Large-Scale Implementation of Evidence-Based Treatments for Children Ten Years Later:

Hawaii’s Evidence Based Services Initiative in Children’s Mental Health

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Abstract

This article provides a follow up account of efforts associated with a statewide initiative established ten years ago for identifying and implementing effective treatments for child and adolescent mental health concerns. The manner in which this initiative has evolved and endured within a complex public mental health service infrastructure may provide some important insights and even optimism about the application of science in public sector settings. This ten year history illuminates the benefits and challenges of maintaining a community-based mechanism for the integration of science and practice. As reported here, such collaborative efforts can produce new ways to conceptualize scientific evidence, overcome interdisciplinary barriers, catalyze other progressive initiatives, and generate a guiding vision for public mental health for youth.

Keywords: dissemination, implementation, evidence based practice, mental health services, quality of care, quality of services
Background of Hawaii’s Evidence Based Services Initiative

Substantive progress has been made in identifying efficacious psychosocial interventions for treating psychopathology (Chambless & Hollon, 1998; Substance Abuse and Mental Health Services Administration, 2008; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The APA Task Force on Psychological Intervention Guidelines, chaired by David Barlow in 1992 developed the first template for judging the quality of psychosocial treatments and outlined two dimensions (i.e., efficacy and effectiveness) along which treatments should be evaluated (APA Task Force, 1995). Since that time, work from this task force, the Division 12 Task Force that followed (Task Force on the Promotion and Dissemination of Psychological Procedures, 1995), and many subsequent initiatives has given the field new criteria with which to understand, evaluate, and select treatments for mental health problems.

Similar processes have unfolded over the years in children’s mental health (Lonigan, Elbert, & Johnson, 1998; Silverman & Hinshaw, 2008; Society of Clinical Child and Adolescent Psychology & Association for Behavioral and Cognitive Therapies, 2009; Weisz, Hawley, & Doss, 2004). Within the state of Hawaii specifically, the Child and Adolescent Mental Health Division (CAMHD) of the Hawaii Department of Health established the Hawaii Empirical Basis to Services Task Force in 1999. This group aimed to provide an interdisciplinary evaluation of interventions for common youth disorders based on controlled treatment studies found in the scientific literature. The primary methodology, procedures, and criteria used were adapted from various related efforts including the Task Force on Promotion and Dissemination of Psychological Procedures (1995) and the Empirically Supported Psychosocial Interventions for Children Task Force (1998). The CAMHD Task Force focused on identifying evidence based treatments for anxiety, attention-deficit/hyperactivity, depressive, conduct and oppositional, and...
autistic disorders and disseminated its initial findings locally through various technical reports issued approximately every other year starting in 2000 and nationally in 2002 (Chorpita et al.).

Evolving Context

The landscape of children’s mental health has evolved on numerous fronts since the CAMHD Task Force (2002) first convened ten years ago. For example, controlled studies of psychosocial interventions have been put to increasingly stringent tests with regard to comparisons with other active treatments such as usual care and inclusion of youth samples with more complex and severe problems (e.g., Huey, Henggeler, Rowland, Halliday-Boykins, & Cunningham, 2004; Leve, Chamberlain, & Reid, 2005). Significant progress has also been made with respect to increasing the evidence-base for certain types of childhood problems that were previously less studied using randomized trial designs (e.g., childhood traumatic stress disorders; Ahrens & Rexford, 2002; Cohen, Deblinger, Mannarino, & Steer, 2004). Meanwhile, the national policy landscape has become increasingly focused on closing the gap between research and practice across all mental health (e.g., Hogan, 2003; Institute of Medicine, 2001; NAMHC Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001; NAMHC Workgroup on Services Research and Clinical Epidemiology, 2006).

Accordingly, conceptual and empirical issues related to dissemination and implementation of evidence-based practices (EBPs) are now also being explored (e.g., Hoagwood, Burns, & Weisz, 2002; Weisz, Jensen, & McLeod, 2005). However, because empirically-based dissemination and implementation initiatives specific to behavioral health care are relatively new, researchers in this area have mostly relied on models outside of the behavioral health field to serve as starting points (e.g., Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005; Greenhalgh, Robert, Bate, Macfarlane, & Kyriakidou, 2005; Rogers, 2003). Encouragingly
though, research reviews across diverse fields (e.g., agriculture, business, information technology, social sciences) suggest at least some level of robustness with regard to dissemination and implementation principles, and investigations and reviews specific to behavioral health care efforts are slowly and steadily emerging (e.g., Beidas & Kendall, 2010).

So one might wonder, amidst this background of the rapidly evolving standards and diversity of initiatives at the national level, how has a state-initiated and run Task Force fared over the past 10 years? How has this local initiative endured political and economic challenges, as well as leadership changes? These questions are not posed merely out of curiosity. The manner in which this initiative has evolved and endured within a state service infrastructure provides some important insights and optimism about the application of science within the complex and challenging environment that characterizes children’s public mental health.

The purpose of this article is to describe the continuing work of the CAMHD Task Force (2002) over the past 10 years. It is hoped that doing so may provide other mental health system initiatives with ideas or perhaps even guideposts for large scale implementation efforts. The current paper has three major foci. First, we outline the evolution of the group’s work within Hawaii’s statewide system of care since 1999, noting some of the major system initiatives that followed. Second, we document the group’s major processes and lessons learned over the past ten years for collaboratively producing synergistic outcomes among a highly interdisciplinary group of professionals. Third, we end by discussing the broader context of the committee’s efforts for disseminating and implementing evidence-based treatments for children on a large-scale level beyond Hawaii. Readers interested in an updated literature review of the initial report are referred to Chorpita et al.’s (2010) follow-up summary review that appears in this issue. This
paper will also not attempt to summarize the practice accomplishments that have occurred within the Hawaii system that have been documented elsewhere (e.g., Daleiden et al., 2006).

Evolution of the Initiative

Since the inaugural meeting of the CAMHD Task Force in 1999, members have continued to meet monthly, with the majority of group efforts spent summarizing the research literature in order to inform best practices for public sector children’s mental health efforts. For example, over 40 evidence-based practice reports having been issued locally by the group over the past ten years. However, since publishing its first major review of the child treatment outcome literature (i.e., Chorpita et al., 2002), the CAMHD Task Force’s (2002) procedures for reviewing and coding psychotherapy research studies, means for reporting, and role in reading, coding, and reporting on the treatment outcome literature have all evolved in several ways.

By the end of 2002, the Task Force became an official standing quality assurance committee within CAMHD. No longer a temporary task force for producing a time-limited set of reports, the group was renamed the Evidence-Based Services (EBS) Committee and was charged with the task of continual literature review for ongoing coding and report generation. Acknowledging that the treatment outcome literature would continue to grow and change over time (Gonzales, Ringeisen, & Chambers, 2002), it made sense to continually code and update summary reports accordingly. The Task Force on Promotion and Dissemination of Psychological Procedures (1995) explicitly recommended updates every 2 years, for example. A subtle but significant innovation of the EBS Committee was the development of refined data management and review procedures that allowed for cataloguing of information in updatable and dynamic formats. Thus, lists became spreadsheets and spreadsheets became relational datasets allowing for complex management and analysis of information derived from the literature. This
investment meant that the committee planned for an ongoing commitment, rather than for periodic isolated reports. In terms of values, this investment was consistent with the CAMHD’s broader quality improvement philosophy and demonstrated an organizational commitment to ongoing innovation rather than investment in an isolated exercise.

Along the same lines, the committee implicitly established a set of democratic principles for establishing definitions of evidence, foci of the reviews, and system priorities. These principles served as a “constitution” that laid a foundation for the system’s commitment to scientific principles, but allowed for “amendments” based on the increasing depth of the committee members’ expertise and interest over time. Of course, there were limits to the scope of such changes, designed to prevent the committee from drifting from an empirical epistemology altogether. To take one example, randomized trials would always be superior to non-randomized trials in the eyes of the committee, but in the absence of randomized trial data for a given context, there would be room to consider defining and prioritizing less reliable sources of evidence. This process for amending and discussing definitions and assumptions—as often as needed and by any member from any discipline—created a safe context for evolution and innovation. When new ideas were raised regarding how different definitions or assumptions might affect the collective interpretation of the literature, these were not simply voted on; rather, analyses were often run in multiple ways, with reports brought back to the committee showing side-by-side comparisons of the effects of different methodologies. Although the process was democratic in nature, science was not defined by vote—strict principles of scientific inference were always held up as the benchmark.

*Major Processes of the Initiative*
Over the course of a decade, the committee and the processes by which it pursued its goals evolved in at least three ways: (a) changes in review methodology, (b) increased emphasis on report design and development, and (c) shifts in the committee’s function from merely consolidating information from the literature to disseminating that information.

Changes in methodology. We found that by virtue of continually digesting the literature, committee members became increasingly sophisticated regarding scientific interpretation and inquiry. Over time committee members thus came to suggest and agree upon numerous methodological innovations. Some of the more noteworthy modifications are outlined here. The first substantive change occurred by 2004 when the committee moved away from organizing treatment research findings around psychiatric diagnoses to particular “problem areas.” This decision was based on the observation that many treatment outcome studies aimed at reducing psychopathology symptoms did not necessarily include youth with psychiatric disorders. For example, many randomized controlled trials of depression (e.g., Clarke et al., 2001; Weisz, Thurber, Sweeney, Proffitt, & LeGagnoux, 1997) used ratings of low mood rather than diagnosis as a means for including study participants. Additionally, efforts for examining the broad construct of treatment outcome expanded to a multi-axial system. Rather than coding the outcome literature for information only along the parameter of target problem area (e.g., depressive symptomatology in a study for reducing childhood depression), the committee began coding for study outcomes along five additional axes. These included, “non-target symptoms,” or symptoms that the active treatment was not specifically designed to address (e.g., depressive symptomatology in a study for reducing aggressive behaviors); “functioning,” referring to overall youth impairment; “education,” or academic performance; “satisfaction,” meaning
consumer satisfaction with the treatment; and “ecology,” or the effects of an intervention other than those on the child (e.g., parents’ reported levels of stress in a study of disruptive behaviors).

Another methodological change for summarizing the child treatment outcome literature was adjusting both “leveling” naming and scoring algorithms. The committee decided in 2004 that its initial naming scheme was awkward for dissemination purposes, and renamed levels one through five to “Best Support,” “Good Support,” “Moderate Support,” “Minimal Support,” and “Known Risks.” Also, noteworthy of brief mention here is the committee’s underlying logic for replacing the term Possibly Harmful Treatments with Known Risks. This decision in part related to the multi-dimensional outcome assessment scheme adopted in 2004. Because the committee routinely examined outcome measures spanning a variety of targets, it was possible to identify a treatment that produced a positive effect in one area (e.g., target problem area of anxiety), but a negative one in another (e.g., non-target symptom of depression).

Another procedural change for coding and summarizing research findings from the child treatment outcome literature came in form of the “practice element” or “common elements” approach for examining treatment protocols. A practice element can be defined as a discrete clinical technique or strategy (e.g., time out, relaxation, etc.) used as part of a larger intervention plan such as a manualized treatment program (Chorpita, Becker, & Daleiden, 2007; Chorpita & Daleiden, 2009; Chorpita, Daleiden, & Weisz, 2005). Using a coding manual detailing over 50 different practice elements, the committee identified discrete techniques that were common among many evidence-based protocols when grouped by problem area. For example, within the area of anxious and avoidant problems, the vast majority of evidence-based protocols utilized the techniques or practice elements of exposure, cognitive (restructuring), and psychoeducation.
These insights ultimately came to drive much of the decision making and planning in the CAMHD’s Practice Development office, a state-sponsored training initiative.

This methodology was not designed to replace the identification and implementation of integrated evidenced based programs; indeed Hawaii formally introduced Multisystemic Therapy into its system in 2000. Rather it reflected the committee’s and therefore the system’s concerns that even after implementing three, four, or five evidence-based programs system-wide, there would still be many youth not served by those programs. Thus, coding for procedures of evidence based practices in general allowed the committee to extract more useable and practical information from the literature, when there was no short-term possibility to implement a formal evidence-based program. This resulted in a system that utilized evidence-based packages for its high-priority targets (e.g., Multisystemic Therapy and Multidimensional Treatment Foster Care for delinquency), while attempting to boost the effectiveness of its usual care services for youth not eligible for those programs (Daleiden et al., 2006). Like many of the other amendments to the committee’s definitions and assumptions, this particular change moved the system away from an all-or-nothing set of options regarding evidence-based treatments and practice improvements. See Table 1 for a timeline outlining these and other selected committee-related events described throughout this paper.

Distributing knowledge. In addition to advancing its methodology for coding research findings, the committee also refined its summary reporting schemes. Over time, the committee came to rely on two major decision support tools for disseminating treatment summary report information: the Biennial Report and the “Blue Menu.” The Biennial Report is a detailed summary on best practices that outlines both efficacy (i.e., levels one through five) and effectiveness (i.e., feasibility, generalizability, and cost and benefit) parameters for psychosocial
interventions. This report has been published on the internet approximately every other year (e.g., Child and Adolescent Mental Health Division, 2004; Chorpita & Daleiden, 2007), and is meant to serve as a resource for steering treatment decisions when highly detailed information is needed. The Blue Menu (named for the blue paper on which it was originally printed and distributed) on the other hand, is a very brief summary containing only condensed efficacy information. This one-page summary table lists evidence based treatments organized by efficacy level (i.e., levels one through five) and problem area (e.g., anxious or avoidant, attention and hyperactivity, depressive or withdrawn, delinquent or disruptive, autism-spectrum, etc.). This document was designed to be user-friendly and transportable, thereby making it amenable to broad and easy dissemination. The review cycle for the Blue Menu was initially every three months, and in 2008 was changed to every six months.

*The committee’s evolving role.* Over the course of the last several years, the analytic and writing responsibilities for the Biennial Report and Blue Menu above have slowly shifted from a model that utilized CAMHD staff, its EBS Committee, and work-for-hire through private consultants to a fully privatized model. This has allowed for increasingly complex data analysis and reporting, as well as cost-sharing with other mental health systems and organizations. This progression is one hallmark of the success of the initiative, in that a routine part of industrializing any enterprise involves increasing specialization. That is, as one moves from the farm stand to the supermarket, there are increasingly differentiated roles, with dedicated expertise for well-defined tasks that allow for increasing efficiency and scale. Such benefits were apparent with regard to this initiative in several ways. First, review responsibilities were shifted to professional coders, who were able to complete the analytic and writing responsibilities much faster than volunteers. Second, freed from having to code papers directly, EBS Committee members were
able to devote more time to the interpretation of both conceptual and pragmatic practice issues. Third, given that other states and external agencies have sought similar analyses and reporting regarding the children’s mental health evidence base, the costs of the professional services could be distributed across a variety of stakeholders, creating economies of scale. These savings have allowed for new developments and innovations that would not have been sustainable at the individual state level. For example, many organizations outside of Hawaii use an interactive online evidence based services reporting application (developed and managed by PracticeWise, LLC, a private corporation specializing in training, analytics, and reporting) that leverages the same data used to create the Blue Menu and Biennial Report.

Group Processes and Lessons Learned

Collaboration among a diverse group of contributors over the past ten years has highlighted several important themes with regard to group processes and lessons learned. These include: (a) the EBS Committee as a community of practice, (b) empirical epistemology and performance evaluation, (c) re-visioning, re-purposing, and re-moralization, and (d) dead ends and false starts. It is believed that these themes are not unique to the work of Hawaii’s EBS Committee, and that explicit documentation of these processes may potentially serve useful for implementation efforts in other systems.

The EBS Committee as a community of practice. As might be apparent to the reader by now, the committee functions as a community of practice (cf. Fixsen et al., 2005). In such a network, members with diverse experiences frequently interact to share their collective wisdom and collaboratively determine new and beneficial courses of action. Certain tenets have helped develop and maintain this community. First, it is openly acknowledged that each member’s experiences and knowledge are uniquely valid in varying ways. Second, members convey and
receive mutual respect to each other and interact with a collegial demeanor, regardless of primary stakeholder affiliation, discipline, or educational degree (or lack thereof). These core values manifest themselves in several ways, but as an example, the committee has an open-door policy to anyone in Hawaii to share concerns about decision-support tools, attend a committee meeting as a guest, or join the committee as a member. As another example, and consistent with implementation strategies outlined by Henggeler and Lee (2002), the committee continues to use collective, rather than directive, decision-making processes. Within such a paradigm, decisions are collectively determined through consensus building. Although such a process is inherently more complex and slower than directives, decisions and procedures about changes and innovations are more likely to be sustained over time (Henggeler & Lee, 2002). Third, within this partnership, efforts are made to bring hidden agendas to light so that all parties involved openly know what everyone stands to gain. For example, committee members not directly invested in research publication know that other members benefit from doing so. These principles have held strong over the years, and several commentaries on Chorpita et al.’s (2002) original report (e.g., Jensen, 2002; Hawley & Weisz, 2002; Kendall, 2002; Roberts, 2002) as well as subsequent influential work (e.g., Fixsen et al., 2005) have highlighted their importance.

*Empirical epistemology and performance evaluation.* Regardless of affiliation, background, or educational degree, all members agree that ongoing evaluation of observable evidence is of utmost importance for making children’s mental health decisions. In other words, allegiance to any one specific course of action or type of treatment is superseded by empiricism and other core scientific, system of care (e.g., Child and Adolescent Service System Program), and business values during decision-making for serving Hawaii’s youth. This type of epistemological orientation for decision-making manifests itself in several ways. First, the
committee looks to all forms of available observable evidence (i.e., both the formalized scientific literature as well as other more “local” forms of evidence; Daleiden & Chorpita, 2005) prior to substantive decision-making processes. Alternative evidence sources are never proposed as a substitute for the scientific literature, but rather, are embedded in a decision support framework that prioritizes different kinds of evidence for different decisions (e.g., using the treatment literature to design an initial treatment plan; using local system data to avoid placing a youth with a runaway risk at a facility with an above-average incidence of elopements; using outcome data to determine length of service episode).

The committee’s allegiance to data-driven decision-making is also expressed in its ongoing commitment to repeated performance evaluation of its own efforts. As part of a larger quality assurance system, the EBS Committee is responsible for routinely assessing its performance towards reaching its observable and benchmarked goals on a quarterly basis. For example, towards the goal of increasing its interdisciplinary composition, the committee explicitly tracks and benchmarks its members’ primary affiliations (e.g., office and/or branch of government, practice setting, specialty training) thereby avoiding disproportionate or absent representation from key stakeholder groups.

*Re-visioning, re-purposing, and re-moralization.* Like other mental health service delivery systems, large child-serving organizations (e.g., CAMHD, State of Hawaii Departments of Education, Human Services, Juvenile Justice, etc.) within Hawaii’s have continued to face difficulties common to the public sector. Frequent and significant staff turnover, financial constraint, and evolving program requirements include just some of the major growth and sustainability obstacles experienced by the EBS Committee. For example, the committee has witnessed significant and numerous changes in varying leadership positions; its core
membership; a major statewide service, fiscal, and business transition in which mandated federal oversight for service delivery and government funding was slowly removed by 2005; and substantial changes in committee goals, procedures, and products. As a result, the committee’s journey towards progress has been traveled on a road riddled with numerous obstacles and detours. In the committee’s experience, successful navigation around these obstacles involves an intermittent process of re-visioning, re-purposing, and re-moralization.

For instance, the previously mentioned transition to a privatized model for producing the Biennial Report and Blue Menu came with some cost to EBS committee membership. Namely, members’ feelings of ownership for creating these reports slowly diminished over time as the locus of responsibilities shifted. Although the committee recognized the outsourcing advantages mentioned above, the process was no longer a grass-roots initiative housed mostly within the committee—it in fact had begun to become industrial, in both good ways and bad. Thus, at least one part of the process no longer felt “local,” which in Hawaii, as in many places, is an esteemed virtue. Initial movement towards the privatized report production model began in approximately 2004, and years since then have served as a transitional time period with respect to the committee’s focal efforts and sense of self-identity. Playing increasingly smaller roles with regard to knowledge accumulation (i.e., coding and summarizing the treatment literature), committee efforts began shifting in the direction of supporting existing and new system initiatives for disseminating and implementing decision-support tools for changing front-line knowledge, attitudes, and practice behaviors.

Many such efforts have been underway for the past several years. As an example, one perennial initiative aims to increase coordination between various stakeholder groups within Hawaii’s system of care for children’s mental health. Since first forming in 1999, the EBS
committee, like many other units within the CAMHD, sometimes found itself performing in a “silo.” Specifically, in the course of coding over 300 articles, a core membership of approximately 30 people learned more and more nuanced details about the randomized controlled trial literature, while many Hawaii stakeholders continued largely unaware of even the most basic of EBS reports. Fixsen et al. (2005) suggested that this can be a common problem in peak-performing manufacturing teams, with a potential solution being cross-fertilization between teams for keeping staff aware of innovations and exposed to a diversity of ideas.

Although the committee has always pushed for cross-fertilization, we continue to witness an ongoing evolution of these types of initiatives. Since the first meeting, membership continues to be open to anyone in the community (i.e., memberships are not appointed), and only requires attending one or more monthly meeting per quarter. Over time, the committee realized that this membership policy was too passive and began inviting key stakeholders from various counties not typically represented to participate in monthly meetings. Between 2005 and 2007, a social engagement strategy was utilized through a monthly presentation called “EBS in my life” during which a member shared how evidence-based services impacted their professional or personal lives. This strategy highlighted the differing contexts in which members worked towards the overarching goal of improving public sector mental health services for children, and hearing of such efforts provided continued hope and optimism for all involved.

In 2009, the committee began explicitly tracking members’ primary affiliations within and across monthly meetings for monitoring and increasing its interdisciplinary nature. Patterns of absence are analyzed and made transparent to the group for developing recruitment action plans for inconsistently represented stakeholder groups. Examples include taking turns for bringing a new guest to monthly meetings, advertising via newsletters, and intermittently
conducting membership drives. Finally, the committee has revisited earlier outreach initiatives and sends its members out into their respective spheres of influence (i.e., serving as “purveyors,” cf. Fixsen et al., 2005) with a call to arms for coordinating dissemination and implementation efforts. Noteworthy of mention is that all of these evolving initiatives are manifestations of collaborative decision making, thereby allowing for legitimate feelings of initiative ownership and hopefully setting the stage for long-term sustainability.

Overall, regarding the notions of re-visioning, re-purposing, and re-moralization highlighted in the example above, two core processes are especially noteworthy. First, as the mental health landscape in which the committee functioned evolved so did the committee’s vision and purpose to best fit the demands of the environment. In doing so, the committee has continually relied on the research literature and the methods of science to best help address new and emerging questions and concerns. Second, throughout this reciprocal evolution between the system’s demands and the committee’s vision, there has been a steadfast emphasis on initiative ownership and fostering a collective sense of identity regarding actions and responsibilities.

Dead ends and false starts. Many of the guidelines believed to be helpful for this type of initiative were drawn from the relevant literatures (e.g., Fixsen et al., 2005; Rogers, 2003). However, given the pace at which the system needed to move, and the lack of precedence for some of this work, a reasonable amount of the committee’s efforts were of the “seat of the pants” variety. Not surprisingly, the committee has experienced several initiatives that have deteriorated to varying degrees, died out completely, or even failed to start at all. Such failures can often be reframed as opportunities to learn, and for that reason, we present some examples here.

Some examples concern the committee’s earlier efforts at reporting on the scientific literature for various clinically relevant topics. For instance, although not included alongside
with the original report on the *psychosocial treatment* outcome literature (Chorpita et al., 2002), the group had also coded and created customized local summary reports on the *pharmacological treatment* outcome literature. The methodology for these pharmacological treatment reports somewhat mirrored psychosocial treatment summary efforts, and medications were classified with regard to their short- and long-term efficacy and short- and long-term safety. These reports made substantial progress for several years, but eventually died out by 2007, due to insufficient resources. Also noteworthy are the committee’s efforts at reading and summarizing both the *care coordination* and *psychosocial prevention* literatures. Efforts at examining the care coordination literature began in 2000, but quickly stopped when the committee concluded that this evidence-base needed more time to mature before any summary statements could be made. Concerning the psychosocial prevention evidence-base, summary efforts began in 2006 when a small subset of members branched off to form a separate committee specific to this task. Owing to several hypothesized factors (e.g., lack of full committee involvement and difficulties with establishing an agreed-upon methodology), this effort never really took hold. More recently, owing to a poor local economy, the biannual review cycle for the committee’s highly-utilized Blue Menu on psychosocial treatments was put on hold at the end of 2009. The decision at hand was whether to maintain a highly local reporting initiative—customized and therefore costly—that has created somewhat of a “brand identity” with the Hawaii system, or to replace the Blue Menu with a less customized or similar report whose development costs are likely to be shared with other systems.

Another strategy that did not reach its intended goals involved the “Tip of the Week” campaign. This initiative aimed to increase provider and consumer knowledge of evidence-based practice through posting on a website numerous one-page informational guides on evidence-based practices on a weekly basis. Across three years, the committee published over 150 facts
from the evidence base on the CAMHD website, but it was eventually realized that this investment was not reaching enough people to justify a continued commitment. People needed relevant information delivered at the time and place of decision making, not on a website that had to be visited regularly and might not deliver a particularly useful fact on any given week. Increasingly, we learned that our dissemination needed to do more than “get the word out.” We needed to understand and map decisions being made by stakeholders, and to deliver information (and only the relevant information) to inform those decisions as they were happening.

*The Committee’s Efforts within a Broader Context*

We have been fortunate that over time, the EBS initiative in Hawaii has found its way into new systems and contexts. Such extensions have provided new lessons and new opportunities, at times fostering revisions and innovations within the Hawaii system and at times allowing for economies of scale through out-of-state cost-sharing initiatives. In this final section, we highlight instances in which the committee’s practice improvement efforts have tangibly influenced broader system practice initiatives (both within and outside of Hawaii).

Within Hawaii, one of the core features of its child system practice model involves the monitoring of all therapy service activities through an online reporting system in which direct-service providers detail their therapy practices through reporting on their use of specific practice elements, rather than unstructured provider narrative reports (i.e., traditional progress report notes). This system allows for repeated surveillance of the extent to which therapists’ self-reported practices align with practices prescribed by the treatment literature. This helps to inform ongoing and repeated feedback initiatives. Therapy practice reports are combined with standardized treatment progress reports, and can be aggregated at any level ranging from a specific patient to an agency, county, or state. Such data are then used to help inform state-
sponsored direct-service training initiatives that also focus on the practice element approach to training, rather than emphasizing specific brand name treatment manuals. Readers interested in more information on these practices and other instances in which the committee’s perspectives on evidence-based practice have shaped CAMHD’s policies and procedures are referred elsewhere (i.e., Chorpita & Daleiden, 2010; Chorpita et al., 2005; Chorpita et al., 2007; Daleiden & Chorpita, 2005; Daleiden et al., 2006; Nakamura, Daleiden, & Mueller, 2007).

Over time, innovations like the ones mentioned above have come to influence evidence-based practice initiatives for Western Australia, the states of Minnesota and California, and the American Academy of Pediatrics (AAP). For instance, many of these stakeholder groups have embraced Hawaii’s five level efficacy system, its framework for examining treatment effectiveness information, and a model that includes a practice element approach for guiding system-wide integration of evidence-based practices. Consistent with innovation diffusion theory (Rogers, 2003), these groups have adopted various Hawaii-born EBS initiative components that seem to fit best with their specific needs and adapted them to their local environments.

In Western Australia for instance, their children’s public mental health system has moved towards using an interactive online evidence based services reporting application that leverages the same data used to create Hawaii’s customized reports. Utilizing this online database, users can access summaries of the best and most current scientific research on psychosocial youth treatments, with the ability to customize results to match a specific child’s age, gender, type of problem, and other characteristics. Similarly, Minnesota’s children’s public mental health system also subscribes to use of this online reporting system for accessing up-to-date treatment literature summaries and performing customized treatment searches for their youth. Additionally, Minnesota has worked with PracticeWise since 2004 for expanding upon several Hawaii-
initiated practice efforts for addressing its local interest needs. For example, stakeholders there were particularly interested in treatment summary reports for problem areas never before examined in Hawaii, and subsequently worked to expand PracticeWise analytic and reporting efforts into the domains of eating disturbances and suicidality. Also unlike Western Australia, Minnesota sought from PracticeWise training assistance for their system’s direct-service providers, thereby acting as a catalyst for the development of professional practice element-based training materials. Initiatives in California have been similar to those of Minnesota in some respects (e.g., use of the interactive online reporting application as well as training assistance for direct service providers), but different in at least one major way. Namely, due to the sheer size of the state of California and its service systems, the point of penetration for evidence-based practice innovations has been at multiple levels, including provider agencies, counties, and school districts. Finally, the AAP, drawn to the user-friendly and transportable nature of Hawaii’s Blue Menu, recently began publishing its own updated versions of a one-page psychosocial treatment by efficacy matrix in their Chapter Action Kits on children’s mental health. Beginning in 2010, this tool, previously associated only with Hawaii’s EBP efforts, will be updated biannually through a pro bono service provided by PracticeWise that allows the AAP to maintain this report free to the public on their website (http://www.aap.org/mentalhealth/).

Overall, several points regarding the committee’s efforts within a broader context are noteworthy of explicit mention. First, as mentioned above, adoption of various Hawaii-initiated practice components have been occurring selectively, with systems adopting pieces that best fit their needs and adapting them to their local environments. Second, it is an interesting observation that local adaptations in one area provide exciting opportunities for many others outside of that area to also benefit. Outlined above for example, Minnesota’s specific interest in expanding the
online reporting application to the problem areas of eating disturbances and suicidality benefited not only Minnesota, but also others such as Western Australia, California, and Hawaii that utilize the search engine or similar reports. Relatedly, privatization has allowed for diversification of material supports, so that a downturn in one entity’s budget or economy does not halt or severely damage the initiative. This is especially apparent for example, with AAP’s recent adaptation of the Blue Menu, Hawaii’s highly local reporting initiative that could not be maintained in their system beginning in 2009 owing to problems with the economy. Finally, a broader lesson learned by the committee was that the group did not realize or anticipate during its earlier years the forthcoming fiscal and catalyst benefits of sharing its new ideas with others. Therefore, perhaps other evidence-based practice initiative groups may consider this last point when beginning new efforts with long-term aspirations for scaling up and industrialization.

**Conclusion**

This paper provides a condensed ten-year narrative of Hawaii’s evidence-based services initiative in children’s mental health. The path thus far has been more difficult than originally anticipated and filled with obstacles and roadblocks. Moving forward, the important and necessary task of disseminating and implementing evidence-based practices into public sector service settings will undoubtedly continue to be challenging. These issues notwithstanding, we believe the accomplishments of Hawaii’s state-run committee should be celebrated, and it is hoped that their experiences can provide some insight and encouragement for the application of science within other children’s public mental health systems. We are grateful to the many members of Hawaii’s EBS community who are not listed here as authors, whose contributions are always respected and valued. Likewise, we are grateful to the broader academic and policy community who have also shaped and influenced this local movement in many ways.
References

Ahrens, J., & Rexford, L. (2002). Cognitive processing therapy for incarcerated adolescents with PTSD. *Journal of Aggression, Maltreatment, and Trauma, 6*(1), 201-216. doi:10.1300/J146v06n01_10


parents. *Archives of General Psychiatry, 58*(12), 1127-1134.
doi:10.1001/archpsyc.58.12.1127

doi:10.1097/00004583-200404000-00005


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<th>Period</th>
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| 1999-2001   | Formation of the Empirical Basis to Services Task Force  
Psychosocial treatment literature review begins  
Pharmacological treatment literature begins  
Care coordination literature begins and ends  
EBS Task Force disseminates initial literature review summary reports (i.e., Biennial Report and Blue Menu) throughout Hawaii |
| 2002-2005   | EBS Task Force disseminates initial literature review summary reports nationally  
EBS Task force becomes a standing quality assurance committee  
Movement from organizing treatment research findings around psychiatric diagnoses to “problem areas”  
Examination of treatment outcomes expanded to multi-axial level system  
Treatment outcome literature leveling naming and scoring algorithms revised  
Introduction of “practice element” methodology  
“Latest date” (year of most recent published successful study) field introduced to EBS reports  
“Tip of the Week” campaign  
Movement towards privatization of EBS reporting begins  
Service and fiscal transition for removing federal oversight begins |
| 2006-2010   | Psychosocial prevention literature review begins and ends  
“EBS in my life” social engagement strategy  
Pharmacological treatment reporting ends  
Known risks reporting put on hold  
Movement towards privatization of EBS reporting complete  
Service and fiscal transition for removing federal oversight complete  
EBS Committee explicit tracking and targeting of stakeholder involvement  
American Academy of Pediatrics begins publishing the updated “Blue Menu” guides in their annual Chapter Action Kits |