Using Research Evidence and Data Analysis in Large-Scale Collaborative Implementations: First 5 LA’s Implementation of PCIT in Los Angeles County

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ABSTRACT

This paper will discuss First 5 LA’s 5-year countywide implementation of the Parent-Child Interaction Therapy (PCIT) program. Proponents of PCIT point to it as a high-quality parenting program with the potential to positively influence child behavior, reduce recidivism into the child welfare system, and increase caregiver’s confidence and self-esteem (Dombrowski, Timmer, Blacker, & Urquiza, 2005; Timmer, Urquiza, & Zebell, 2006, 2009). First 5 LA was created in 1998 and is currently one of the leading early childhood advocate organizations working in Los Angeles County. The $20 million countywide implementation of PCIT began in 2012 and has been a collaborative effort between First 5 LA, the Los Angeles County Department of Mental Health (DMH), the Los Angeles County Department of Children and Family Services (DCFS), and the University of California, Davis (UC Davis). The authors of this paper were contracted to conduct an evaluation of the implementation of the countywide PCIT program and preliminary outcomes were analyzed after the first round of data collection in early 2015. During this round of data collection, 10 major stakeholders from the 4 major implementing organizations and other early childhood advocates participated in semi-structured interviews.
After a brief review of the literature, this paper will discuss this case to examine examples of how research evidence and data analysis influenced the policymaking and implementation process. First, the paper will present examples of how research evidence influenced the perceptions and goals of the major stakeholders involved with the policy. Second, it will discuss examples of how data analysis and research were used to make adaptations during the early stages of the program’s implementation throughout the county. Third, the paper will discuss bureaucratic challenges and constraints with the collaborative use of research and data. Finally, the paper will conclude with some recommendations on how research and data can effectively be used to influence policy implementation in large-scale implementations involving collaborative efforts among multiple organizations.
Proponents of the Parent-Child Interaction Therapy (PCIT) highlight the intervention as a high-quality parenting program with important benefits for participating children and caregivers. PCIT is an evidence-based practice (EBP) for effectively reducing symptoms among children between the ages of 2 to 7 years with emotional and behavioral challenges.

In October 2012, First 5 Los Angeles (First 5 LA) launched a 5-year, $20 million initiative to implement the First 5 LA PCIT Training Program throughout all of Los Angeles County. The overarching goal of this program was to establish a workforce with the skills to serve children between the ages of 2 to 5 years old using PCIT interventions. In particular, the $20 million initiative allocated funds for the following: 1) PCIT training for up to 400 mental health clinicians at up to 100 agencies, 2) build-outs for new PCIT therapy rooms in agencies offering PCIT, 3) PCIT therapy services to children in Los Angeles County ages 2 to 5 years, and 4) administration and evaluation costs associated with the implementation.

Consequently, in September 2012, First 5 LA entered into a strategic partnership with the Los Angeles County Department of Mental Health (DMH) to: 1) coordinate PCIT trainings of mental health clinicians for certification, 2) increase the number and geographic areas of trained PCIT providers, and 3) deliver PCIT therapy services to eligible children in Los Angeles County ages 2 to 5 years.

First 5 LA also entered into a 5-year, $3 million contract with the Regents of California, University of California (UC) at Davis, Child and Adolescent Abuse Resources and Evaluation (CAARE) Diagnostic & Treatment Center (hereafter UC Davis PCIT Training Center). Its PCIT
Training Center was established in 1999 and has trained over 130 agencies worldwide in PCIT. UC Davis PCIT Training Center was contracted to provide direct training to clinicians and agencies as well as to collect data on trainings and client outcomes.

A memorandum of understanding (MOU) was also developed with the Los Angeles County Department of Children and Family Services (DCFS) for the First 5 LA PCIT Training Program. This MOU established a partnership DMH and DCFS. The purpose of the MOU was to work together to inform child welfare offices and social workers about the First 5 LA PCIT Training Program and facilitate linkages for child-welfare involved children to PCIT services. The desired outcomes for these efforts were increasing referrals and linkages to agencies providing PCIT services and increased service for child-welfare involved children.

**Table 1. First 5 LA PCIT Training Program Partners**

<table>
<thead>
<tr>
<th>First 5 LA</th>
<th>Program Funder</th>
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<tbody>
<tr>
<td>LA County Department of Mental Health (DMH)</td>
<td>Manage both the PCIT training of mental health service providers and PCIT service delivery</td>
</tr>
<tr>
<td>LA County Department of Children and Family Services (DCFS)</td>
<td>Target PCIT services and outcomes for children at risk of abuse and neglect.</td>
</tr>
<tr>
<td>UC Davis PCIT Training Center</td>
<td>Conduct PCIT training for DMH providers, formative evaluation of training, and limited evaluation of effectiveness of PCIT</td>
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**METHODOLOGY**

This paper will discuss the countywide implementation of the First 5 LA PCIT Training Program and the collaborative work between First 5 LA, DMH, UC Davis PCIT Training Center, and
DCFS. In particular, the paper will discuss examples of how research and data analysis influenced the policymaking and implementation processes.

In July 2014, First 5 LA contracted with Seedling Consulting Group to conduct an independent evaluation of the countywide implementation. The three preliminary goals of the evaluation as described by the Request for Qualifications (RFQ) were as follows:

- Describe, using qualitative and quantitative methods (including document review and ongoing collaboration with the PCIT training program team), the efforts undertaken at the county level and the provider agency level to support the expansion of the PCIT service delivery system in Los Angeles County.

- Evaluate the preliminary outcomes of the expansion of the PCIT system in Los Angeles County at the level of the provider agency, the consumers (parents and children), as well as the county level.

- Develop an iterative process to provide feedback to the PCIT team (DMH stakeholders and providers, other trained PCIT entities, UC Davis trainers, and First 5 LA PCIT staff) on the progress of the program so they can maximize success of the program.

To be clear, the evaluation project was not designed to assess the effectiveness of PCIT as a treatment since much research has already been conducted that has established it as an EBP. Instead, the purpose of the evaluation process was to assess the very large-scale dissemination and implementation of PCIT for Los Angeles County. Consequently, the goals of the evaluation project were to:
• Identify the target consumer population of the PCIT Training Program and assess the capacity of the program to meet their needs at the county level

• Identify what resources were put into place to support the implementation,

• Assess how the program fits into the existing mental health system

• Assess the effectiveness of PCIT in meeting the needs of the consumers in LA County

• Examine the cost-effectiveness of the program for LA County

In early 2015, Seedling Consulting Group worked with all the major partners and many stakeholders of the program to conduct the first round of data collection. Subsequently, preliminary outcomes were analyzed and summarized in a mid-project report for First 5 LA. Seedling evaluators developed interview protocols for original data collection. Evaluators conducted qualitative interviews and focus groups with county stakeholders, participating agencies, and mental health therapists in PCIT trainings. Parents and caregivers who participated in PCIT were also interviewed. Secondary quantitative data was provided by DMH and UC Davis PCIT Training Center regarding training results, service capacity, and demographics of the clients served. In addition, the evaluators integrated public data on mental health provider agencies, child population statistics (e.g., birth rates), and child welfare (e.g., trends in rates of abuse reports) to provide projected data for planning purposes.

The observations and conclusions summarized in this paper are based on the data and learning process that occurred during this first round of data collection and analysis. Three of the authors of this paper (Bahng, Taborga, and Bae) are working as consultants on the evaluation project for
Seedling Consulting Group. The fourth author of this paper (Peterson) has worked closely with evaluators to coordinate the evaluation project for First 5 LA.

First, this paper will present a brief literature review examining how research and policymaking can influence each other. Second, the paper will present examples of how research was used to influence and inform the policymaking process as well as the perceptions and goals of major stakeholders. Third, the paper will discuss examples of how data analysis was used to make adaptations during the early stages of implementation. Fourth, the paper will discuss bureaucratic challenges and constraints that arose with the collaborative use of research and data. Finally, the paper will conclude with some recommendations on how research and data can be effectively used to influence large-scale implementations involving collaborative efforts among large organizations.

**BRIDGING THE GAP FOR EVIDENCE-BASED POLICYMAKING**

The challenge of bridging the gap between researchers and policymakers is by no means a new one. Smith (1991, p. 2) argues that this gap has existed for well over a hundred years as the policy elite struggles to find better ways to bring research and evidence into policymaking. Bogenschneider and Corbett (2010) describe the gap between *knowledge producers* and *knowledge consumers* in policymaking. Knowledge producers include groups such as academic researchers, program evaluators, and analysts who interpret research and data. Knowledge consumers, on the other hand, describe those who create, implement, and manage policies and programs. The challenge of evidence-based policy can become even harder as more and more knowledge is created and policy consumers struggle to find relevant ways to sort through all the data.
There are several theories as to why research is often underutilized in policymaking. Policymaking has never been a completely rational process. The importance of values and power can often surpass the importance of the evidence-based conclusions. Haskins (2006) argues that many felt that the welfare reform initiative in 1996 was one example of how personal perceptions, value preferences, and political maneuvering could influence policy more than evidence or research (Bogenscheider & Corbett, 2010, p. 23). Furthermore, real world policy situations often change more quickly than research can accommodate.

Differences in institutional cultures can also create challenges in bridging this gap between research and policymaking. The nature of democratic institutions and the fragmentation of power in decision-making works to keep necessary checks and balances. However, this fragmentation can also work to slow down decision-making and can prioritize other interests other than science and research. Policymakers often operate in contexts that can be more responsive to money and power while researchers can be more motivated by evidence and reputation. Similarly, policymakers often want definitive answers while researchers are comfortable with and often prefer ambiguity (Bogenscheider & Corbett, 2010, p. 8).

Bridging this gap between research and policymaking is crucial, however, as children and families cannot benefit from effective services if they never receive them (Metz & Bartley, 2012). Balas and Boren (2000) found that it takes 17 years or longer for science to make its way into clinical practice and only 14% of scientific discoveries get put into practice. Thus, where there are examples of policymakers and organizations using research effectively to design and
implement their programs, it is all the more important that we highlight such cases and learn from them.

**FIRST 5 LA PCIT TRAINING PROGRAM**

First 5 LA was created in 1998 after voters passed California’s Proposition 10. The proposition established a tax on tobacco products that generates approximately $700 million a year funding organizations like First 5 LA. As one of the leading early childhood advocate organizations in Los Angeles, First 5 LA has invested more than $1.2 billion in programming aimed at children from prenatal to 5 years. Its mission it to partner with others to “strengthen families, communities, and systems of services and supports so all children in L.A. County enter kindergarten read to succeed in school and life” (First 5 LA, 2016). Its vision is that “all children are born healthy and raised in a safe, loving and nurturing environment so that they grow up healthy in mind, body, and spirit” so that they are eager to learn and have “opportunities to reach their full potential” (First 5 LA, 2016). Its main strategy is to focus on “increasing its emphasis on system change, collaboration and public policy” (First 5 LA, 2016).

PCIT was first developed in 1974 by Shiela Eyberg for families with children between the ages of 2 and 7 years who had externalized behavioral disorders and challenges. Since then, PCIT has been disseminated widely primarily first by the University of Florida’s graduate training program (Funderburk & Eyberg, 2011). It has been widely recognized as an evidence-based practice (EBP) and is included in registries, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the California Clearinghouse for Evidence-Based Practices in Child Welfare (CEBC).
PCIT incorporates live coaching into its sessions. During the sessions caregivers receive feedback and instruction from the clinician on their interactions with the child. This collaboration provides opportunity for a discussion of challenges at home and strategies for problem solving (Allen, Timmer, & Urquiza, 2014). Among its noted benefits are the potential to influence child behavior, reduce recidivism into the child welfare system, and increase caregiver’s confidence and self-esteem (Dombrowski, Timmer, Blacker, & Urquiza, 2005; Timmer, Urquiza, & Zebell, 2006, 2009).

Los Angeles County has a population of approximately 10 million people and is the most populous county in the nation (US Census Bureau, 2014). The county has a larger population than 40 of the 50 states in the nation. As such, the Los Angeles County Department of Mental Health (DMH) is the largest county-operated mental health department in the United States. Operating programs in more than 85 sites, providing services and DMH staff at approximately 300 co-located sites, DMH serves on average more than 250,000 residents every year. Additionally, DMH contracts with community-based organizations (CBOs) to provide mental health services. At the time of this article, there were approximately 120 contracted CBOs providing mental health services to children through the LA public mental health system. The Los Angeles County Department of Children and Family Services (DCFS) is the largest child safety agency in the United States. As part of the larger child safety and child welfare network in Los Angeles County, DCFS focuses on child welfare and abuse charges, foster care children, and adoption.
The UC Davis CAARE Center began providing PCIT services in the early 1990s and created the PCIT Training Center in 2000. It currently provides PCIT services for approximately 100 families per week and has been a leader in disseminating PCIT to agencies in California and around the world.
INFLUENCING POLICYMAKING AND GOALS

PCIT Training Program Proposal Process

One of the earliest examples of how research influenced the policymaking and program design process for the PCIT Training Program came as a small group of stakeholders got wind of the research on PCIT that was first being conducted in Florida. During our interviews with key stakeholders of the PCIT Training Program, one particular stakeholder shared about the process in which she began to strongly advocate for investment in a PCIT training program for caregivers in Los Angeles. Her actions in lobbying for PCIT to various First 5 offices around the region led in no small part to the eventual formal proposal that would come before First 5 LA’s board of commissioners.

Though she had no official relationship with First 5 LA, she described herself as a “true believer” in the therapy. This key stakeholder discussed what motivated her towards such actions and recalled that she, along with another colleague, began researching PCIT as an EBP in previous years as more research was coming out of the University of Florida. She described the problem as she saw it as being a deficit in parent training throughout Los Angeles County. What excited her about PCIT was the respect that it showed for both the parent and the child as it empowered parents to learn new ways of interacting and strengthened the bridge between the two. Additionally, she was also excited about the opportunity to build an infrastructure that trained clinicians all over the county with several layers of oversight and training from a university. She remarked that it was very rare to have a solution embraced so widely as to be implemented over all of Los Angeles County.
The stakeholder described how she along with her colleague discussed their enthusiasm for PCIT to one of the commissioners of First 5 LA and that led to the eventual proposal for PCIT at the board of commissioners’ meeting. Eventually the board of commissioners would vote to dedicate $20 million to the expansion of PCIT in Los Angeles County.

Her enthusiasm for the therapy would continue to grow, as First 5 LA would later invite her to actual demonstrations of PCIT. The interaction that she saw between the parent and child continued to inspire her belief in the therapy. She continued to engage in the research and attended the annual PCIT conference where she was exposed to more findings surrounding the use of PCIT.

This particular example demonstrates the effectiveness and important role that “knowledge brokers” can have as intermediaries between knowledge producers and knowledge consumers (Bogenscheider & Corbett, 2010, p. x). In this case, one or two particularly motivated stakeholders, who were aware of the research being produced on PCIT and also understood who to persuade to influence the proposal process for First 5 LA, were the key bridge to an evidence-based policy.

This example also demonstrates the sort of conceptual and instrumental influence research can have on policymaking (Nutley, Walter, & Davies, 2007). Instrumental influence can be thought of as having a direct impact on policy and practice decisions whereas conceptual influence can be thought of as complex and indirect impact on the knowledge and attitudes of policymakers. In this particular instance, the knowledge brokers use of the research on PCIT had a direct impact on the policy as well as the knowledge and attitudes of the PCIT Training Program.
Finally, not to be underestimated are the existence of registries, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the California Clearinghouse for Evidence-Based Practices in Child Welfare (CEBC). Registries such as these allow consumers to easily understand and validate various treatments as evidence-based practices (EBPs) in an accessible and simplified manner.

MAKING ADAPTATIONS IN PROGRAM IMPLEMENTATION

Adjusting Target Audiences for PCIT

Another example of how implementers used data analysis to make early adaptations in the program design and implementation came as First 5 LA began working with DCFS. While the main target population of the PCIT program focused on children receiving mental health services with DMH, many stakeholders also believe the children in the child welfare system under DCFS would benefit from receiving PCIT services. Stakeholders were influenced by a study from Washington State Institute of Public Policy (Lee, Aos, & Miller, 2008), which found that there was a cost benefit for children in the child welfare system receiving PCIT. In order to increase the number of referrals for PCIT for children in the child welfare system, an MOU with DCFS was put into place. In addition, many stakeholders expressed the hope that there would be a priority on pregnant and parenting teens among those served by the PCIT program.

Thus, early meetings between the First 5 LA and DCFS focused generally on how DCFS could help involve pregnant and parenting teens in the PCIT program. However, after some initial data analysis regarding the number of pregnant and parenting teens in the DCFS system, both sides
soon realized that the referral numbers would be small given what the data indicated. The system did not have sufficient numbers in this demographic for the scope of the PCIT program.

First 5 LA and DCFS quickly realized that it would be more fitting to broaden the DCFS child welfare focus from pregnant and parenting teens to all children within the child welfare system ages 2 to 5 with mental health challenges. This broader population included: 1) parenting TAY (transition age youth), 2) kinship care or long-term foster care, 3) adoption, and 4) family reunification. Thus, the use of data analysis during planning and the early stages of implementation helped to prevent failed goals and paved the way for evidence-based adaptations to be made.

*Adjusting the Training Process for Agencies*

Another example of how data monitoring and analysis led to adjustments in the program early on concerned the training process and timeline for agencies. As evaluators began monitoring the data on training, one of the things that became evident was that none of the agencies were completing the PCIT training in the time that had been planned. The original plan specified agencies would receive one year of training.

In their mid-project report, the evaluators presented the finding that 18 of the 20 agencies from the first year of implementation were still in the training process almost a full year beyond the one year that had been originally planned for agencies. The other two agencies from the first year of training were well short of their allotted training hours and were not near completing the training process as well. As a result, there were several important adjustments that were made to
the PCIT Training Program implementation to facilitate agencies getting through the training process.

Even prior to the mid-project report, UC Davis PCIT Training Center and DMH had noticed that agencies were not completing the training within the original time frame. UC Davis began offering additional support to trainees such as “Coding College” where trainees could get additional help in understanding PCIT coding (coding the skills the parents must learn in PCIT). By the third year, an additional adaptation was made adding “pre-training support” to better ensure clinicians had a mastery of the first set of skills, Child Directed Interaction (CDI) and coding prior to beginning to see clients. The purpose of this support was to better equip clinicians before they started the live PCIT training with clients. This will undoubtedly ensure that clinicians reach mastery sooner as it means they are starting training with some mastery already in place, which previously happened during the live training process.

Additionally, during the first round of data collection with Seedling evaluators, agency staff indicated that the training had taken much more time and effort than they had anticipated. Many agencies struggled with finding the right balance for their clinicians with regards to the time spent in training versus the time spent providing billable therapy services. Agencies could recoup some of the training costs: under the First 5 LA Training Program, they could invoice for two hours of training time per clinician per week but agencies shared this did not cover the full day that clinicians spent in training. Some agencies shared one way around this was to split their training day into two days so that instead of staff spending a full day in training, each only spent half the time in training. This was an adaptation to the original PCIT Training model, to allow
agencies to split the time. The original training model for PCIT is that the team of trainees all watch each other’s therapy sessions and have multiple opportunities to learn. By the second year of implementation, DMH noticed that spending a full day in training vs. a half day was one predictor of agency success in that that successful agencies (those who submitted data, had client referrals, and whose clinicians were moving along in training) were spending a full day in training as the PCIT training was originally designed.

Thus, the second adjustment that was made to the First 5 LA PCIT training program came as DMH wrote a proposal to First 5 LA to increase the number of hours that agencies could invoice to get reimbursed for training time. It took a full year to get the funds to agencies but beginning in the third year of the implementation, DMH was able to triple the total number of training hours that were agencies could invoice for training time, increasing the hours from two to six hours per week per clinician.

A third change was made in that same proposal. DMH and First 5 LA built in concrete support to the families going through the PCIT therapy. This was in response to a finding from an internal data review by DMH, which indicated that PCIT had the highest attrition rates (approximately 50-70%) among evidence-based therapy practices for children in LA County. Clinicians must show competencies in live sessions with real clients, thus without families clinicians can’t progress through the training. In interviews with agency staff, the evaluators learned that the agencies that struggled the most didn’t have enough families for their clinicians to go through the training process. DMH program staff inquired further and learned from agencies that childcare, transportation, and even shortage of toys were barriers for families. Thus the proposal to First 5
LA also included concrete items to address those barriers; childcare vouchers, gas cards, taxi vouchers, bus passes, and even gift cards for toys so families could do the required one-on-one playtime at home. While it is too early to know from data, DMH feels these additional supports to agencies and families have been well received by agencies and that clinicians are going through their training faster as a result.

**BUREAUCRATIC CHALLENGES AND CONSTRAINTS**

Bogenschneider and Corbett (2010) discuss the role that institutional cultures and incentives can play in exacerbating the gap between evidence and policymaking. They argue that different professions operate with types of cultural baggage and incentives. Furthermore, aligning the norms, incentives, and constraints between organizations and professions can pose challenges in coordinating and collaborating to produce evidence-based policymaking.

Thus, it was expected that First 5 LA and its partners would experience challenges in working together on the PCIT Training Program. With different systems, constraints, and incentives, challenges could often result in months of delay. Furthermore, often, only when there was a self-motivated advocate to push forward to work towards better coordination between systems were the challenges overcome.

**Challenges in Sharing Data**

Sharing data across multiple organizations is often a necessary component of evidence-based policymaking that can pose challenges to those owning and using the data. In this case, because much of the data being used was owned by a public mental health partner, there was an added layer of complexity. Accessing data from a public mental health provider is highly challenging
because of the legal responsibility to protect client data (e.g., participation in therapy is privileged information, part of the client’s health record). Because there is much concern surrounding whether data can be tied back to clients or recipients of services, people within the organization can have a cautious attitude about the types of data that can be shared. For example, dates that services were provided or agencies that provided the services may be difficult to ascertain because of client confidentiality. Gaining the consensus that different types of data are to be made available to outside organizations can be a long and tedious process as well for every agency in training.

In addition to client protection, bureaucratic hurdles can also pose challenges to accessing data. In the case of DMH, the data used by the partners was itself in separate programs within DMH and was, thus, supervised by different leadership. Even though DMH is technically one entity, it is comprised of many different departments in various buildings throughout Los Angeles. Even internally for those who work in the DMH, accessing data in a different department can be very difficult.

Part of this may be because workers have multiple demands and requests for data come on top of existing work responsibilities. In multi-partner collaborations in particular, departments or organizations can face a large number of requests from the other partners. For example, each partner may collect and manage their own data and have requests for data for additional monthly calls, quarterly meetings, quarterly reports, and annual reports from the other partners. Furthermore, often there is not one party facilitating or organizing all the data sharing and tracking so that the onus falls on each partner with no one entity overseeing or managing the
process for data requests. Instead, data requests are typically added onto the normal workload of the program staff in each organization involving many different processes. These provide weak incentives for data requests to be fulfilled in a timely manner and can delay the process of analysis and application.

For example, there may be strong incentives for data requests involving the funder to be completed. However, data requests between the other partners where no funds are exchanged can take longer to complete since there are weaker incentives. This can impact not only data sharing at the beginning of the analysis process, but it can also impact data sharing after the analyses have been completed. Often, what is needed in cases such as this is a strong ally within the entity with sufficient power to move the paperwork forward through the proper channels. Furthermore, even with a strong influential ally working to push the process along, much of the data that partner organizations were seeking to get from DMH still took over a year to obtain.

**Challenges in Coordinating Change**

Even where stakeholders were able to identify areas where the evidence supported policy and program change, implementing the change throughout the system proved challenging and time-consuming. One example was the change mentioned in the previous section involving how DMH sought to change the number of reimbursable billable hours for agencies from two to six hours. While initial data quickly showed DMH that changes in the number of reimbursable training hours would be beneficial for agencies in scheduling their training days to complete them more quickly, the process needed for this change to occur system-wide was quite complicated and slow.
The process involved DMH writing proposals for the contract amendments, which then needed to go through a process of being approved up the chain of command. Thereafter, First 5 LA then had to go through a similar process within their organization to obtain approval for the contract amendments as well. Finally, once both organizations had the necessary approvals, DMH then had to go through the actual process of amending each contract.

Thus, even where the data may point strongly to a policy or program change, coordinating that change throughout multiple systems can be quite time-consuming. This underscores the importance of having a planning phase based on data or evidence. This can help avoid time-consuming changes in the middle of the implementation process.

**Challenges in Coordinating Calendars**

Another bureaucratic challenge that partners experienced may not be directly related to applying research and evidence to policymaking but is one that resulted from the differing institutional cultures and norms. Different institutional cultures can be common sources of challenge that make it difficult for evidence-based policymaking.

One significant challenge for the organizations was the fact that organizational fiscal calendars of the various partners did not align. One example of this came with the process of including PCIT funding into CBO agency contracts for DMH so they could start training and provide PCIT service. While both First 5 LA and DMH have fiscal years that start on July 1st, DMH completes its contracts with CBOs in March for the upcoming fiscal year. First 5 LA, however, completed its contracts with DMH a month to two months later.
Furthermore, when First 5 LA’s PCIT Training Program funds to provide services came to DMH in May of 2013, DMH had already distributed and finalized agency contracts for the upcoming fiscal year. These contracts, however, did not include PCIT funding in them as they were drawn up in March 2013. Thus, in order to access funding for the PCIT Training Program, contracts for the agencies that would receive PCIT training in the upcoming fiscal year beginning July 1st, 2013 needed to have their contracts amended. This amendment process ended up taking several months to complete delaying the program start. On the side of the trainers, UC Davis was put into a holding pattern, with a full team ready to go but unable to start for months. In fact, it was not until UC Davis began to experience serious funding issues due to the delay and expressed the potential crisis to an advocate within DMH that DMH was able to push to get the contracts amended quickly. In the end, this misalignment of contracting cycles delayed the first cohorts training start time by three and four months (it varied by CBO). Nevertheless, by the second year the delays were foreseen and shortened and by the third year agencies were able to start on time.

Other challenges that are created by organizations having to coordinate calendars include difficulties scheduling crucial meetings with key leaders in the organizations. Full schedules of key leaders in organizations often made it difficult to have timely meetings and were a common source of delays.

**RECOMMENDATIONS**

First 5 LA’s PCIT Training Program provides an insightful case study of how First 5 LA and its partners were able to effectively bridge research and data analysis with policymaking and implementation. Although, the process to marry research and policy was not without its
challenges, stakeholders were able to overcome constraints and delays to make the overall PCIT Training Program more responsive to research and data. The efforts to overcome these challenges were largely facilitated by key intermediaries or advocates located strategically throughout the process.

**Intermediaries from Research to Policy**

In the case of the actual proposal of PCIT to First 5 LA, it was a key intermediary who was connected to the current body of research surrounding PCIT that played a pivotal role in pushing the ideas forward. As a believer of the impact that PCIT can have for parents and families, this intermediary connected key policymakers for First 5 LA to the body of research surrounding PCIT. In addition to key intermediaries, because PCIT is an established EBP that is registered in widely used databases such as SAMHSA and CEBC, one could argue that the evidence itself was more accessible for intermediaries and policymakers to understand.

**Intermediaries from Data to Partners**

While the process of sharing data can be full of various challenges with weak incentives to push through paperwork, intermediaries who have access to the requested data as well as relationships with organizational partners can be an important part of pushing through the tedious and long process of fulfilling data requests. Because administrators can often place priority on other program related tasks, data requests can often fall through the cracks. It often takes a determined ally within an organization to take responsibility for pushing a data request through while navigating internal processes. This ally must also value the need for data for external partners either because they have an interest in helping out the external partner or because they have an interest in the use of data for more responsive and evidence-based policies and programs.
Intermediaries and Internal Pressure

Similarly, the influence of an intermediary or ally that can put internal pressure on processes to meet external deadlines can be vital in collaborating successfully with others as well. While not directly related to the application of research and evidence, in the case of First 5 LA, these types of intermediaries played a significant part in helping institutions with varying cultures, norms, and constraints coordinate and align their processes more efficiently and prevented crises.

The processes of amending agency contracts as well as amending reimbursable training hours were both tedious internal processes within DMH. Furthermore, after significant delays and in order to prevent significant problems, stakeholders within the partner organizations found it effective to appeal to key allies on their behalf to move the process along more quickly. Through these appeals and through the internal pressure that followed, an end of the delays and a timely resolution of the tedious processes emerged.

CONCLUSION

The use of research and evidence in policymaking can allow more logical and established approaches to find their ways into policy solutions. Nevertheless, because the policymaking process itself is not often a rational process, expecting the evidence to speak for itself can be shortsighted and insufficient.

Instead, political factors ought to be considered. Even more political allies and intermediaries should be utilized to create more responsive and accessible processes to allow data usage to become part of the planning process and early stages of implementation.
First 5 LA’s PCIT Training Program was not without its challenges concerning this subject. Nevertheless, it provides an insightful case study with successful examples of research and data influencing the policies and programs for the children receiving mental health services in Los Angeles County. One stakeholder remarked about the program, “It’s been a really amazing process and it’s very rare to have something move at this speed through such a big bureaucracy within [DMH] as well as [DCFS] and First 5 LA. And it’s just amazing. I can’t believe how much we’ve accomplished really.” She continued, “It is possible to move through the bureaucracy. It really truly is. But you just need to have a real dedicated team.” One might add that a dedicated team supported by key intermediaries has made that much more possible to overcome challenging bureaucratic constraints and create a more responsive program in general.
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