CASE STUDY

Implementing the Modular Approach to Therapy for Children (MATCH-ADTC) within a Learning Collaborative

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THE BAKER CENTER
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Summary

The Center for Traumatic Stress and Comorbidity (CTSC) was developed by The Baker Center in response to a nationwide need for enhanced training in trauma-informed, evidence-based practices (EBPs) that address co-occurring mental health conditions in youth. Funded by the National Child Traumatic Stress Network (NCTSN), the CTSC supports agencies already using trauma-focused treatments by equipping them with MATCH-ADTC, a modular protocol designed to address complex clinical presentations. Through a structured learning collaborative, over 600 children and families across six states received services from trained clinicians. Five agencies participated in clinical training, implementation coaching, fidelity support, and data-driven continuous quality improvement activities. Despite varying levels of infrastructure, all agencies successfully adopted MATCH and built internal capacity for long-term sustainability. Improvements were observed across multiple levels—from youth symptom reduction and caregiver engagement to increases in provider self-efficacy and organizational readiness—demonstrating the collaborative's effectiveness in driving trauma-informed care for children with complex needs.

Background

PRESENTING PROBLEM

In 2021, The Baker Center administered a needs assessment to National Child Traumatic Stress Network (NCTSN) Category-3 Sites, which include clinics that provide direct services to children impacted by trauma. The assessment found that 94% of responding sites reported a need for training in EBPs designed to address co-occurring conditions to improve youth and family outcomes associated with trauma exposure. All of the responding agencies were currently using trauma-focused evidence-based practices (EBPs; e.g., 82% using Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) as a primary treatment approach) but still identified a need for additional support. These findings led the Baker Center (with funding from the NCTSN) to develop The Center for Traumatic Stress and Comorbidity (CTSC).

The Center for Traumatic Stress and Comorbidity (CTSC) supports child-serving agencies with training and implementation support for complementary, trauma-informed evidence-based practices. This training and implementation support aimed to:

- Improve youth and family outcomes related to traumatic stress and comorbid conditions
- Increase agency capacity to treat traumatic stress and comorbidities
- Improve clinician empowerment to implement EBPs for traumatized youth
- Increase agency capacity to partner with communities and policymakers to integrate complementary EBPs into trauma-informed treatment.

POPULATION SERVED

Youth and families from five (5) agencies (with and without NCTSN Category 3 designation) across six (6) states participated in our learning collaborative. For Cohort 2, this would represent the states of Alabama, Alaska, Colorado, Florida, North Carolina, and Tennessee. As of April 2025, clinicians who have participated in the training and implementation support have served over 600 children and families in the MATCH-ADTC protocol.

IMPLEMENTATION NEEDS FOR AGENCIES

Participating agencies faced a range of organizational needs that the CTSC sought to address through training, technical assistance, and tailored implementation support. These needs were identified through initial and ongoing assessments with agencies, and these programmatic needs included:

Limited Agency-Level EBP Capacity Building

MATCH was new to all sites, requiring intentional efforts to build infrastructure for long-term sustainability. While agencies could build off prior implementation initiatives, implementing this protocol required specific capacity.

Difficulty Integrating a Measurement-Based Care Systems

A core component of MATCH is measurement-based care (MBC), and MBC was another practice new to some agencies. The MBC software additionally was a new resource going into the learning collaborative.

Demand for Telehealth Adaptation and Implementation

Many providers offered services exclusively via telehealth, while others worked in-person or across multiple service regions.

Need to Better Engage Caregivers in Treatment

Engaging caregivers, especially in cases involving disruptive behaviors, adoptive families, or caregivers managing high social needs – was a consistent challenge.

Need for Multicultural Tailoring

Participating agencies served diverse communities, including Alaskan Native populations, Spanish-speaking families, and immigrant communities.

Implementation Process

PHASE I

Preparation

The Learning Collaborative begins with the preparation phase to engage the sponsoring agency in planning. Goals for the Learning Collaborative are developed, and potential participating organizations are identified. The requirements for participation are communicated to potential participants and selection and commitment of organizations is finalized.

PHASE II

Pre-Work

Once the preparation phase is complete, the pre-work phase begins. The focus of this phase is on assessing organizational factors that might serve as opportunities or barriers to implementation. This phase also includes the design and installation of structural supports for implementation.

PHASE III

Active Implementation

The active implementation phase includes the installation of the evidence based practise into the participating organizations and the initial implementation of EBP services. Participants engage in a number of structured and self-guided learning activities to deliver the EBP with high integrity.

PHASE IV

Sustainability

To ensure ongoing success of the EBP, the sustainability phase facilitates organization independence in the EBP through activities designed to eliminate barriers to practice utilization and create flexible plans for adapting to new challenges.

The structure and activities of each Learning Collaborative are strategically designed to maximize the development of clinical skills and the sustainability of practice within organizations and broader systems. It is divided into the following phases: **I) preparation, II) pre-work, III) active implementation, and IV) sustainability.** Each phase is tailored toward the unique needs that arise as organizations and systems are implementing new practices. As organizations and systems move through each phase, the themes and tools from the previous phase become building blocks towards independent sustainability.

Training and Capacity Building

WHAT IS MATCH

The Modular Approach to Therapy for Children with Anxiety, Depression, Traumatic Stress, and Conduct Problems (MATCH; Chorpita & Weisz, 2009) is a treatment protocol for children aged 6-17. Unlike most evidence-based practices (EBPs), which focus on single disorder categories (e.g., anxiety only), MATCH is designed for multiple disorders encompassing anxiety, depression, post-traumatic stress, and disruptive conduct, including the conduct problems associated with ADHD. These four clinical categories represent approximately 70-80% of clinical caseloads in public practice clinics.

MATCH is accompanied by the **Clinical Health Assessment and Response Tracking (CHART)** program. CHART is a user-friendly, web-based program that:

- Tracks how children and families are responding to counseling on a weekly basis.
- Allows the therapist to continually refine the counseling program in real time in response to the progress of each family

CLINICAL TRAINING AND CONSULTATION

At the heart of the NCTSN MATCH Learning Collaborative was a structured "Therapist Training and Consultation" model designed to support sustained implementation of the MATCH protocol. Over five days, therapists received 35 hours of foundational clinical training covering each MATCH module and core competencies. Training used adult learning strategies, including modeling, case vignettes, and role-plays with feedback. Between training days, participants completed "**action period**" tasks to reinforce key concepts.

Each therapist received a MATCH Professional Development Portfolio to track skill development. Following training, therapists began applying MATCH with clients and participated in 10 months of ongoing consultation (25 calls total—15 weekly, then bi-weekly). Consultation was delivered in small groups (8 participants per call) to balance individualized support and peer learning. Sessions covered practical applications of MATCH, CHART integration, fidelity, and clinician-requested topics. CHART, the MATCH measurement feedback system, was used to track client outcomes, inform treatment planning, and support data-driven decision-making in real time.

Midway through the Learning Collaborative, selected therapists completed a 2-day (14-hour) Supervisor Training. This "Train-the-Trainer" model was designed to build internal capacity to train and support future MATCH therapists. Supervisor training focused on advanced clinical skills, supervisory strategies, and organizational sustainability. Supervisors then co-led MATCH consultation calls with expert faculty and received 10 months of small-group consultation (25 calls) with peers. These calls supported their transition to independently leading therapist training and maintaining fidelity to MATCH.

LEARNING SESSIONS

The Learning Collaborative was anchored by three structured Learning Sessions, each designed to support implementation of MATCH at different phases.

Learning Session I

Focused on building engagement and cohesion within and across teams, introducing MATCH and the CHART system, and launching cross-agency Affinity Groups to foster shared learning.

Learning Session II

Centered on identifying and addressing early implementation challenges, with a strong emphasis on continuous quality improvement using tools like the Plan-Do-Study-Act (PDSA) cycle. Teams also explored adaptations to better fit MATCH with their client populations and agency structures.

Learning Session III

Participating teams shared their clinical and organizational successes and highlighted strategies for sustaining MATCH over time. This final session reinforced advanced clinical competencies and allowed teams to present their sustainability plans, while Affinity Groups provided one last opportunity for role-specific collaboration and peer problem-solving.

IMPLEMENTATION LEADERSHIP SUPPORT

Leading an agency-wide implementation initiative is no easy task, no matter how many times the process has been initiated (e.g., training clinicians in a new EBP). The implementation process is a phasic approach, including phases for Exploration, Preparation, Implementation and Sustainability, as the EPIS framework states. Each phase requires agency leadership to think strategically about how the EBP will be implemented and build out necessary support, infrastructure, and relationships to support long term sustainability. Key activities, including coordinator consultation calls and cross-site senior leadership calls, supported the capacity-building of implementation leadership in the Learning Collaborative .

Such calls allow agency leaders and program champions to convene and dedicate time to discuss the implementation of the EBP within their site-specific context and share best practice strategies. Topics of discussion have included CHART integration into existing systems, time expectations of internal MATCH training, and sustainability plan progress.

FAMILY ENGAGEMENT AND EDUCATION

Staring in Learning Session 1, agencies were provided with the "Community Outreach and Engagement Toolkit" ("COE Toolkit") developed in collaboration with Baker Center staff and the **Parent Professional Advocacy League of Massachusetts**. The purpose of this toolkit is to increase an agency's ability to connect evidence-based services (e.g., MATCH) to families who need them the most by providing effective language and resources to communicate with communities upon first contact. Resources shared in this template include sample MATCH flyers and frequently asked questions (FAQ) documents. Agencies were encouraged to download the templates provided and revise them for their own marketing needs to distribute.

ONGOING SUPPORT AND QUALITY IMPROVEMENT

Throughout the learning collaborative, a feedback loop was established to monitor outcomes and refine the implementation process. Staff participated in regular case consultation and received additional implementation support from Baker Center staff.

In addition to clinical training, Baker Center faculty provided multi-level implementation consultation throughout the Learning Collaborative. Each participating agency formed an implementation team that included therapists, supervisors, non-clinical administrators, senior leaders, and family support specialists (if applicable). These teams meet regularly (weekly or biweekly) to plan for MATCH installation and long-term sustainability. Baker center faculty supported teams through scheduled and ad hoc consultation, including co-facilitated site-based meetings. Consultation was also provided to the state sponsor to address systems and policy barriers impacting implementation.

Addressing Organizational Needs of Participating Agencies

Agencies entered the Learning Collaborative with varying levels of readiness, requiring tailored strategies to bridge capacity gaps and sustain MATCH over time. The Implementation Workplan ("Change Toolkit") served as a central resource, **offering a structured roadmap for building infrastructure in areas such as outreach, determination of client eligibility, clinical training, progress monitoring, and sustainability.** By translating broad capacity-building goals into time-bound, site-specific action plans, the toolkit helped agencies move from planning to execution, fostering both accountability and momentum.

Integrating measurement-based care (MBC) posed another cross-cutting challenge, as the CHART system was new to many providers and organizations. **Successful adoption of CHART required more than training and supervision.** Agencies embedded CHART touchpoints into existing electronic health record systems, redistributed data collection tasks across intake staff and lay providers, and invested in building clinician confidence in interpreting and sharing progress data. These adaptations shifted MBC from one of compliance to a driver of treatment planning and caregiver engagement.

The demand for telehealth adaptations offered both logistical and clinical challenges. **MATCH's modular format lent itself to innovation, with providers creatively translating activities into virtual formats, building multi-state peer support networks, and tailoring materials for online delivery.** Teams developed cohesive learning environments despite geographical distance, ensuring fidelity to the model while meeting families where they were - whether in rural areas or in linguistically diverse communities.

Engaging caregivers in treatment remained a priority across agencies. **Clinicians used CHART's visual progress reports to make outcomes tangible, while refining their skills in setting expectations and preparing caregivers for the treatment process.** These strategies not only improved session attendance and follow-through but also reframed caregivers as active partners in their child's progress.

Finally, agencies demonstrated a commitment to cultural and linguistic relevance in service delivery. **MATCH materials were translated into multiple languages, training content was adapted for cultural resonance, and, in some cases, entirely new resources were developed to meet the needs of specific communities.** These efforts reinforced the principle that fidelity to an EBP and responsiveness to cultural context are not competing priorities, but mutually reinforcing drivers of effective, equitable care.

AGENCY NEED	STRATEGY/ADAPTATION	OUTCOMES
EBP Capacity Building	Implementation Workplan with time-bound action plans	Clear roadmap for change, accountability for infrastructure growth
Integrating MBC Systems	Embedded CHART into existing documentation practices, task-shifting and protected time	MBC used as a core driver of MATCH clinical decisions
Telehealth Adaptations	MATCH adaptations to virtual delivery settings, multi-state team networks	Expanded access without loss of integrity to MATCH
Caregiver Engagement	CHART visual reports (i.e., client dashboards), FAQ documents, and expectation setting	Caregivers became active partners in MATCH treatment
Multicultural Tailoring	Translation of existing materials, development culturally relevant resources	Increased accessibility and equity in MATCH care delivery

By addressing these agency-level needs with targeted, context-specific strategies, the NCTSN MATCH Learning Collaborative created the conditions for MATCH to take root across diverse organizational settings. The combination of structured tools, adaptive workflows, and culturally responsive practices not only strengthened agency infrastructure but also enhanced the quality and reach of services. These efforts translated into measurable gains for youth, families, and providers while demonstrating that meaningful implementation change begins with meeting agencies where they are.

Outcomes

The implementation of MATCH-ADTC at NCTSN resulted in measurable improvements:

CLINICAL TRAINING AND CONSULTATION

Across treatment measures (e.g., Top Problems and Brief Problem Monitor), **both youth and caregivers reported significant improvements in emotional and behavioral symptoms,** as well as in the severity of personally identified challenges (i.e., Top Problems). These outcome metrics affirm that the learning collaborative supported measurable gains in child and family mental health functioning - especially in areas like attention regulation, emotional distress, and day-to-day problem-solving.

PROVIDER KNOWLEDGE, ATTITUDES, AND SKILLS

Over the course of the learning collaborative, participating clinicians demonstrated meaningful improvement in key domains of readiness to deliver evidence-based care. Drawing from repeated measures of provider self-efficacy, attitudes, and organizational context, several clear patterns emerged:

- **Providers reported steady gains in their confidence using general therapy strategies, cognitive behavioral techniques, and MATCH-specific skills.** Self-efficacy scores were notably higher by the end of the collaborative, suggesting that the structured training, technical assistance, and hands-on learning opportunities meaningfully enhanced provider skillsets. While some variation existed in confidence levels by modality, the upward trajectory was consistent across participants, indicating that capacity-building efforts were effectively supporting clinical implementation.
- **Attitudinal data showed that most providers expressed willingness to adopt evidence-based practices,** especially when required by their organizations. Scores related to "Requirements" (The extent to which provider would adopt EBP if it were required by an agency, supervisor, or state) and "Divergence" (The extent to which the provider perceives EBPs as clinically useful) were consistently moderate to high, indicating that while providers acknowledge the utility of EBPs, some still weigh these practices against their own clinical experience. Interestingly, measures of "Openness" and "Appeal" were more modest highlighting an opportunity for continued efforts to make EBPs feel more intuitive, adaptable, and aligned with provider values and community needs.
- **Job satisfaction data reflected a generally stable and supportive work environment throughout the collaborative.** Providers reported strong perceptions of supervision and peer support, with slightly lower scores in pay and promotion, which aligns with broader sector-wide challenges in behavioral health workforce retention related to average clinician salary and opportunities for advancement. Still, the consistency of these ratings suggests that agency climates remained conducive to practice change, particularly in relational and supervisory support, which may have facilitated the successful agency wide adoption of MATCH.

Lessons Learned from the NCTSN MATCH Learning Collaborative

This cohort demonstrated significant growth and adaptability, offering key insights into how systems can more effectively support mental health initiatives across agencies.

FOSTERING ORGANIZATIONAL INNOVATION

A major success of this cohort was the ability of participating agencies to adopt and tailor the MATCH intervention to meet their unique organizational needs. This capacity for innovation manifested in several ways:

- Formation of core services, using the MATCH Learning Collaborative as the vehicle to develop an agency's outpatient clinic.
- Refinement of "frequently asked questions" (FAQ) documents to improve communication with families. This included enhancing the document to include questions most commonly asked by caregivers regarding treatment – and translating the finalized document to other languages (e.g., Spanish).
- Development of parent support workshops that directly addressed community-identified needs. (e.g., MATCH for groups, MATCH conduct support groups for caregivers)
- Creation of supplemental assessments and surveys to gauge parent engagement and organizational readiness (e.g., patient satisfaction and caregiver engagement questionnaires)

These examples reflect how agencies exercised creativity and autonomy to enhance family-centered practices and strengthen internal capacity.

STRENGTHENING ENGAGEMENT WITH FAMILY PARTNERS AND COMMUNITY LIAISONS

This cohort marked a significant step forward in intentionally supporting family partners and community liaisons—an affinity group that had seen limited engagement in past cohorts. Key efforts included:

- The integration of the community outreach and engagement toolkit ("COE Toolkit") that helped shape a dedicated curriculum for these roles.
- Development of tailored role flyers to clarify responsibilities and guide expectations throughout the collaborative.
- Assignment of prework specifically designed for family partners and community liaisons, ensuring their perspectives and expertise were reflected in every phase of learning and implementation.

CULTIVATING A MEASUREMENT FEEDBACK CULTURE

This cohort made notable strides in building a culture of measurement-informed care. Agencies reviewed and interpreted agency-level dashboards within their internal implementation teams, focusing on four core data trends: client enrollment, client demographics, survey completion rates and interference. One agency in particular administered an internal survey to clinicians in order to ascertain perspectives of measurement-based care and CHART utilization in current practice. Clinicians moved beyond individual progress tracking to engage families in meaningful discussions about treatment milestones. Simultaneously, agency teams began examining these insights collectively identifying organization-wide patterns and engaging staff in reflective dialogue about what the data was showing and how it could inform care.

This shift toward shared data interpretation helped teams make more informed decisions about MATCH implementation, allowing for adaptive responses and improved alignment with family needs. Importantly, agency leaders didn't just observe trends—they actively questioned, explored, and applied insights to refine their approach.

Conclusion

The NCTSN MATCH Learning collaborative fostered significant and sustainable advancements in trauma-informed mental health care. Youth and families experienced measurable improvements in emotional and behavioral functioning, particularly in attention regulation and externalizing concerns. Providers reported increased confidence, positive shifts in attitudes toward EBPs, and a supportive work environment conducive to continued growth. Agencies strengthened their ability to deliver data-informed, family-engaged care despite challenges related to telehealth, caregiver complexity, and system integration. Importantly, this cohort illustrated that implementation is not a one-size-fits-all process; success stemmed from localized innovation, cross-role collaboration, and a shared commitment to learning. By investing in tailored support and embedding measurement feedback into practice, The Baker Center's CTSC has laid a replicable foundation for transforming how agencies support youth with trauma and comorbidities - one that centers flexibility, family voice, and integrity to evidence-based care.

Success Stories

Clinicians have shared appreciation for the structure and guidance MATCH provides, while using measurement feedback systems to track clinical progress. In clinical consultation, a MATCH clinician shared that they successfully graduated and discharged a client who had been seen for over 2 years. They were doing grief work with the client, then transitioned to MATCH conduct. The clinician reported that MATCH enhanced the caregiver's skills, and the clinician felt confident and empowered to discharge them through MATCH. Before starting MATCH, the clinician shared that they did not know how else to help the client and family, but when they began MATCH (and started using the progress monitoring system, CHART), they witnessed survey scores decrease, and the client reported "feeling better." The family loved rewards and earning time with the caregiver, and the clinician felt really empowered to give tools to the caregiver that would get them where they needed to go.

Clinicians have also shared appreciation for how MATCH balances flexibility while staying focused on the primary target. In another example, a clinician had a complicated trauma case where it was unclear how they were going to initiate trauma work due to limited engagement and challenging family dynamics. After doing the initial trauma modules (e.g., getting acquainted, fear ladder, safety planning), the clinician incorporated depression skills to address these challenges, and was then able to return to the trauma protocol and do the narrative successfully.

Lastly, MATCH serves as a strong alternative for agencies that primarily use other treatment models. A MATCH clinician shared that they had been working with a challenging client for some time, and since transitioning to using MATCH from another EBP, they have seen tremendous progress. Although their agency primarily uses another EBP model, MATCH is an effective alternative that clinicians love.

During this past year, our MATCH trainees were able to provide feedback on their training experiences. We have compiled some of the comments from the training evaluation to better illustrate the experiences of these providers:

What was your overall impression of MATCH Training?

"I love the structure and appreciate that it's rooted in research and is evidence based."
- MATCH Learning Collaborative Participant

"This was amazing, you managed to turn a 5-day training into something engaging and useful."
- MATCH Learning Collaborative Participant

"Loved the mix of practice, presentation, video, and activities! Humor kept me engaged!"
- MATCH Learning Collaborative Participant

"I hope MATCH becomes a foundational practice at my agency for all clinicians, especially for new clinicians."
- MATCH Learning Collaborative Participant

What did you learn that was new or different? How and/or will this information change how you practice?

" [I] learned a ton about sequencing of treatment, monitoring progress, using info to make decisions."
- MATCH Learning Collaborative Participant

"This was amazing, you managed to turn a 5-day training into something engaging and useful."
- MATCH Learning Collaborative Participant

Appendix

CHART Data (January 1, 2024 – June 30, 2025)

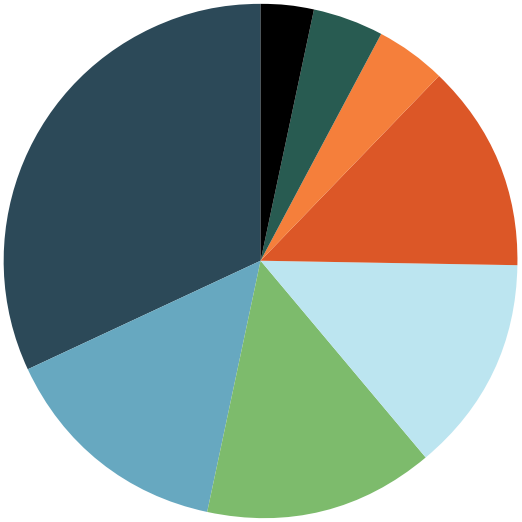
Total Clients Enrolled: 694

Total Clients Made Inactive: 474

Average # Sessions Completed : ~9

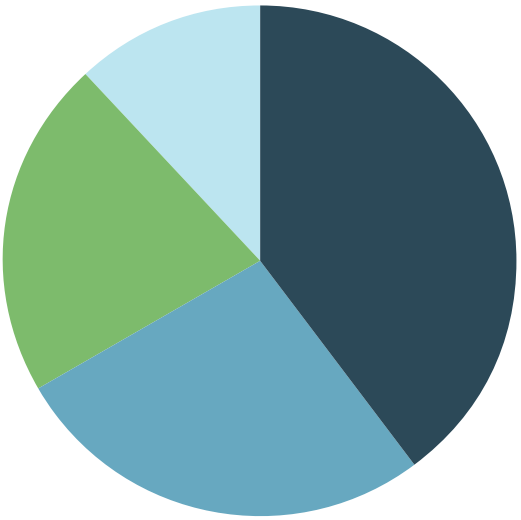
Average Length of Treatment for Completed Clients: 132.75 (days)

Reasons Clients Became Inactive

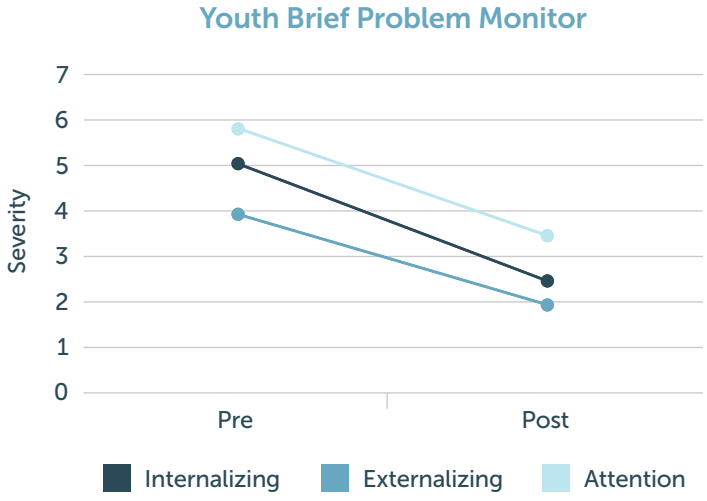


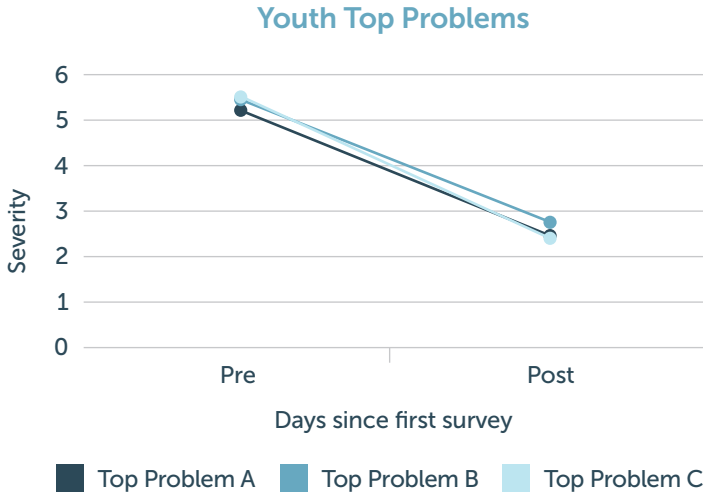
- **31.86%** Treatment Completed - All Goals Met
- **14.56%** Treatment Completed - Some Goals Met
- **14.56%** Treatment Incomplete - Family Withdrew From Services
- **13.71%** Treatment Incomplete - Lost Contact With Family
- **13.08%** Other
- **4.43%** Missing
- **4.22%** Higher Level of Care Needed
- **4.22%** Treatment Incomplete - Therapist Left or Transferred to New Therapist

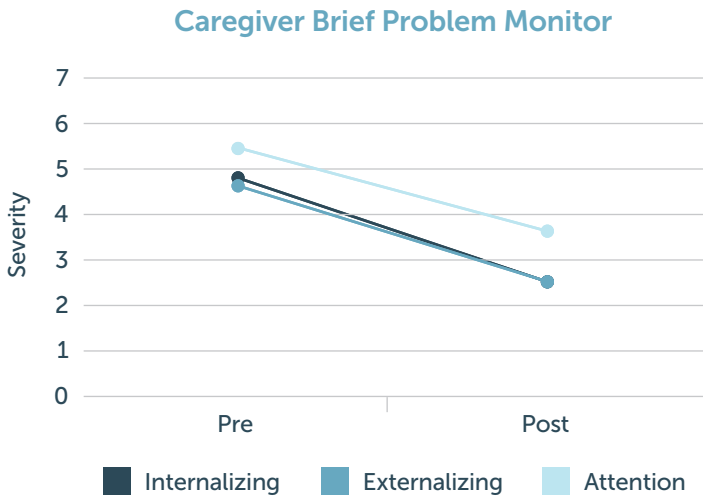
Clients Treatment Focus

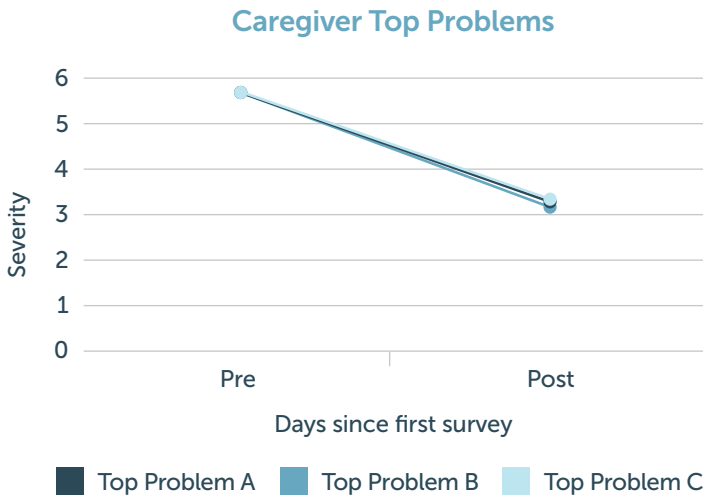


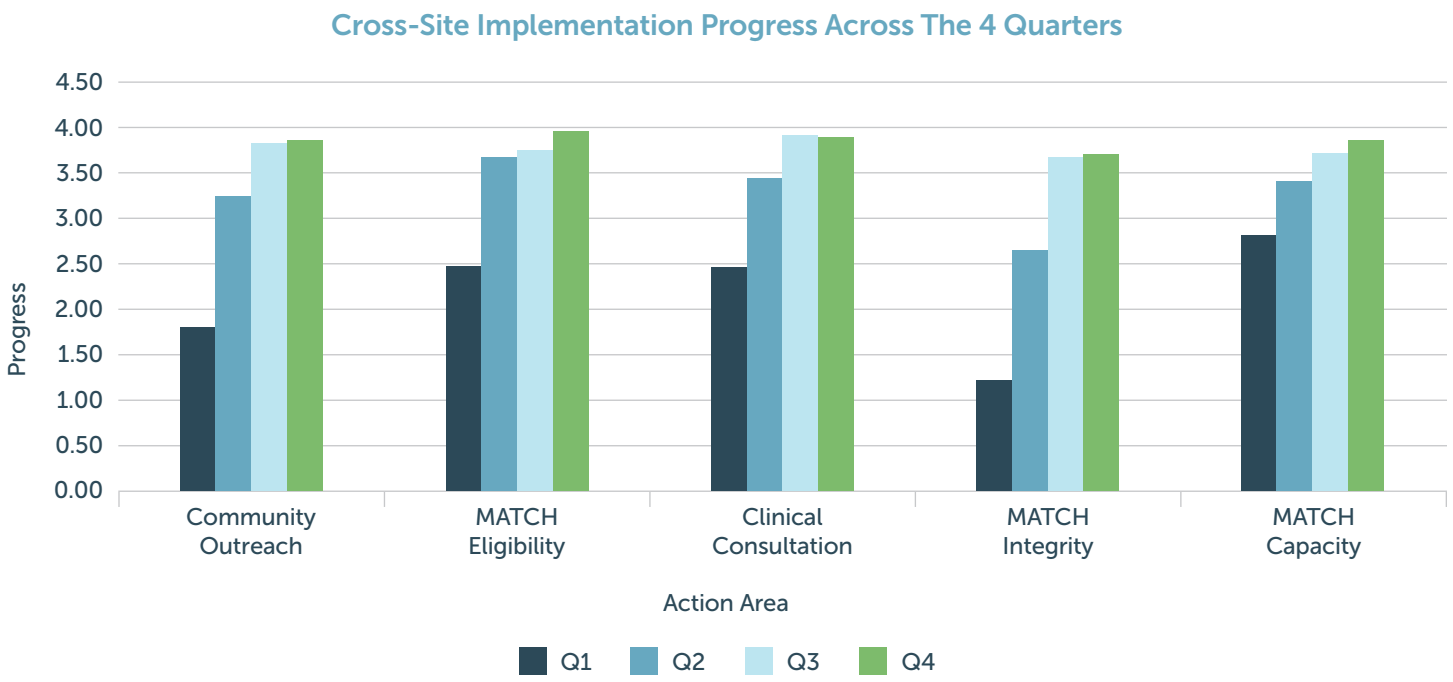
- **39.77%** Anxiety
- **26.95%** Conduct
- **21.61%** Depression
- **11.67%** Trauma


Youth Brief Problem Monitor
Severity
7
6
5
4
3
2
1
0
Pre
Post
Internalizing
Externalizing
Attention


Youth Top Problems
Severity
6
5
4
3
2
1
0
Pre
Post
Days since first survey
Top Problem A
Top Problem B
Top Problem C


Caregiver Brief Problem Monitor
Severity
7
6
5
4
3
2
1
0
Pre
Post
Internalizing
Externalizing
Attention


Caregiver Top Problems
Severity
6
5
4
3
2
1
0
Pre
Post
Days since first survey
Top Problem A
Top Problem B
Top Problem C


Cross-Site Implementation Progress Across The 4 Quarters
Progress
4.50
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
Community Outreach
MATCH Eligibility
Clinical Consultation
MATCH Integrity
MATCH Capacity
Action Area
Q1
Q2
Q3
Q4