



the prevalence of children's behavioral disorders is well documented, with 10 to 20% of youth (about 15 million children) in the United States meeting diagnostic criteria for a mental health disorder. Many more are at risk for escalating problems with long-term individual, family, community, and societal implications (National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001; President's New Freedom Commission on Mental Health, 2003; U.S. Public Health Service, 2000). Child mental health services are historically and consistently underfunded with the result that children and adolescents often do not receive the mental health care they need (Knitzer, 1982; Masi & Cooper, 2006). For example, among those with a recognized disorder, only 20 to 30% receive any specialized mental health care in a given year (Burns et al., 1995; Kataoka, Zhang, & Wells, 2002). The situation is even worse for youth from low-income families, those in the juvenile justice and child welfare systems, ethnic minority youth, and those with substance abuse problems (Masi & Cooper, 2006). Latino children and adolescents are most likely to go without needed mental health care (Health Care Financing & Organization (HCFO), 2004; National Center for Children in Poverty, 2006). In this report, we adhere to the definition of evidence-based practice (EBP) developed by the 2005 Presidential Task Force on Evidence-Based Practice of the American Psychological Association and the policy statement on practice recommended by the task force that the APA Council of Representatives adopted as **policy**:

Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. This definition of EBPP closely parallels the definition of practice adopted by the Institute of Medicine (2001, p. 147) as adapted from Sackett and colleagues (2000). The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case, formulation, therapeutic relationship, and intervention.—Adopted by APA Council of Representatives, August 17, 2005

The **EVIDENCE-BASED PRACTICE FOR CHILDREN AND ADOLESCENTS (EBPCA)** report focuses specifically on psychological practice with children and adolescents. We agree with the framers of the original task force report that integrating science and practice must be a priority. In addition, we believe that developmental considerations and cultural/contextual factors warrant specific, distinctive attention by researchers and practitioners who focus on youths and their families. Evidence-based practice (EBP) denotes the quality, robustness, and/or scientific evidence on prevention, assessment, treatment, access, engagement, and retention of targeted patient populations (Cournover & Powers, 2002; Hoagwood & Johnson, 2003). EBP assumes the presence of a coherent body of scientific knowledge relevant to a broad range of services that optimizes the effectiveness of interventions, treatments, or services on a particular student, client, or system. Although growing evidence exists for effective practice for children with mental health problems, the integration of science and practice and the development of systems for assuring that children receive effective treatment and services present myriad challenges. Effectively implemented EBP requires a contextual base, collaborative foundation, and creative partnership among families, practitioners, and researchers. Children and adolescents should receive the best available evidence-based mental health care based on scientific knowledge and integrated with clinical expertise in the context of patient characteristics, culture, and preferences. Evidence-based care should be provided as consistently as possible with children and their families across clinicians and settings. Care systems should demonstrate responsiveness to youth and their families through prevention, early intervention, treatment, and continuity of care. Equal access to effective care should cut across age, gender, sexual orientation, and disability, inclusive of all racial, ethnic, and cultural groups.

THE PSYCHOLOGIST'S FRAMEWORK

The practice of the psychologist providing EBP to children and adolescents must include partnerships with other providers, cultural responsiveness, a developmental approach, and a socioecological framework. Although many evidence-based interventions are intended for implementation by clinicians (e.g., manual-based treatment for anxiety disorders), multiple stakeholders are increasingly becoming involved in developing, shaping, and providing behavioral health services to children and adolescents, including, for example, families, administrators, direct care professionals, and teachers. Psychologists frequently work in collaborative multidisciplinary settings in which they help to organize and structure EBP and consult with and train other professionals to implement evidence-based interventions and address systemic processes that have an impact on the effectiveness of the practice (Friedman, 2006; Kratochwill, 2007; Kratochwill & Hoagwood, 2006; Sheridan & Kratochwill, 2007). This form of EBP requires psychologists to function as collaborators, consultants, and problem solvers in order to optimize the effectiveness of their practice. Psychologists must also be culturally responsive, that is, have the skills, values, attitudes, and beliefs to reduce bias in assessment and intervention approaches. They must have the knowledge and training to integrate multiple developmental processes (e.g., physical, mental, cognitive, social, emotional) in treatment and practice. They must be able to develop or adapt evidence-based interventions and practices that are responsive to the needs and cultural beliefs and values of the local communities they serve.

CONTEXT

Service delivery for children cannot occur without attention to context, including the family, schools, the health care system, and the child mental health system. Within each of these systems, particular attention must be paid to integrating EBP with culturally, geographically, and socioeconomically diverse groups. Research has provided evidence for the success of EBP with ethnic minority youth, for example in the treatment of anxiety-related problems, ADHD, depression, conduct problems, substance use problems, trauma-related syndromes, and other clinical syndromes and problems (Huey & Polo, 2008). In addition to developmental and other factors, psychologists providing EBP should take into account sociocultural and familial factors (e.g., gender, gender identity, ethnicity, race, social class, religion, disability status, family structure, and sexual orientation) and environmental context (e.g., institutional racism, health care disparities) (American Psychological Association, 2006).

Psychologists should adapt services and subsequently monitor these modifications and evaluate treatments developed within and for specific cultural and socioeconomic groups. Culturally insensitive treatments can cause the therapist unwittingly to select goals or embrace values that reflect the culture of the therapist rather than that of the child and family (Comas-Díaz, 2006).

THE FAMILY

Children and most adolescents typically access care via an adult “gatekeeper,” most often a parent, school or juvenile

justice personnel, or physician. Although many psychosocial treatments emphasize the child as an individual, those that include family context and actively engage families in fostering adaptive development represent optimal approaches. Some evidence-based treatment approaches explicitly engage family members and target family change as a necessary outcome. However, even in treatments that lack this explicit focus, it is clear that families are essential partners in clinical engagement of children, support for children who are learning new ways of functioning and coping (e.g., Mendlowitz et al., 1999; Thienemann, Moore, & Tompkins, 2006), and support for sustaining changes after children are no longer receiving care (Hawley & Weisz, 2005).

SCHOOLS

Schools are influential forces in the development of prosocial and problem behavior and provide opportunities for prevention and treatment. Limited access to health and behavioral health care increases the likelihood that untreated behavioral concerns will emerge in schools. Traditionally, special education services have served students with special needs, wherein they were referred, evaluated (typically by a school psychologist), and placed in special education classes. Among students between the ages of 6 and 21 years, nearly 3 million with learning disabilities (LD), 500,000 with emotional and behavior disorders (EBD), and more than 78,000 with autism received special education services in 2001 (Office of Special Education Programs, 2003). After years of implementation, the limitations of this model became evident. Students had to develop serious problems prior to receiving needed services (frequently called the “wait-to-fail model”), and schools placed a disproportionate number of minority students in special education. Because the category of “learning disabilities” was the most common and purportedly overused category of services, a long series of research reviews, task forces, commissions, and work by various government groups targeted and proposed alternatives (Gresham, 2006).

One recommendation for services to students at risk for academic and behavioral problems is response to intervention (RtI) that employs evidence-based interventions implemented in a multitiered model of services, using student outcomes in learning and behavior domains to make decisions about the need for subsequent and more intense interventions, including special education (National Association of State Directors of Special Education, 2005). A corollary to RtI in the behavior disorder domain is a prevention and intervention movement called positive behavior support (PBS) that uses functional assessment

and analysis to design intervention programs for individual students.

THE HEALTH CARE SYSTEM

Pediatricians may be the first to detect potential precursors of health or behavioral concerns that warrant further attention, especially for those children and adolescents who may not receive evidence-based treatment through the mental health or educational systems. Unfortunately, pediatricians and pediatric health care systems are often not able to treat these problems. That is, pediatricians may feel unprepared to accurately diagnose behavioral problems and to treat complex problems that may necessitate both pharmacologic and behavioral treatments.

Pediatric psychologists and other behavioral health care professionals are often integrated into multidisciplinary treatment teams for children with disorders such as cancer, asthma, diabetes, chronic and acute pain, sickle cell disease, neurological disorders, HIV/AIDS, cystic fibrosis, cardiac disease, organ and stem cell transplantations, burns, gastroenterological disorders, rheumatic diseases, injuries, sleep disorders, and genetic disorders, among others. While disease-specific expertise is needed for a subset of each pediatric group noted, more generic problems common across diseases include strategies for coping with pain and distressing procedures, adherence to medical treatment, family functioning, and child anxiety and depression. Evidence-based practices are available and broadly utilized (Drotar, 2006; Roberts, 2003; Shaw & DeMaso, 2006; Spirito & Kazak, 2006). The pediatric health care system can implement additional diverse intervention efforts, including, for example, cognitive remediation for children with impairments to the central nervous system, end-of-life care, and the impact of child death on families.

CHILDREN'S MENTAL HEALTH CARE SYSTEM

The most salient characteristic of the children's mental health care system is, unfortunately, its fragmentation and lack of coordination of services. In addition to creating considerable burden on families, it is inefficient for states, providers, and systems and destructive to the shared goal of service integration. At least six separate sectors or administrative structures constitute the “system” serving children with psychological problems: the mental health sector; education; child welfare, including foster care and adoptive services; substance abuse; general health; and juvenile justice. These sectors themselves are asymmetrical

in that each offers a range of programs with varying levels of restrictiveness and no consistent standards for access or discharge and sometimes parallel in that services offered in one sector are not coordinated with services in another sector.

JUVENILE JUSTICE SYSTEM

Mental health problems and behavioral and social dysfunction are highly prevalent among youngsters in the juvenile justice system (Skowrya & Coccozza, 2006), and the evidence base on interventions, including anger management and systematic problem solving, for such behavior is particularly extensive (United States Public Health Service, 2001). Unfortunately, many youngsters do not have access to sufficient intervention to prevent their entry into the juvenile justice system, particularly youth of color. For example, African American youth ages 10 to 17 years make up about 16% of the juvenile population in the United States; yet, they accounted for 38% of almost 100,000 juveniles in secure residential placement (National Council on Crime and Delinquency, 2007). Youth of color comprise the majority of youth held in public and private facilities, and youth of color, especially Latino youth, represent a much larger proportion of juveniles in public facilities, which are often harsher environments than private facilities (National Council on Crime and Delinquency, 2007). In a national study of youth from various juvenile justice programs, 72% of girls and 63% of boys in the aggregate sample had a clinical elevation on at least one scale on the Massachusetts Youth Screening Instrument-Version 2 (Vincent, Grisso, Terry, & Banks, 2008).

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CHILD PROTECTION

Child maltreatment, encompassing both neglect and abuse, is evident in all regions of the country, necessitating child protective service systems in every state. Sometimes lost in the complexity of the bureaucracy designed to handle such situations is attention to the trauma the children have experienced, as related to the identified maltreatment, the investigations by child protective services and law enforcement, involvement in legal proceedings, and subsequent changes in the children's living situation.

Evidence-based assessment methods exist for identification of problems and disorders that warrant clinical attention, and evidence-based treatments exist for some of the most likely problems and disorders (see, e.g., Cohen, Mannarino, & Deblinger, 2006). However, because child protection and justice systems often operate independently from mental health systems, awareness of these assessment and treatment methods may be limited. In addition, the personnel responsible for child protection, criminal investigation, and legal proceedings may have training relevant to their primary work, but relatively little exposure to evidence-based assessments or treatments.

SUBSTANCE ABUSE

Substance use may be more prevalent in certain subgroups of youth, and the approaches necessary (e.g., for GLBT youth) may differ from more "traditional" treatment models (Russell, 2006).

Alcohol and drug abuse in children and adolescents often co-occur with mental health problems, and the existence of separate "systems" (substance abuse treatment, behavioral health, general health, and juvenile justice systems) pose a significant challenge for children, adolescents, and their families. Evidence-based treatment programs for children or adolescents with co-occurring disorders are still rare.

ASSESSMENT, INTERVENTION, AND PREVENTION

A large and ever-expanding scientific literature documents the existence of two major elements of evidence-based practice: assessments shown to be psychometrically sound for the populations on whom they are used and interventions with sufficient evidence for their effectiveness. Sound assessment is required for accurate identification of children's problems and disorders, for ongoing monitoring of children's response to interventions, and for evaluation of the outcomes of intervention once termination has occurred. Evidence-based interventions, and particularly those utilizing longitudinal data for short- and longer-term outcomes, are required if practitioners are to draw on clinical care procedures that have track records—i.e., procedures shown to ameliorate problems or symptoms—or to otherwise bolster or sustain children's adaptation or well-being.

Using assessment approaches with a well-demonstrated evidence base can make it possible to properly match the

child's condition to the appropriate treatment. Assessment should also identify each youngster's strengths, as these are the resources upon which intervention can build and encompass environmental and system factors that are so often critical to successful treatment. Once treatment has begun, culturally responsive and psychometrically sound assessment at regular intervals (e.g., each treatment session, weekly) will gauge the child's response to the intervention, inform adjustments in treatment strategy, and guide decisions about how long treatment needs to continue. After treatment ends, posttreatment assessment will gauge the overall impact of care.

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Several narrative reviews and meta-analyses have shown that prevention programs for young people can produce significant benefit by reducing rates of later social, behavioral, academic, and psychological problems. Researchers have designed some specific programs to promote a broad array of positive outcomes, called health promotion or positive youth development programs. In one program with elementary school students in high-crime areas, teacher training, parenting classes, and child social skills training resulted in more positive outcomes, including reduced rates of risky sexual behavior, pregnancy, and delinquency, and higher levels of school achievement among youths who participated in the program versus those who did not (Lonczak, Abbott, Hawkins, Kosterman, & Catalano, 2002). Other programs focus on universal prevention in an entire population. One "whole school program" markedly reduced bullying, vandalism, fighting, and theft in schools by improving school recess supervision, establishing anti-bullying school rules, and arranging meetings with bullies, victims, and parents of both (Olweus, 1994).

Still other programs employ selective prevention, targeting specific groups that are especially at high risk of unwanted outcomes. In the Nurse Home Visitation Project (Olds et al., 1998), designed specifically for low-income women experiencing their first pregnancy who were younger

than 19 or unmarried, nurses worked with the expectant mothers to promote healthy behavior during pregnancy and the child's early years, to build competency in child care, to link mother and child to services and social supports, and to support the mother's personal development. The program has shown benefits that include reduced rates of substance use, antisocial behavior, and child maltreatment—effects documented over 15 years after birth. In a fourth category of preventive intervention, indicated prevention, the focus is on youngsters who already show some evidence of the target problem. In the Montreal Prevention Experiment, Tremblay, Pagani-Kurtz, Masse, Vitaro, and Pihl (1995) identified inner-city kindergarten boys who already showed significant disruptive behavior and provided the boys with school-based social skills training and their parents with home-based parent training. This indicated prevention program led to better school performance and reduced delinquency over the subsequent 5 years.

BENEFITS OF YOUTH TREATMENT PROGRAMS

There is a rich evidence base of sound assessment and intervention strategies tailored to particular conditions, contexts, and needs demonstrating that structured, empirically tested treatment programs can have beneficial effects with children and their parents. Many of these programs include individual therapy with children and others—particularly for conduct problems and other externalizing behavior—and address child problems primarily by working with parents. Still others focus intervention on multiple levels of children's social ecology.

AN EVIDENCE-BASED ORIENTATION TO PRACTICE

Central to an evidence-based orientation to clinical practice is a scientifically minded approach characterized by knowledge and skills in applying psychological science, including models of etiology and change, as well as a constant process of observation and inquiry. The three primary elements of an evidence-based clinical practice are (a) assessment that guides diagnosis, intervention planning, and outcome evaluation; (b) intervention that includes, but is not limited to, those treatment programs for which randomized controlled trials have shown empirical support for the target populations and ecologies; and (c) ongoing monitoring, including client or participant feedback, conducted in a scientifically minded manner and informed by clinical expertise (e.g., judgment, decision making, interpersonal expertise). In addition, efforts to alleviate

concerns, align expectations about treatment, culturally adapt or tailor treatment, and provide support for individuals and families to receive treatment can enhance treatment engagement.

Barriers to positive outcomes may exist, including chronic and severe child psychopathology, parental psychological difficulties, needs of siblings, and familial inability to access or utilize services. Competencies in areas such as case formulation; treatment planning; implementation of treatment; monitoring; formation of therapeutic alliances; and understanding of individual, cultural, and contextual influences (APA Presidential Task Force on Evidence-Based Practice, 2006) are necessary to address such barriers.

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IMPLEMENTATION AND DISSEMINATION

The momentum to move new and tested practices into real-world settings has created both a set of challenges and a set of opportunities. Some of the challenges include the acceptance of EBP by providers, administrators, families, and other stakeholders; the effect of the adoption of EBP on caseloads or supervisory practices; and the integration of EBP by existing organizational and management structures. Prompted in part by recognition of these challenges, a series of major federal, state, and local policies launched in recent years has created unprecedented opportunities for partnerships among researchers, practitioners, and policymakers to encourage the implementation and dissemination of EBP into public mental health systems. Several foundations are also supporting major studies to improve delivery of EBP for children. Though empirical testing of implementation or dissemination strategies is lacking, there are several relevant strategies, frameworks, and guiding principles emerging in the literature that can help guide the efforts of those seeking to disseminate EBP and promote their adoption into large systems.

CHALLENGES TO IMPLEMENTATION AND DISSEMINATION

A number of macro (e.g., systemic) and micro (e.g., individual, such as clinician, supervisor, administrator,

family) factors hamper implementation of EBP. In addition to the lack of integrative conceptual models described above, other issues include inconsistent definitions for the major constructs; the role of families and local communities in EBP; methodological, measurement, and data analytic challenges; insufficient training and consultation models; and system fragmentation. Complicating this is the fact that children in treatment often present with multiple co-occurring problems and disorders (Angold, Costello, & Erkanli, 1999) with complex social and family problems and situations and diverse cultural contexts. By contrast, most evidence-based treatments are designed for single conditions or groups of closely related conditions (e.g., a cluster of anxiety disorders with partially overlapping symptoms) and do not specify how to deal with the complex social and family circumstances that relate to the children's problems or to the cultural contexts in which the children's problems are manifested and interpreted. Comorbidity may either undermine or enhance the effects of treatment on the primary problem targeted in treatment (see Curry et al., 2006; Hinshaw, 2007), and complexities associated with social and family circumstances and cultural contexts may hamper the effects of treatment if they are ignored (Koss-Chioino & Vargas, 1999). In any treatment episode, those problems and contexts not targeted by the evidence-based treatment in use may persist, continuing to cause difficulty.

METHODOLOGICAL, MEASUREMENT, AND ANALYTIC CHALLENGES

Those seeking to implement new clinical service models in their systems face numerous methodological, measurement, and analytic challenges. These include (a) the lack of reliable or valid methods for determining the preparedness of providers, agencies, regions, or specific stakeholder groups in adopting or sustaining new EBP technologies; (b) the lack of metrics or measures for determining the efficacy and effectiveness of implementation efforts; (c) the lack of adequate measures for assessing the fidelity of implementation efforts at multiple levels (families/youth, clinicians, supervisors, administrators, policymakers) and contexts (e.g., rural vs. urban, or Korean Americans in South Central Los Angeles vs. Ethiopian Americans in Silver Lake, MD); (d) the problems of using data collected within real-world service systems for research purposes, often compromised by missing elements due to random and/or nonrandom factors, as well as observer biases; and (e) the un-ideal nature of service organization and delivery, such that rigorous control of potential confounds or even knowledge of potential sources of bias are increasingly difficult. From a policy perspective, this is very problematic, as substantial analytic and interpretative problems in costly trials result

from noncompliance, treatment switching, variable attendance, and differential attrition/dropout (Little & Rubin, 2000). In the child arena, for example, some evidence shows that these factors vary as a function of cultural or ethnicity variables (McCabe, 2002); failing to assess and account for such factors in the analytic models is likely to obscure genuine understanding (Kazdin & Mazurick, 1994).

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Increasingly sophisticated research designs, assessment methods, data capture techniques, and analytic approaches are becoming more common in services research studies. However, investigators at a systems level almost always encounter particular research design and analytic challenges resulting from the nested nature of children/families within clinicians, clinicians within supervisors and clinics, clinics within provider organizations, and provider organizations within geographic regions. In addition, the same potential sources of bias that operate at smaller scales, e.g., attrition (perhaps due to lack of EBP “preparedness” or self-selection factors at the family, clinician, or clinic level), adherence/fidelity to EBP methods/procedures, and incomplete or missing data for both random and nonrandom reasons complicate the ability to examine EBP.

Training and consultation issues range from the fact that EBP training is unavailable—or when available, uses ineffective training models, such as half-day workshops at professional meetings with no substantial follow-up or support (Grimshaw et al., 2001); manualization of current psychotherapy models varies widely (Chorpita, 2003); families often will not attend the 16 to 20 sessions needed to complete many of the models (Armbruster & Kazdin, 1994; Kazdin, 2004; McKay & Bannon, 2004); and new clinical practices do not take into account organizational or systems variables characterizing the practice environments (Hoagwood, Burns, & Weisz, 2002; Weisz & Addis, 2006; Weisz, Hawley, & Doss, 2004).

Strengthening the science base requires the ability to identify, measure, track, and monitor processes and outcomes for multiple stakeholders (families/children, clinicians,

supervisors, directors, payers, policymakers) across each of these systems. This would be a difficult undertaking in a simple system, and the asymmetry of the current contexts of care and the cultural, geographic, and economic diversity of the populations these mental health systems are intended to serve make it much more complex.

PROMISING APPROACHES

The EBP movement is beginning to recognize and examine issues related to organizational, clinical, and monitoring supports and how to embed these into systems. The development of a policy research base regarding state oversight of mental health service system transformation and implementation of EBP has begun. There have been some encouraging first steps. In addition, research is proposing new models of intervention development to help accelerate the application of research findings to routine practice. These approaches are creating learning communities with typical practice settings, encouraging these settings to become empirically driven centers for both delivering services and examining the impact of routine practice on outcomes. Such normalization of research-based approaches to practice can demystify the scientific enterprise and facilitate the constant re-evaluation, refinement, and improvement of services. This approach also encourages the construction of locally relevant evidence and creates a context for systematic evidence gathering within routine service settings, leading ultimately, one hopes, to improvements in quality.

TRAINING AND SUPERVISION

There are many implications of EBP for the training and supervision of psychologists. Educational efforts in graduate training will have to ensure that students have (a) a firm foundation in philosophy of science and an appreciation of the definition of science from different theoretical and disciplinary perspectives; (b) an understanding of and appreciation for current dominant views about science, how the valued methodologies derived from these views are culturally and historically situated, and the inherent strengths, biases, and limitations of these views; (c) an understanding of varied forms and levels of evidence and methods of evidence gathering, the use and suitability of certain types of evidence in developing treatments (e.g., as derived from qualitative and quantitative methods), and an appreciation for the knowledge that different types and levels of evidence can contribute in the process of scientific inquiry; and (d) an understanding of the knowledge about EBP currently available, the essential practice and contextual aspects necessary to effectively implement an intervention in a particular setting or community, and the strengths and

limitations (e.g., characteristics of patients and ecologies for which the treatment is intended) of EBP.

Because EBP extends to diverse contexts and delivery systems and attends to aspects of access, engagement, treatment process, and retention, students will have to develop specific skills in these areas of practice and appreciate that optimal application of their expertise—whether in research or practice—occurs only in collaboration with the participants in a study or the patients in the office, clinic, school, or community. Students must understand and appreciate the varied and complex characteristics of the target populations, including participants' values, beliefs, and views, the varied treatment contexts, and the delivery systems of psychological services. Students must be able to implement a prevention or intervention program with specific patient populations in specific communities, attend to structural and procedural aspects in order to facilitate access to care, respond to individual and cultural diversity in the efforts and techniques used to increase patient engagement and retention, promote cultural responsiveness in the administrative and organizational systems involved in service delivery, and establish collaborative relationships with the communities of targeted patient populations.

These educational efforts also will have to be directed toward practicing and supervising psychologists. This will likely require close partnerships among the American Psychological Association, state licensing board, state psychological associations, and the Association of State and Provincial Psychology Boards (ASPPB) in order to develop and implement effective strategies to (a) provide training in EBP to practicing psychologists through continuing professional education and (b) encourage state licensing boards to include requirements for training in and implementation of EBP in state licensing board rules and regulations.

APA must be prepared to provide consultation and technical assistance to behavioral health care, health care, juvenile justice, and school systems interested in providing EBP. This will require that APA establish a priority to provide such consultation and technical support and that it develop an organizational mechanism by which to provide such consultation and technical support, ideally in partnership with other professional associations, such as the American Medical Association, American Psychiatric Association, National Association of School Psychologists, National Association of Social Workers, and American Counseling Association.

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