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Evidence-based intervention and services for high-risk youth: a North American perspective on the challenges of integration for policy, practice and research

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ABSTRACT

This paper explores the cross-national challenges of integrating evidence-based interventions into existing services for high-resource-using children and youth. Using several North American model programme exemplars that have demonstrated efficacy, the paper explores multiple challenges confronting policy-makers, evaluation researchers and practitioners who seek to enhance outcomes for troubled children and youth and improve overall service effectiveness. The paper concludes with practical implications for youth and family professionals, researchers, service agencies and policy–makers, with particular emphasis on possibilities for cross-national collaboration.

INTRODUCTION

Across many national boundaries and within multiple service contexts – juvenile justice, child mental and child welfare – there is a growing concern about a proportionately small number of multiply challenged children and youth who consume a disproportionate share of service resources, professional time and public attention. While accurate, empirically validated population estimates and descriptions remain elusive. The consensus of many international youth and family researchers, including those reported by McAuley and Davis (2009) (UK), Pecora *et al.* (2009a) (US) and Egelund and Lausten (2009) (Denmark) in this present volume seems to be that some combination of externalizing, 'acting-out' behaviour, problems with substance abuse, identified and often untreated mental health problems, experience with trauma and challenging familial and neighbourhood factors are often, and in various combinations, manifest in the population of children and youth most challenging to serve. Many of these find their way into intensive out-of-home care services, and Thoburn (2007) provides a useful window into the out-of-home care status of children in 14 countries and offers useful observations on improvements in collecting administrative data for child and family services to inform both policy and practice. Others call for a critical re-examination of the present status of 'placement' as a central fulcrum in child and family services policy and practice (Whittaker & Maluccio 2002).

A sense of urgency is conveyed by the fact that many child and youth clients of 'deep-end', restrictive (out-of-home) services disproportionately represent underserved and often socially excluded families and communities of colour, and pose additional challenges in service planning around the cultural compatibility of proffered interventions (Blasé & Fixsen 2003; Barbarin *et al.* 2004; Miranda *et al.* 2005). Important work in this area includes ethnic and cultural

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variations on known effective practices. Lau (2006), for example, offers a nuanced and sensitive treatment of actual and potential adaptations in existing parent training models. A basic concern with questions of equity and social justice, coupled with a growing scepticism about the efficacy of traditional residential, 'place-based' services, has heightened the search for more preventive, family- and community-based, culturally congruent service alternatives. All of this is set against a backdrop of concern about the state's ability to provide effective parenting oversight and support for children in care, as well as those who remain with their families (Bullock *et al.* 2006). Fortunately, this search is occurring at a time when researchers in many countries are shedding light on mechanisms of risk and resilience (Sameroff & Gutman 2004), change processes involved in effective interventions (Biehal 2008) and the challenges faced by parents in multiply stressed environments (Ghate & Hazel 2002; Ghate *et al.* 2008) that are rich in their potential for contributions to intervention design and evidence-informed practice.

The primary purpose of this paper is to examine some of the challenges and opportunities in incorporating evidence-based strategies and interventions into existing service systems to better meet the needs of high-resource-using children and youth. The growing corpus of empirical research on promising treatment strategies offers, if not clear-cut prescriptions, then rich implications for future policy initiatives and service experiments.

Indeed, the pursuit of evidence-based practice, in its many forms, increasingly attracts the attention of those who plan, deliver and evaluate critical treatment and rehabilitative services for vulnerable children and their families across national boundaries and regions. While definitions of 'evidence-based practice' emphasize different dimensions of that construct, the common themes of bringing 'science-to-service', and its reciprocal 'service-to-science', are increasingly evident in the child, youth and family services systems in many European countries and North America, as well as elsewhere. Simultaneously, reform efforts in the USA and many European countries press for community-based, family-oriented, non-residential alternatives to traditional residential care and treatment programmes for acting-out children and youth with identified mental health problems (Chamberlain 2003; Weisz & Gray 2008). However, the impulse for service reform and the availability of at least some empirically validated model interventions do not of themselves constitute a sufficient basis for system reform, but instead serve to illuminate some of the many fault lines that exist in the child and family services field:

- The continuing tensions between 'front-end', preventive services and 'deep-end' highly intensive treatment services and the unhelpful dichotomies these tend to create and perpetuate
- The tensions between a widely shared desire to adopt more evidence-based practices and the genuinely felt resistances to these, particularly when they are used in a rigid fashion that requires strict adherence to established protocols with little opportunity for experimentation, customization or practitioner discretion. For example, as one family support researcher recently observed, we need much more fine-grained analyses of the actual lived experience of client families with the services offered to them (S. P. Kemp 2008, personal communication). Such analyses will almost certainly involved a 'mixed-methods' approach using qualitative measures and methods to augment quantitative studies
- The tension, as manifested in North America and elsewhere between evidence-based and culturally competent practices, reflects, among other things, antagonism towards certain practice strategies based on perceptions of the under-representation of ethnic minorities in the study samples on which certain models have been validated

As model programmes proliferate and are increasingly removed from the particular political and cultural niches within which they were developed, we would do well to heed the cautions offered by Munro *et al.* (2005) that researchers, planners and youth and family practitioners are at a moment in time when cross-national perspectives are critical in helping identify new ways of both framing problems and shaping service solutions. Cross-national dialogue can help in identifying different formats for collecting, analysing and utilizing routinely gathered client information, analysing subtle local adaptations of internationally recognized evidence-based services and examining the effects of differing policy contexts on service outcomes.

THE QUEST FOR MORE EFFECTIVE INTERVENTIONS

For the remainder of this paper, I wish to do three things: (1) briefly identify where we are in our search for effective (evidence-based) interventions; (2) assess how we are doing in increasing their availability to high-resource-using troubled youth and their families;

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and (3) identify some particular challenges faced by the individual practitioner, the social agency and the public policy context in furthering the shared goal of improving outcomes, and thus life prospects for troubled children. The author's bias will soon be readily apparent. First, as one who has spent a lifetime trying to bring both the precision of research methods and the richness of research findings to the 'shop floor' of children's agency practice, I am convinced that the evidence-based practice movement will not succeed until it is embraced by those closest to the children: the child and youth care workers, the social workers, teachers, family support workers and others who, with parents, toil on the front lines of helping. This is not in my view a one-way street – Science-to-Service – but presumes a vital feedback loop from Service-to-Science where the insights and hypotheses of those most directly involved in interventions (including parent and child consumers) inform and improve successive generations of applied research studies. Second, I readily acknowledge the North American bias apparent in many of my examples – I write of what I know best – while recognizing a deeply felt need in my country for European and other cross-national perspectives if we are ever to achieve success with our internal efforts at improving outcomes.

The search for evidence-based practices with children and families is now well underway on both sides of the Atlantic. Kazdin and Weisz (2003), Weisz (2004), Burns and Hoagwood (2002), Macdonald (2001), Pecora *et al.* (2009b) and McAuley *et al.* (2006) survey effective interventions in child welfare and child mental health services, as well as review current research on service populations that will inform the creation of novel interventions.

The simple, nominal definition of evidence-based practice offered by Professor Geraldine MacDonald of Queen's University in Belfast provides a useful starting point:

> Evidence-based practice indicates an approach to decision-making which is transparent, accountable and based on careful consideration of the most compelling evidence we have about the effects of particular interventions on the welfare of individuals, groups and communities. (MacDonald 2001, p. xviii)

It is clear that debates about what constitutes the sufficiency and quality of evidence – where to set the bar for rigour, how to distinguish evidence-based vs. evidence-informed practice – continue apace both in academic and practitioner discourse even as the evidence-based practice movement as a whole continues to raise its profile in policy and services. These competing definitions and nuances are, *in toto*, a sign of health as they simply serve to underscore one or another aspect of what is emerging as a more fulsome understanding of what evidence-based practice consists of. These aspects include, but are not limited to:

- a dual focus on aetiology and outcomes
- the incorporation of ethics and values as key components
- the development of a collaborative process with affected client groups
- a commitment to transparency in processes and accountability

Many practitioners and practice researchers have participated in the work of international groups such as the Campbell and Cochrane Collaborations (Littell 2008) – originating in the health field – that attempt to sift, sort and categorize the state of the evidence around particular illnesses, socio-behavioural problems or social welfare concerns. Many have also experienced – closer to home – the increasing impact of national, state and regional initiatives designed to increase the content of proven, efficacious practices into child, youth and family service systems. Such initiatives typically use two strategies, often in combination:

> Positive Reinforcement: e.g. 'Laying Flowers Along Certain Pathways' by encouraging adoption of selected efficacious model interventions. (One notes in passing that 'efficacy' of a given intervention often increases in proportion to the distance from its country of origin!)
>
> Coercion: e.g. Penalizing a programme, agency or practitioner whose interventions do not reflect a sufficient quantity of evidence-based practice according to an agreed-upon time schedule. In the USA, this typically means that a practitioner or service agency follows a prescribed protocol for intervention or risks losing reimbursement for services rendered.

MOVING FROM 'EFFICACY-TO-EFFECTIVENESS'

In the USA at the moment, there is growing respect for the complexities involved in moving from pilot demonstrations of effective child, youth and family interventions to broad-scale application: i.e. moving from 'efficacy' to 'effectiveness' (Jensen *et al.* 2005; Weisz & Gray 2008). What these terms signify are:

1. That individual investigators can demonstrate significant results for novel treatments over standard (or traditional) services through carefully controlled, rigorously conducted studies often including randomized controlled trials: the 'gold standard' of clinical research. That is, they can demonstrate *efficacy*.

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2. Yet, these impressive results do not, on close examination, appear to influence what might be thought of as routine, day-to-day practice as conducted in more familiar agency settings. Thus, the evidence-based practice movement, while demonstrating *efficacy*, cannot as yet demonstrate overall *effectiveness*.

What explains this disconnect? Lisbeth Schorr, an astute analyst of child and family services innovation, sums it up succinctly: 'Successful programs', she says, 'do not contain the seeds of their own replication' (Schorr 1993, quoted in Fixsen *et al.* 2005).

Thus, if we are truly interested in *effectiveness* – i.e. achieving wide-scale adoption of proven efficacious interventions, we need to look beyond efficacy studies: (1) to those contextual elements that influence practice decisions and client outcomes (Kemp *et al.* 1997); and (2) to a different kind of research undertaking that focuses directly on the processes involved in successful adoption of proven efficacious interventions (Weisz & Gray 2008).

John Weisz, one of the nation's leading research analysts in child mental health and a professor of psychology at Harvard University as well as President of the Judge Baker Children's Center in Boston, points the way forward on what is needed to ultimately resolve the efficacy/effectiveness challenge:

> A very important focus for the next stage of research on interventions for children will be the effective implementation of evidence-based practices by practitioners in service settings. This will require an active collaboration between the researchers who develop and test interventions and the clinical, child welfare, and education professionals who serve children and families. (J.R. Weisz 2008, personal communication)

EXPLORING THE LANDSCAPE OF EVIDENCE-BASED SERVICES FOR HIGH-RISK YOUTH

Let us proceed, then, by exploring the context within which evidence-based services are nested. Here, we find some common and proximate elements familiar to all who labour in the child and family services field, as well as a few more distal forces that, nonetheless, have a potential for considerable impact on the identification, validation and eventual integration of evidence-based practices. I will refer, briefly, to more or less typical examples from within the US context.

Model intervention programmes

For purposes of illustration, I offer three interventions that have received considerable attention in children's mental health services in the USA, and which have been the objects of numerous community replications and research study both in North America and elsewhere (Whittaker 2005). These include:

- *Multisystemic Therapy* (MST), developed principally by Dr Scott Henggeler, a psychologist now at the Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina (Henggeler *et al.* 1998; Schoenwald & Rowland 2002; Henggeler & Lee 2003). http://www.mstservices.com
- *Treatment Foster Care* (MTFC), developed in several clinical/research teams in the USA and represented here by the model (Multi-dimensional Treatment Foster Care) principally developed by Dr Patricia Chamberlain and colleagues at the Oregon Social Learning Center – a highly influential applied behaviour analysis developmental research centre – one of whose founding members is Dr Gerald Patterson (Chamberlain & Reid 1998; Chamberlain 2002, 2003). http://www.MTFC.com
- *Wraparound Treatment*, a novel, team-oriented, community-centred intervention developed by a variety of individuals including the late Dr John Burchard, formerly Professor of Clinical Psychology at the University of Vermont, John Van Den Berg, Carl Dennis and others beginning in the early 1980s (Burns & Goldman 1999; Burchard *et al.* 2002). http://www.rtc.pdx.edu/PDF/PhaseActivWAProcess.pdf

[While space does not permit in depth analysis here, the interested reader is directed to the previously cited references, as well as to the web sites for each of these three models that include multiple references to completed and in-progress research and demonstration efforts, as well as specifics on programme principles and components. A variation of the of the MTFC model designed for younger children in regular foster care is described in this present volume by Price *et al.* (2009)].

These three interventions are specifically designed to provide alternative pathways for children who otherwise would be headed into more costly and restrictive residential provision. Dr Barbara Burns, Professor of Psychology at Duke University in North Carolina and a principal author of the children's mental health section of our latest Surgeon General's Report on Mental Health (US Department of Health and Human Services 1999) provides a succinct rationale for why this is warranted:

> The most critical question for the future is, what will it take to convince payers, public and private, to support the

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> interventions that are backed up by evidence about improved outcomes? Assuming that the pool of dollars available for mental health treatment will not increase, it will be necessary to shift resources away from institutional care (which lacks evidence of effectiveness) toward community alternatives. This will require a reduction in funds allocated to institutional care, where a significant portion of the child mental health money is still being spent. (Burns & Hoagwood 2002, p. 13)

While reviews of residential care in both the UK (Sinclair 2006) and the USA (Whittaker 2006) confirm a move away from residential services, recent comparative international contributions have urged critical re-examination of the multiple varieties of residential service (Courtney & Ivaniec 2009) to meet the needs of at least some high-resource-using youth. In part, this sentiment reflects the fact that theory and model development, particularly in the arena of intensive residential services has languished as development of comparable family-centred services has flourished. Some have urged the development of a conceptual schema for intensive services – e.g. the 'prosthetic environment' – which transects more traditional residential, family and community boundaries is strengths-oriented and incorporates educational, socialization and family support services along with intensive treatment (Whittaker 2005).

In focusing here on a few programme models specifically designed to serve as alternatives to residential care and treatment, and other forms of intensive out-of-home service, one must acknowledge omission of a great deal of promising, empirically based work that is presently being done with a wide range of family-, school- and community-centred interventions that is both more preventive in its focus and appropriate for a much wider population of children and families than space allows us to examine here. See, for example, Carolyn Webster Stratton's *Incredible Years Program* (Beauchaine *et al*. 2005) and the work of many others whose contributions in such areas as family support illuminates a segment of services more preventive in focus (Kemp *et al.* 2005; Lightburn & Sessions 2006) and the contribution of Jackson *et al.* (2009).

What, then, are the similarities and differences of these three promising interventions? A recent review (Burns & Hoagwood 2002) yields the following:

1. All three interventions adhere to 'systems of care' values: The 'systems of care' framework derives from both our National Institute of Mental Health and private foundation initiatives in the 1980s, and is defined as:

> A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families. (Stroul & Friedman 1986, p. xx)
> The system of care thus defined is based on three main elements. First, the mental health service system efforts are driven by the needs and preferences of the child & family and are addressed by a strengths-based approach. Second, the locus and management of services occur within a multi-agency collaborative environment grounded in a strong community base. Third, the services offered, the agencies participating and programs generated are responsive to cultural context and characteristics. [Though, as noted, this remains a contested area with respect to some communities of color.] (Burns & Hoagwood 2002, p. 19)

2. All three interventions are delivered in a community – home, school, neighbourhood – context as opposed to an office
3. All have operated in multiple service sectors: mental health, juvenile justice, child welfare
4. All were developed and evaluated in 'real world' community settings, thus enhancing external validity
5. All show preference for the model treatment condition in multiple randomized controlled trials
6. All lay claim to being less expensive to provide than institutional care (Burns & Hoagwood 2002, p. 7).

Differences of course exist. For example, both MST and MTFC possess a higher degree of specificity with respect to intervention components than does wraparound. As of this writing, MST has perhaps the strongest evidentiary base, particularly in clinical trials showing positive effects, though some recent reviews, including one by Prof. Julia Littell of Bryn Mawr University in Pennsylvania conducted for the Campbell Collaboration, have raised critical questions about the evidence base offered in support of MST (Littell 2005, 2008). Finally, from a staffing perspective, MST appears to make higher use of master's-level-trained professionals in service delivery than either MTFC or wraparound.

To these three model programmes, we must of course add numerous other evidence-based treatment techniques targeted to specific conditions and problems, as reflected in recent reviews by Kazdin and Weisz (2003), Weisz (2004) and Chorpita *et al.* (2007). These model intervention programmes do not of course exist in a vacuum, but both influence and are influenced by a host of other elements in a typical state or regional context in the USA.

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PUBLIC, VOLUNTARY AND PROPRIETARY SERVICE PROVIDERS

Model programmes such as MST, MTFC and wraparound are typically adopted by some segment of the mixed system of service agencies (Public/Voluntary/Proprietary) that make up the delivery system in a given state, county or municipality. Public service providers are typically service funders as well, creating in the view of some voluntary agencies an unequal influence in terms of what particular models are selected for adoption, as well as on the masking of true administrative costs of programme implementation, given the public sector's economies of scale and presumed ability to mask start-up costs. Given the wide variations in state and county service systems within the USA, there are some anecdotal reports of the tendency of certain model programmes to bend and shape themselves into a widely varying array of funding arrangements (referred to as 'pretzelling') in order to gain a foothold and a leverage in a given public system (K. Blasé 2007, personal communication) with the result that local service providers may be held to similar outcome and process standards while enjoying widely varying reimbursements to support their efforts.

NATIONAL, REGIONAL AND LOCAL RESEARCH CENTERS AND RESOURCE NETWORKS

In addition to evidence-based programme models that typically have their own internal capacity for programme development, marketing, training, evaluation and dissemination, a wide variety of university and institute-based resource networks and research centres play an increasingly important role in the promotion of evidence-based programmes and practices. For example, the National Implementation Research Network (NIRN) was begun at the University of South Florida as part of a larger effort to bring science-based information to the forefront of child mental health practice. Recently relocated to the University of North Carolina, NIRN has done significant work in documenting national, state and regional capacity to support model programme development, and has provided consultation to individual states and organizations on effective strategies for integrating evidence-based practices into the fabric of existing services (Fixsen *et al.* 2005). For more information, see: http://www.fpg.unc.edu/~NIRN/. The California Evidence-Based Clearinghouse for Child Welfare Practice is funded by the California Department of Social Services, Office of Child Abuse Prevention and guided by a state advisory committee and a National Scientific Panel. The Clearinghouse provides guidance on selected evidence-based practices in simple straightforward formats, reducing the consumer's need to conduct literature searches, review extensive literature or understand and critique research methodology (http://www.cachildwelfareclearinghouse.org/). The Clearinghouse has developed a six-tiered schema for sorting out promising programmes ranging from 'Well-Supported – Effective Practice' to 'Concerning Practice' (e.g. shows negative effects on clients and/or potential for harm).

A legislatively generated state institute, the Washington State Institute on Public Policy (WSIP) was created by the Washington state legislature to conduct cost/benefit and a range of other studies on a variety of classes of intervention, including child welfare and early intervention (http://www.wsipp.wa.gov/board.asp). Its generally thorough and well-executed analyses have achieved wide dissemination beyond the region and are frequently cited by model programme developers as confirmation of their effectiveness. Methodological concerns have recently been raised about the general quality of intervention research reviews (Littell 2005, 2008), including those generated by WSIP, and within local practice communities, one hears anecdotally some concerns about the potential for overly concrete inferences by legislative bodies and funding sources whose attention may extend only to the executive summary section of detailed reviews of model programmes and not to the caveats and nuances contained in their appendices and footnotes.

Beyond these particular exemplars, there are a wide variety of government-, university- and institute-based research centres and clearinghouses devoted to the identification, review, evaluation and promotion of evidence-based practices. Such centres are not typically coordinated, resulting oftentimes in an overload of information for busy practitioners desirous of identifying the most appropriate interventions for troubled youth and their families. The problem is intensified as estimates place the number of documented treatments for children and adolescents in excess of 500 (Kazdin 2000). Here, the work of Dr Bruce Chorpita at the University of Hawaii offers at least a partial solution. For a number of years, Chorpita's research team has been refining a 'common elements' approach to identified evidence-based treatments and then matching these with identified

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problem clusters and characteristics of youth and families in service systems. The model's particular focus on the practitioner's adoption of discrete strategies, as opposed to whole-cloth approaches, is directly addressed to one of the major identified barriers to the implementation of evidence-based practice: the resistance to treatment manuals (Chorpita *et al.* 2007). In a related area, the empirical research of Professor Charles Glisson of the University of Tennessee and colleagues sheds important light on the organizational factors that may impede or enhance the uptake of evidence-based practices in service settings: e.g. organizational structure, organizational culture and organizational climate (Glisson *et al.* 2008).

JUDICIAL AND LEGISLATIVE INITIATIVES

Vocal community advocacy calling attention to service inadequacies and lacunae – for example, failure to meet the mental health needs of children in the state foster care system or excessive numbers of placement changes – frequently end up in the court system. The resultant settlements, or 'consent decrees', can exert considerable direct and indirect pressure on the service system to adopt particular models of evidence-based practice as a remedy to the perceived problem. In addition, within an individual state or jurisdiction, there are not infrequently legislative initiatives designed to promote certain evidence-based practices, as well as initiatives generated from within the public service agency itself. Taken together with the already identified promotional efforts of model programme developers, sometimes augmented by the largesse of voluntary foundations that seek to promote particular strategies for service improvement, the resulting pressure for individual practitioners and voluntary service agencies to follow certain prescribed pathways to practice can be intense.

EVIDENCE-BASED PRACTICE: MEETING THE CHALLENGE OF IMPLEMENTATION

For each of the features of the evidence-based practice landscape – model programmes, public and voluntary service providers, individual youth and family practitioners, research centres and clearinghouses, legislative and judicial bodies and client communities – there are challenges to achieving the generally agreed-upon goal of improving outcomes for high-resource-using youth and their families through the adoption of proven, efficacious practices. While these challenges vary depending on the point one occupies in the overall landscape of evidence-based practice, there appears to be a growing consensus in the USA for a far more intensive focus on what some have termed 'implementation science':

> . . . the scientific study of methods to promote the systematic uptake of clinical research findings and other evidence-based practices into routine practice. (Implementation Science: UK: on-line journal)

Thus, while different in their focus: (1) the previously cited efforts of NIRN to identify effective pathways for the integration of evidence-based practices into existing service systems (Fixsen *et al.* 2005); (2) the plea from research scholars like Julia Littell (2008) and others to bring more rigour, precision and systematization to the scientific review processes for evidence-based approaches; and (3) the numerous contributions of senior research analysts like John Weisz and others (Weisz & Gray 2008), directed towards identifying pathways for bringing practitioners and researchers into a closer working relationship, are best viewed as part of a unified effort. There is, I believe, a growing awareness that integration of proven efficacious practices in youth and family work will happen only when there is a fully functioning infrastructure to support desired changes and various individual actors see their 'part' in relational to the 'whole'.

Thus, for model programme developers, there is the critical task of identifying what are the active ingredients in their interventions. What are the *necessary* and what are the *sufficient* components in a service unit of MST, MTFC or wraparound? Despite the fact that raising the question of 'active ingredients' leads one, ineluctably, to what noted child psychiatry researcher Peter Jensen calls 'the soft underbelly' of evidence-based treatment, it is an area of critical importance for future research (Jensen *et al.* 2005). The costing and 'scaling-up' implications alone of adding even a modest increment of evidence-based practice to existing services warrants seeking answers to the question: 'How much of *what* is enough'? There has been an understandable resistance on the part of many model programme developers to disaggregate their interventions for fear of compromising treatment integrity, and thus weakening outcomes. That said, it is heartening to note the flexibility of some models to customize their interventions to fit the needs of particular service populations and environmental niches. The previously cited modification of the MTFC programme reported elsewhere in this volume offers one

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such excellent example (Price *et al.* 2009). We must find ways to hold model programme developers harmless for their results if they are willing to experiment with modifications of their 'packages of service' to address particular needs.

From the perspective of the individual service agency – whether it is a voluntary body, local authority or a large, public bureaucracy – a key question vis-à-vis the adoption of exemplary evidence-based programme models concerns the basic strategy for implementation: is it to be *additive* or *integrative*?

The *additive* approach that appears to prevail in many sectors of service in the present US context means that service agencies adopt one model programme at a time, adhering strictly to the intervention, assessment, training and evaluation protocols of the developer. This is meant to insure model fidelity and programme (treatment) integrity and to prevent what has been called 'program contamination'. The result, in the author's view, can lead to an encapsulation of discrete programmes – each with its identified staff and protocols for assessment and intervention – within a single agency structure. This results in fewer opportunities for cross-fertilization (e.g. common, or cross-training) and is silent on the preferred order of implementation: e.g. does it make a difference *which* model is adopted first? Moreover, the administrative complexities involved in managing multiple discrete programmes in a single agency can be considerable, particularly in smaller units with limited supervisory resources.

An alternate, or what might be termed an *integrative* approach, would seek to identify common elements across successful model programmes and train towards those. The previously cited work of Chorpita *et al.* (2007) provides a potentially valuable foundation to such an approach. A slight variation on the integrative approach would be to identify a common platform of foundational knowledge and skill – e.g. around client engagement – or 'therapeutic alliance', the present legatee of the old concept of 'relationship' (Rauktis *et al.* 2005), and first establish that core competency with all staff before moving to incorporate the specific strategies and techniques contained within successful model programmes. At present, the enthusiasm for what might be called the 'intervention-du-jour' seems to suggest a continuation of the additive, seriatim, approach at the expense of the integrative.

Behind the specific issue of the preferred method for adopting efficacious model interventions lies the broader question of the service agency's capacity to integrate, utilize and generate practice-focused research. Weisz and others have proposed models for closer integration of research and practice (Hoagwood *et al.* 2002; Weisz & Gray 2008) within the service agency, but at the moment these are not widely in evidence. Whittaker *et al.* (2006) offer a five-stage model template for integrating evidence-based practice in a child mental health agency, including logic modelling of existing programmes as a means of developing a common language of service, including implicit theories of change, selected evaluation activities, strategic researcher–agency staff partnerships and benchmarking against practice models of national significance. A barrier to building research capacity in existing agencies is that present contracts are typically tied to designated services, not to building an infrastructure supportive of research.

Challenges for the service agency include *data management* where the adoption of electronic records lags in certain sectors and where many agencies lack the capacity to systematically analyse routinely gathered data at either the case or the aggregate level. As noted, the proliferation of assessment and evaluation measures – often tied to specific programmes – adds complexity to the data management needs of the service agency. In the critical arena of *supervision*, the question arises of the adequacy of a single supervisor to provide oversight and support to a staff operating in widely disparate intervention models with their differing change theories, assessment protocols, outcome measures and time frames. In the related arena of *training*, similar problems can be found, including almost exclusive reliance on the use of external (and often expensive) consultants during the start-up phase of a model intervention with unclear plans for transition of oversight to internal agency staff. Moreover, the determinants for training foci in some agencies remain strongly with worker interests and are not necessarily related to client characteristics. Of particular concern among many smaller, voluntary service settings in the USA is the factor of *agency history*. Many such agencies were residential in their origins, typically following a pathway from orphanage to treatment setting. Thus, boards of governors and major donors may be more oriented to place-based services and 'bricks & mortar' than to community-based programme alternatives. A quote from a senior head in one such agency captures the tension for those in leadership: '*How do I insure that my program plan for the agency is in synchrony with my business plan?*' (K. Scott 2002, personal communication).

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SUMMARY AND TAKE-AWAY MESSAGES

The growing corpus of research on evidence-based approaches to work with troubled youth and their families offers both hope and challenge. In the area of alternatives to residential services for high-resource-using youth, model programmes like MST, MTFC and wraparound appear to hold much promise, but their full-scale adoption into existing service systems will require addressing a series of complex implementation challenges. Public sector children's services often work with families who are challenging to engage and for whom permanency and continued child safety remain as core service objectives. The sensitive application of evidence-based programmes and practices into the real world of contemporary child and family practice must necessarily involve parents, social workers, model developers and researchers in bidirectional communication. All of these efforts will benefit greatly from sustained and multilevel cross-national collaboration. Of the several US originated programme models identified in this brief review, virtually all are intruding to some degree on the work-plans of service planners, evaluation researchers, supervisors and practitioners in Europe, Australia and elsewhere. Similarly, interventions or intervention components as varied as 'Patch' (geographically centred, generalist services) (Adams & Krauth 1995) and 'Family Group Conferencing' (Pennell & Anderson 2005) have come to the USA from the UK, New Zealand and elsewhere in recent years. Since all of these 'imports' will likely undergo modification and appear again as 'exports', it behoves staff at all of the above levels to carefully track how these novel interventions are being incorporated into widely differing political, geographic, cultural and organizational contexts. Fortunately, the wide availability of instantaneous, direct, point-to-point electronic communication and the increasing prominence of cross-national journals, networks and conferences make such communication more possible than ever. From a research perspective, the widely varying environments into which model programmes are being introduced hold the distinct possibility for comparative research, including natural experiments.

For youth and family practitioners, service agencies and researchers and policy-makers, some concrete take-aways include:

1. For practitioners
   - Challenge the 'conventional wisdom' of practice wherever it resides – including in your own personal theories of change: for example, 'insight is a requisite for behaviour change'; 'longer service produces better outcomes'.
   - Seek out and read one up-to-date review of interventions most relevant to the children and youth you presently work with. Discuss what you have garnered with peers.
2. For researchers
   - Focus on application to real-world practice in your dissemination efforts: for example, 'What are the top five practice implications of your latest study and where might these most usefully be disseminated?'
   - Seek practice-partners for agency-centred research projects specifically focused on issues of implementation of evidence-based practices.
3. For child and family service agencies
   - Discover first what is working within the agency and build on that as a foundation before purchasing 'off-the-shelf' models.
   - Develop an internal capacity to systematically analyse routinely gathered data at the case level and aggregate level and 'mine' this information to inform practice.
4. For the service system/policy level
   - Here, and speaking from a parochial perspective, with all of our resources in the USA, we are sorely in need of a new structure or body within a state or authority that 'connects-the-dots' between relevant service policy, research and practice in support of enhancing the implementation of evidence-based practices to improve outcomes. While the title and organizational form for such a body proves elusive – clearinghouse? executive steering committee for evidence-based programme improvement? – its key function should be to focus laser-like attention on the question of what is most important in evidence-based practice implementation in a state, local authority or region: What do we need to learn over the next 12 months? How will we learn it? How will we decide 'what-trumps-what': Cost? Urgent service need? Level of evidence? Cultural relevancy? Organizational compatibility? Special opportunity to experiment with proven efficacious model programmes? While the fruits of such a new body would be experienced locally, one hopes that its field of vision and, eventually, its impact would extend cross-nationally.

In sum, evidence-based practice has added greatly to the 'tool kit' of social services in the identification of proven efficacious models of intensive intervention such as those referenced earlier in this paper. That said, the task of scaling-up these exemplars is proving to be

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complex and challenging, and will require both focused attention on the multiple contextual elements that impede and enhance the adoption of evidence-based alternatives, as well as a critical re-examination of existing biases – for example, the current and often reflexive negative attitudes towards residential provision in any form – that underlay current services planning. Both of these conversations will be greatly enhanced by multilevel, sustained and data-oriented cross-national collaboration among practitioners, service planners and researchers. Fortunately, through technological innovations such as electronic communication, the means for such collaboration are close at hand. High-resource-using youth and their families presently in, or at risk of entering the intensive services system, will be the ultimate beneficiaries of our efforts.

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