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ARTICLE

Evidence Based Practice in Systems of Care for Children with Complex Mental Health Needs

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ABSTRACT

Purpose: Community-based social work with families and youth with complex behavioral health needs highlights challenges to incorporating empirical evidence into routine practice. This article presents a framework for integrating evidence in community-based Systems of Care for these children and their families.

Method: This article reviews research on various approaches to integrating evidence into children's behavioral health and community-based care and contextualizes it within dominant paradigms of Systems of Care (SoC) and Wraparound principles.

Results: Based on this review, this article proposes the Evidence-Based Practice in Systems of Care (EBP in SoC) model. The model describes how to incorporate evidence into every aspect of community-based SoCs for children with mental health concerns.

Discussion and Conclusion: Discussion of the model will focus on implications of using the framework for practitioners, mental health organizations, communities, and state and federal administration and policymaking.

KEYWORDS

Community-based social work; child and youth mental health; evidence based practice

Evidence-Based Practice in Systems of Care for Children with Complex Mental Health Needs

For the past few decades, federal policy and funding have supported the organization and delivery of public behavioral health services for children with complex mental health needs through a System of Care (SoC) framework. Today, almost every state in the nation has received federal funding to implement or expand SoCs at the state, community, or tribal level (Stroul, 2019). As SoCs expanded and the framework was adopted more widely, the Evidence-Based Practice movement spurred the development of several models for integrating research evidence into human services (e.g., Gambrill, 2006; Satterfield et al., 2009). Simultaneous efforts of the American Psychological Association supported the identification, creation, and dissemination of many specific, manualized, or codified research-supported treatments (RSTs) demonstrated to effectively reduce symptoms and increase functioning for many emotional and behavioral disorders in children (Hoagwood et al.,

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2001). Though the development of SoCs, Evidence-Based Practice (EBP) models, and RSTs all emerged out of efforts to improve services for children with significant mental health needs, they are rooted in distinct and separate origins and philosophies. As such, research efforts and conceptual development of the SoC framework, EBP, and RSTs have advanced in separate, siloed efforts.

Despite these efforts, the use of evidence in daily practice in children's mental health settings, whether it is the EBP process or RSTs, continues to be minimal (Bruns et al., 2016). Complex funding environments and government oversight create barriers to adopting and sustaining RSTs (Ganju, 2003). Additionally, many children in the public mental health systems present with medical, developmental, and behavioral comorbidities (Pires et al., 2013), where as many RSTs target one or two specific diagnoses. Further, RSTs are not formulated to fit well into the individualized, interdisciplinary team-based treatment approaches required to support these children in a system of care environment (Bachmann et al., 2010; Santucci et al., 2015). Finally, perceptions that the use of RSTs disregards clients' values and perferences (Gambrill, 2006) violates the imperative for family-driven and family-centered care in SoCs (Bruns et al., 2014; Jensen & Foster, 2010).

A guiding principle of the SoC model calls for services and supports to "include evidence-informed and promising practices" (Stroul et al., 2010, p. 6). Still, the framework offers little direction regarding how to use or select relevant evidence or interventions. This article proposes a model for incorporating a variety of evidence-supported interventions into an SoC. The model addresses the need for a roadmap to fully integrate research evidence across all service settings, providers, interventions, and funding mechanisms that make up a well-functioning and comprehensive children's system of behavioral health care. It specifies how, when, and where to use empirically supported interventions within the SoC structures and processes and highlights how to integrate Wraparound approaches into care planning with the five-step process of Evidence-Based Practice.

The following pages will briefly describe the SoC model and related Wraparound approach to care planning and coordination. Challenges in implementing RSTs and integrating evidence within community-based care systems will be reviewed, and a variety of proposed solutions will be presented. Drawing upon and integrating the broad array of possible approaches to incorporating evidence into real-world, community-based practice, a framework for conducting Evidence-Based Practice in an SoC (EBP in SoC) will be presented and explained. Discussion of the model will focus on implications of using the framework for practitioners, mental health organizations, community-wide SoC service planning, and state and federal administration and policymaking.

SoCs and Wraparound

Receiving home and community-based mental health services (HCBS) through a comprehensive SoC (Cordell & Snowden, 2017) can stabilize children and adolescents with significant and complex behavioral healthcare needs in their homes and communities. The SoC was conceptualized as a "systemic, policy-oriented change in the structure and delivery of services" (Rosenblatt & Campain, 2006, p. 202). It emphasizes linkage and coordination of care across child-serving agencies (e.g., child welfare, juvenile justice, education). It also prioritizes providing of a broad array of community-based services

over more restrictive placements such as psychiatric hospitals or long-term care facilities (Rosenblatt & Compian, 2006).

HCBS delivered through an SoC can include – but is not limited to – crisis response, intensive treatment planning and care coordination, in-home therapy, respite care, peer support, or therapeutic behavioral support services (Stroul et al., 1992). Multiple service sectors can provide these services simultaneously. As such, a vital role in the SoC is a care coordinator or case manager. This provider works to plan and manage the delivery of services to seamlessly surround a family with various supports from across the range of child-serving sectors, including mental health, education, healthcare, and social services (Stroul et al., 1992).

SoCs often use a process called "Wraparound" to plan and coordinate the range of services a child needs. Wraparound (WA) is a philosophy and approach to care planning and coordination developed alongside the SoC framework (Rosenblatt & Compian, 2006). It is a strengths-based "collaborative process for developing and implementing individualized care plans for children with severe disorders" (Bruns et al., 2004). The process is grounded in a set of principles that focus on team-based decision-making and rely on the family's perspective to determine their needs and identify appropriate goals for the plan of care. It also emphasizes engaging natural support systems from the family's community to participate in the treatment plan's goals and activities. The natural support system's participation helps develop and strengthen relationships that will remain available to the family after professional support has ended (Bruns et al., 2004). Both the SoC approach and WA emphasize youth and family voice, individualization of treatment, and the provision of culturally competent and integrated care (Rosenblatt & Compian, 2006).

The SoC framework has guided federal and state reforms in children's mental health systems for decades. The dominance of the SoC model is demonstrated in the recommendations of the Surgeon General's Conference on Children's Mental Health (US Department of Health and Human Services et al., 2000) and the President's New Freedom Commission on Mental Health (Huang et al., 2005) and is evidenced by the receipt of federal funding to establish SoCs at the state, local community, or tribal level in almost every state (Stroul, 2019). The development and administration of an SoC are primarily the responsibility of publicly funded Community Mental Health Centers (CMHCs). These organizations and their contractors coordinate with other public child and family service sectors to deliver services to youth with complex mental health needs and their families (Stroul et al., 1992).

A seminal federally funded, quasi-experimental study evaluating the SoC model found that youth receiving services through a coordinated care system had gains in clinical functioning *equal* to youth served in usual care. However, youth served in the SoC received services faster, in less restrictive settings, stayed in treatment longer, and families expressed greater overall satisfaction with services (Bickman, 1996; Bickman et al., 2004 Bickman, 1997). Further examinations of the SoC model have rarely employed random-assignment or other rigorous causal designs (for exception see Bickman, 1997), and there is variation in the extent to which studies control for disparities in state or community contextual factors. However, multiple federally-sponsored and peer-reviewed evaluations of publicly funded SoCs indicate that children and youth served through this care model demonstrate better classroom, home, and community functioning. Improved function is exemplified by reductions in school-based discipline and contacts with law enforcement and the child welfare system, improved grades, and decreased substance use. Families report reduced caregiver

strain, more support from their community, family, and friends, enhanced problem-solving and behavior management practices, and reduced reliance on formal helping systems (Stroul et al., 2012).

The evidence base for WA, though still emerging, is also promising. A meta-analysis of 7 WA evaluations – all of which were non-randomized but compared the treatment group with a control group – found an overall moderate positive effect for WA participants, based on improvements in functioning and mental health outcomes (Schurer Coldiron et al., 2017). Youth participation in WA is also associated with higher levels of family satisfaction with services (Martin et al., 2003) and reduced public spending for outpatient and inpatient mental health care (Snyder et al., 2017).

Evidence in Public Sector Mental Health Care for Children with Complex Needs

Medicaid provides comprehensive coverage for intensive and highly specialized home and community-based mental health services, while commercial health insurance plans do not (Graaf & Snowden, 2017; Howell, 2004). Due to this, combined with ongoing federal fiscal and technical support for SoC expansion (Lourie & Hernandez, 2003), children with the most complex mental health needs receive services through public SoCs. However, concerns remain about the efficacy of services provided through public SoCs (Bruns et al., 2016; Cooper et al., 2008).

Researchers and policymakers have directed significant resources to develop research-supported treatments (RSTs) and support the use of them through the establishment of clinical practice guidelines to ensure effective mental health care for children (Hoagwood et al., 2001). Research-supported treatments (RSTs) – often referred to as Evidence-Based Treatments (EBTs), or Empirically Supported Interventions (ESIs) or Treatments (ESTs) – are specific interventions, including assessment tools, treatment protocols, or multi-faceted or multi-media manual-based interventions demonstrated to be reasonably effective by at least two random-controlled trials (RCTs) or extensive and well-designed single case studies (Thyer & Pignotti, 2011). Various authorities designate clinical interventions that meet this standard of evidence (e.g., The "What Works" Clearinghouse, the Coalition for Evidence-Based Policy, the California Evidence-Based Clearinghouse for Child Welfare) as research-supported treatments, or RSTs (Thyer & Myers, 2011). Organizations like the National Guideline Clearinghouse, the American Academy of Child and Adolescent Psychiatry, and the American Psychiatric Association have developed and disseminated clinical practice guidelines (CPGs) to support the use of RSTs. CPGs draw on research findings and professional consensus to offer specific direction for assessing clients and determining what treatments to provide for various presenting conditions (Andrade et al., 2019).

RSTs and CPGs targeting the improvement of symptoms or functioning through diagnosis-specific treatments have been accumulated, cataloged, and disseminated publicly via websites, practice manuals, and clearinghouses to youth and family service administrators and practitioners (Andrade et al., 2019; Thyer & Myers, 2011). Children and adolescents receiving research-supported treatments (RSTs) are significantly more likely to achieve positive outcomes than those treated with usual care (Weisz et al., 2017). The provision of evidence-based interventions for children and families results in community and administrative cost-savings by preventing child involvement in other public service systems and increasing organizational efficiency (Fixsen et al., 2013).

However, despite the known benefits of providing empirically-proven services to children with serious emotional or behavioral disorders, the wide-spread use of such programs in public and community-based organizations has been limited (Bruns et al., 2016). Scholars have proposed that the specific and unique forces shaping community practice with behaviorally complex youth create particular barriers to using evidence in these settings (Ganju, 2003; Hoagwood et al., 2001). Funding structures and reimbursement mechanisms (contractual relationships, reimbursement rates, billable services) at the federal and state level, as well as local and federal governance structures (centralization of authority, accreditation and licensing standards, consumer protection processes, technological infrastructure), present obstacles to the adoption of RSTs (Ganju, 2003).

Further, most RSTs have limited support for working with youth with complex behavioral health needs because clinicians need to know numerous protocols to address the multiple and diverse service needs of at-risk families and youth. SoC providers would also need to build RSTs into a complex and comprehensive service array spanning multiple agencies and funding streams (Bachmann et al., 2010; Santucci et al., 2015). Additionally, the guiding principles of SoCs and WA – which hinge on flexibility and responsiveness for team-based, individualized treatment planning tailored to the unique needs, preferences, values, and perceptions of the family and youth – conflict with the highly structured, inflexible nature of many RSTs, embedded in classic models of clinician-client interactions (Bruns et al., 2014; Jensen & Foster, 2010).

Transportable, Evidence-Informed Intervention in Systems of Care

Because policy and practice prioritize serving children in their natural settings, experts have called for developing interventions that fit into these contexts (Kazak et al., 2010). The imperative to deliver mental health treatment in the usual contexts of children's lives has spurred research in the last 10 to 15 years to formulate more portable RSTs that can be delivered effectively in the "youth mental health ecosystem" (Santucci et al., 2015, p. 68). Thus, stakeholders and service providers work in non-clinical and uncontrolled settings to deliver care. These settings are dominated by the complexity of families' homes and communities, children's school policies and practices, in addition to the usual mental health and funding regulation-related constraints (Santucci et al., 2015).

Graaf and Ratliff (2018) suggest a model of Evidence-Informed Social Work (EISW) in the interest of offering flexible and portable approaches to incorporating research into community-based practice. EISW is rooted in the collaborative development of a working care plan emerging from the five-step EBP process (Gambrill, 2006), adopted from the model for Evidence-Based Medicine (Sackett et al., 1997). In this process, practitioners 1) identify information needed, 2) seek empirical information that addresses those needs, 3) critically appraise that information, 4) combine the best evidence with their professional clinical expertise and the client's values, preferences, and unique circumstances to collaboratively develop a treatment plan, and 5) evaluate the effectiveness and efficiency of the process. In the EISW model, in the absence of sufficient evidence or predictable clinical settings, practice guidelines or clinical theory should guide which RSTs, Common Elements (see Chorpita et al., 2005a), or modular treatments (see Chorpita et al., 2005b) to include in the care plan.

To facilitate this model's use, Graaf and Ratliff assert that providers should be trained and competent in a limited set of RSTs. They should also have access to more complex RST programs in the community. This training and accessibility enable client participation in RSTs if evidence and client preference suggest these types of interventions. Throughout all processes and interactions, providers should utilize the Common Factors of helping relationships (see Wampold & Imel, 2015) as a foundation in the delivery of all interventions – including shared decision-making and treatment planning. EISW and its elements are described in greater detail elsewhere (Graaf & Ratliff, 2018).

Evidence-Informed Social Work provides an excellent framework for using evidence in Systems of Care for several reasons. First, it was developed for application to community-based social work, advocating for integrating evidence in multiple levels of practice, which fits well into the multilevel, multi-organizational, and community-based SoC framework. Further, social workers account for most of the child behavioral health workforce (Frank & Glied, 2006; Salsberg et al., 2017) and are trained to work in home and community settings. As such, EISW is compatible with the educational background, professional training, and experience of the majority of the children's behavioral health SoC providers (Olson & Tracey, 2017). EISW's emphasis on the collaborative and informed decision-making process (integrating best research evidence with client perspectives, preferences, needs, and available organizational, community, and provider resources) also aligns with SoCs' core value of being family and youth-driven.

EISW also mirrors children's behavioral health services researchers' suggestions over a decade ago to integrate RSTs into the SoC framework and WA process. Weisz and colleagues (2006) highlight that SoC and WA improve service access and engagement for families and excel in cultivating and maintaining support and commitment from community and governmental partners. However, these models offer no guidance or input regarding what should happen within the actual interventions provided by service providers (e.g., schools, child welfare or juvenile justice authorities, mental health agencies) in the SoC or listed in the treatment plan. On the other hand, there are many specific, manualized, or codified mental health interventions that effectively reduce symptoms and increase functioning for many emotional and behavioral disorders in children in school, child welfare, juvenile justice, and mental health settings (Burns et al., 1999; Hoagwood et al., 2001; Weisz et al., 2017).

For this reason, Weisz and other scholars propose the unification of the two approaches to quality improvement in children's mental health services – integrating the use of RSTs into the SoC framework (Harper et al., 2014; Rosenblatt & Compian, 2006; Weisz et al., 2006): "Given that the contents of both SoCs and WA are free to vary with available services in the community, why not ensure that those specific services are, in fact, interventions that have been tested and shown to work?" (Weisz et al., 2006, p. 645). In response, in 2014, Bruns and colleagues proposed and reported on a model for integrating the use of Common Elements or modular treatments and RSTs within WA planning and care coordination processes, using the support of a formal knowledge management system. Preliminary findings from pilot programs using these approaches to WA planning and service delivery demonstrate positive outcomes for youth, families, and service providers (Bruns et al., 2014).

A Model for Integrating Evidence in SoCs Service Delivery

The conceptual practice model proposed here, illustrated below in Figure 1, builds on these ideas of integrating two levels of evidence-informed approaches to mental health care for children: the evidence-supported model of service delivery (SoC) and the use of empirically supported interventions within that model (RSTs and Common Elements or modular elements of RSTs). By combining this concept with elements laid out in the EISW framework (use of the five steps of Evidence-Based Practice, the role of theory, and Clinical Practice Guidelines in care planning; the use of Common Factors in engaging families and youth), the proposed framework attempts to integrate multiple approaches to utilizing evidence in all levels of children's behavioral health services. It illustrates the process and model proposed by Bruns and colleagues in 2014, making explicit how the five-step process of Evidence-Based Practice mirrors WA's principles and practice. It also specifies where to use research-supported treatments, Common Elements, Common Factors, and theory within the SoC service delivery approach.

Figure 1 illustrates that the process of Evidence-Based Practice is at the core of WA and the family's engagement in the SoC. This figure builds upon the most common representation of SoCs and WA as a circle of services surrounding a family and maps the use of evidence into these existing conceptualizations. First, because it involves all the elements and procedures outlined in Step Four of the EBP process, the steps of EBP can be embedded within the WA process (represented by the funnel at the top of Figure 1). In WA, the treatment team – made up of the child and family, their natural support systems, and providers from participating service sectors – combines 1) the child and family's input (personal preferences, values, needs, strengths, and goals) with 2) professional input (expertise of service providers, the best available research evidence, clinical practice guidelines, theory, and professional resources available in the community) and 3) input from the family's natural support systems (resources available to the family in their community) to collaboratively determine the course of treatment. The WA team can draw on provider expertise, research evidence (either original research, systematic reviews, or practice guidelines), and theory to identify intervention approaches most likely to help the family meet their goals. In doing so, they must consider the professional resources available within their scope of practice, their organization, and the SoC. The care plan may include carefully selected RSTs or Common Elements. These interventions and approaches can be discussed with the youth and family in the WA process, and the needs, preferences, and values of the family, as well as the limitations and strengths in professional and community resources, will be considered in the collaborative development of the plan of care.

EBP in SoC in Action

The youth, their family, the family's natural supports, and their treatment team – which includes all participating professionals in the SoC – execute the plan of care. The SoC includes the public agencies and community organizations providing services, the array of services available through all these agencies, and how these agencies or organizations coordinate – both formally and informally – to ensure smooth delivery of services. This system is illustrated in Figure 1 by the series of circles representing each child-serving agency or service sector that makes up the mental health SoC for children. The system

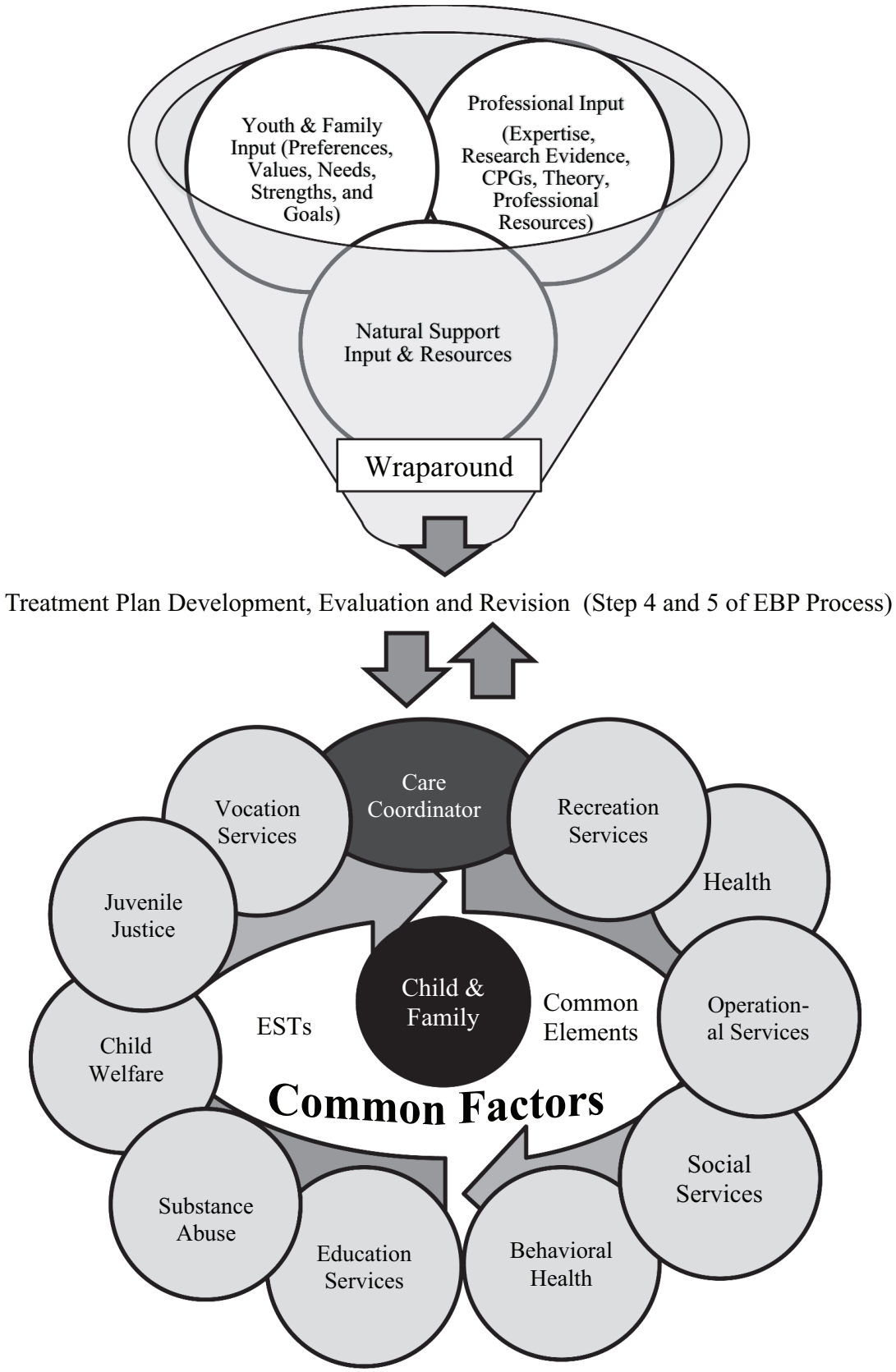

Figure 1. Evidence-Based Practice in Systems of Care.

includes behavioral health (both residential and outpatient), health, social services (e.g., child welfare, juvenile justice, welfare programs), educational services, vocational services, recreational services (e.g., camps, afterschool programs, community clubs), and operational services. Services essential to the family's smooth and effective operation in the SoC are operational services. These can include case management, transportation, advocacy, support groups, and legal services. In executing the plan of care, the SoC service providers may use judiciously selected RSTs (if available) and can draw upon Common Elements or modular treatments in their formal interventions with the family and youth in home or community settings. They can also increase family and youth engagement, belief in the process, and enhance the therapeutic rapport through the consistent employment of the Common Factors of helping relationships.

Throughout this process, the care coordinator's role is to ensure that the family receives all the services and interventions specified in the plan of care and coordinate communication across participating service sectors and providers. They monitor the family's engagement, responsiveness, and progress through communication and collaboration with the family's treatment team (Bruns et al., 2014). To do this, the care coordinator/WA facilitator can engage iteratively in steps 4 and 5 of Graaf and Ratliff's (2018) Evidence-Informed Social Work model – assessing the participants' responses to interventions and adjusting the care plan accordingly (Bruns et al., 2014). Steps 4 and 5 also monitor the treatment team's adherence to the care plan and the implementation fidelity of RSTs. The extent to which fidelity lessens and adaptations are implemented as needed – to both the care plan and any RSTs within it – should be documented and assessed for future application.

Fidelity to RSTs is likely to falter in the complex and uncontrolled environment of home and community spaces (Santucci et al., 2015). Thus, to ensure maximum system and clinical effectiveness, all participating SoC providers across all agencies should be well trained in the Common Factors and employ them in all interactions with children and their families. For example, all providers should deliver interventions in the context of a warm therapeutic alliance with the youth and family and encourage hopefulness that individual and family wellness is attainable.

Contributions of the EBP in SoC Model

Despite extensive theoretical and research literature about RSTs for children with mental health disorders, the process of EBP, and alternative means of integrating research into practice, these ideas have yet to be synthesized into a framework for use in community-based SoCs and WA processes. EBP in SoC capitalizes on EISW's explicit description of how to embed the use of RSTs, Common Elements, modular treatments, and Common Factors within the process of EBP. As such, the model makes a unique contribution to the debate about quality and the use of evidence in children's behavioral health. (Efforts to upgrade the effectiveness of children's behavioral health care have largely excluded the five-step process of Evidence-Based Practice.) The model highlights and leverages the conceptual and philosophical alignment between the five step-process of EBP, the SoC values, and WA's principles by embedding the five steps into the WA process.

It should be noted here that EBP in SoC departs from other EBP process models in a few significant ways. First, in other models of the EBP process, client input is combined with natural support system input (Matthieu et al., 2016). In the EBP in SoC model, the family's

natural supports are illustrated as separate from the child and family to highlight the importance of the family's natural supports and child and family voice as equal to that of the professional treatment team. WA's goal is to transition a family from relying on professional resources to leveraging the nonprofessional resources that exist in their community after professional services have ended (Bruns et al., 2004). The child and family's natural supports are included as a separate element to represent their equal but distinct role from the family and the professional resource team and emphasize the unique function served by natural supports in the treatment and recovery process.

Other EBP process models conceptualize clinical expertise as separate from research evidence (Haynes et al., 2002) and illustrate organizational and community environment and resources as the context for decision-making (Satterfield et al., 2009). In EBP in SoC, however, decision-making results from the input and resources available from the family, their natural supports, and the professional care team – including clinician expertise, research evidence, and the limitations and resources available in the local community. WA in many SoCs must result in an individualized plan of care that guides treatment (e.g., see Kansas Guidelines WA Facilitation Guidelines, 2012), and constructing a realistic care plan requires considering all resource limitations and stakeholder input from the start. For this reason, in the EBP in SoC framework, all contributions and resources from professional systems are encompassed in one professional element that is considered in the development of the plan of care.

Finally, the EBP in SoC model is unique from all other proposed models for EBP. It is the only one that includes the client's strengths as an element to be considered and integrated into the decision-making process. Because a core value of the SoC model is that youth and their family's strengths and needs determine the plan of care (B. A. Stroul et al., 2010), this element is essential to EBP in SoC.

Implications for Practice

Though the model proposed here attempts to integrate multiple and flexible approaches to evidence integration in care, the realities of implementation involve coordinated investment at the policy, organization, practitioner, and researcher level.

Policy Implications

As private and public funders are increasingly implementing results-based contracting and value-based payment systems (Bachman et al., 2017; Tomkinson, 2016), pressure is increasing for mental health organizations to deliver more positive outcomes. In response, states are investing in technical assistance to support implementation of RSTs or modular treatments in public systems. Some are embedding funding for RSTs into Medicaid reimbursement systems (Graaf & Snowden, 2020, 2019). Medicaid funding for these treatments reduces cost-burdens for states by sharing costs with the federal government and creates more permanent funding streams to support these treatments (Graaf & Snowden, 2019). State and local leaders across all communities and sectors can work with the state Medicaid agency to propose legislation or Medicaid plan amendments allowing Medicaid funding to support identified and prioritized RSTs more broadly. Such amendments or changes to state Medicaid plans might also include payment for non-direct service time, either through

bundling of services, episodic payment structures, or fee-for-service structures that support treatment planning and care coordination. These funding changes will allow practitioners more time for consulting research evidence and communities of practice, engaging in coaching and clinical supervision, and to meet with families to establish a care plan. Alternatively or additionally, higher Medicaid reimbursement rates for RSTs can help offset the increased costs incurred through training and measurement tracking needed to adopt such interventions (Graaf & Snowden, 2020).

States and local communities must invest time and resources in collaboration across all child-serving sectors (education, child protection, justice, health). Together, they must draw upon the best and most relevant research to identify the RSTs that would have the highest impact and the lowest barriers to sustainability for children with significant mental health needs in their community. This type of collaboration and planning encourages braiding and maximization of funding streams, enhances cross-sector buy-in and commitment, and avoids duplication of services (Graaf & Snowden, 2019). If state administrations are not supporting or engaging in this level of planning and cross-sector collaboration, local community coalitions can do so.

Researchers are developing models that can assist service system administrators in doing this, including Coordinated Strategic Action and "relevance mapping" (Bernstein et al., 2015; Chorpita & Daleiden, 2018). Relevance mapping rigorously matches clients within a community's target population with interventions identified as effective in addressing similar populations' needs. This process can identify evidence-based interventions that will best fit the variety of mental health needs and demographic characteristics of a given population (Bernstein et al., 2015). Coordinated Strategic Action builds on relevance mapping and "calls explicit attention to the interfaces of each program with other programs within the service layer (e.g., how multiple EBTs work together in an array), with non-programmatic direct services (e.g., how usual care can be managed to complement that array effectively), as well as with other layers within and beyond the system" (Chorpita & Daleiden, 2018, p. 5). This framework assists mental health system administrators in ensuring coverage for all system users' needs by coordinating intervention adoption and related infrastructure development across all agencies and service providers within a service community.

Finally, state or local policymakers can allocate funds to finance and incent the development of knowledge sharing structures that support practitioners' ability to access easily consumable and applicable research evidence (Dill & Shera, 2015; Graaf et al., 2017). Community or agency grants can award these funds. Policymakers can also allocate resources to financially and politically support practitioner and researcher partnerships (Brookman-Frazee et al., 2016), developing more transportable, effective interventions deliverable in various practice settings.

Organizational Implications

It is essential to note that many workers in community-based mental health systems for children and families are not master's level clinicians. Case managers, providers of paraprofessional behavioral supports, respite care, psychosocial groups, and parent and youth peer-support workers are usually not trained at the master's level or even required to have a bachelor's degree (e.g., see Texas YES Waiver Policy & Procedure Manual, December 2017 or New York Comprehensive Medicaid Case Management

Manual Policy Guidelines, January 2019). Because the EBP in SoC model relies heavily on practitioner training, effort, and buy-in, organizations and agencies participating in an evidence-informed SoC would need to provide guidance and time for practitioners of all professional or education levels to access, assess, and apply research evidence to their work. To develop practitioner skills, organizations must develop learning cultures that hone practitioner skills through workforce development initiatives, communities of practice, and other knowledge-sharing systems (Graaf et al., 2017). The use of knowledge brokers through partnerships with external research organizations or an internally identified role committed to the synthesis and dissemination of relevant empirical evidence can also enhance research uptake in practitioner decision-making (Bornbaum et al., 2015; Graaf et al., 2017).

Organizations would also need to invest effort and resources to adopt and sustain a handful of RSTs, depending on the community's needs and the organization's size. RST implementation will involve substantial costs for initial adoption and ongoing training and coaching, as well as costs that frequently emerge in efforts to observe and report fidelity measures and program outcomes (Lang & Connell, 2017). Organizational processes must also embed the expectation of and support for using the EBP process, practice guidelines, Common Elements or modular treatments, Common Factors, and RSTs through quality assurance practices and performance review documentation, reporting, and assessment. These processes can be cumbersome and costly for agencies (Lang & Connell, 2017), but they enhance organizational effectiveness, increasing consumer satisfaction and lowering staff burnout (Aarons et al., 2009; Caron & Dozier, 2019; Fixsen et al., 2009).

Bruns and colleagues (2014) have developed and piloted a tool to help identify and use RSTs, Common Elements, or modular treatments in direct practice settings. Their Managing and Adapting Practice (MAP) knowledge management system (Bruns et al., 2014) is a database that includes a library of 2-page summaries of the most common practice elements in RSTs. It provides a flowchart describing how to organize the elements in service delivery. MAP also includes a searchable database of RSTs for youth that delivers information about intervention content, setting, dosage, and strength of evidentiary support specific to client goals, diagnosis, age, gender, and ethnicity.

Direct practice organizations within the SoC also need leadership buy-in to obtain and leverage public financial support for quality improvement initiatives. Leadership support is needed to sustain funding and incentives for thorough and high-quality evaluations of services and organizational processes and practices and to embed the use of data into all aspects of organizational and practitioner decision-making. Well-trained and skilled evaluators need to work collaboratively with practitioners to develop methods for assessing the impact and effectiveness of RSTs and other evidence-informed interventions. Enhancement of organizational reporting infrastructures – critical for collecting accurate and high-quality data – will also be needed. Evaluation of programs, processes, and tracking of youth and family outcomes is critical to the continuous quality improvement of services (Ganju, 2006) – and is essential for organizations operating in an increasingly performance-oriented funding environment (L. Martin, 2007). These processes also facilitate the successful adoption and sustainment of RSTs (Fixsen et al., 2009) and help establish a culture of learning (Austin, 2008).

Practitioner Implications

Federal policy continues to support the development of community-based SoCs through ongoing planning, implementation, and expansion grants to states and communities. As such, practitioners of *all* levels of practice that work in communities with families – either in direct practice or administrative capacities – need to be familiar with the guidelines, principles, and structures involved in developing and executing a plan of care through an SoC. Further, given the growing evidence base, as well as the state and federal funding to support the use of WA as the central planning and coordination component of the SoC (Bruns et al., 2014; Suter & Bruns, 2009), all practitioners must understand the values and philosophy of WA. They must also comprehend the five-steps of the EBP process and how these are embedded in WA, and how the Common Factors are essential in effectively engaging families in the process.

To ensure that provider preparedness for integrating research evidence and knowledge in SoC and WA service delivery, the places within these models where evidence can and should be utilized must be made explicit through system-wide training. While many researchers and educators have shared ideas about incorporating evidence-based practice education and training into existing and established curricula (Bender et al., 2014; Bertram et al., 2014; Gambrill, 2015; Thyer, 2015), no model explicitly discusses how to equip practitioners with the knowledge and skills they will need to practice within the existing governance and service structures of children's community behavioral health. Curricula aimed at preparing service providers to engage in evidence-informed practice must consider the types of questions that can arise in in-home and community-based programs. Learning approaches must provide training that equips young professionals to confidently and competently contend with a wide variety of circumstances in a broad array of settings.

Practitioners in all SoC service agencies will need to be familiar with practice guidelines, fundamental theories of human development and family systems, and a wide variety of Common Elements or modular treatments that are effective for children with significant mental health needs and their families. Knowledge management and quality feedback tools such as those available through the MAP framework (Bruns et al., 2014) can facilitate this knowledge. Further, practitioners will likely need to be trained and skilled in delivering one or two RSTs, depending on their practice level and role within the SoC. Finally, all providers should be competent and skilled in the Common Factors of helping relationships–especially in their ability to develop a culturally responsive therapeutic rapport with diverse populations of children and families. Though clinical training for master's level, licensed providers usually teach these skills, practitioners with less experience or professional education need formal training and ongoing modeling and coaching from peers and supervisors.

Research Implications

This model's success and applicability for integrating evidence into SoCs for children with significant mental health needs rely on the successful creation of highly portable and applicable interventions. Development can be either through establishing new interventions or adapting existing protocols and treatments. It will also involve identifying and disseminating many more Common Elements, modular treatments, and practice guidelines applicable to the broad array of populations and presenting problems encountered in community-

based mental health care for children with complex mental health needs (Chorpita, 2019). Recent research investigating the level of fidelity needed to effect clinical change in established RSTs should continue (Barnett et al., 2018).

Intervention development, adaptation, and fidelity testing can be conducted effectively in collaboration with practitioners through university-community partnerships (Brookman-Frazee et al., 2016). These partnerships may also help develop RSTs for non-master's level service providers. As stated previously, these providers represent a significant portion of the behavioral health workforce in community-based SoCs targeting children with the most significant behavioral health needs. Some strides have been made to develop a protocol for strengths-based case management in children's services (Schuetz et al., 2020) and identify the Common Factors of case management (Gilgun & Hirschey, 2017). However, there are currently very few RSTs, Common Elements, or modular treatments suitable for mental health providers with only secondary education or a bachelor's degree to use. As a result, public systems have to adapt interventions and navigate associated state licensing concerns to enable non-master's level clinicians to deliver evidence-based interventions (Gopalan et al., 2019). Fully infusing an SoC with evidence will require the development and dissemination of effective interventions that can be delivered by mental health providers of all educational backgrounds and all levels of professional training in community settings.

These research-practice partnerships can also support public mental health organizations to maximize the use of data collected through their management information systems for continuous quality improvement in organizational processes, service provision, and provider skills. Such partnerships can also be leveraged to build and manage information systems that collect and integrate treatment data from members of the treatment team in other service sectors to monitor treatment plans, track RST fidelity, and assess child and family outcomes in real time.

Conclusion

The model proposed here is conceptual and presented to provide guidance and clarity about opportunities to integrate research evidence into existing SoCs and Wraparound processes. The model is not explicitly or intentionally implemented in any specific SoC at this time. However, though a significant investment of time, energy, and fiscal resources are required for SoCs to incorporate evidence fully, many states and communities are already infusing evidence through many aspects of their mental health service system (Graaf & Snowden, 2020). Several states offer Trauma-Focused Cognitive Behavioral Therapy and Multisystemic Therapy statewide. A similar number of states have implemented Family-Focused Therapy and Parent-Child Interaction Therapy in parts of their state (*Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2015*, 2017). A few states have created Medicaid billing codes for specific RSTs (Graaf & Snowden, 2020). However, because the use of the other forms of evidence in practice (e.g., Common Factors, Common Elements or modular treatments, practice guidelines, or the five-step EBP process) is not monitored as systematically as RSTs, their scope of use is unknown in children's SoCs.

System-wide transformation to the EBP in SoC model will take a significant public investment of time and financial resources – the capacity for which varies widely from state to state and from county to county (Graaf & Snowden, 2019). As such, it may be more

useful to conceptualize evidence-informed practice at a systems-level as a spectrum in which more or less evidence is utilized and incorporated – based on a system or organization's position within that spectrum and according to the resources and constraints unique to each system (Graaf & Ratliff, 2018).

The model presented here represents an initial step in codifying and communicating a roadmap for incorporating research evidence into every aspect of service delivery and mental healthcare within a community-based SoC. Developing research and practices – such as those around integrated and chronic care models and increased attention to the role of adverse childhood experiences in youth mental health – will have implications for how and what advances in understanding will be incorporated into community-based care. As such, scholars and other stakeholders should develop and adapt the EBP in SoC model as needed to respond to changing trends in public funding models and the development of new knowledge and perspectives.

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