trials</li> <li>-Several Effective and cost effective studies</li> </ul>	<ul style="list-style-type: none"> <li>-Active MD TFC Coalition</li> <li>-Science to Service Recommendations</li> </ul>	Primary
<p><b>Multisystemic (MST)</b></p> <p>The goal of this therapy targeted at youths age 11-17 at risk for at of home placement is to facilitate change in the natural environment to promote individual change. The therapist works with the caregiver(s) to enhance parenting skills and coordination with other community services.</p>	<ul style="list-style-type: none"> <li>-Agency, provider, family perception high</li> <li>-Number of youth moderate</li> <li>-Extremely high risk population</li> </ul>	<ul style="list-style-type: none"> <li>-Local demonstration projects (PG, BC, Frederick)</li> <li>-Compacting</li> </ul>	<ul style="list-style-type: none"> <li>-Efficacy and evidence high (more randomized trials than any other EBP eval.)</li> <li>-Public health benefit, rates of re-arrests shown to be up to 70% better</li> </ul>	<ul style="list-style-type: none"> <li>-High competing interests</li> <li>-Cost of implementation and training high</li> </ul>	Combined Focus
<p><b>Cognitive Behavioral Therapy (CBT)</b></p> <p>Individual or group therapy that emphasis how behavior is impacted by child's thoughts. The premise is a person can change the way they feel/act despite the environmental context. CBT can include psycho educational, social skills, social competency, and problem solving.</p>	<ul style="list-style-type: none"> <li>-Number of youth high</li> <li>-Family, provider, and agency perception low to medium</li> </ul>	<ul style="list-style-type: none"> <li>-Reimbursable</li> <li>-No current grants or demonstration project locally</li> <li>-Community support is unknown</li> <li>-Provider, system support, ongoing costs medium</li> </ul>	<ul style="list-style-type: none"> <li>-Endorsed by the APA as EBP</li> <li>-Major efficacy studies complete</li> </ul>	<ul style="list-style-type: none"> <li>-Buy in is low to medium</li> <li>-Have to "rally" the system with paid support</li> <li>-Clinical resistance would be low</li> </ul>	Primary
<p><b>Brief Strategic Family Therapy (BSFT)</b></p> <p>Family therapy where the focus is on identifying and changing unhealthy patterns of family interaction. Improving relationships between the family and other systems involved in the youth's life are also included.</p>	<ul style="list-style-type: none"> <li>-Co-occurring population with substance abuse</li> <li>-Provider and family perception is mixed</li> </ul>	<ul style="list-style-type: none"> <li>-Past local training of public and private providers</li> <li>-Child welfare has high buy in</li> <li>-Medicaid billable</li> </ul>	<ul style="list-style-type: none"> <li>-Some trials and replication</li> <li>-No fidelity tools</li> <li>-SAMSHA rates high</li> </ul>	<ul style="list-style-type: none"> <li>-Stiff costs</li> <li>-High competing interests</li> <li>-Buy in is low to medium</li> </ul>	Primary, but shared
<p><b>Functional Family Therapy (FFT)</b></p> <p>A phased program where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family. The phases are engagement, motivation, assessment, behavior change, and generalization.</p>	<ul style="list-style-type: none"> <li>-High cost population</li> <li>-Little knowledge on the practice so agency, family, and system perception is low to unknown.</li> </ul>	<ul style="list-style-type: none"> <li>-Two local demonstrations but grant dollars leaving</li> <li>-Some existing providers with shared department responsibility</li> <li>-Ongoing costs and system support low</li> </ul>	<ul style="list-style-type: none"> <li>-Number of efficacy studies high with high effect sizes</li> <li>-Low on generalizability and relevance</li> <li>-Good fidelity instruments</li> </ul>	<ul style="list-style-type: none"> <li>-MST as well as others high competing interests</li> <li>-High training requirements</li> <li>-Little local capacity</li> </ul>	Combined Focus

**Table 1: Evidence Based Subcommittee of the State of Maryland's Blueprint Committee  
Summary of Findings**

<b>Practice Based Evidence</b>	<b>Need</b>	<b>Resource</b>	<b>Evidence</b>	<b>Implementation</b>	<b>MH focus</b>
<p><b>Reducing Seclusion and Restraint</b></p> <p>Trained clinicians working with facilities such as RTCs, group homes, and or schools to implement key strategies associated with reducing or eliminating seclusion and restraint.</p>	<ul style="list-style-type: none"> <li>-High risk population</li> <li>-Family and provider perception high</li> </ul>	<ul style="list-style-type: none"> <li>-SAMSHA grant currently to implement in public RTCs</li> </ul>	<ul style="list-style-type: none"> <li>- No currently published efficacy studies</li> <li>- Nationally several studies showing effectiveness, case reports</li> <li>- Impact on well being of staff high</li> </ul>	<ul style="list-style-type: none"> <li>-Local resources for training</li> <li>-Widespread facilities</li> <li>-Overall low costs - manual and 12 one hour training sessions</li> </ul>	Primary
<p><b>Family to Family Support Program</b></p> <p>Systematic efforts to increase psychological and social resources for families as they respond over time to caregiver stress. Several models exists such as targeted parent assistance, parent connectors, and family support groups and education under the auspices of a family organization.</p>	<ul style="list-style-type: none"> <li>-Family perception of need is high</li> </ul>	<ul style="list-style-type: none"> <li>-State and local contracts</li> <li>-MD Advocacy well coordinated</li> </ul>	<ul style="list-style-type: none"> <li>-No efficacy, some effectiveness studies, work in this area is primarily with families of adult consumers</li> </ul>	<ul style="list-style-type: none"> <li>-Scope is difficult to define</li> <li>-Local training and low costs</li> </ul>	Primary, but shared
<p><b>Crisis Intervention</b></p> <p>Varied definition of immediate response to a child crisis (i.e. suicide attempt, trauma, abuse) that can include home mobile intensive emergency service, short term residential services for youth in crisis, and short term plan of care post crisis. The service is brief, short-term, and designed to provide an immediate clinical response to support an individual remaining in the least restrictive environment.</p>	<ul style="list-style-type: none"> <li>-Hard to define true population</li> <li>-Family, community, and provider perception is high</li> </ul>	<ul style="list-style-type: none"> <li>-Good models locally</li> <li>-Funding streams are piecemeal</li> <li>-State and local support high</li> </ul>	<ul style="list-style-type: none"> <li>-Some efficacy and effectiveness studies</li> <li>-Cost effective</li> <li>-No fidelity</li> </ul>	<ul style="list-style-type: none"> <li>-Need interagency buy in</li> <li>-Would take good mobilization at state level</li> </ul>	Primary, but shared
<p><b>Respite</b></p> <p>Provides time away and support for the primary caregiver of youth with mental health disorder. Goal is to help reduce stress of caregiver to improve family functioning. Services are designed to support the child remaining in their home.</p>	<ul style="list-style-type: none"> <li>-High risk and expensive population</li> <li>-Highest requested service in Baltimore County</li> <li>-Family, provider, and agency population is high</li> <li>-Population is unclear</li> </ul>	<ul style="list-style-type: none"> <li>-Model dependent on costs, rates are low</li> <li>-Some local demonstration projects</li> <li>-Local and interagency support low</li> </ul>	<ul style="list-style-type: none"> <li>-No formal trials on efficacy</li> <li>-Some Maryland evaluations on effectiveness</li> </ul>	<ul style="list-style-type: none"> <li>-Buy in High</li> <li>-Competing interests; costs; and resources low</li> <li>-Training can be challenge</li> </ul>	Combined Focus

**Table 1: Evidence Based Subcommittee of the State of Maryland's Blueprint Committee  
Summary of Findings**

Promising Service Delivery Frameworks	Need	Resource	Evidence	Implementation	MH focus
<p><b>Early Childhood Mental Health</b></p> <p>System of Care approach to targeting young children and their parents from pregnancy through 5 years of age to offer a multidisciplinary approach at building protective factors and resiliency within children, the family, and communities.</p>	<ul style="list-style-type: none"> <li>-Family and provider perception high</li> <li>-Costs become higher without early intervention</li> </ul>	<ul style="list-style-type: none"> <li>-Existing providers is low</li> <li>-Community and system support high</li> </ul>	<ul style="list-style-type: none"> <li>-No efficacy, fidelity, and little costs research for the overall model</li> <li>- Good efficacy for specific EBPs used in the service delivery model</li> </ul>	<ul style="list-style-type: none"> <li>-Competing interests</li> <li>- Well developed local resources</li> <li>- Workforce issues</li> </ul>	Primary, but shared
<p><b>Wraparound</b></p> <p>Set of individualized child and family support and services planned with a community based team that focuses on strengths. Families are active partners and supports are balanced between informal and formal with flexible funding. Care coordination with families to help meet their goals in multiple life domains.</p>	<ul style="list-style-type: none"> <li>-Children at risk for residential treatment</li> <li>-Families and Provider perception high</li> <li>-Benefit of decreased residential treatment, decreases delay of delivery of mental health services, and increase in collaborative care</li> </ul>	<ul style="list-style-type: none"> <li>-High program costs</li> <li>-Current demonstration projects</li> <li>-Future Medicaid waiver</li> <li>-System, local, and admin support high</li> </ul>	<ul style="list-style-type: none"> <li>-Few efficacy studies with low effect sizes</li> <li>-Wide range of effectiveness studies</li> <li>-Valid and reliable fidelity instruments</li> </ul>	<ul style="list-style-type: none"> <li>-Local implementation available</li> <li>-Cost high</li> <li>-Competing Interests</li> </ul>	Combined Focus
<p><b>School Based Mental Health</b></p> <p>Expanded School Mental Health (ESMH) involves providing comprehensive continuum of mental health services in schools, including assessment, intervention, prevention, and consultation.</p>	To Be Reviewed At Later Date				
<p><b>Trauma Informed Care</b></p>	To Be Reviewed At Later Date				

## Appendix 1: Background Questions for EBPs

### Prioritizing Evidence-Based Practices Background Information

**EBP Name:**

<b>Need</b>	Describe the target population for the EBP. Please indicate the number of children and adolescents who might benefit from this practice, the level of risk associated with the target population, and the cost of treating the population.
	What is the consumer/family perception of the need for the EBP?
	What is the provider perception of the need for the EBP?
<b>MH Focus</b>	Describe the problems/diagnoses/illnesses that are targeted by the EBP.
<b>Evidence</b>	Summarize the research base regarding the efficacy of the EBP.
	Summarize the research base regarding the effectiveness of the EBP.
	Summarize the research base regarding the cost effectiveness of the EBP.
	Summarize the practice-based evidence suggesting that the EBP is appropriate for different age groups, service settings, and cultural/ethnic groups, etc.

	Summarize the development and testing of materials for monitoring fidelity of implementation of the EBP.
<b>Ease of Implementation</b>	Describe the implementation process for the EBP. Include information about training requirements, technical assistance, costs for materials, etc. Indicate whether these resources are available locally or nationally.
<b>Resources</b>	Describe the costs associated with on-going use of the EBP Statewide.
	Describe current funding mechanisms used to support the EBP. Include public assistance, grants and contracts, community resources etc.
	Describe the current use of the EBP by providers in the State.

## Appendix 2: Scoring Matrix

### Prioritizing Evidence-Based Practices

Number of youth  
High risk population  
Expensive population  
Family perception  
Provider perception  
Agency perception

Need

Program cost  
Funding mechanisms  
Grants  
Demonstration projects  
Community support  
Shared departments  
Existing providers  
On-going costs of EBP  
replication & sustainability  
Administrative & system  
supports needed

Resources

Ease of  
Implementation

Buy-in  
Competing interests  
Training requirements  
Cost of implementation  
Local vs. national  
resources

Evidence

Effect sizes  
Number of studies  
Efficacy  
Effectiveness  
Cost effectiveness  
Generalizability  
Relevance (age,  
urban/rural, cultural)  
Fidelity instruments

MH Focus

Sole focus  
Primary, but shared focus  
Combined focus  
Secondary focus  
DD/DA/LD interests

EBP Name			
	High	Medium	Low
Need			
Resources			
Evidence			
Implementation			
MH Focus			
Total Score:			

Score is the sum of the five ratings. High = 5; Medium = 3; Low = 1. Midpoints can be used and scored as a 2 or 4.