Role of the Intermediary Organization in Promoting and Disseminating Mental Health Best Practices for Children and Youth: The Connecticut Center for Effective Practice

by Robert P. Franks*

Introduction and Background

Over the past decade, as evidence-based practices (EBPs) in mental health have become more prevalent, there has been a need to develop mechanisms for implementing these practices in real-world settings. Treatment developers often create new practices based on theory and previous research in the hopes of addressing an identified mental health concern. However, these practices are sometimes criticized for being difficult to replicate in community-based settings or within a large-scale system of care. More and more emphasis has been given to the challenging process of moving science to practice and the often complicated process of implementing best practice models in real-world settings (Brekke et al., 2009; Chorpita & Regan, 2009; Fixsen et al., 2009: Stelk & Slaton, 2010).

To address these concerns, a variety of organizations have developed that bridge the gap between science and practice (Fixsen et al., 2009). These organizations help identify and adapt best practice models or EBPs and then act as intermediaries between the treatment developer/evidence-base and the implementation of the practice by provider organizations (Fixsen et al., 2005). These organizations have been called "intermediary organizations" and/or "purveyor organizations" and have emerged at the local, state, and national levels.

Fixsen and colleagues (2005) define a purveyor organization as, "an individual or group of individuals representing a program or practice who actively work with implementation sites to implement that practice or program with fidelity and good effect." A purveyor typically is involved in the implementation of a specific evidence-based program or practice, whereas an intermediary organization can be seen to have a broader role in the development and support of multiple programs or practices. The intermediary organization has been described as having a major role in building the capacity within a system or agency in order to implement and sustain a best practice model (Lopez et al., 2005).

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More and more emphasis has been given to the challenging process of moving science to practice and the often complicated process of implementing best practice models in real-world settings.

One such intermediary organization, the Connecticut Center for Effective Practice (CCEP), was developed in the State of Connecticut almost a decade ago (Franks & Adnopoz, 2007). The CCEP is a division of a nonprofit policy and research institute, the Child Health and Development Institute (CHDI) of Connecticut. Although the CCEP has often defied categorization, it is sometimes described as a center for policy, research, and implementation of best practices or, as previously defined, as an intermediary organization. This article describes the history, early structure, and evolution of the CCEP as an example of a successful intermediary organization that has helped bridge the gap between research and practice within a statewide system of care.

History and Development of the Connecticut Center for Effective Practice

The impetus for creating the CCEP (or the "Center") stemmed from a confluence of factors in the State of Connecticut that started in the late 1990s and led to a need for an intermediary organization to disseminate identified EBPs to children within the state's system of care. Connecticut has a consolidated state agency that serves children, the Department of Children and Families (DCF). DCF has four mandates: child welfare, behavioral health (including substance abuse), juvenile justice, and prevention. Like many state agencies across the nation, DCF has been confronted with serving many children and families with high levels of need who are using high levels of care, including inpatient treatment and residential care. In 2000, the CHDI, an independent policy and research institute, released a study entitled, *Delivering and Financing Children's Behavioral Health Services in Connecticut* (Meyers, 2000). In this influential study, Meyers determined that 70% of the resources the State of Connecticut was devoting to children's mental health was being spent on a relatively small number of children who were receiving high levels of care, mostly out-of state residential placements. The remaining 30% of state resources was spent on the far greater number of children receiving community and home-based services (Meyers, 2006).

As a result of the CHDI study, the Connecticut legislature and the Governor's Blue Ribbon Commission on Mental Health called for system reform. By 2001, a variety of stakeholders from across the state worked with the state's legislature to pass sweeping children's mental health reform legislation entitled "Connecticut Community KidCare." This legislation called for a variety of reforms, including:

- A "carve-out" of the state's behavioral health services;
- Development of a statewide "system of care" model;
- An emphasis on family driven, family-centered care; and
- A shift of resources to create more community-based services—and to consequently decrease the number of children being sent to out-of-state residential facilities (Meyers, 2006).

A strategy identified for creating more community-based services was to determine effective alternatives to residential treatment that could be delivered in the home or community. EBPs had begun to emerge as effective means of accomplishing this goal. Although this legislation was essentially an unfunded mandate, champions at DCF began to explore opportunities for ways to shift resources or identify new sources of funding to implement EBPs as alternatives to costly residential care. An additional impetus for state agencies to explore the adoption of EBPs came from the Connecticut Alcohol and Drug Policy Council on Juvenile Justice, which cited the importance of effective programs for children and youth involved with substance abuse.

As a result of these factors, the state awarded DCF the funds for an initial pilot program to implement Multisystemic Therapy (MST), an in-home EBP developed for high-risk children and youth with substance abuse and behavioral problems (Henggeler & Lee, 2003). The first MST team was put into operation in 1999 and its outcomes were monitored closely. The early indicators suggested that this treatment was indeed an effective alternative treatment that allowed these youth to remain in their homes and communities. As a result, there was an increased interest in disseminating MST more widely across Connecticut.

Given the early pilot's success and a desire to build and expand the program, the State of Connecticut was confronted with the challenge of how to bring MST to scale within the state's system of care. Because the agency lacked the internal resources to be the "purveyor" of MST, it turned to stakeholders within the system who had the expertise and mission to expand effective models of care. This resulted in the founding of the Center as a division of CHDI. The Center was initially created as a partnership that included an independent institute, CHDI; state agencies that serve children; and the state's major academic institutions with medical schools (Yale University and the University of Connecticut). Early partners included the Connecticut Department of Children and Families (DCF); the Court Support Services Division of the Judicial Branch of Connecticut (CSSD); the University of Connecticut Health Center, Department of Psychiatry; and the Yale Child Study Center. As the Center developed over time and its work evolved, additional partners were invited, including The Consultation Center at Yale University and FAVOR, a statewide parent advocacy organization.

Over time, the Center began to function less as a partnership and more as an independent entity with its own internal capacity to achieve its vision and mission.

Although the original goal of the Center was to disseminate MST across the State of Connecticut, founding partners saw an opportunity to create an entity with a much broader mandate. Early stakeholders anticipated that there would be a growing need to identify and implement best practice models of care and to support the reforms being driven by Community KidCare. The Center's vision was thus established so as:

> to enhance Connecticut's capacity to improve the effectiveness of treatment provided to all children with serious and complex emotional, behavioral and addictive disorders, [and its mission **w**as] to develop, train, disseminate, evaluate and expand effective models of practice to improve the diagnosis and treatment of children with serious and complex mental health conditions in Connecticut.

In 2005, the Center further refined its mission by identifying a framework for action, which includes:

- Identification, adoption, and implementation of evidence-based and best practices;
- Research, evaluation, and quality assurance of new and existing services;
- Education and raising public awareness about evidence-based and best practices; and
- Development of infrastructure, systems, and mechanisms for implementation and sustainability.

The Center's Funding

The Center was initially funded by a start-up grant and received subsequent core funding from the Connecticut Health Foundation (CHF), a charitable conversion foundation based in Connecticut that includes mental health systems change as part of its mission. In addition, soon after the early start-up of the Center, Connecticut's DCF also provided a multi-year contract to support the operations of the Center, initially funding the dissemination of MST and providing core support for the Center's broader mission. Because both DCF and CHF funding have since ended, core funding has become a challenge that can affect future sustainability of the Center. However, by building on early successes, a variety of successful bids for state contracts and other successful grant-seeking efforts have sustained the Center over time. In addition, the parent foundation of CHDI—the Children's Fund of Connecticut—where the Center is housed, has increased its funding and support in recent years to partly address the gap resulting from the discontinuation of funding from state and foundation sources. Despite these successes, in the absence of core funding, the Center is now dependent on bidding for available grants and contracts and is no longer able to proactively identify and address problems as it has in the past. Thus, the Center continues to function as an intermediary organization, but it now must be more responsive than proactive in its approach to effect systems change.

Partnership and Governance

As noted above, the early vision for the Center was that it would be a partnership including the main academic institutions in the state (Yale University and the University of Connecticut), state agencies serving children (DCF and CSSD), and a nonprofit institute (CHDI), where core issues affecting children's mental health could be identified and analyzed to promote systems change. However, due to a changing economic climate, tighter restrictions in state contracting procedures, and challenges with identifying the capacity in the partner

academic institutions to do the work, the Center began, over time, to function less as a partnership and more as an independent entity with its own internal capacity to achieve its vision and mission.

Initially, the Center was governed by a steering committee composed of representatives from each of the partner institutions. This committee met on a monthly basis, provided oversight, and helped steer the direction of the Center and use of its resources. On an annual basis, the Center's board would identify and vote on strategic priorities that would be addressed during the next year. Over time, as staff gained expertise and built internal capacity, their reliance on affiliated academic institutions diminished and the Center acted more autonomously.

In 2008, the governance for the Center shifted to the board of CHDI, the institute where the Center is housed, but the original partner organizations continue to act as an advisory board. The Center continues to function much as it did previously, but it is now integrated into CHDI as its mental health initiative. The director of the Center is also the vice president for mental health initiatives at CHDI. This transition has enabled the Center to continue to function effectively as an intermediary organization in Connecticut.

Scope of Work

The Center has engaged in a range of activities since its inception, which can be categorized into seven main areas:

1. Consultation activities;
2. Best practice model development;
3. Purveyance of EBPs;
4. Quality assurance and improvement;
5. Outcome evaluation and research;
6. Training, public awareness, and education; and
7. Policy and systems development.

These activities are conducted through two main mechanisms: (1) internal capacity through expertise of the Center staff and (2) collaboration with external experts and resources. As the Center has evolved over time and staff have gained both experience and recognition with statewide stakeholders, the range of activities conducted by the Center has relied less on external expertise and more on internal capacity.

Consultation to State Agencies and Provider Organizations. A major activity of Center staff involves providing ongoing consultation to state agency personnel and provider organizations that deliver or procure mental health services for children and families in the State of Connecticut. The original structure of the Center—the open-ended, multi-year contract with DCF—allowed state agency program staff to consult with Center staff on a regular basis for a range of issues during the contractual period. Further, the CSSD also benefited from this arrangement. Agency leadership and program staff would routinely seek consultation about identifying and implementing best practices within the statewide system of care. In some instances, these consultations would lead to specific products and initiatives (see discussion below). In other cases, consultations were time limited and targeted specific needs in the system. This arrangement worked well until the end of the contractual period, when core support for the Center was discontinued due to statewide budgetary constraints. Although the Center continues to provide consultation to state agencies and provider organizations, these consultations are somewhat limited to the specific programs and initiatives for which the Center has a contractual relationship with the state.

One result of the Center's consultation to state agencies and stakeholders has been the development of major reports that analyze current practices, identify opportunities for improvement, and make recommendations for change at the policy, systems, and practice levels. Two major early reports focused on practices within the juvenile justice system and made recommendations for improvements in service delivery. *Close to Home* described existing practices in the juvenile justice system and made recommendations to improve and enhance those services to better meet the behavioral health needs of children and families (Ford et al., 2003). This report was instrumental in being a catalyst for many of the improvements in service delivery in the juvenile justice system in Connecticut and shifts toward more evidence-based, family-centered treatments. A follow-up report, *Not Just Child's Play*, focused on the role of screening and assessment in the juvenile justice system, identifying best practice models and identifying gaps within the Connecticut system (Williams et al., 2005). Like its predecessor, this report helped facilitate changes in the system, including ways in which screening and risk assessment are used to help identify children's needs and match them with the most appropriate available services.

Other reports developed by the Center focused on areas of high need identified by state agency and academic partners. Reports focusing on youth suicide (Dore et al., 2006) and substance abuse and caregiver parenting and attachment (Tay, 2005) were also developed to address challenges being confronted by the state's behavioral health system. Recently, the Center completed a report analyzing the state's outpatient system of care for children, which is being used to promote system improvements and implementation of best practices (Vanderploeg et al., 2010). These reports helped identify best practice models of care and made recommendations for enhancing and improving services at the policy, systems, and practice levels. These activities have helped to improve behavioral health services in Connecticut and to establish the Center, with CHDI, as an expert consultant and intermediary organization that is positioned to be a catalyst for and leader in systems change.

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Best Practice Model Development. As DCF began to examine the effectiveness of behavioral health services in Connecticut, it turned to the Center to help identify best practice models of care. In many cases, services provided by the state do not have a clearly defined model or research base. In the past four years, the Center has developed best practice models of care for several different key services within the spectrum of care. At DCF's request, CHDI worked with an external expert consultant to develop and identify a model of practice for therapeutic support services (often referred to as "therapeutic mentoring"; Davis, 2007). The Center

surveyed best practice models nationally and described existing resources and practices in Connecticut to develop a model of care that was based on evidence and was also responsive to the ecology and history of service delivery in Connecticut.

Similarly, the Center worked with DCF to develop a best practice model for Extended Day Treatment (EDT) services (Vanderploeg et al., 2009). In collaboration with one of its partner organizations, the Yale Consultation Center, the Center developed a theoretical foundation and practice model recommendations for EDT services in Connecticut. This process included identifying established best practice models, interviewing and documenting the practice of existing EDT service providers in the state, and building recommendations on demonstrated successful practices. This effort led to an ongoing collaborative process between DCF, provider organizations, and the Center that resulted in the implementation of new practice standards and improvements in the delivery system.

The Center also was asked to develop a model of care for the Emergency Mobile Psychiatric Services (EMPS) program. EMPS is a mobile statewide service that is meant to relieve the burden on emergency departments and provide urgent assessment, triage, short-term treatment, and referral for children in their community anywhere across the state. After a comprehensive process that involved identifying national best practice models of care, a series of interviews with expert researchers and consultants, analysis of the current services being delivered in Connecticut, and identification of best practices that were currently being delivered, the Center developed a new model for this service that resulted in a major reprocurement and reorganization of these services across the state (Vanderploeg et al., 2007). Despite initial resistance to these changes at the practice and policy levels, the changes in service delivery have been very successful, with documented improvements in practice and outcomes.

Purveyance of EBPs. In addition to enhancing or improving existing behavioral health services in Connecticut, the earliest work of the Center involved disseminating an established EBP—Multisystemic Therapy (Henggeler & Lee, 2003). As documented in the Center's evaluation of MST in Connecticut (Franks et al., 2008), the Center helped disseminate MST across the State of Connecticut and implemented more than 25 MST teams over a five-year period between 2001 and 2006. Initially, the Center worked closely with MST Services, Inc., to become a licensed systems supervisor, providing all the training, coaching, quality assurance, and outcome evaluation through collaboration with local and national partners. Over time, the Center transitioned the quality assurance and systems supervision to another Connecticut-based organization, Advanced Behavioral Health, but used the experience to build its internal capacity and develop expertise in the dissemination of EBPs. Since the dissemination of MST, the state has invested and built capacity in providing a range of other in-home EBPs, including Functional Family Therapy (FFT), Multidimensional Family Therapy (MDFT), Brief Strategic Family Therapy (BSFT), and Multidimensional Treatment Foster Care (MTFC). Because of the variety of in-home EBPs now available in the Connecticut system, the Center developed a decision-making model to help state agencies and provider organizations make appropriate decisions regarding use of these services (Vanderploeg & Meyers, 2009).

An integral aspect of the Center's work as an intermediary organization is quality assurance and continuous quality improvement.

As it evolved, the Center continued to act as a purveyor of other large-scale initiatives to disseminate evidence-based or promising practices across Connecticut. Recently, in the summer of 2010, the Center worked closely with DCF to complete a three-year dissemination and implementation of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen et al., 2006). Through funding from DCF, this established EBP was disseminated to 16 outpatient providers geographically distributed across the state to meet the needs of traumatized children and their families. The learning collaborative methodology, developed by the Institute for Healthcare Improvement and adapted by the National Center for Child Traumatic Stress at Duke University, was used as the mechanism to disseminate this EBP. The learning collaborative is proving to be a highly effective mechanism for disseminating EBPs, as evidenced by both outcomes and practice changes across the state. This model has been embraced by the Center as a viable model for systems change that can be applied and adapted to other best practices within a large-scale system of care.

The Center, through contracts with state agencies supported by a Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Transformation State Incentive Grant (MHT-SIG), is implementing the Wraparound Milwaukee model in two demonstration sites (one urban, one non-urban), to explore and establish the benefits of family-centered community-based care for children and families. Through collaboration with external experts from Wraparound Milwaukee and local academic, state, and family partners, the Center is acting as the coordinating center for the initiative, providing training, consultation, capacity building, coaching, and outcome evaluation of the Wraparound initiative in two communities. It is hoped that the outcomes of this initiative will inform system-of-care development across the State of Connecticut.

The Center is also providing consultation on the learning collaborative methodology, quality assurance, and technical assistance to help implement Child FIRST, an emerging EBP, across Connecticut. This early childhood parent-child home-based intervention was developed by a Connecticut developmental pediatrician and has been shown to have extremely promising outcomes for children and caregivers who receive these early intervention services. Through the support of a Robert Wood Johnson Foundation grant, the Center is working with the treatment developer to help disseminate the Child FIRST model to six agencies across the state over a two-year period, to help establish an infrastructure to support this practice across Connecticut and to further expand the early childhood system of care.

Quality Assurance and Improvement. An integral aspect of the Center's work as an intermediary organization is quality assurance and continuous quality improvement. In many of its initiatives, the Center helps individual providers and state systems use metric and quality assurance

data to monitor program fidelity, improve practice, and promote higher standards of care. This is evidenced in the Center's work on the TF-CBT initiative, where it continues to collect, analyze, and disseminate quality assurance data to provider organizations that have implemented the practice. In collaboration with DCF, the Center has established a comprehensive system for continuous quality improvement. The Center is also working with the developers of Child FIRST to develop a similar system for quality assurance and improvement.

Perhaps the best example of the role of the Center in promoting quality is through the Performance Improvement Center (PIC), which was established by DCF following the implementation of the recommendations for service improvement in the Emergency Mobile Psychiatric Services (EMPS) initiative (Vanderploeg et al., 2007). The PIC is housed at the Center and provides all training, technical assistance, and continuous quality improvement services to providers of EMPS across the state. The PIC trains the provider organizations in core practice elements and collects data that examine quality and performance over multiple domains. These data are shared transparently across all providers and analyzed at the system and provider levels to help drive practice improvement.

Outcome Evaluation and Research. The Center also engages in outcome evaluation and research of existing programs to help promote the use of data to improve the quality and outcomes of behavioral health services. In several of the initiatives previously mentioned, research and evaluation are critical aspects of the Center's efforts. In particular, the TF-CBT and Wraparound initiatives include comprehensive research and evaluation components for which the Center is responsible. The Center also engaged in a major research and outcome evaluation study of MST in Connecticut following its transition from its role as system supervisor (Franks et al., 2008). In this instance, the Center shifted from the role of implementation to research and evaluation. This large-scale study examined not only MST outcome data, but also objective reports of recidivism, and established that MST is indeed improving outcomes for children in Connecticut and is a cost-effective alternative to residential treatment and other congregate care services (Franks et al., 2008). This evaluation report was used to educate stakeholders as to the effectiveness of MST in Connecticut and was instrumental in policy decisions and resource allocation.

The Center has also conducted some smaller scale evaluations of initiatives such as a local truancy prevention program. The Center undertakes these projects when there is potential to help establish the evidence base for an existing practice or if the practice has some potential to address a demonstrated need or to be brought to scale within the statewide system of care.

As the Center has developed and evolved, the importance of engaging families in all aspects of its work and ensuring that its work is culturally competent has emerged as a core value.

Training, Public Awareness, and Education. The Center also engages in ongoing efforts to train and educate both professionals and consumers of behavioral health services, as well as academic and community partners. By sharing the outcomes of the Center's work in a variety of forums, both formal and informal, the Center consistently works to raise awareness about the importance of delivering high-quality, effective behavioral health services. Center staff are also contacted by state agencies and other stakeholders to provide training on a wide range of topics ranging from child and adolescent development to implementation of EBPs. As an integral part of CHDI, the Center also works to develop resources and materials to help educate professionals who deliver care to children across the state. In a variety of roles, the Center helps to promote workforce development and identification of the capacities needed to implement quality care. The Center is also committed to working with its family partners to engage parents and caregivers and to raise their awareness and create demand for effective services. Examples of this work include the development of a comprehensive guide to the juvenile justice system for families (Williams et al., 2008) and an extensive website recently launched to help parents and caregivers navigate the behavioral health system (*www.kidsmentalhealthinfo.com*).

Policy and Systems Development. In addition to its other activities, the Center also actively engages in systems and policy development that help shape the landscape of children's behavioral health in Connecticut. Through participation in statewide forums, advisory committees, and governance committees, Center staff sit at many tables where change is facilitated. The Center has become a respected voice on behalf of best practices and research in children's mental health. The Center is often sought out for consultation on the development of policies and procedures that affect children. Although careful not to act as lobbyists or advocates, Center staff work to educate and inform, acting as catalysts for systems change.

Family and Consumer Involvement and Cultural Competency. As the Center has developed and evolved, the importance of engaging families in all aspects of its work and ensuring that its work is culturally competent has emerged as a core value. Because of the importance of family and consumer involvement, a statewide family advocacy organization was invited to be one of the Center's partner organizations and is now a member of the Center's advisory board. In addition, whenever possible, family members actively participate in the Center's initiatives. All staff have undergone cultural competency training and participate in an ongoing cultural competency assessment. Cultural competence has also been built into staff's annual review process. Products and materials produced by the Center are often reviewed by families and consumers to ensure that they are family centered and culturally competent. These values are an integral aspect of the Center's work.

Challenges and Lessons Learned

A variety of challenges have been encountered by the Center since it was created almost 10 years ago. As discussed above, funding, governance, and barriers to accessing state resources have been continual challenges. It has often been asked whether some of these challenges could be

addressed by moving the Center to a state academic institution. However, past successes, lack of bureaucracy, and organizational independence have always prevailed as reasons to maintain the Center as part of an independent nonprofit institute.

The multiple roles of the Center, with regard to academia, policy, systems, and practice, have been challenging and sometimes difficult to manage. Despite the variety of activities in which the Center has been engaged, it has been essential to serve multiple roles to advance its mission. Each of the systems with which the Center works has its own demands and cultures, and it is therefore necessary for the Center, as an intermediary organization, to remain flexible and responsive. For example, state agencies operate on different timelines and have very different expectations regarding utility of research and data and how it is presented. The world of academia can often move too slowly and be overly obtuse for the needs and demands of a state agency or provider organization. Much care must be taken in the ways in which information is analyzed, translated, and presented. Otherwise, miscommunication and misunderstanding can occur, leading to frustration and ineffectual working relationships.

Another challenge is the importance of sharing and publishing the Center's work in multiple forums. Although the Center is affiliated with academic institutions, it is not a part of a university, and its impetus for publishing is to change state systems and improve the standard of mental health care in Connecticut. The Center's staff and board wrestle with the value and importance of publishing the Center's work in forums other than those for local audiences, but publishing in peer-reviewed journals takes effort and time that can otherwise be devoted to the Center's full agenda. However, lack of recognition of the Center's accomplishments makes it more difficult to attract other resources, particularly external federal grants. Thus, an ongoing challenge is balancing the practical versus academic value of the Center's work.

As an intermediary organization, the Center's work can sometimes feel like the proverbial "two steps forward, one step back." Systems change can be extremely difficult and take many years to achieve. Some initiatives undertaken by the Center have lasted more than twice their anticipated duration. Further, systems change that occurs too quickly or without proper planning may also have negative consequences. In addition, it is difficult to create change without some type of real incentive—be it monetary or otherwise. As Fixsen notes, an intermediary organization must be attentive to the "drivers" of system change (Fixsen et al., 2005).

An organization cannot function as an intermediary if the entities among which it intermediates are not ready and do not have sufficient motivation and capacity for change.

Many of the projects the Center has undertaken have required actively collaborating with a variety of stakeholders, state agencies, treatment developers, provider organizations, researchers, and consumers. This can be a daunting task. Over time, the Center has recognized that strong consultation skills and good relationships are vital ingredients to being a successful intermediary organization. It is very difficult to move forward with this work without some evidence of past success, good relationships with stakeholders, and a positive reputation and track record upon which to build. However, the work, in some ways, does get easier over time as capacity is developed and lessons are learned. For example, one major lesson learned is the importance of being inclusive when developing or implementing best practices or models of care. If one does not attend to stakeholders' needs, interests, and concerns at the beginning of the process, there is a great likelihood that those same entities will later become significant barriers to successful implementation and sustainability.

Assessing the capacity of organizations and systems for change is a critical first step. An organization cannot function as an intermediary if the entities among which it intermediates are not ready and do not have sufficient motivation and capacity for change. From the treatment developer's side, the treatment must be well defined, demonstrate a solid evidence base, and have some evidence of successful replication. From the provider's side, the organization must have the capacity for change and have buy-in from multiple levels. Further, the provider organization must be amenable to change and have sufficient sophistication to use quality assurance and evaluation data to drive practice. Without the proper ingredients and context, it is very difficult for change to occur in organizations or systems.

Finally, the Center has come to realize that change is an ongoing process that needs constant attention. Once a new practice has been embedded in an agency or system, the Center cannot just "walk away." There must be systems and procedures in place to assure fidelity and adherence to the model. Without some type of continuous quality improvement in place, whether it is delivered by the intermediary organization or whether it is built into the provider agency or system itself, there is likely to be model drift over time. Thus, in order for true change to occur and be sustained, there must be recognition that there is an ongoing process.

Conclusions

In the Center's experience, past success has fostered future opportunities. In the changing landscape of mental health service delivery across the nation, the role of the intermediary organization is a vital component of effective and sustained systems change. As described, the greatest challenge the Center continues to face is lack of core funding and access to state resources to continue to do its work. However, despite diminished resources, ample opportunities abound, and with the support of the Children's Fund and integration into CHDI's mission, the Center is likely to be sustained well into the future. There certainly is much work to be done. As the Center focuses on moving forward, it looks to new opportunities and collaboration with untapped stakeholders, both locally and nationally, to sustain and grow its work. It must broaden its focus on the continuum of care and work to identify and prevent mental health concerns earlier, before they become costly and more difficult to address.

With limited resources, the Center must act strategically to achieve the greatest impact resulting in sustainable changes at the policy, systems, and practice levels. Ultimately, the Center's goal is to work toward a statewide system where its services are no longer necessary. The Connecticut Center for Effective Practice is one example

of a successful intermediary organization that has promoted improvements in the delivery of mental health services within a statewide system of care. Other developing intermediary organizations can learn from the Center's successes and challenges and work with the ecology of their own state or region and establish the relationships and resources necessary to effect systems change on behalf of children, youth, and families.

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