



Results of a Survey of State Directors of Adult and Child Mental Health Services on Implementation of Evidence-Based Practices

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I. Introduction

Evidence-based practices (EBPs) are becoming an integral part of the public mental health system to improve service delivery quality and effectiveness. The impetus for this focus came from the 1999 Surgeon General's report on mental health that underscored the gap between science and practice and called for an increase in the use of EBPs in mental health, as was the trend in general healthcare. The 2004 President's New Freedom Commission Report reinforced this call to bring practices with documented positive consumer outcomes to the field, thus aiding in the transformation of the entire system.

Initiatives to close the science/practice gap have arisen through efforts at federal, state, and local levels. On the federal level, for example, the SAMHSA, CMHS-funded National EBP Demonstration Project created the first funding program for states to demonstrate the implementation of six different evidence-based practices (EBP) for adults. Subsequently, SAMHSA and NIMH have jointly funded special initiatives of states to plan for the integration of EBPs into their mental health service systems. In addition, SAMHSA has introduced a new requirement in their existing Child Mental Health Initiative for grantees to incorporate the implementation of EBPs into their system of care demonstration grants. At state and local levels, some initiatives to promote the implementation and dissemination of EBPs have been stimulated through a combination of state or foundation funding, advocacy, consensus-building, leadership, professional values, or legislative mandates.

Several articles have now described the challenges faced by providers, practitioners, consumers, and families engaged in implementing evidence-based practices (EBP), and suggested 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.

The NASMHPD Research Institute (NRI), through the State Profiles project, obtains information from states on EBP implementation every two years. However, these data do not provide in-depth information about the strategies and mechanisms used by a state, the lessons learned from the state's EBP-related experiences, or whether a state's efforts have been successful. In-depth information from a limited number of states has been obtained through the evaluation of the state mental health authority component of the SAMHSA Center for Mental Health Services-funded "Toolkit" Project. However, no systematic study has been undertaken to examine the organizational and policy-level initiatives designed to incorporate EBPs into existing state mental health service systems for both adults and children.

This report presents results of a 50-state survey conducted by the NRI Center for Mental Health Quality and Accountability to: 1) obtain detailed descriptive information on state mental health agencies' policies, strategies, and mechanisms for implementing evidence-based practices in mental health service systems for adults and children; 2) identify models of successful EBP implementation; 3) identify challenges, barriers, and facilitators that influence statewide implementation; and 4) identify needs related to current and future implementation. Survey results will be used to promote the exchange of information, knowledge, and technical expertise necessary for disseminating and sustaining evidence-based practices in state mental health service systems.

II. Methods

A. Design and Measurement

A qualitative study design was used to obtain in-depth information about the policies and organizational strategies used to integrate evidence-based practices into existing service systems. The survey instrument was developed in collaboration with states and other stakeholders, and was composed of primarily open-ended questions covering the following topic areas:

- Type of EBPs and promising practices being planned or implemented
- Integration of EBP initiatives with other major initiatives such as promoting recovery, cultural competence, or trauma screening and treatment
- 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
- Infrastructure and 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 coordinate or 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

B. Sample and Data Collection

The sample was composed of the 50 states, plus DC and territories. Primary respondents were State Mental Health Agency (SMHA) Directors of Adult and Child Mental Health Services. Supplemental information was provided by other personnel such as program managers, evaluation directors, or MIS directors.

The survey was conducted during December 2003 to June 2004 through telephone interviews lasting 1 to 1.5 hours. In most states two separate interviews were conducted--one with the director of adult mental health services, and the other with the director of child and family mental health services. Interviews were audio taped and transcribed. The directors were first asked about the range of evidence-based and promising practices that were currently being implemented in their states at the time. To structure this question, we first asked them to verify information about their states' evidence-based services provision that was previously submitted to the State Profiles System (NRI, 2004)¹. We asked them to verify this information and to

¹ State Mental Health Agencies submit data on their organization, financing, and service delivery to the State Profiles System every other year. The EBP section of the State Profiles inquires about type of EBPs implemented, stage of development, and number of programs.

inform us about other EBP or promising practices that may not have been reported in the State Profiles System. The resulting comprehensive list of EBPs and promising practices was then used as the anchor for all of the other questions in the present survey that inquired about implementation strategies and issues.

III. Results

Findings will be presented in 5 major sections. First, global themes that emerged from interviews will be presented. These themes primarily concern conditions that impact the implementation of evidence-based practices in state mental health systems, such as SMHA structure, motivation for EBP initiatives, scale and stage of EBP initiatives, issues related to promising practices not yet established through research as evidence-based, and issues related to monitoring fidelity and outcomes. The second section lists the types of EBPs being implemented, scope of implementation, and specific strategies/mechanisms that states have used to promote statewide implementation. Third, the essential role of interagency collaboration is detailed in examples of how collaboration is used in areas of developing consensus, implementing various types of EBPs, financing, and training. In the fourth section, we summarize approaches that states are taking to integrate EBP initiatives with other emerging issues, such as cultural competence, needs of rural and frontier areas, and the notion of “recovery”. The final section summarizes factors that facilitate the implementation of EBPs, as well as on-going challenges faced by states as they implement large EBP initiatives or individual practices.

A. Global Themes

1. SMHA Governance and Structure of State Mental Health Systems

Incorporating EBPs into existing mental health service systems requires major changes not only in provider, practitioner, and consumer/family behaviors, but also requires major change in the external interagency environment and the administrative infrastructures into which EBPs are being installed. Therefore, EBP initiatives are greatly influenced by the varied and somewhat unique governance and administrative structures of State Mental Health Agencies. For example, whether SMHAs are single state agencies or divisions of larger health and human services agencies, plays a role in the ease or difficulty of implementing any type of change in management or service delivery. SMHAs’ ability to influence change in management and service delivery practices at the community mental health center level varies in the extent to which SMHAs exert direct or indirect control over regional or county community mental health centers, and whether community health centers are public or private organizations. Some SMHAs are administratively linked with State Medicaid Authorities, which can facilitate restructuring of Medicaid programs to cover EBPs. These complex system and organizational attributes appear to contribute to the scope, progression, and success of EBP initiatives.

2. Motivation for EBP Initiatives

Besides the impetus of the U.S. Surgeon General’s report and the acknowledged need to utilize research findings of effective interventions, most evidence-based practice initiatives were started because of 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 seemed to provide the vehicle to start initiatives through collaborative demonstration grants.

3. Scale of EBP Initiatives

The scale of states' EBP initiatives appears to fall into three categories: large-scale implementation, incremental implementation, and planning implementation. Relatively few states are moving ahead aggressively with large-scale implementation that involves introducing multiple EBPs and corresponding initiatives to facilitate EBP implementation. Most states in this category began with a federally funded demonstration project. The majority of states are moving in an incremental fashion and proceeding slowly while grappling with issues of financing, workforce development, training/technical assistance, and data collection. Because EBPs are so different than usual care, and the approach to implementation is not full-scale system change, these states are incrementally adding EBPs to their existing service systems while straddling the old system and pieces of a new one. For those states that are primarily in the planning stage, activities are focused on consensus building, answering basic questions related to system readiness, and exploring alternatives for restructuring services and resources to integrate EBPs into their service systems.

4. Stage of EBP Initiatives and Competing Initiatives

The stage of EBP initiatives in which states are in set the tone of interviews. States in early-stage initiatives of limited scope focused their responses more on plans they have for implementation, their consensus building and training efforts, and evaluations of their demonstrations. States with a longer history of EBP implementation focused on how to promote statewide dissemination and the need for changes in the infrastructure of management, financing, and service delivery to sustain and expand initiatives. In states where there was a longer history of implementation and greater commitment to EBP initiatives there were more examples of innovative strategies undertaken to realign policies and procedures consistent with evidence-based practices (e.g., wholesale restructuring of financing programs vs. piecemeal approach, changing contracting procedures to include the use of EBPs). These states with more experience also emphasized the need to ensure that evidence-based "practices" were used holistically in assessing clients, selecting the most appropriate interventions, and monitoring outcomes. In addition, these states expressed the need to be involved in promoting research on promising and emerging interventions to advance them to the level of EBPs, and to ensure the use of EBPs for their entire client base not just for select target populations.

In most states, including those in later stages of implementation, there was some trepidation about the notion of EBPs being mandated legislatively and thereby replacing existing practices that are seen as valuable by practitioners and consumer/families. This issue was particularly relevant in children's mental health services where initiatives to develop effective "systems of care" already are requiring major change in practices. Therefore, in most states there was an expressed need to align EBP initiatives with competing initiatives to change the operation of service systems.

5. Promising and Emerging Practices

The need for more research on promising and emerging practices was most frequently expressed for adult interventions such as supportive housing, consumer-operated services, peer support, and recovery-related services; and for child/family interventions such as wraparound approaches, respite, use of paraprofessionals for behavioral interventions, and family support. Frequently mentioned was also the need to adapt and

evaluate EBPs, previously developed and tested on select populations, for more diverse cultural, ethnic, and geographic populations.

6. 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. When EBPs are adapted for rural and frontier areas, efforts are made to adapt standards accordingly. A few states are evaluating their adapted standards with the original research standards to assess the impact. Most states have plans for integrating and using outcome data in MIS systems, but do not routinely collect and analyze data to generate information related to the on-going effectiveness of EBPs.

B. Strategies for Implementing and Disseminating EBPs Statewide

As the mental health system moves towards a system based on quality and accountability, evidence-based practices sit as a corner stone of this new foundation, with states implementing EBPs at a rapid pace. Table 1, containing data from the State Profiles System (NRI, 2004), shows that 46 states are implementing at least one EBP for adults and/or children. Close to half are implementing six or more EBPs, with three states implementing these EBPs on a statewide basis. Nineteen states are implementing two to three EBPs on a statewide basis. The definition of statewide may vary however. It can mean that a program has been disseminated statewide so that it is available in every county or regional mental health agency. This would not necessarily mean that all residents of the geographic region have access.

Table 1. Number of States Implementing EBPs (State Profiles, 2004)

Number of EBPs Being Implemented by States	Number of States that are Implementing	Number of States that are Implementing Statewide
One EBP	1	7
Two to three EBPs	11	19
Four to five EBPs	11	4
Six or more EBPs	23	3
No Response	(5)	(5)

Data from the State Profiles is also used to illustrate the number of states implementing EBPs for adults (Table 2), and EBPs for children (Table 3) by type of EBP and scope of implementation.

Table 2. Number of States Implementing Adult EBPs by Type and Scope of Implementation (State Profiles, 2004)

Implementation Status	Assertive Comm. Treatment	Supported Employ.	Med. Mgmt for Schiz.	Med. Mgmt for Bipolar	Family Psychoed.	Integrated MH/SA	Self Mgmt.
Statewide	10	22	7	6	10	5	8
Parts of State	27	19	9	7	18	26	13

Table 3. Number of States Implementing Children’s EBPs by Type and Scope of Implementation (State Profiles, 2004)

Implementation Status	Multisystemic Therapy	Therapeutic Foster Care	Other
Statewide	1	12	9
Parts of State	17	8	6

The State Profiles Survey inquires only about selected EBPs. The range is particularly restricted in children's mental health. In fact, upon verifying and updating the types of EBPs being implemented in children's mental health, the present survey found that the "Other" category of EBPs included school-based mental health interventions (reported by 19 states), clinical interventions such as cognitive behavior therapy and multidimensional family therapy (18 states), functional family therapy (13 states), intensive home intervention (11 states), and evidence-based early childhood interventions (7 states).

Introducing a new practice into the mental health service delivery system is an intricate task involving the interplay of resources, policy/procedure changes, training and technical assistance, and data collection and utilization. States typically introduce the new program incrementally and struggle with how to bring the practice statewide based on available resources and issues of oversight and accountability.

Those states that have gone statewide typically began in the more urban areas, from which they learned lessons on what resources and structures were necessary for effective implementation and parlayed that into a statewide strategy. Many examples of EBPs going statewide are within the adult mental health system. The strategies thus far employed include securing funding from the legislature, creating policies and licensing requirements, restructuring Medicaid to cover the practice, and partnering with other organizations. As the following examples will show, no one strategy is used alone, but in conjunction with one another to piece together the infrastructure for statewide implementation. Some particular strategies are highlighted as well as how putting them all together creates a unique strategy. ACT is the most frequent practice taken statewide and that is facilitated by deinstitutionalization. One important note is that some states report that a particular EBP is statewide, but have no monitoring system in place to ensure that the provider agency is adhering to a particular model. This was particularly true of supported employment – of the twenty-two states reporting statewide implementation 60 percent reported that they were monitoring fidelity.

1. Leveraging the Legislature, Financial Resources

A legislative mandate, backed with resources, is a powerful tool to promulgate an EBP statewide. One successful way a few states have utilized such a tool is to use advocacy and data to show that the practice will be beneficial as shown by the already demonstrated effects.

Florida originally funded 8 ACT sites and is now expanded to 29. Using data to show positive outcomes, advocates such as NAMI and other stakeholders successfully lobbied the legislature to fund ACT teams across the state. In addition, a special Medicaid rate was negotiated. Tobacco and block grant money are also used in the total pool of funds available. The “enhancement funding” helps pay for items such as pharmaceuticals and other necessary items such as first and last month’s rent.

Massachusetts began ACT as a demonstration and evaluation project measuring outcomes (e.g. employment) compared to the clubhouse model. With the success of the ACT teams, additional funding was secured to bring at least one program on line in all of the 6 community mental health areas. The state used the method of putting out an RFP for interested providers to implement the program. The RFP required particular program standards, and they are currently working on a structure to conduct audits for compliance. The state is also considering incentives, possibly monetary, to reward fidelity.

2. Required Service/Deinstitutionalization

The need for deinstitutionalization has been a major instigator for states to implement ACT statewide. States reported having an available funding source and a readily available program to implement. Making the practice a required service as a condition of funding from the state is a powerful tool for implementation.

The state of Delaware contracts with private, non-profit providers to implement ACT teams that use Medicaid case rate, state general funds, and block grant money. The state is linking recovery outcomes (employment and housing) to monetary incentives.

In Illinois, where the state directly funds the community mental health providers and employs regional managers, they used funding from the reduction of state hospitals to create ACT teams that span the state.

Texas reorganized their system and now requires supported housing, supported employment and ACT to exist in every local mental health agency. Medicaid can be billed for ACT. To aid with this requirement, the state has offered training in the program areas, but are in need of more academic partners to assist in training.

3. Partnerships/Technical Assistance

Many EBPs work in conjunction with other agencies/organizations and this type of collaboration is an important statewide facilitator. Louisiana implements the Journey of Hope program (Family Psychoeducation) in most parts of the state in conjunction with NAMI and volunteers. In Maine, both providers and the state independently pushed for grants to fund supported employment. These providers were not always community mental health providers. The state collaborated with the University of Maine to develop a special, web-based curriculum for employment specialists and use general funds to support it. Section C. of this report illustrates many more examples of how collaboration is instrumental in implementing EBPs.

4. Multiple Strategies

A few states have implemented more than one EBP across the state and, depending on the EBP being implemented, used a combination of these strategies to tailor implementation to their system.

Connecticut has had strong leadership from the beginning. Quality is a defining characteristic and the largest statewide initiative is sustained practice change. The

legislature passed a bill called the Community Mental Health Strategy Board that created a special set aside beyond the general mental health funds to kick-start the implementation of EBPs. The state partnered with national research experts for technical assistance on EBP implementation and collaborated with the Governor's Mental Health Policy Council. For those individuals with co-occurring disorders, the state was able to create flexible funding through a welfare behavioral health carve out plan. A needs assessment of the welfare recipients identified service needs and the funds were able to be diverted either to mental health or addictions. Data was used to see if the service recipients had positive outcomes and identify any needs in the system. Results of this program led to the statewide implementation of Integrated Dual Diagnosis Treatment which began as a research project, with full cooperation from Addiction Services, and later went statewide. For Supported Employment, a special vocational rehabilitation position was created with half the salary from vocational rehabilitation and the other half from mental health. This position is housed in the Medicaid agency for maximum collaboration from all relevant organizations.

New Jersey implemented statewide ACT, supported employment, IDDT, and Family Psychoeducation. For ACT, the state created a special code under Medicaid to facilitate billing. In addition, the state provides all new relevant staff with ACT training and holds an annual ACT training for all staff. The state also utilizes training by holding an annual training as well as providing all new hires with training in the model. Supported employment has been slowly integrated over a 3-year period. Again, the state provides SE community providers as well as sponsors a network for SE supervisors and jobs coaches to facilitate collaboration. The state also funds two Employment Resource Institutes for consumers. To implement IDDT, the state assigned staff to each county task force to collaborate with addiction services, provide training (150 sessions) to staff and consumers, and provide technical assistance to agency level staff. State psychiatric hospitals are approved practicum sites for both the certification in addictions (CADC) and for the College of NJ's masters in alcoholism program. DMHS and DAS funded three regional model programs to define best practices, training, and technical assistance which were adopted statewide. Family Psychoeducation is part of the Intensive Family Support services menu in every county. The state formed a partnership with NAMI NJ to coordinate training. Each program has a dedicated training budget as part of the state contract, and fidelity to model is incorporated into state licensing and practice standards outcomes.

Hawaii has taken a readiness approach before bringing ACT statewide. They conducted an assessment of current providers to evaluate lessons learned from implementation to inform new providers. Before bringing IDDT statewide, they are creating a statewide integration team, led by the MISA service director (special population director) and using the Continuous Comprehensive Integrated System Care Model. They will use a consultant to assess system readiness, provider readiness, and consumer readiness. They have started some training and education in IDDT.

These general strategies are useful to understand the various mechanisms to facilitate statewide implementation. Although no step by step process is apparent from these examples, conducting a needs assessment and readiness is a logical first step for planning.

C. Strategies Based in Interagency Collaboration

Discussing the policy and administrative practice implications of implementing evidence-based practices (EBP), Goldman and colleagues (2001) pointed to several factors that impede the widespread dissemination of EBPs in state mental health systems. They pointed to barriers such as lack of a long-term vision for the service system and lack of agreement on outcomes, lack of provider incentives for using EBPs, competing political mandates or priorities, resource limitations, and uncertainty associated with change. Introducing EBPs into the interorganizational context of service systems introduces another level of complexity. Adults with severe and persistent mental illnesses have simultaneous needs in domains of treatment, social services, housing, employment, and other concrete supports. Children and adolescents with serious emotional and behavioral disturbances, and their families, often require coordinated efforts of mental health, education, child welfare, social services, and juvenile justice agencies. Other key players in the service system include service provider organizations, consumers and family organizations, funders, and universities. Therefore, integrating evidence-based practices into complex service systems requires rethinking of historical assumptions about the nature and purpose of treatment; the roles of consumers, professionals, and organizations; service delivery settings; administrative practices; and financing. Such large redefining of the playing field, therefore, necessitates broad consensus building, new collective goal setting, and joint enterprises with shared commitment to action.

To learn how State Mental Health Agencies (SMHA) use interagency collaboration as a mechanism for integrating EBPs into service systems and to overcome barriers in implementing and disseminating EBPs, a special section of the EBP State Survey was included to inquire about interorganizational relationships. The survey instrument included a series of questions inquiring about relationships that exist between State Mental Health Agencies (SMHA) and other state agencies and organizations related to EBP implementation, and mechanisms used to work with other agencies in implementing EBPs. The mechanisms included: memoranda of agreement, joint powers agreements, contracts, pooling funds, co-location of personnel, joint facilities, integrated databases, joint training, single intake, information sharing, providing consultation, and joint service planning on community or individual levels. Results are presented in 6 major areas that include strategies used for:

- Consensus development,
- Implementing specific types of EBPs or promising practices,
- Financing EBPs,
- Translating science into practice and training practitioners through public-academic partnerships, and
- Working with other state agencies and providers in general.

1. Collaboration in Developing Consensus

The need to develop early and on-going consensus has been emphasized by states participating in the National Implementing Evidence-Based Practices Project, funded by the Center for Mental Health Services. Consensus of all partners is required to establish the need for a particular EBP to be introduced in a community, and in the planning, implementation, and evaluation stages of the joint venture. Several states have addressed consensus development through statewide initiatives. For example, the

Colorado Work Group for Evidence-based Mental Health Practices was formed in 2002 to develop priority recommendations for EBP development, identify factors that affect implementation and dissemination, provide resources and information, and update recommendations periodically. The group was composed of key stakeholders, including consumers, family members, and advocates, provider agencies, the Colorado Behavioral Health Care Council, and the Colorado Psychiatric Society. The group published a report of the recommendations and priorities; and is implementing the plan that resulted. A similar large stakeholder forum was convened in Florida between Mental Health, the Department of Children and Family Services, and providers to help in promoting EBPs throughout the state.

In Utah, the leadership within the Division of Mental Health, affiliate organizations, NAMI, Vocational Rehabilitation, the Corrections agency, and Police Departments developed a program called Community Intervention Treatment to develop a comprehensive approach for the state. They reviewed and established program guidelines as minimum standards for treatments such as Assertive Community Treatment and developed fidelity measures. In Texas, implementation of EBPs was nested into a major state initiative to create a new benefit design system. Services to be included in the benefit design packages were identified through a consensus building conference, with participation from national experts, family members and community representative and providers. Another example can be seen in the State of New York where the SMHA convened a series of focus groups and conferences to develop consensus among provider, consumer and family groups, and other agencies regarding EBPs to target for development and methods of implementation. New York marketed the initiative with a title, "Winds of Change" and disseminates a great deal of information about the developing demonstration projects (information about and definitions of EBPs, fidelity standards) on their state internet site.

2. Collaboration on Specific EBPs or Promising Practices

Certain EBPs, such as Integrated Mental Health/Substance Abuse Services, cannot be implemented without collaboration between mental health and substance abuse sectors to provide integrated treatment for persons with dual disorders of mental health and substance abuse. Similarly, Supported Employment is typically undertaken as a joint initiative between mental health and vocational rehabilitation. The following examples illustrate the types of collaborative strategies being used to implement these and additional EBPs. Treatments and services, which were considered by states to be *promising* or *best* practices are included.

a. Integrated Mental Health/Substance Abuse Services

As the name implies, interagency collaboration is an essential component of Integrated Mental Health/Substance Abuse Services for persons with co-occurring mental health and substance abuse disorders. A basic principle of this approach to service delivery is that consumers will not be refused treatment when entering the service system through either a mental health provider or a substance abuse provider. Both types of service providers are trained to screen for dual disorders and arrangements for referral and treatment are coordinated. The mechanisms used for collaboration are summarized. Examples of states that are using the strategies are included, though this notation should not be seen as exhaustive.

- Merging mental health and substance abuse divisions within one agency; and jointly demonstrating implementation through a Co-occurring State Infrastructure Grant, or other SAMHSA demonstration or planning grant (AK, AS).
- Joint development of a co-occurring program and joint training within an umbrella agency in which both mental health and substance abuse services are situated (AL).
- Attempting to restructure Medicaid regulations to cover integrated services (AK).
- Statewide training to bring providers up to a standard referred to as “co-occurring competent” (AZ).
- Statewide integration team to lead implementation and dissemination, using the Continuous Comprehensive Integrated Care System model (HI).
- Five consortiums throughout the state with formal agreements between agencies to treat individuals with a full range of service regardless of where they enter the system (IL).
- Co-location of personnel and joint facilities, training, and databases (LA).
- Statewide training to discuss initiative and to stimulate planning on local level (MD).
- State agencies and local counties work together to provide co-occurring programming (since 1983). DMHS and Division of Addictive services jointly fund additional resources to make detoxification services available to all of the designated screening centers. Jointly funded program to identify and provide best practice models in 3 regional programs.
- Joint cross training and joint funding of dual diagnosis coordinators (NY)
- KODIAC Committee (Co-occurring Disorders Interagency Advisory Committee) looks at issues related to co-occurring disorders. They also pool funds for inpatient programs, and have an MOU around integrated research and treatment initiatives (WA)
- Managed care programs being demonstrated as model program (Redesign Demonstration Sites) to be disseminated statewide in future (WI)

b. Supported Employment (SE)

Supported employment (SE) is another EBP in which natural points of collaboration occur between SMHA's and State Vocational Rehabilitation (VR). Collaboration occurs at state and/or local levels, and includes:

- Intergovernmental agreements or contracts, or other coordination agreements to establish joint funding between SMHA and VR. This provides VR with the federal match to draw down their federal funds (AZ, MN, NE, NJ, NY, SC, TN, WA, WI).
- Informal monthly meetings between mental health SE specialist and VR to discuss specific clients that may be ready for VR services (AK, AL).

- Joint training for providers serving clients with developmental delays or mental illness through a special grant mechanism awarded to SMHA, VR, and a private employment agency (AS).
- Arizona State University develops training for SE that is rolled out statewide.
- Co-funding a VR staff person (CT)
- Project to demonstrate SE that is supported by MH, VR, and a private foundation (Johnson & Johnson) (MD)
- Local memoranda of agreements around the state with providers to implement SE (MI)
- Special initiative in several parts of the state where they have 31 joint interagency teams. The initiative includes MH providing funds to VR to draw down federal funds; collaboration with League of Women Voters who lobbied legislature for additional funds; now SE is funded by Medicaid and VR (MN)
- VR contracts directly with psychosocial rehab programs and provides them with an employment staff person (NE)
- SE is funded through VR. There is an interagency agreement and task force that meets quarterly to review agreement and initiatives that can be jointly supported (OK)
- Blending of funds among VR, MH, and Department of Developmental Disabilities to provide SE for persons with mental illness and developmental disabilities (PA)
- To address structural barrier of consumers losing income and health benefits (through Social Security Income) in returning to work because of a new Medicaid initiative to fund SE, MH worked with VR, the Medicaid agency, and congressional delegation, and instituted a rapid reinstatement of benefits program (VT).

c. Family Psychoeducation

Most states reported that they collaborate with NAMI to provide family support services, though this is not the EBP multi-family psychoeducational model developed by McFarlane and other researchers. States typically contract with NAMI for training and direct service provision. New York has an initiative to work with the University of Rochester to support training in the use of the EBP model of family psychoeducation. New York also collaborates with five Schools of Social Work in the state to develop curriculum for various EBPs, including Family Psychoeducation. Graduates students are trained and placed in agencies which provide these EBPs.

d. Illness Management & Recovery

The state of New Jersey is collaborating with the Center of Excellence in Psychiatry at the University of Medicine and Dentistry to develop and implement a pilot project in six community agencies and two state hospitals. They evaluate the readiness of agencies to implement the EBP and provide training and technical assistance. New York is working with one correctional facility and housing to include an IMR component for persons transitioning from prison to the community.

e. Medication Algorithms

Many states reported that they are coordinating with state psychiatric hospitals to pilot medication algorithms. Rhode Island is coordinating with primary care via the Department of Health. In this arrangement the SMHA has a seat on the Pharmacy and Therapeutics Committee where decisions are made about best practices used in hospitals for inpatient and aftercare. They are also coordinating on best practice committees with a private insurer, Blue Cross.

f. Housing

Providing housing for persons who are mentally ill is considered to be a best practice to prevent homelessness. Supportive housing, where persons are provided long-term housing and supportive treatment and social services is a promising practice. In Arizona, they have housing specialists located in all of their regional centers. California has established a major initiative to provide integrated services for persons who are mentally ill and homeless. Through coordination with the state housing authority, Oregon has been able to raise \$19 worth of funding for every \$1 of MH funds. This has created millions of dollars in funding for housing in the last twelve months for adults with mental illness. Similarly, Tennessee has a Creative Housing Initiative. Through formal agreements with banks and housing authorities, the state has been able to leverage state and federal dollars to create new housing options. Wisconsin has an agreement with the state housing authority to use federal HUD funds for rental assistance for homeless mentally ill persons and is able to fund other mental health services. They also have joint funding with the State Aging Agency for placing elderly patients with mental illness residing in nursing homes into community-based housing.

g. School-Based Mental Health Services

Most 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. California is collaborating with child welfare, health, and education to implement a large-scale initiative. Since 1983 South Carolina has been instituting a “best practices model” in every school district in 467 elementary and middle schools. Their goal is to have a MH therapist in every school. Therapists provide direct services and referrals to community mental health centers, and are jointly funded by DMH and school districts. In West Virginia there is a large collaborative initiative between MH, schools, and primary health care that is funded through block grant, state dollars, Medicaid, and/or Foundation dollars. Funding packages vary in different areas of the state. There are 17 school-based mental health centers. Centers are effective in increasing access to mental health services in rural mountain areas.

h. Multisystemic Treatment (MST) for Children and Youth

States that have implemented MST are most often collaborating with juvenile justice where MST has been found to be effective in reducing delinquency and antisocial behavior. In South Carolina where MST was developed there are six current sites,

and they are planning to expand to ten. They will be implementing in two new rural sites within a SAMHSA system of care site. The initiative was started using Juvenile Justice block grant funds; but now it is mainly a MH initiative using Medicaid, Juvenile Justice, and state dollars. Medicaid funds the entire service except for the transportation cost, which is difficult in a state with many rural areas. A State Coordinator conducts training and site reviews for fidelity adherence, and is jointly funded by SCDMH and MST Services.

In New Mexico, MST started about two and on-half years ago through a collaboration with child psychiatrists at the University of New Mexico, the Department of Psychiatry, juvenile justice agencies, and 3 managed care organizations that provide the Medicaid package under contract with the Medicaid agency. The Child, Youth, and Families Department funded the training and ongoing supervision. The managed care organizations created an enhanced service package to fund the service through Medicaid. The roll out was also accomplished through much collaboration with the children's court judges, especially those located in Albuquerque, Santa Fe, and Las Cruces. Success can be attributed also to the partnership between the juvenile probation and parole offices and the MST providers who have formed the MST teams to cover broader areas beyond one county in those areas that want to expand.

i. *Other EBPs for Children and Youth*

Several states are implementing initiatives to implement a range of EBPs under the umbrella of interagency collaboratives. A few of these are described as follows. The state of Connecticut has nested implementation of EBPs for children and youth within 27 local systems of care called community collaboratives. They provide a range of EBPs including, multi-systemic therapy, therapeutic foster care, intensive in-home psychiatric services, multidimensional family therapy, school-based mental health services, positive behavioral intervention and supports, wraparound services, and trauma-focused services. Their partners include juvenile justice agencies, child welfare agencies, schools, courts, managed care organizations, and Medicaid.

New York has worked with child welfare agencies to implement functional family therapy, and with schools to implement a large-scale initiative to disseminate positive behavioral intervention and supports. Another major initiative with schools and universities involves training school-based clinicians in the use of cognitive behavioral therapy for anxiety (Coping Cat Manual developed by Kendall), CBT for depression (STEADY Manual developed by Clarke), Interpersonal Psychotherapy for Adolescents (IPT-A), an evidence-based treatment for depression, and the use of functional behavioral assessment (FBA) to develop behavior management plans for disruptive classroom behavior.

In Oklahoma, the Governor recently held a press conference to announce the Partnership for Children's Behavioral Health with the goal of creating a new system design for services within a year and then to move into implementation. Eight state agencies comprise the Partnership and all commissioners signed a statement that they would personally sit on the council. EBPs planned for implementation include: multi-systemic therapy, family functional therapy, cognitive behavioral therapy, parent-child interaction therapy, structural sensory interventions for children with trauma, and wraparound services.

3. Collaboration in Financing EBPs

Financing EBPs is one of the major barriers to implementation, which often requires collaboration in investigating and changing funding streams and mechanisms to adapt to new services in community-based settings, to provide training, and to ensure that the new services and treatments meet fidelity standards. Following are some examples of collaboration strategies that have been used to establish funding for EBPs. As stated above in the section on supported employment, many states have established intergovernmental agreements or contracts, or other coordination agreements to establish joint funding between SMHAs and VR. This provides VR with the federal match to draw down their federal funds (AZ, NE, NJ, NY, SC, TN, WA, WI, MN).

In an initiative to refinance services in the state, Vermont moved toward a pre-paid plan (monthly fee for each consumer), and received an 1115B Medicaid waiver. Prior to April 1999, Vermont had a fee for service approach to funding day treatment program and clubhouse programs. The employment components of these programs tended to be focused more on transitional employment than supported employment. The new pre-paid plan included job matching, development, assessment, coaching, and on-going support on the job. The waiver also allowed providers to use their total monthly payment on behalf of all of their clients to support case management, supportive housing, access to medication and medication evaluation, and individual treatment. To address the structural barrier of consumers losing income and health benefits (SSI) in returning to work via the SE initiative, MH worked with VR, the Medicaid agency, and a congressional delegation, and instituted a rapid reinstatement of benefits program. Seven full time staff were hired to focus on implementing these two strategies. By 2002 the amount of employment service delivered by agencies tripled, the employment rate doubled, and wages have increased by 25%.

Legislative allocation was used by the state of West Virginia to fund supported employment because it is related to two consent decrees and was identified by the interagency state planning council as a priority service.

Wisconsin has 3 different approaches to funding “best practices” systems of care with multi-agency involvement. These include CMHS-funded System of Care federal grants, state-funded Integrated Service projects (community and system focused) and state-funded Coordinated Service Teams (individual child focused). The different approaches are all aimed at providing treatments and services for hospital diversion and crisis services. The state programs are funded by MH, Substance Abuse, Department of Child and Family Service, and local dollars. There is also one program that is organized by a managed care organization.

4. Collaboration between State MH Agencies and Providers

Michigan provides an interesting example of working with providers in a quality improvement paradigm to generate and use data to improve service delivery and move the system toward use of EBPs. Their approach in children’s mental health involved building an infrastructure for EBP by training mental health centers and providers in how to collect, use, and interpret outcome data which they collected using a standardized functional scale; then to match needs with treatment in their local areas; then to

implement interventions to respond to needs such as state sponsored training for cognitive behavior therapy. Access to expertise and training was used as an incentive for provider participation. The state has a 1915 B-C waiver combining managed care and community-based target objectives, and is applying for research grant funding to investigate the effectiveness of different training methods.

5. Public-Academic Collaboration for Translating Science to Practice and Training Professionals in EBP

One of the most productive areas of collaboration has been the partnerships developed between states and universities in transporting evidence-based interventions into the field through evaluation and training activities. Most states reported working with their major universities and private colleges to support the implementation of EBPs. For example, the state of Connecticut has relationships with Yale, the University of Connecticut, and nearby Dartmouth. New Jersey collaborates with its College of Medicine and Dentistry and Rutgers. These partnerships have taken on various forms. Ohio has gained much recognition for instituting eight “Coordinating Centers of Excellence” (CCOE). The CCOEs were built on preexisting relationships with universities to train mental health professionals in the fields of psychiatry, psychology, and social works. However, the CCOEs emphasize technology transfer through training current practitioners in EBPs. The centers each have a distinct focus. Some focus on EBPs for various populations, including adults with mental illness and developmental disabilities, or persons with substance abuse and mental illness. Others focus on training professionals in specific EBPs such as supported employment, illness management and recovery, medication algorithms, and services for jail diversion. Two specialize in meeting children’s needs through disseminating technology on multisystemic therapy, diversion from juvenile justice, and mental health services in schools.

Other examples include Hawaii’s Center for Evidence-Based Practices, which is a collaboration between the state and university departments of psychology, social work, medicine, psychiatry. The schools have responsibility to train professionals in line with the 6 EBPs identified in the Surgeon General’s report. New York has a unique arrangement with five Schools of Social Work to develop curriculum for EBPs and to place interns in agencies providing EBPs. California has relationships with UC Davis, Berkley, San Francisco, and Los Angeles on various projects to develop, implement, and evaluate EBPs. Collaborating researchers are required to build training into their protocols to benefit provider organizations. Oklahoma partners with the University of Oklahoma to provide training for some of its 18 assertive community treatment sites (ACT). One of the sites is housed at the University’s Tulsa College of Medicine where the Dean of the college procured an endowment for a chair for the program. Pennsylvania also collaborates with four major universities to provide training institutes.

6. Collaboration with other state agencies in general

In many states preexisting or new interagency councils are used as forums to plan for the implementation of EBP or related service delivery initiatives. For example, Arizona has intergovernmental agreements with all of the other state agencies to coordinate wherever possible in service delivery. Under their agreement with child welfare they collaborate in a program of rapid response to child protective services when children are removed from their homes. Colorado and Connecticut use the platforms of their

Governor's Interagency Council, in combination with other local mental health planning councils and memorandums of understanding. West Virginia and Wyoming are examples of other states that mentioned that their state interagency planning councils function as a main driver of their initiatives.

Nebraska is undertaking a statewide redesign of behavioral health services, through legislation, to significantly downsize institutional beds and move toward community care. Their initiatives take place on several fronts including: working with psychiatrists and primary care physicians to use best practices concerning antipsychotic medication; working with the Dept. of Economic Development and Housing agencies to increase low-income housing for persons with mental illness; locating VR counselors in psychosocial rehabilitation clubhouses; and convening an "Academic Support Group" to engage universities in partnerships with public behavioral health system, especially for rural areas.

Several states reported that they were working with their Departments of Corrections to plan or provide services for persons with mental illness who were transitioning from prisons or jails into the community (e.g., Iowa, Missouri, Montana, Oklahoma, Tennessee, Maine, Minnesota, Washington). For example, Washington State collaborates with criminal justice agencies on a "Dangerously Mentally Ill Offenders Initiative" to fund extensive follow-up and support services for person with SMI and violent histories upon release from prison. Maine and Minnesota use intensive case management for re-entry services. Oklahoma uses crisis intervention strategies with the mental health courts in the state. Tennessee created 18 positions statewide in mental health agencies to interface with the criminal justice system. Many of these positions are located in jails to provide training to criminal justice staff and to assist in individual cases. In Virginia there is an initiative near Roanoke to partner with local law enforcement and the local Mental Health Association to develop a crisis intervention team based on the Memphis model. The state has been working very closely with criminal justice agencies for three years to improve treatment in jails and juvenile detention centers, to develop mental health courts, drug courts, and crisis intervention teams.

D. Emerging Issues related to Cultural Competence, Rural Areas, and Recovery

The survey also included questions about how states integrate EBP initiatives with other emerging issues, such as cultural competence, needs of rural and frontier areas, and the notion of "recovery".

1. Cultural Competence

States are critically aware of the lack of culturally relevant services as well as disparity of different ethnic and culture groups in receiving services. States are desperate for more information on specific adaptations to practices for different culture and ethnic groups. Just defining the issue of what is culture poses problems. A few states stated they are homogenous and therefore do not have cultural competence issues. One state recognized the differences in their population due to socioeconomic and educational levels and made adaptations to the program to adjust for these differences.

As an initial step, many states are designating a staff member in charge of cultural competence to provide education, technical assistance, policies, and implementation both at the state and community provider level. Specific examples include:

- State training, education, and social marketing on cultural competence issues.
- Annual conference that addresses issue.
- All community mental health centers must have training on cultural competence.
- Cultural competence coordinator is engaged in EBP implementation planning.

Adaptation of the EBPs is cited as a need, but states have no particular direction on how to do. Examples of approaches taken include:

- Conducting focus groups to see how to adapt FPE for three ethnic/culture groups.
- Hawaii is focusing on core components of programs to allow for adaptations.
- Partnerships with University to explore how adaptations can be made.
- All literature translated into several languages.
- Using Hawaii approach cited above.
- Treatment planning is individualized and strength based.
- For family psychoeducation, hiring a family liaison of the same ethnic/culture group.

Another common approach involves ensuring that provider staff and/or local planning board members reflect the composition of the community. Examples include:

- Hiring lay individuals from the community or tribal members and training them to provide services.
- Hiring providers who specifically focus on a particular ethnic or cultural group.
- Hiring bilingual staff.
- Staff composition reflects cultural/ethnic groups of the geographic area.
- Providers have a social marketing plan that conveys their awareness of the community and capabilities to serve the community.

Other approaches focus on exploring access to services and how culture impacts services:

- Assessing if/how culture is a factor in access to services.
- Piloting cultural competence programs addressing access, retention, and quality.
- Collecting data to use for planning services for Native American populations.
- Conducting assessment of providers in relation to cultural competence.

2. Implementation in Rural Areas

States are struggling with how to bring best practices to rural and frontier areas. Lack of resources in terms of funding, workforce, and infrastructure capacity present the biggest barriers. The main source of these barriers is the fewer number of individuals to serve and a small pool of available workers. As with adapting for cultural competence, guidance on how to properly adapt for rural and frontier areas is scarce. Missouri is piloting Integrated Dual Diagnosis Treatment in both urban and rural areas to see what works and what issues arise from the different locations. Alabama is adapting ACT for rural areas and assessing differences in programs outcomes between the adapted and standard ACT models.

States reported the need to be ingenious in their ways of bringing services to rural areas. Vermont's approach is to let the community decide for itself what services to provide and how, while the state mandates which outcomes/values must be incorporated into the services.

For the adult system, program adaptation, mostly related to ACT, is the most common strategy. Some states are allowing ACT to either be combined with intensive case management teams or allowing smaller teams (i.e., lower psychiatrist to consumer ratio). Other ACT adaptations include:

- More reliance on natural supports and outreach
- After hours crisis support via phone as opposed to in-person
- Utilizing teleconferences
- Not distinguishing between rural and urban sites, but allowing a minimal level of care for smaller teams in rural areas.

As with the issue of cultural competence, Arizona is recruiting professionals from Mexico as well as hiring lay individuals from the local community or tribe and training them to provide basic healthcare services for rural and border communities.

Children services utilize a variety of strategies including more reliance on telemedicine, offsite services and collaboration among providers and between agencies. In Texas, the mental health and juvenile justice systems integrated funding so as to provide MST teams and therapeutic foster care. Since every geographic area has a school, a few states are providing mental health services in the school. In both Arkansas and Mississippi, Medicaid allows for offsite interventions including the use of satellite offices.

3. Strategies Related to Recovery

The manner in which states promote recovery ranges from tangible approaches to more conceptual ones. Tangible examples include the provision of specific EBPs (e.g., Illness Management and Recovery, Journey of Hope, peer-oriented Integrated Dual Diagnosis Treatment), contractual requirements, consumer-centered planning and training, consumer involvement in planning on state and local levels, and the development of a recovery based decision-making tool. Several states are implementing WRAP. Approaches that are more conceptual are common in states reporting that they promote recovery principles through inclusion in work plans, sharing the principles with providers,

and having a consumer affairs director committed to recovery. A few states stated that EBPs, in themselves, promote recovery.

A few highlights of state strategies include:

- Promoting recovery through contractual agreements with requirements for consumers to be involved in treatment planning; use of the MHSIP survey and outcomes of housing, employment, and self-agency. Providers receive monetary rewards for favorable outcomes.
- Redesigning the underlying principles of the current mental health system as a service purveyor that disengages when the consumer is stabilized to one that provides support to the people based on their own desires and needs and follows the person throughout for continued support.
- Recovery coach (either consumer or professional) who assists the consumer in developing a recovery plan and helps guide the consumer through services to enact the plan.

E. Facilitators and Challenges/Needs

The next section summarizes frequently mentioned factors that facilitate EBP implementation and those that continue to pose barriers that need to be overcome.

1. Facilitators

Beyond the obvious need for funding and resources, the basic ability for cooperation and collaboration between states and providers is essential. Consensus building, education, and social marketing are a few strategies that were consistently mentioned as facilitators.

Others included:

- Funding and grant opportunities
- All stakeholders acknowledging a shared problem and need to work together to address community needs
- Long term relationships with providers
- Providing incentives to providers
- Trainer credibility and using experts that developed EBPs for training and technical assistance
- High project visibility
- Leadership removing barriers
- State information-sharing

2. Challenges/Needs

The need to change state infrastructure and funding mechanism point to a larger and more complicated issue that involves many organizations beyond the state MHA and local providers.

- Entrenchment of the office-based approach to treatment that is reinforced by the funding system (Medicaid) that does not allow for full funding of all EBP program components.
- Provider lack of information about the effectiveness of EBPs and what is needed for implementation
- Provider agencies are different in their staff composition (part time/full time, education levels, turnover) and the services they provide, thus making it difficult for a universal implementation and training strategy.
- Training is intensive, but providers have trouble sending staff to three day training because they lose billable hours.
- Need universities to change their curriculum to include EBPs.
- No system in place to measure fidelity, and at provider level a lack of understanding why fidelity measurement is important.
- Having the resources to bring the program statewide
- Need for coordination among all state agencies and local providers involved, for example, in the provision of children services (juvenile justice, mental health, child welfare, education). Part of the coordination is building common values and philosophies for consistency and deciding who will control what
- Federal barriers to blending funding streams and similar grants coming from different federal agencies.

3. EBP-Specific Challenges

States reported that many EBPs have unique challenges, such as the following:

Assertive Community Treatment – Funding to cover the expense of start-up and the cost of maintaining the staff to client ratio; psychiatrist shortages; difficulties in adhering to fidelity, and the nuances in adhering "somewhat" to adhering "closely".

Supported Employment - Some employment providers are not used to working with mental health clients and are not familiar with supported employment concept; stigma in the community; problems arranging for Medicaid coverage.

Family Psychoeducation – Challenges in implementing the EBP model of family psychoeducation model when other family education/support programs are available that tend to be implemented by NAMI with local expertise and assistance.

Integrated Dual Disorder Treatment - Coordination and collaboration of two systems with two different funding streams and philosophies, and low level of accountability regarding who will take the lead and blend the services together.

When the two systems are integrated, the mergers can cause job loss, larger caseloads, and budget cuts.

Medication Management – Difficulties in integrating public sector program with private pharmaceutical companies for a long list of medications; challenges in changing physician behavior.

Multisystemic Treatment – Cost for initial start up, and sustaining training, supervision to adhere to model fidelity; arranging for Medicaid coverage of the clinical supervision component.

Wraparound - Many states that are using their System of Care grants to start wraparound programs are not sure how they will sustain or take statewide after federal grant is over.

IV. Summary

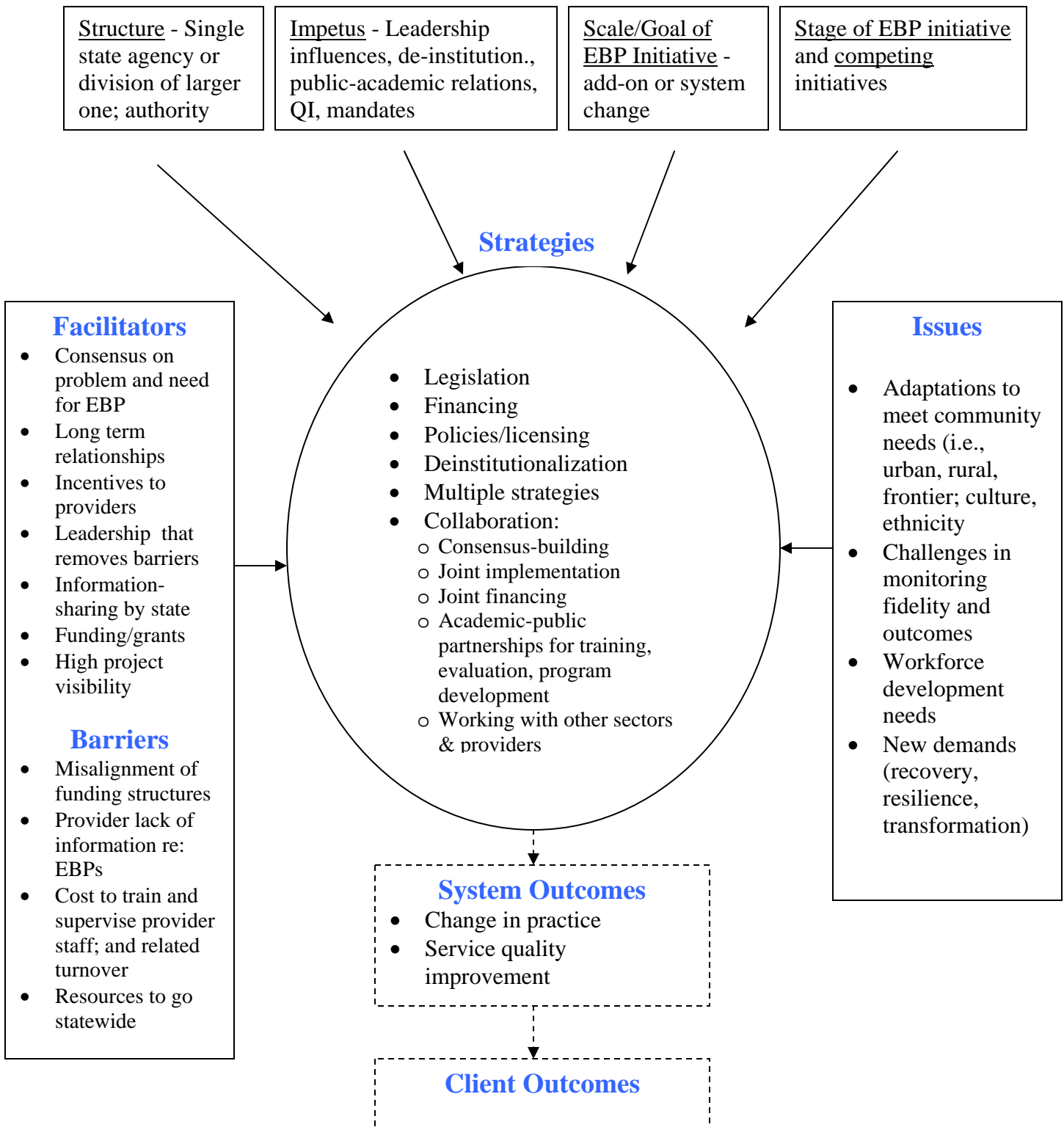
State directors of adult (n= 48) and child (n=44) mental health services were interviewed by telephone to learn about the strategies used by State Mental Health Agencies to incorporate and sustain evidence-based practices into their existing service arrays. This qualitative survey allowed for a broad-brush assessment of state EBP and promising practice implementation scope, strategies, and challenges. It is important to mention that because of the variation in state mental health agency structures and reporting criteria, the mental health authorities may not know every EBP being planned, piloted, or offered (especially clinical ones) in their states. Therefore, the frequency and types of practices reported here are most likely lower than if we also included county-level mental health authorities.

Survey results showed that most states are still in the implementation phase, versus dissemination. SMHAs are exploring, trying out, and developing methods to integrate EBPs into their own unique current service systems and make the necessary adaptations to infrastructure to accommodate the new practices. However, several states are out in front leading the way. Many of these were supported initially by the SAMHSA-funded National EBP Demonstration project.

Figure 1 illustrates some of the major points that emerged from the analysis of the qualitative data. The four boxes at the top of the table, labeled as *situational*, refer to the particular circumstances in which an effort to implement/integrate EBPs is embedded. Situational factors were described as affecting an agency's ability to make changes in their systems and in the selection of the strategies used to affect change. For example, if the **structure** of the SMHA sponsoring an EBP initiative is a single state agency, it may be easier to institute the organizational adaptations (i.e., training, staff assignments, funding structures, etc.) needed to accommodate an EBP, than if the EBP initiative is situated in a larger multi-division agency with more complex bureaucratic layers. SMHAs with greater authority over regional and local mental health providers, and those with greater structural/functional connections to the State Medicaid agency might encounter less barriers to instituting change in practices.

Figure 1. Key Findings: SMHA Directors' Perceptions of EBP Implementation Strategies

Situational Factors



States reported that the **impetus** to implement evidence-based practices came from varying sources, including charismatic leadership, the pressing need to de-institutionalize their service systems and hasten the development of community-based treatment, opportunities presented by historic linkages between the SMHA and universities/colleges, over-arching quality improvement initiatives which embrace evidence-based practice as a cornerstone, and finally through legislative or other policy mandates.

The **scale** and **goals** of an EBP initiative appear to be critical influences on the service system. Are EBPs rolled out slowly, one at a time, with a goal to incrementally add the new approach to the existing system? Or, is the goal to transform the system by strategically installing a group of EBPs in a multi-pronged approach (e.g., New York, Ohio, Connecticut).

States in more mature **stages** of implementation were more likely to try out innovative strategies to realign policies and procedures consistent with evidence-based practices, and to integrate their EBP initiative with **other competing initiatives**. Greater experience in implementing evidence-based interventions also stimulated the expressed need to introduce more holistic evidence-based approaches in assessing clients, selecting the most appropriate interventions, and monitoring outcomes.

The figure shows arrows extending from the situational factors to the strategies, illustrating that the various situational factors could shape the selection of implementation strategies. The body of the survey report presented here described the various **strategies** used by states to incorporate EBPs into their service systems. Typically multiple strategies were used, often to correspond to the various stages of the initiative (e.g., early stage - marketing and consensus building; later stage - adding contractual requirements for providers to use EBPs in their service arrays). Collaboration was both a strategy in itself and a mechanism for developing strategies. As reported, collaboration among the SMHA, regional and local providers, consumers and families, other service sectors, higher education, advocates, funders, and other stakeholders was used, for example, to create consensus in planning EBP development, in joint implementation/evaluation projects, in financing EBPs, and in academic-public partnerships for training and intervention research. Figure 1 also summarizes some of the main **facilitators** of and **barriers** to implementation and dissemination. Additionally, there are numerous **issues** surrounding EBP implementation, including the need to adapt EBPs for different community contexts and cultures, how to incorporate new procedures for monitoring fidelity and outcomes, how to build a new workforce with different skills, and emerging demands such as refocusing from illness management to recovery, and from managing mental health systems to transforming mental health systems.

Also shown in the figure with dotted lines are the projected **outcomes** of using EBPs: changing practice, increasing the quality of treatment and services, and client improvement/recovery. These areas were not directly assessed in this exploratory qualitative survey, though we did ask about their methods for measuring client outcomes. Achieving these types of outcomes was clearly the ultimate aim of EBP initiatives. However, results showed that most states are not routinely collecting such information for the purpose of monitoring the on-going effectiveness of EBPs. They conduct formal evaluations during the demonstration phase of implementation, but not typically beyond that. A few states did report that they are developing management information systems that will allow them to associate services received and client outcomes.

Our next step is to conduct more focused, in-depth studies in states where successful strategies are being implemented so these can be documented and disseminated for other states and

localities to learn from. In addition, a more quantitative survey will be developed, using the constructs that emerged from the interviews, so that we can measure change in state-level EBP implementation processes, strategies, and system outcomes over time.

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