CALIFORNIA INSTITUTE FOR MENTAL HEALTH RECOMMENDATIONS TO MARIN COUNTY COMMUNITY MENTAL HEALTH SERVICES CHILDREN'S MENTAL HEATLH

Bill Carter LCSW

January 18, 2006

CALIFORNIA INSTITUTE FOR MENTAL HEALTH
RECOMMENDATIONS TO THE
MARIN COUNTY COMMUNITY MENTAL HEALTH SERVICES
CHILDREN'S MENTAL HEATLH

INTRODUCTION

The California Institute of Mental Health (CIMH), at the request of the Marin County Community Mental Health Services (CMHS), has completed this evaluation of the county's children's mental health service system. The purpose of the evaluation is to identify system strengths and areas for improvement, with a focus upon offering recommendations designed to support the community's efforts to further improve services. There is a particular request for recommendations regarding "evidence-based practices" – practices for which there is a level of research supporting their effectiveness (See Appendix A)

Bill Carter LCSW, CIMH consultant to the project, participated in a series of meetings November 28 and 29, 2005. The meetings, organized by Marin County Community Mental Health Services, were designed as semi-structured or informal exchanges to allow participants to share information and have a dialogue with the CIMH consultant concerning areas of interest.

MEETING SUMMARY

The consultation included six meetings with a variety of service system and community constituencies. These meetings included:

- CMHS Children's Services Administrator - Ann Pring PhD, Program Manager, Youth & Family Services met with the CIMH consultant to offer an overview of CMHS children's services and the meetings that would follow.
- Early Childhood Mental Health Service Providers – Administrators, managers and service staff from county mental health departments, private provider agencies, and First 5 Marin County.
- Marin County Community Mental Health Children's Services Administrators – Administrator/managers of Marin County CMHS children's services.
- Cross Agency Administrators - Administrators and managers from county mental health, social services, and juvenile probation agencies, as well as private provider organizations.
- Community Stakeholder Meeting - Public and private agency supervisors and direct service staff from mental health, alcohol and other drug services, social service, and education agencies, as well as family members of children and youth with serious emotional disturbance/mental illness.
- CMHS Administrators – Marin County Community Mental Health Services Administrators.

The majority of CMHS children's system is focused upon providing special education services to students who qualify for Emotional Disability, and clinic-based services for children and families who qualify for Medi-Cal Specialty Mental Health Services. Special education services include CMHS support to self-contained classrooms – one elementary school, 2 middle school and 5 high school sites.

Marin County CMHS clinics are well designed facilities with art and play rooms comfortable for children and their families. Some of the clinics are not located as conveniently as CMHS would like; therefore, CMHS provides a number of services in more easily accessible community locations as well. The majority of services are individual therapy for children and adolescents with mood disorders and behavioral problems. CMHS administrators have an interest in increasing the amount of group therapy offered. There is a particularly well received parenting program, based upon the practice "Catch Them Being Good," that is offered to different sets of families: families of young children and adolescents, and English and Spanish Speaking families. CMHS clinicians and Family Partners also provide an educational and support group for families with children in residential treatment facilities. A particularly unique and innovative characteristic of this program is that it is delivered in partnership with families of children with serious emotional disturbance.

CMHS established a Placement Return Team in 2001 that has been extremely successful reducing the number of Marin county youth placed in residential facilities. Utilizing a Wraparound service strategy the county has reduced out-of-county AB 3632 mental health residential placements by 50% (from approximately 40 to 20) over the last four years.

A common area of strong interest across all of the meetings that took place in preparation of this report was *early intervention*, both for very young children, as well as older children/youth who are *at-risk* of emotional/mental health disorders. Marin County has a solid foundation upon which to continue to build services for infants and toddlers. CMHS, First 5 Marin County, and community-based private non-profit providers, with expertise serving this population are in an ongoing process to strengthen collaboration and build a comprehensive and cohesive service system. As is to be expected of a relatively new system, services are uneven across the county with some areas having more opportunities available than others. County partners are organizing a Regional Roundtable for screening and tracking in five high need areas and there are efforts to strengthen the partnerships between early childhood mental health programs and First 5 sponsored special needs and school readiness sites. A Coordinating Council created to inform the community and community-based organizations has included a focus upon early childhood development.

Consistent with the state's public mental health system Marin County CMHS does not offer a significant amount of service to children and youth who are *at-risk* of a mental health disorder. However, CMHS provides a clinician consultant for one program for children 0-5 years, which is an early intervention service that has strong evidence of its effectiveness – Second Step. The county is pleased with its experience with this

program, but notes that many schools do not have the infrastructure to support it, inhibiting its broad adoption across the county.

The Mental Health Services Act is entering the Community Supports and Service development phase of implementation. This phase emphasizes the creation of Full Service Partnership Programs[1], for different populations. Marin County CMHS planning has identified two priority areas of Mental Health Services Act program development in the area of children's mental health:

1. Retain Children's System of Care[2] as a Full Service Partnership Program(s) with a focus upon youth in the probation system and Community School. Continue CSOC support for Family Partnership Programs.
2. Developing a Full Service Partnership Program for Transition Age Youth.

Stakeholders across the service system and community have common interest in improving evaluation, and CMHS has identified Managing for Results as priority area for future development. Marin County Child Welfare, Juvenile Probation, Private Provider Organization administrators and managers are linking their interest in increased evaluation to the implementation of evidence-based practices. During the Marin County visit for this project, the CIMH consultant reviewed a training *Applying Evidence-based Practices*, that offers information and principles Marin County can consider as it develops strategies in this area. This training is designed to provide an introductory overview of the strengths and limitations of evidence-based practices, including strategies that require administrators and direct services staffs to function differently than they traditionally have.

RECOMMENDATIONS

Each of the meetings that took place in support of this project concluded with a review of specific requests for recommendations. This report offers preliminary recommendations for all requests documented. See Appendix B for a full listing of the requests by stakeholder group. Recommendations are organized into three areas:

- Expanding Services
- Improving Outcomes with Evidence-based Practices
- Building capacity to evaluate services and systems.

Primary recommendations include those that address high priority areas of interest, areas in which there is very broad interest across stakeholders and/or hold promise for more significant positive impact upon Marin County CMHS. Secondary recommendations, summarized in Appendix C, address areas that are of interest to a particular subset of stakeholders and/or may have modest or distant impact upon CMHS.

[1] Full Service Partnership Program is a construct designed by the California Department of Mental Health in its implementation of the Mental Health Services Act.
[2] State funding for Children's System of Care was reduced and eventually eliminated in FY 03-04.

Table 1: Primary Recommendations
Expanding Services
Recommendation 1**:** Deepen and broaden the interagency collaborative efforts in Marin County to improve services and enhance CMHS's ability to implement evidence-based practices.
Recommendation 2**:** Complete an analysis or fiscal mapping to determine whether or not funding is being maximized.
Improving Outcomes with Evidence-based Practices
Recommendation 3: Adopt a two pronged approach that includes implementing evidence-based practices and evaluating existing practices
Recommendation 4**:** Choose a strategy for implementing the Mental Health Services Act Full Service Partnership Program(s) (FSPP), that is consistent with support for evidence-based practices: • Strategy A: Choose practices with strong evidence, which meet all or most of the FSSP criteria. OR • Strategy B: Implement a Care Management process that has access to a continuum of evidence-based practice.
Recommendation 5**:** Conduct an analysis of the Marin County Transition Age Youth (TAY) population and consider Assertive Community Treatment (ACT) and/or Transition in Independence Process (TIP) as FSPP(s) for TAY.
Recommendation 6**:** Implement one effective/efficacious parent training program and one effective/efficacious family intervention**.**
Recommendation 7**:** Implement Multidimensional Treatment Foster Care.
Building capacity to utilize data to select, implement & evaluate services & systems
Recommendation 8: Build capacity to implement and sustain practices with high fidelity.
Recommendation 9**:** Establish an outcome and evaluation process that monitors service fidelity, practice outcomes and system outcomes.

RECOMMENDATIONS AND DISCUSSION

Expanding Services - Marin County CMHS is poised to expand services to reach more children and families with mental health needs. The Mental Health Services Act is creating opportunities to intensively respond to the needs of traditionally unserved, underserved and inappropriately served populations. Stakeholders across service systems and the community express a strong desire to increase the provision of early intervention services for very young children, and older children/youth who are at risk of developing serious emotional disorder/mental illness.

Recommendation 1**: Deepen and broaden the interagency collaborative efforts in Marin County to improve services and enhance CMHS's ability to implement evidence-based practices.**

Effectively expanding services requires high levels of interagency collaboration. Effective collaboration across agencies, at all levels (e.g. direct service staff, management, administration), including youth and families of children in need of mental health services, creates opportunities to develop and implement effective strategies, and maximize community resources to increase early identification, access, and coordination of care.

Similarly, high fidelity implementation of any practice - a theme of many of the recommendations to follow - can be difficult for smaller counties, requiring strong interagency collaboration. Establishing practices with high fidelity requires a lead manager who is dedicated to the project, specific caseload sizes with both minimum and maximum limits, and a commitment to staff training and monitoring. Efficient and effective implementation of evidence-based practices will require strong collaboration between county mental health, child welfare, health, education, alcohol and other drug services, and juvenile justice departments, along with community-based organizations and private providers. Sharing resources, work force, and consumers (children and families) will be necessary for the county to build and maintain high quality services in the manner proposed.

There are many instances of strong interagency collaboration in Marin County. For example, the previous section described the collaborative efforts to establish services for children 0-5 years. Additionally, the Interagency Case Management Council (IACMC), composed of representatives from Juvenile Justice, CPS, Education, Marin Employment, CBOs and other stakeholders meets monthly to discuss shared cases and problem solve across agencies.

However, there are indications suggesting opportunities for new levels of collaboration that hold promise for supporting the changes that are sought. For example, juvenile probation, child welfare and mental health independently place children for whom they are responsible, in residential care. Similarly, child welfare makes most arrangements for mental health services for children and families served on its own. Joint efforts to establish, support and utilize evidence-based programs for these populations will be necessary for Marin County to realize the system transformation it envisions.

***Recommendation 2*: Complete an analysis or fiscal mapping to determine whether or not funding is being maximized.**

It is very difficult for counties to expand to serve children and families who do not have Medi-Cal or other benefits. Counties that have been able to expand services to this population accomplish this through careful fiscal analysis and planning that assures that all funds are maximized to purchase the most services. It is not unusual for counties that undertake this type of effort to find that one agency is spending funds for services that would be better purchased with other resources. For example, counties have found that Child Welfare spends realignment funds to purchase Medi-Cal eligible services for Medi-Cal eligible clients. When these counties maximize Medi-Cal, additional state and federal dollars flow into the county and county realignment funds are freed up to purchase services for those who are not qualified for Medi-Cal. It was not clear following the visits to Marin County whether or not a careful analysis has been recently completed. If so, Marin may be doing as much as it can. If not, it may be that Marin has an opportunity to utilize existing fiscal resources to expand services.

Improving Outcomes with Evidence-based Practices

There is a growing body of research demonstrating that some practices are more effective than others. Recognition of this, along with the fact that very few practices with strong research support are currently available, has led to a call for the implementation of "evidence-based" practices. (See Appendix A for CIMH Introduction of Evidence-based Practices.)

Practices supported by high level research hold promise for improving outcomes for children, youth and families, and result in significant cost savings. Marin County CMHS has identified the adoption of practices with research support as a priority area, and are interested in choosing research supported practices as they move forward with new initiatives and system/service improvement activities. See Table 2 for a Summary of Marin County Interests and Related Practices.

Recommendation 3: **Adopt a two pronged approach that includes implementing evidence-based practices and evaluating existing practices.**

Adopting mental health practices that research has established as effective or efficacious holds promise for improving child and family outcomes. However, most practices currently offered in mental health systems are untested. Replacing all existing services

with established evidence-based practices is neither feasible nor preferable. First, there are many conditions for which there are no practices that have strong research support. Second, high fidelity adoption of a practice is complex and embarking upon an effort to replace all existing untested practices with new evidence-based practices may not be feasible. Lastly, it is very likely that some existing, untested, practices are effective. Replacing practices that are "home grown," functioning well and effective would be an unfortunate expenditure and loss of resources. Therefore, CIMH recommends that CMHS apply a two pronged approach.

A two-pronged approach encompasses the following:

1. When establishing a new service or replacing an existing service that is not achieving desired outcomes, adopt a practice with research that supports a known level of effectiveness – an evidence-based practice.
2. When there is confidence in an existing untested practice, systematically evaluate it with sufficient rigor to allow for monitoring of fidelity to the stated treatment protocol and achievement of child and family outcomes.

Prong 1, adoption of practices with established effectiveness, promotes quality by selecting and implementing practices that have been proven to be effective in controlled national trials. Prong 2, evaluation of current practices, promotes quality by clarifying which of the many practices currently used, but unproven, demonstrate effectiveness. All practices under Prongs 1 and 2 will be evaluated for fidelity (model adherence) and achievement of child and family outcomes. Through this process, treatments that show positive outcomes will be identified, supported and expanded while those that are shown to be ineffective can be revised or discontinued.

***Recommendation 4*: Choose a strategy for implementing the Mental Health Services Act (MHSA) Full Service Partnership Program(s) (FSPP) that is consistent with support for evidence-based practices:**

- **Strategy A: Choose practices with strong evidence that meet all or most of the FSSP criteria. OR**
- **Strategy B: Implement a Care Management process that has access to a continuum of evidence-based practices.**

The Mental Health Services Act, Community Services and Support, Full Service Partnership Programs are to be designed to have the following characteristics:

- Offer services 24 hours a day, 7 days a week
- Assign a Care Manager
- Have the flexibility to "do whatever it takes" to support the child and family

Strategy A: Choose practices with strong evidence that meet all or most of the FSSP criteria.

By choosing a practice that has strong research support for its effectiveness, and meets the needs of the identified FSPP population CMHS will serve, the county can increase the

likelihood that it will achieve superior outcomes. Three practices, Multidimensional Treatment Foster Care, Multisystemic Therapy, and Family-based Intensive Case Management, have the highest levels of research support – Effective or Efficacious. A fourth practice, Wraparound, has much less research support and is considered a Promising Practice.

1. *Multidimensional Treatment Foster Care* (*MTFC)* - Multidimensional Treatment Foster Care (MTFC) is a cost effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents[3] who have problems with chronic antisocial behavior, emotional disturbance, and delinquency, including youth in the child welfare system. Community-based foster families are recruited, trained, and closely supervised to provide MTFC adolescents with intensive supervision at home, in school, and in the community; clear and consistent limits with follow-through on consequences; positive reinforcement for appropriate behavior; a relationship with a mentoring adult; and separation from delinquent peers. In addition, a team of practitioners provides individual therapy and skills-based intervention for the youth, and family therapy and parenting skills training for biological parents. Finally, 24-hours 7-day a week support is provided by the lead clinician. The average length of stay in MTFC is 8-9 months. CIMH is supporting the implementation of MTFC in nine California sites, and there is one site that is implementing MTFC independently.

2. *Multi-Systemic Therapy (MST)* - Appropriate for youth residing in their homes but at-high risk of out-of-home placement, Multisystemic Therapy (MST) is an intensive community- and home-based program that primarily targets serious, violent and/or substance abusing juvenile offenders (12-17 years of age). Teams of practitioners (master's or doctoral level) work together and are available 24-hours a day, everyday. Therapists have multiple contacts with the family each week. The average course of treatment lasts 60 hours over 4 months. Therapists partner with youth and families, to empower and improve their effectiveness to build on natural supports and access needed services to enhance protective factors and reduce risk factors. Therapists use a combination of approaches including cognitive-behavioral, life/social skills training, peer-resistance education, parent training and family therapies. Once engaged, parents or guardians collaborate with the therapist on best strategies to set and enforce curfews and rules, decrease the adolescent's involvement with deviant peers and promote friendships with pro-social peers; improve the adolescent's academic and/or vocational performance, and cope with any criminal subculture that may exist in the neighborhood.

3. *Family-Centered Intensive Case Management* – This is a very specific intensive case management model, to be distinguished from generic or other intensive case management models. While this program, developed by Mary Evans and Mary

[3] *Early Childhood Treatment Foster Care* is a promising program for younger children, adapted from MTFC.

Armstrong through the New York State Office of Mental Health, has strong research evidence it has not been disseminated widely.

4. *Wraparound* – Wraparound is a planning process that is child/youth and family driven, resulting the use of formal and natural supports to assist children/youth and families meet their goals. Wraparound has mixed research findings and is considered a promising practice. National evaluations, to date, find that Wraparound, like Children's System of Care, brings considerable improvements in the following areas:
    - Reducing group home placement rates.
    - Improving continuity of care.
    - Increasing child and family satisfaction.

   However, Wraparound has not demonstrated improved child and family outcomes, and is more expensive, when compared to usual care.

Strategy B: Implement a Care Management process that has access to a continuum of evidence-based practice.

Employing this strategy, CMHS would utilize a generic intensive case management model that is served by a continuum of evidence-based services. The case management function would support the child/youth and family's full participation in the planning process, organize the sequence of services (chosen from a menu of evidence-based practices) and provide the 24/7 response capability. The individual evidence-based practices would target specific needs.

This option would require planning for implementation of a number of evidence-based practices that would meet the needs of the FSPP. All of the practices described throughout this report would be practices to include in such a continuum.

***Recommendation 5*: Conduct an analysis of the Marin County Transition Age Youth (TAY) population and consider Assertive Community Treatment (ACT) or Transition in Independence Process (TIP) as FSPP(s) for TAY.**

Transition Age Youth may be divided into two different populations with very different needs. The majority of TAY who have been served in the child service system can be described as having serious emotional disturbance. Another set of TAY will be experiencing the early stages of serious mental illness, and include the population that has traditionally been served by the adult mental health system. These two populations have some characteristics in common; however, they have very different needs as well. Marin County CMHS should complete an analysis of the TAY population they expect to serve and adopt a Full Service Partnership Program(s) accordingly.

All of the programs previously reviewed have been found to be effective with a subset of youth who fall within this age range. Therefore, each one can be implemented as the FSPP for adolescents who fit the age range and profile of those for which the practices are proven. However, to fully serve TAY a system may need to identify other practices

that have been developed for TAY in the upper age range (19-25 yrs.) and/or those who are independent. Two options, practices with considerable or growing research support, merit consideration when creating a FSPP for TAY 19+ years:

1. Assertive Community Treatment (ACT) – ACT has very strong research support for its effectiveness with adults, including young adults with serious mental illness. Marin County has experience implementing this program, as it is a part of a study of a forensics application of ACT. It may be efficient and economical to consider a TAY FSPP based upon ACT. In this case, the CSOC FSPP could be available to youth under the age of approximately, 18 years, and ACT could be available for older youth and/or youth who will be imminently independent of family. The research support for this practice points to its use with the TAY population that is experiencing serious mental illness.
2. Transition in Independence Process (TIP) - TIP has been developed and is being studied by Hewitt "Rusty" Clarke PhD. and his colleagues at the University of South Florida. Dr. Clarke did one of the few random assignment control group studies of Wraparound and built the TIP program from this experience. With a growing research base, this is an emerging or promising practice that is one of the few programs developed specifically for the TAY population. It is likely that this program is most appropriate to the TAY population that has experienced serious emotional disturbance, and continues to exhibit social and developmental (emotional) delays.

***Recommendation 6*: Implement one effective/efficacious parent training program and one effective/efficacious family intervention.**

Implementing one effective/efficacious parent training program and one effective/efficacious family therapy will address a number of Marin County priorities. These interventions are the most effective for the largest and highest service utilizing percentage of consumers - children and adolescents with conduct disorders and other emotional problems. For children 12 years and younger there are more parent training practices available[4]. For adolescents, there are several proven family therapy interventions. These interventions can prevent and can be alternatives to out-of-home placement. Moreover, they can be delivered as community – home – and/or clinic-based services. Lastly, several effective or efficacious practices in these two categories have research supporting their effectiveness with culturally/ethnically diverse populations, including African-Americans, Latinos and Caucasians.

Parent Training Programs That Are Effective/Efficacious

There are a significant number of parent training programs from which to choose. Two merit additional consideration:

- Incredible Years – Incredible Years is a prevention and early intervention program, for children 4-8 yrs that includes five components. The components are parent training (BASIC & ADVANCED – inc. a component to teach parents how to support their child's school performance), teacher/school based (Teacher

[4] In addition to Triple P, other parenting programs for families of older children and adolescents include, Parenting Wisely and Adolescent Transitions Program.

Training & Classroom IY) and small groups with children (Dina Dinosaur Curriculum). It is required that BASIC Parent Training be offered; however, other components can be added to meet community needs. CIMH is sponsoring the implementation of Incredible Years based upon the strength of its research support, the unique video vignette format that supports strong adoption of the practice, and the flexible and comprehensive multi-component nature of the practice.

- Positive Parenting Program or Triple P Parenting – Triple P is designed for a larger age range of children 0-16 yrs. This program distinguishes itself in that it has individual components that are Universal, Selected and Indicated interventions ranging from a public service campaign delivered to the entire community, to brief phone or session consultations to parents, to intensive group and home-based family interventions. One county in California is embarking on an independent implementation of this program.

There are many other parent training programs, each with unique characteristics that may appeal to Marin County communities. These programs include, but are not limited to: Strengthening Families, Helping the Noncompliant Child, Adolescent Transitions Program, Parenting Wisely, Parent-Child Interaction Therapy and Raising a Thinking Child. More information on these programs can be provided upon request.

Supplementary Recommendation Regarding Parent Training Programs: Marin County CMHS utilizes the program "Catch Them Being Good," and delivers it in a comprehensive manner. I was unable to ascertain the level of research support for this program. It is not listed on a number of sites that track effective parenting programs, and a search of the program's name did not find any research support for this program. Among Marin County staff interviewed, there is considerable enthusiasm for "Catch Them Being Good." If the support for, and the investment in, this practice is such that Marin County CMHS is reluctant to replace it with a practice established as effective or efficacious, it may be appropriate to consider retaining and evaluating it. The first step would be to conduct a thorough review to conclusively determine what level of scientific support exists for the practice. If it is not an effective, efficacious, or perhaps a promising practice, Marin County CMHS may carry out an effort to evaluate it. This would be a rigorous process that would require defining the practice, developing fidelity tools, etc.; however, the staff and community may determine that it is worth the effort.

Family Therapy Practices that Are Effective/Efficacious

There are several family therapy practices with extremely strong research support for their effectiveness with very high need youth and families. Options include:

- Functional Family Therapy (FFT) – Targets youth, aged 11-18, at risk for and/or presenting with delinquency, violence, substance use, Conduct Disorder, Oppositional Defiant Disorder, or Disruptive Behavior Disorder. FFT is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. FFT is being implemented in seven California counties through CIMH supported projects, and one county is implementing independently.

- Multidimensional Family Therapy - Multidimensional Family Therapy (MDFT) is a family-based treatment developed for adolescents with drug and behavior problems and for substance abuse prevention with early adolescents. The MDFT intervention has evolved over the last 17 years within a federally funded research program designed to develop and evaluate family-based drug abuse treatment for adolescents. CIMH is beginning its first project to support MDFT implementation in California sites early this year.
- Brief Strategic Family Therapy (BSFT) - The target population is children and adolescents between 8 and 17 years of age displaying, or at risk for developing, behavior problems, including substance abuse. BSFT adopts a structural family systems framework to improve youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms. There is one independent implementation of BSFT in California.
- Multisystemic Therapy (MST) – Reviewed previously.

Recommendation 7**: Implement Multidimensional Treatment Foster Care.**

As reviewed in Recommendation #1, MTFC, a practice with strong scientific support could be a MHSA FSPP. However, MTFC can address other Marin County CMHS goals as well: further reducing the number of children placed out-of state, out-of-county and in residential treatment facilities.

Over the last four years, Marin County CMHS has made a significant reduction (50%) in the number of children and youth placed out-of-county in residential placement facilities. Twenty to twenty five children are placed via special education, and another twenty are placed by child welfare and juvenile probation. Most of these youth are adolescents. Approximately one-third of special education placements are made unilaterally by families.

Given the reduction in placements already achieved, I expect that the remaining children and youth placed in residential treatment settings are extremely high need and are judged to be, unprepared to benefit from available Wraparound services. While CMHS may be able to further reduce the need for residential treatment with the introduction of community-based and family therapy practices reviewed in previous recommendations; it is likely that CMHS would benefit from an effective/efficacious service to children and youth who require out-of-home placement.

Reports from the research on residential treatment range from finding few if any positive outcomes to negative outcomes. Only one out-of-home placement alternative has been supported by high level research as effective/efficacious – MTFC. MTFC was reviewed briefly earlier in this report; however, two additional points will be addressed here.

First, some Marin County representatives expressed questions as to whether or not Marin County can support a foster care program, because recruiting foster homes in the county has been very difficult. Given property costs and other economic factors, there is concern that a sufficient number of MTFC foster homes cannot be recruited and sustained in

Marin County. Before investing in implementation of MTFC, Marin County should consult with TFC Inc., the developer of MTFC, as well as two California counties with similar economic environments that have successful MTFC programs – San Luis Obispo and Orange counties.

Secondly, MTFC is a complex program to implement and sustain, and any county undertaking it should look carefully at the resources and effort it requires. However, CIMH has teamed with TFC Inc. to submit a research grant proposal to NIMH and SAMHSA. It has received very positive feedback and there is reason to believe it will be accepted. If funded, this project will offer training and technical assistance, free of charge, to all interested counties. Marin County could join this project, drastically reducing the cost of implementation, to pilot MTFC.

If over a multiyear period Marin County continued it's Wraparound program and Placement Return Team activities and established a strong parent training program, an effective family therapy, and Multidimensional Treatment Foster Care, it could be assured that it has a comprehensive strategy to reduce or eliminate the need for residential placement.

Table 2: Summary - Marin County Interests and Related Practices

	Key Informant Areas of Interest							
Practice	**Level of Scientific Evidence**	**Imple-mented in CA**	**FSPP**	**Universal Selected Indicated**	**Includes School-based Services**	**Group Format**	**Addresses Conduct Disorder**	**Prevents Need for Group Home Placements**
Incredible Years	Effective	X		U, S, I	X	X	X	
Triple P Parenting	Effective	In process		U, S, I		X	X	
Functional Family Therapy	Effective/ Efficacious	X		I			X	X
Multidimensional Family Therapy	Effective/ Efficacious	In process		I			X	X
Multisystemic Therapy	Effective/ Efficacious	X	X	I			X	X
Brief Strategic Family Therapy	Promising	X		I			X	
Multidimensional Treatment Foster Care	Effective/ Efficacious	X	X	I			X	X
Intensive Case Management	Effective/ Efficacious		X	I			X	X
Wraparound	Promising	X	X	I			X	X

Building capacity to utilize data to select, implement and evaluate services and systems

In order for Marin County CMHS to carry these and other recommendations to conclusion, it will be necessary to build the capacity to effectively select practices to

establish within the system, implement new practices with fidelity, monitor the fidelity of all services provided, and collect and analyze outcome data and make decisions about course corrections.

Recommendation 8: **Build capacity to implement and sustain practices with high fidelity.**

Perhaps the single greatest barrier to high fidelity adoption of effective practices, in the experience of CIMH, has been reliance upon the traditional approach to implementing innovation. These familiar approaches are incompatible with the high fidelity adoption of new practices, and counties must develop strategies that fit their culture to address this. High fidelity practice delivery will require a well developed and detailed plan for the implementation of new practices. Building capacity for this will require, but not be limited to, dedicating administrative/management staff and developing a strategic plan. Some considerations for this planning process include:

- Be cautious when selecting new practices. Some require more investment of staff, staff time, and other resources than others. Choose the practice that meets your county needs and is feasible given resources.
- Dedicate a specific administrative/management staff member to lead the implementation process.
- Consider staff assignment strategies that will increase the efficiency of the uptake of the new practice. When staff are a part of the decision process to adopt a new practice their investment increases, and the ability to learn the new practice improves.
- Adopt a two pronged approach that adopts new practices and evaluates existing practices. When creating a new program, or replacing a program that is clearly unsuccessful, engage in the high fidelity adoption of new effective or efficacious practices. However, at the same time begin to evaluate existing "home grown" practices in which the county has confidence – defining the practice, establishing fidelity tools, monitoring delivery and analyzing outcomes.

Recommendation 9: **Establish an outcome and evaluation process that monitors service fidelity, practice outcomes and system outcomes.**

County Mental health departments have few resources to support active evaluation of services and systems; however, this is a key set of activities that allows the community to understand the effectiveness of mental health services, where outcomes are strong and where they must be improved. This information is necessary to continue to transform a system for the better. An effective evaluation system evaluates three levels:

Level I – Service Fidelity
Level II – Practice Level Outcomes
Level III – System Outcomes

Level I – Service Fidelity
This level of evaluation monitors the degree to which a child/family receives a high quality service. It allows determination of whether outcomes are the result of the service or poor service delivery. Each practice has, or must have developed, a unique fidelity tool to be used for this level of monitoring. Service Fidelity answers the question – Did the child and family receive the service as it is designed, with adherence to the model?

Level II – Practice Level Outcomes
Practice level outcome measures provide data regarding the effectiveness of a particular practice or cluster of practices. It measures individual child/family change, outcomes that can be observed during or soon after treatment. Practice Level Outcomes answer the question – Did the practice result in achievement of expected outcomes?

Level III –System Level Outcomes
System level outcomes measure overall effectiveness of the system. Similar to the State Performance Outcome Measurement Process that was in place up to two years ago, it is designed to provide data about how the overall system(s) is doing. System Level Outcomes answer the question – Does the system insure that children and families have access to effective services resulting in community-wide improvements?

A complete implementation of such an outcome and evaluation structure will be a key component of some of Marin County Community Mental goals:

- High fidelity implementation of evidence-based practices.
- Managing by results
- Supporting transformation of the mental health system.

CONCLUSION

The preceding review and recommendations are preliminary, and CIMH is prepared to follow up and offer Marin County Community Mental Health Services more information and support for next steps. As a part of this project, CIMH will continue to consult and offer a report addenda in response to questions and requests for information. As Marin County takes next steps forward CIMH may be able to support the county though other Institute projects, or create Marin county specific activities.

APPENDIX A
EVIDENCE-BASED PRACTICES OVERVIEW

Use Treatments with Proven Effectiveness

All services are intended to be helpful; however, an increasing body of research on the effectiveness of mental health treatments indicates that some treatment approaches are more effective than others. As a result of this research, a growing emphasis is being placed on identifying and linking families to proven practices that exist within the current service system, and in adopting proven practices when an opportunity exists to develop new programs or expand the capacity of the current service systems.

Evidence-based practice is a general term referring to practices with some level of research supporting their effectiveness. Effectiveness research is designed to investigate the degree to which a particular treatment results in, or is responsible for, the achievement of one or more specific outcomes (child and family goals). The relationship between mental health or social service interventions and the achievement of child and family goals is complicated. Research studies try to sort out the degree to which a particular outcome is the result of the intervention itself, as opposed to other factors in the life of a child and family.

A variety of research designs and methods are helpful in determining the impact of a particular treatment. Stronger or better controlled research studies support stronger conclusions about the impact of the treatment. Treatment effectiveness research is developmental, with increasingly rigorous research progressing over time in the course of investigating a specific practice. Confidence in the effectiveness of a practice, the degree to which the practice is likely to achieve outcomes comparable to those in published studies when implemented in local communities, is increased when the research has been rigorous, conducted in real-world settings, and replicated by independent investigators (researchers other than the developer of the practice).

It is increasingly important for administrators who are responsible for program development to be knowledgeable about a practice's level of effectiveness or level of science. Information about a practice's level of scientific support can be challenging to locate; however, a growing number of resources have been developed by federal and state agencies, and universities that help organize and make this information available. Although the terms used to describe levels of treatment effectiveness vary, the following general categories are helpful:

- *Effective and efficacious*—refers to a practice that consistently achieves positive outcomes, based on a course of rigorous controlled research (random clinical trials). When the research is conducted in real-world settings it is referred to as *effective*, and when the research is conducted only in controlled settings it is referred to as *efficacious*. Confidence in the feasibility of implementing a practice in a new community is higher when the course of research includes studies conducted in real-world settings.
- *Not effective*—refers to a practice that consistently fails to achieve positive outcomes, based on a course of rigorous controlled research.

- *Promising*—refers to a practice that has shown positive outcomes based on one or more "quasi-experimental" research studies. Quasi-experimental studies consist of a broad range of methods that are less rigorous than random clinical trials. This level of research is commonly a precursor to random clinical trials.
- *Emerging*—refers to a distinct practice, based on a clearly articulated theory, that is grounded in the literature, or supported by expert-opinion, and is the focus of planned effectiveness research.
- *Not researched*—refers to the large number of practices routinely available in service systems that have not been the focus of research. These practices may or may not be based on a clearly articulated theory, but in either case they have not been the focus of any outcome evaluation. The effectiveness of these "usual care" practices is not clear.

It is advisable to consider the effectiveness of a practice when developing or improving programs, giving priority to practices that have demonstrated effectiveness. However, practices with lower levels of research supporting their effectiveness, including promising and emerging practices, may be strong options when there is not a suitable alternative practice with a higher level of proven effectiveness available, or when there is a deliberate decision to implement and evaluate a new or innovative, promising or emerging practice.

APPENDIX B
AREAS OF INTEREST IDENTIFIED BY KEY INFORMANTS

CMHS Children's Services Administrator

- Developing effective CSOC and TAY Full Service Partnership Programs.
- Looking for opportunities to further reduce the number of children and youth served in residential treatment.
- Improving and increasing the amount of group therapy and treatment for mood disorders at the clinics.

Early Childhood Mental Health Services Providers

- Offering evidence-based parent training and school-based skills training.
- Introducing early mental health screening into pediatric offices.
- Learning more about public health home visiting programs.
- Funding for early childhood mental health services for children who don't have Medi-Cal.
- Taking the current MH consultation model to scale in county, offering it to all family-based and other child care centers.

Marin County Community Mental Health Children's Services Administrators

- Implementing evidence-based practices, when current staff is spread thin with maximum work responsibilities.
- Learning more about how other Counties have integrated CSOC and EBP.
- Identifying the best practices for children who are oppositional and defiant.

Cross Agency Administrators

Because this meeting had a training format, I did not collect information about areas of interest. CMHS may consider convening another meeting of this important stakeholder group, with or without the CIMH consultant, to do so. CIMH can write an addendum to this report responding to areas of interest.

Community Stakeholder Meeting

- Learning about how other counties are delivering integrated services.
- Learning more about how other counties are collaborating and consolidating federal, state and local initiatives.
- Investing more in prevention and early intervention.
- Increasing community-based services.
- Serving children at-risk of developing emotional and/or mental health disorders. For example, children whose parents may have mental health or AOD needs.

CMHS Administrators

- Managing for results.
- Determining when services should be delivered by CMHS or CBO.
- Creating shared community understanding about and investment in evidence-based practices.

APPENDIX C
SECONDARY RECOMMENDATIONS AND DISCUSSION

***Recommendation A*: Review the outcomes of the BEST PCP project and Infant Preschool Family Mental Health Initiatives (IPFMHI) in California.**

Utilizing standard well baby and other pediatric appointments to improve screening for social-emotional health, is a very high priority in the early child mental health field. However, health insurance benefits limit the amount of time and services pediatricians can offer during these appointments, and there is little incentive or ability for physicians to do this screening. Similarly, counties do not have a long history providing mental health services for infants, toddlers and their families. Two projects in California may offer information from which Marin County can benefit.

With the BEST PCP Project, the state departments of health services and mental health, with national funding, are piloting two efforts to introduce early mental health screening into standard pediatric care. The results of these efforts may provide information or create opportunities for Marin County to promote improved screening.

IPFMHI has been a project in which eight counties, with support of First 5 California and DMH, developed and evaluated early childhood mental health screening, assessment and treatment services. Most recently this project published three guides to support other county efforts to improve services for this population. The following guides can be accessed at www.cimh.org.

- *Mental Health Screening and Referral Capacity for Children 0-5*
- *Compendium of Early Childhood Social-Emotional Development Screening Tools*
- *Strategies for Financing Mental Health Screening, Assessment and Services*

***Recommendation B*: Review the Nurse Family Partnership Program.**

There was a request for more information about public health nurse home visiting programs. The Nurse Family Partnership Program has extremely strong research support for outcomes for first time mothers and their children. The outcomes are very broad including those important to mental health, child development, health, child welfare and alcohol and other drug, and employment. Furthermore, several positive outcomes were found at follow up fifteen years later.

It is not clear that Marin County interest in this area is strong enough to recommend its implementation; therefore, the recommendation is that interested parties review some of the program information and data and make a determination about whether or not to move forward.

***Recommendation C*: Conduct an analysis of the Mental Health Consultation Model currently promoted in Marin County.**

Jewish Family Services representatives described their early childhood consultation model, developed in cooperation with UCSF, that is under evaluation. This program is perceived as being very successful and they have a desire to take it to scale in the county.

Early childhood consultation models are very popular in the field; however, there has been very little research into the effectiveness of this type of approach. The model described likely has considerable promise; however, given the lack of research support I recommend that the practice be evaluated further before a decision is made to propagate it throughout the county. A thorough analysis of this practice, along with evaluation of others that may exist and a review of the literature will assure a well considered and fully informed decision, if CMHS takes such a practice to scale across the county.

***Recommendation D*: System and service plans should develop principles that guide decisions about what agencies, public or private, should deliver different services.**

A strong local mental health system will have an appropriate mixture of publicly and privately operated services, delivered in the context of effective community collaboration. The determination of which services should be delivered by county programs and which by private non-profit community-based providers is affected by a significant number of considerations. Marin County CMHS planning efforts should identify principles to use to guide decisions about how services should be delivered. Such principles can be developed in a process with those who understand the system and community; however, examples of what these principles can encompass follow:

- Consider the culture of the community served and the agencies providing services. Research suggests that outcomes for consumers of color improve when services are delivered by ethnic specific service agencies.
- Consider agency access to, and credibility within, the community to be served.
- Consider the impact of resource availability upon service delivery. Who has the most flexibility to provide 24/7 staffing? What agencies have the most responsibility for, and access to, intensive services for high need children, youth and families?
- Consider which agencies can recruit the most qualified individuals.
- Consider how care coordination and delivery of specific services can be most efficiently assigned within the system.

***Recommendation E*: Carry out a public education campaign directed at county staff, community based organizations and the general public regarding the potential benefits and risks of high fidelity adoption of practices with high levels of research support.**

While the movement to implement evidence-based practices has strong state and national support, there is misunderstanding about this approach as well. In some cases constituencies do not trust the research knowledge base or the way in which it will be utilized. Others believe that they are currently implementing effective practices, when they are not.

The California Institute for Mental Health has, for the last five years, engaged in a public education process promoting the adoption of evidence-based practices. CIMH has supported individual county efforts to do the same. Utilizing CIMH services and/or resources, Marin County Community Mental Health can engage in a county-wide public education and "dialogue," very similar to its efforts to build its MHSA CSS plan. This process would both disseminate information, including communicating county priorities, and allow for community input that will improve implementation plans and build support for these efforts.

***Recommendation F*: Collect information from, and conduct site visits to, selected counties that have made concerted efforts to deliver integrated services.**

Several of the requests for information were predicated upon interest in what other California counties are doing to address a number of needs. One way to acquire information about best practices or current strategies of other California counties is to contact and visit selected counties directly. CIMH has strong working relationships with many counties and can assist Marin County in linking with the following:

- Santa Cruz County –Santa Cruz County has a long history of Children's System of Care implementation based upon extremely strong interagency collaboration. It has maintained its CSOC following the end of a federal grant and the elimination of state CSOC funding.
- Humboldt County – Aided by the consolidation of all county mental health and social services under a strong Health and Human Services Agency, Humboldt County is using a number of waivers to support significant county integration. A component of this integration is the cross system implementation of significant number of evidence-based practices along with the targeted evaluation of "home grown" programs and services.
- Placer County – Placer County has a long running integrated care system that is unique in California. In addition to very high levels of interagency integration, including the consolidation of child welfare, children's mental health and health under a Children's System of Care, Placer county has invested in implementing evidence-based practices over the last two years.
- Several California counties have undertaken to implement multiple evidence-based practices within their children's mental health, child welfare, health and juvenile justice systems. In addition to Humboldt county referenced earlier, Marin county should consider collecting information from Fresno county, which is participating in four CIMH projects to implement evidence-based child and family practices (MTFC, Functional Family Therapy, Aggression Replacement Training and Incredible Years) and Sutter-Yuba Counties that are implementing a practices (FFT, MTFC) independently and with CIMH support.

***Recommendation G*: Join the CIMH Depression Treatment Quality Improvement (DTQI) Project.**

Marin County administrators and CIMH have already reviewed this recommendation and Marin has joined this project. It offers an excellent opportunity to establish an effective

practice that can be delivered in a clinic setting, by available clinic staff, to a primary consumer of clinic based services – adolescents and young adults experiencing depression. Marin will be a part of the DTQI

***Recommendation H*: Complete an analysis of the remaining clinic population to determine other services to introduce.**

A clinic offering evidence-based treatments for adolescent/TAY depression and child/adolescent externalizing behavior disorders would have a very strong service menu; however, these services would not meet the needs of all youth. An analysis of the remaining population would be required to make a well informed decision about additional practices to eventually offer through the clinic. Findings could, for example, suggest the implementation of some combination of the following:

- Interpersonal Therapy (IPT) – This is an effective practice for youth with depression. Its premise is that depression can be treated in the context of interpersonal relationships. IPT could be available for youth who do not respond well to DTQI or those who want an alternative.
- Trauma-focused Cognitive-Behavioral Therapy – This is an effective practice for children and youth who suffer from PTSD.
- Cognitive Behavioral Therapy for Anxiety – Anxiety is a condition with relatively high prevalence in child and adolescent populations. Several promising, efficacious and effective CBT models for this condition exist.