

**State Activities in Implementing Evidence-Based Programs for
Children, Youth, and Families**

Jacqueline Yannacci, MPP
NASMHPD Research Institute, Inc.
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
703-739-9333 – phone
703-548-9517 – fax
Jacqueline.yannacci@nri-inc.org

Jeanne Rivard, PhD
NASMHPD Research Institute, Inc.
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
703-739-9333 – phone
703-548-9517 – fax
Jeanne.rivard@nri-inc.org

Vijay Ganju, PhD
NASMHPD Research Institute, Inc.
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
703-739-9333 – phone
703-548-9517 – fax
vijay.ganju@nri-inc.org

Paper presented at the 18th Annual Research Conference, A System of Care for Children's
Mental Health: Expanding the Research Base, March 6-9, 2005. Tampa, FL.

Introduction

This paper presents preliminary results of a state survey conducted by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute. The survey was designed to obtain detailed descriptive information on state mental health agencies' (SMHA) policies, strategies, and mechanisms for implementing evidence-based practices (EBP) in mental health service systems for children, youth, and families. The study was conducted in the national context of the U.S. Surgeon General's Report (1999) which highlighted the discrepancies between the scientific knowledge base of effective interventions and routine practice in mental health service delivery settings; and the more recent report of the President's New Freedom Commission on Mental Health (2004) which underscored the pressing need for access to effective mental health interventions.

Demonstration projects have revealed the challenges faced by providers, practitioners, and consumers/families engaged in implementing evidence-based practices and strategies to overcome barriers (Bachman & Duckworth, 2003; Dixon et al., 2001; Drake et al., 2001; Hoagwood et al. 2001; McFarlane et al., 2001; Schoenwald & Hoagwood, 2001; Torrey et al., 2001, 2002). Consideration has also been given to the policy-level implications (Goldman et al., 2001; Ganju, 2003) of incorporating EBPs into statewide mental health service systems. By documenting current state activities and implementation strategies, the field can understand the current scope of EBP and promising practice implementation, identify successful strategies for replication, and pinpoint areas of change and further research.

Methods

The survey instrument was developed in collaboration with states and other stakeholder partners and was composed of primarily open-ended questions covering the following topic areas:

- Types of EBPs and promising practices being planned or implemented
- Integration of EBP initiatives with other major initiatives
- How EBPs are implemented in rural and frontier areas
- Description of policy, procedural, or programmatic approaches used to integrate EBPs into practice settings
- Financing strategies
- Mechanisms used for training, coaching, and technical assistance
- Strategies used for evaluating and monitoring fidelity and outcomes; and methods for incorporating these data into management information systems
- Mechanisms used to collaborate with other agencies on initiatives related to EBP implementation
- Differential implementation strategies and needs for varying EBPs
- Facilitators of EBP adoption and implementation
- Needs for future implementation and dissemination

The sample was composed of 50 states. Primary respondents were State Mental Health Agency (SMHA) directors of adult and child/family mental health services. The survey was conducted during the period from December 2003 to June 2004 through telephone interviews lasting 1 to 1.5 hours. Interviews were audio taped and transcribed. Qualitative data from the transcribed interviews were collated into tables containing responses to each topic area from all states. Data in each table were then reviewed for emerging themes and categorized.

Results

A sample of findings from the larger survey results are presented in three areas: a) cross-cutting issues faced by most states in implementing EBPs in both adult and child systems, and general approaches/strategies used; b) types of EBPs being implemented across the states in

children's mental health; and c) examples of specific strategies being used to implement children's EBPs.

Cross-Cutting Issues

SMHA Governance and Structure of State Mental Health Systems

EBP initiatives are greatly influenced by the varied and somewhat unique governance and administrative structures of State Mental Health Agencies. These vary by type (e.g., single state agency or divisions of larger health and human services agencies), extent of direct or indirect influence over regional or county community mental health centers, and whether provider agencies are public or private organizations. Some SMHAs are administratively linked with State Medicaid Authorities, which can facilitate restructuring of Medicaid programs to cover EBPs.

Motivation for EBP Initiatives

Most evidence-based practice initiatives were stimulated by leadership influences and the demand to transition high-need target populations from hospitals and other institutional settings into community-based treatment settings. Existing public-academic partnerships often were vehicles to start initiatives through collaborative demonstration grants.

Stage of EBP Initiatives and Competing Initiatives

States in early-stage initiatives of limited scope focused their responses more on implementation plans, consensus building, training efforts, and evaluation. States with a longer history of EBP implementation focused on how to promote statewide dissemination and make changes in the infrastructure to support EBPs. In these states more examples of innovative strategies were evident. States also faced the challenge of trying to integrate children's EBPs with other important initiatives and demonstrations related to Systems of Care, trauma interventions, early intervention, and violence prevention.

Promising and Emerging Practices

The need for more research on promising and emerging practices was most frequently expressed for child/family interventions such as wraparound approaches, respite, use of paraprofessionals for behavioral interventions, family support, and practices effective for more diverse cultural, ethnic, and geographic populations.

Monitoring Fidelity and Outcomes

Monitoring fidelity of EBPs remains an important concern of states in early phases of implementation. Some states in later stages of implementation have eased up on compliance to the original EBP standards, but acknowledge the need to focus on adherence more intensively. In contrast other states in later implementation stages have made adherence to fidelity a contract stipulation.

General Approaches and Strategies for Incorporating EBPs into Service Systems

The survey revealed states using an amalgam of approaches and strategies to bring EBPs and promising practices to their service delivery systems. Examples of the types of approaches include:

- Special legislative initiatives to fund EBPs
- Pooling funds from multiple agencies, and other forms of leveraging finances
- Statewide planning initiatives used to build consensus with multiple stakeholder groups
- System reform/deinstitutionalization as the driver of EBP initiatives
- Nesting EBP initiatives in quality improvement initiatives
- Nesting EBP initiatives in Systems of Care
- Building on existing service platforms
- Building new relationships with providers
- EBP information dissemination

- Interagency collaboration

Types of Practices Being Implemented

Table 1 outlines the proportion of states that reported implementing a particular evidence-based or promising practice in children’s mental health services. However, with the exception of Multisystemic Therapy and Functional Family Therapy, the other practices listed do not signify adherence to a particular model. In addition, states reported having varying program standards and reporting criteria. The table shows a broad range of evidence-based and promising practices being implemented, but a relatively low proportion of states using most practices.

INSERT TABLE 1

Specific Strategies for Implementing Children’s EBPs

Following are a few examples illustrating strategies used to implement some of the most frequently utilized evidence-based and promising practices.

Multisystemic Therapy - The 27 states implementing MST reported collaboration with juvenile justice, the courts, and/or child welfare, often for children being diverted or transitioning from the juvenile justice system or out-of-home placements. Funding is accomplished through a variety of structures--sometimes using funds from Medicaid, juvenile justice, child welfare, and/or state funds. Medicaid is used, either by billing as an in-home service, using the rehabilitation option, or the Medicaid managed care organization providing an enhanced service package. Initial training is typically conducted by MST services. In a few states the responsibility has been transferred to the state training and supervision infrastructure. One state has a state coordinator co-located at MST services.

School-based Mental Health - Many states report that they are working with schools to provide mental health services in schools, either through locating mental health counselors in schools or collaborating in school-based mental health centers. South Carolina has been

instituting a “best practices model” which is currently in 467 elementary and middle schools. Therapists provide direct services and referrals to community mental health centers, and are jointly funded by the state mental health agency and school districts. In West Virginia 17 school-based mental health centers have been created through a collaborative initiative between Mental Health, schools, and primary health care that is funded through block grant, state dollars, Medicaid, and/or foundation dollars. These centers are reported to be effective in increasing access to mental health services in rural mountain areas.

Clinical Interventions - Many states reported providing clinical EBPs, such as functional family therapy, cognitive behavior therapy, dialectical behavior therapy, multidimensional family therapy, and intensive in-home psychiatric services. The states of Hawaii, Connecticut, and New York have public-academic relationships to provide the infrastructure for training clinicians. In New York school-based mental health counselors are being trained in a range of clinical EBPs, and the state is also collaborating with Child Welfare to implement family functional therapy.

Wraparound Services - Wraparound is reported in 24 states, with the Vandenberg model most frequently mentioned. Funding for the program is pooled from the State Mental Health Authority, other state agencies, state general funds, block grant dollars, Medicaid (targeted case management) or the System of Care grants. Training is provided by the state for certification, or national experts are utilized with the responsibility then transferred to the state. Family members are also used as trainers in some states.

Conclusion

This qualitative survey allowed for a broad-brush assessment of state EBP and promising practice implementation scope, strategies, and challenges. However, because of the variation in state mental health agency structures and reporting criteria, the mental health authority may not

know every EBP being planned, piloted, or offered (especially clinical ones). The frequency and types of practices reported here are most likely lower than if we also included county-level mental health authorities. The results show that most states are still in the implementation phase, versus dissemination stage. This involves exploring, trying out, and working through how to integrate EBPs in the current service system and how to change the system as needed. The next step is to conduct more focused, in-depth studies of specific EBPs and strategies integrating process and outcome data for better understanding of impact and effectiveness.

References

- Bachman, S.S., & Duckworth, K. (2003). Consensus building for the development of service infrastructure for people with dual diagnosis. *Administration and Policy in Mental Health, 30*(3), 255-266.
- Dixon, L., McFarlane, W.R., Lefley, H., et al. (2001). Evidence-based practices for services to families of people with psychiatric disabilities. *Psychiatric Services, 52*(7), 903-910.
- Drake, R.E., Goldman, H.H., Leff, H.S., et al. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services, 52*(2), 179-182.
- Ganju, V. (2003). Implementation of evidence-based practices in state mental health systems: Implications for research and effectiveness studies. *Schizophrenia Bulletin, 29* (1), 125-131.
- Goldman, H.H., Ganju, V., Drake, R.E., et al. (2001). Policy implications for implementing evidence-based practices, *Psychiatric Services, 52*(12), 1591-1597.

- Hoagwood, K., Burns, B.J., Kiser, L., Ringeisen, H., & Schoenwald, S.K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52(9), 1179-1189.
- McFarlane, W.R., McNary, S., Dixon, L., Hornby, H., & Cimett, E. (2001). Predictors of dissemination of family psychoeducation in community mental health centers in Maine and Illinois. *Psychiatric Services*, 52(7), 935-942.
- President's New Freedom Commission (2004). *Report of the President's New Freedom Commission on Mental Health*.
- Schoenwald, S.K., & Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of interventions: What matters when? *Psychiatric Services*, 52(9), 1190-1197.
- Torrey, W.C., Drake, R.E., Dixon, L., et al. (2001). Implementing evidence-based practices for persons with severe mental illnesses. *Psychiatric Services*, 52(1), 45-50.
- Torrey, W.C., Drake, R.E., Cohen, M., et al. (2002). The challenge of implementing and sustaining integrated dual disorders treatment programs. *Community Mental Health Journal*, 38(6), 507-521.
- U.S. Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. DHHS.

Table 1. Types of Evidence-Based or Promising Practices Implemented Across States

Evidence-Based or Promising Practice	Percent of States Implementing (N=44)
Therapeutic Foster Care	86 %
Multisystemic Therapy	61%
Wraparound	55%
School-based Mental Health	45%
Clinical Interventions (CBT,MDFT)	43%
Functional Family Therapy	30%
Intensive Home Intervention	27%
Family Support	27%
Trauma Interventions	27%
Respite	23%
Independent Living Skills	18%
Early Childhood Interventions	18%
Medication Guidelines or Algorithms	11%
Crisis Intervention	11%
Telepsychiatry	9%
Parent Management Training	9%
Screening/Assessment Support	5%

