

Quality and Accountability: An Agenda for Public Mental Health Systems

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INTRODUCTION

The six aims of the Institute of Medicine's *Crossing the Quality Chasm* report – making healthcare more safe, effective, patient-centered, timely, efficient and equitable – are consistent with both the values and priorities identified by public mental health systems. These aims are reflected in strategic plans and performance measurement systems (e.g., the NASMHPD President's Framework for Performance Indicators and Outcomes Measures, and the Mental Health Statistical Improvement Program (MHSIP) Consumer-Oriented Mental Health Report Card). As a result of such priorities, great strides have been made in identifying and promulgating effective practices and in implementing systems to monitor and improve the quality of care for persons with mental illness.

In many ways, the National Association of State Mental Health Program Directors (NASMHPD), the organization representing the state mental health authorities in the 50 states, the District of Columbia, and the territories, has been at the forefront, providing leadership in the areas of recovery-oriented systems of individualized care, evidence-based practices, seclusion and restraint reduction, performance measurement for quality improvement, and cultural competency. State mental health commissioners have identified quality and accountability and the implementation of evidence-based practices as the next “wave” of activity in the public mental health arena. (This would be the third wave, with the first being the development of state mental hospitals and the second being the development of community mental health systems.) Building on the states' community-based infrastructure over the past two or three decades and the availability of proven new technologies and interventions, we are seeing an emphasis not only on the *context* of care, but also on the *content* of care and the need to consider both simultaneously. Addressing structural issues without consideration of factors that influence the quality of clinical care and service provision results in inadequate implementation. Attention must be given to both what happens between the provider and the recipient of care and the systemic supports that are available to facilitate the appropriateness and quality of this interaction. To advance this perspective, the state mental health commissioners are promoting an approach that is outcomes-based and built on the three pillars of evidence-based practices, performance measurement and quality improvement. In other words: do what works best, collect data, use that data to monitor what does and does not work, and apply a systemic approach to address the system's gaps and deficiencies.

Built on this framework, this paper first summarizes the current activities in the areas of evidence-based practices and performance measurement and makes recommendations for advancing them so they can contribute more meaningfully to systems change. Recognizing that to be effective such activities must be linked and integrated into an overall quality and accountability agenda, this paper also addresses the broader issue of

systems transformation within which these more specific activities are ensconced and makes recommendations for activities to start this effort as well.

EVIDENCE-BASED PRACTICES: STATUS AND RECOMMENDATIONS

Environmental Scan

Increasingly, evidence-based practices (EBPs) are becoming part of the mental health landscape. As issues related to quality of care and systems accountability receive more emphasis, the inherent effectiveness of evidence-based practices is attractive to policymakers and purchasers of services. This trend in mental health parallels and follows a similar trend in general health where there is increasing emphasis on evidence-based healthcare. As in general health, the mental health field has embraced disease management approaches (e.g., the schizophrenia PORT, the HRSA Disparities Initiative on Depression, etc.) and evidence-based program interventions (e.g., Assertive Community Treatment (ACT) and supported employment). *The Surgeon General's Report on Mental Health* (1999) provided a major impetus to EBP dissemination and, combined with the National EBP Demonstration Project (also known as the Dartmouth "Toolkit" Project), resulted in an emphasis on the promotion and dissemination of specific evidence-based practices. The model of the future mental health system envisioned by NASMHPD and the NASMHPD Research Institute (NRI) that focuses on quality and accountability (with performance measurement, EBPs and quality improvement as key components) supports this trend. More recently, this trend has been reinforced by the recommendations of *The President's New Freedom Commission Report* (2003) and through several grant initiatives developed by the federal Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Mental Health Services (CMHS).

Despite the momentum building around EBPs, current approaches are limited in scope, both in terms of consumer access to them and outcomes. Even the six implementation resource toolkits developed by CMHS for ACT, Supported Employment, Family Psycho-Education, Integrated Treatment for Persons with Mental Illness and Substance Abuse Disorders, Illness Management and Recovery, and Medication Management have relatively low prevalence. For example, most states do not yet implement any of these EBPs on a statewide basis. Moreover, current estimates suggest that fewer than five percent of persons served in the public mental health system have receive evidence-based practices (using the definition of EBPs at the highest level of fidelity).

Of course, the lack of resources to promote and implement EBPs is an important factor. The number of states receiving support from SAMHSA to implement EBPs for adults is limited (less than 25% of all states and territories). There is even less support for children's EBPs, although new system-of-care grantees are being required to include an evidence-based practice in the array of services being offered. But even with minimal funding, states have moved forward with EBP implementation, mostly through

demonstration pilots. Based on these pilots, some have managed to go statewide. Furthermore, states are investing in interventions that have less evidence to support their effectiveness, but are considered promising by providers, consumers and advocates.

While priority is being given to the implementation and dissemination of EBPs (such as the SAMHSA six), their fit within the larger array of services has not been well defined or articulated. This is especially true in terms of objectives of mental health systems related to recovery and resilience. Evidence-based practices can clearly play a role in helping mental health systems achieve this task, but they cannot achieve this goal on their own. A range of other services – “promising” or “emerging” practices – are needed to achieve the range of goals consonant with recovery and resilience. These services are considered beneficial by both consumers and providers, even though they are not scientifically proven by randomized control trials. Even as the science related to promising and emerging practices is developed, there is a great need to implement them in an optimal and most cost-efficient way. The need for such an approach is especially important now, given the budget cuts that states are experiencing.

SAMHSA INITIATIVES

SAMHSA has four major initiatives related to mental health EBPs:

1. The National EBP Demonstration Project, through which SAMHSA's toolkits for six EBPs are being tested and refined in eight states (described in greater detail below).
2. The State EBP Training and Evaluation grants, through which states (some overlapping those in the National Demonstration project) received three-year grants to implement and evaluate at least one toolkit.
3. The NIMH-CMHS EBP Planning Grants, which were for states to start the EBP implementation planning process, and
4. NRI's Center for Mental Health Quality and Accountability (CMHQA), to promote the development and dissemination of EBPs.

The SAMHSA 8-State National EBP Demonstration Project

This project was a major initiative at the New Hampshire-Dartmouth Psychiatric Research Center and supported by SAMHSA’s Center for Mental Health Services and resulted in the construction of “toolkits” (implementation intervention packages consisting of manuals, videotapes, and other implementation support materials) for six EBPs: Supported Employment; Illness Self Management; Family Psycho-Education; Medications; Assertive Community Treatment; and Integrated Treatment For Persons With Co-Occurring Mental Health And Substance Abuse Disorders. For each EBP, there are toolkit components directed to the state mental health authority, the provider organization, the clinician or service provider, the consumer, and the family member. The toolkits are currently being tested in eight states (Indiana, Kansas, Maryland, New Hampshire, New York, Ohio, Oregon and Vermont). These packages are being tested and

refined in the multi-state initiative so that the final versions can be used to address implementation issues at each of the relevant levels.

This new approach is a fundamental shift from previous models of implementing innovative practices in mental health systems. The approach recognizes that the individual clinician's or service provider's willingness, knowledge, and skills alone will not result in broad-based implementation of EBPs. It also recognizes that structural arrangements and changes in policies, regulations, administrative procedures, and financing are also insufficient. These two levels, combined with consumer and family member education and choice, must be addressed for sustained uptake.

State Initiatives

Besides the SAMHSA-supported specific EBP initiatives, many states have implemented their own EBP initiatives. In some states, such as Ohio and New York, which are participating in the toolkit project, these initiatives are much wider in scope than what is required by the parameters of the toolkit project. For example, Ohio has established Centers of Excellence for several EBPs to promote statewide implementation. Similarly, New York has implemented a statewide consensus-building initiative and has developed EBP-related standards for several practices. Other states such as Connecticut, South Carolina, Wyoming and Texas, have embarked on EBP initiatives without federal support. Some states such as Oregon are required by state law to implement EBPs with the proportion of funding devoted to EBPs increasing over time.

Based on meetings and surveys conducted by CMHQA, the next sections identify priorities and recommendations for moving the EBP agenda forward.

PRIORITIES IDENTIFIED BY STATE MENTAL HEALTH COMMISSIONERS FOR IMPLEMENTATION OF EVIDENCE-BASED PRACTICES

The state mental health agencies have recently identified some key areas that are critical to EBP implementation:

- *Information/Communication Networks.* Establish a central location where states could get the latest research related to EBPs and lessons learned from states' experiences with specific EBPs.
- *Consensus Building.* Create models and materials to develop consensus related to EBP implementation and address stakeholder concerns. Consensus building also involves developing a common understanding of EBP implementation and educating legislators, funders, other state agencies, and provider organizations.
- *Infrastructure Readiness.* Assess the readiness of the system to implement EBPs, including training, information systems, staffing and resource base.
- *Ongoing State Training.* Given high levels of staff turnover in most state and local mental health systems, develop an ongoing training capacity (rather than, as

is often the case, a one-time training initiative when a service is first implemented, with inadequate follow-up).

- *Planning/Budgeting Models.* Develop EPB budgets that would include appropriate target populations, start-up and transition costs, and services that may be replaced.
- *Fidelity Measurements/Monitoring.* Create models for measuring and monitoring fidelity, and how these could be incorporated in quality improvement mechanisms.

EBPs: Recommendations

1. **There is a need to expand the evidence base to include the wider array of services that consumers, family members and providers consider effective. The evidence base for *implementing* EBPs also needs to be developed.**

Recommendation: The science-to-service agenda must be put on an accelerated, high priority schedule. Both NIMH and SAMHSA should collaborate to develop a larger range of evidence-based practices that address the recovery/resilience agenda identified in the New Freedom Commission report. (At this stage, not all the interventions identified will have the highest levels of evidence.) At the same time, mechanisms to support services-to-science initiatives need to be developed and promoted. The experiential lessons learned need to be studied more rigorously and put on a more unambiguous scientific footing.

2. **There is no national consensus on the definition of an evidence-based practice.**

A consensus of definition of EBP – as well as promising and emerging practices – is critical to make advances in the field. Both misconceptions and apprehensions abound. This makes the topic of evidence-based practices contentious.

Recommendation: SAMHSA should convene key stakeholders (e.g., advocates, consumers, and researchers (for both children and adults) to establish necessary guidelines and criteria for EBPs.

3. **States implementing or planning to implement EBPs need technical assistance and support for these initiatives.**

Recommendation: As with the Data Infrastructure Grants, SAMHSA should develop an EBP Implementation Support Grant to help all 50 states advance their EBP initiatives.

Recommendation: The Mental Health Block Grant should explicitly be directed to promote the implementation of EBPs and other promising and emerging practices.

4. The “fit” of EBPs in the larger array of services is not clear.

While EBPs are being promoted, there are fears that this might be at the expense of promising practices that address key goals related to recovery and resilience. This is a point made by both consumers and managers. It is important to establish how EBPs will augment the current array and how they might substitute for existing services being provided.

Recommendation: Explicit models need to be developed so that it is clear which EBPs are needed to produce defined outcomes for specific populations. These models should address how to use EBPs as an effective tool *within a mental health system*, not just by themselves. Another important aspect of these models is that they should address how EBPs fit in individualized service plans and relate to high quality assessments and treatment plan approaches.

5. Access to EBPs and the development of EBPs for children/adolescents are high priority needs.

While several EBPs exist for children/adolescents, they apply largely to small, specific subsets of children with SED. Specific EBP treatments have also been identified which are being promoted through the system-of-care projects. At a recent meeting on Children’s EBPs convened by NRI’s Center for Mental Health Quality and Accountability (CMHQA), the major need identified was for the promotion of an EBP culture to develop, implement, and sustain EBPs. Specific content areas were developed for family members/adolescents, providers and administrators.

Recommendation: SAMHSA should continue to develop and disseminate materials supporting EBP implementation for children/adolescents.

6. There is a need to define, monitor and refine the relationship of EBPs to recovery and cultural competence.

Recommendation: The IOM Report should develop a statement about these relationships which could support and guide state activities in these areas.

Recommendation: SAMHSA and NIMH should support preliminary studies and research on relationships among EBPs, recovery and cultural competence.

7. Planning and financing models and strategies are needed to justify and incorporate EBPs into service systems.

Recommendation: SAMHSA should work with CMS to develop guidelines for financing EBPs and strategies that encourage their implementation.

Recommendation: SAMHSA should develop user-friendly information related to the benefits and cost-effectiveness of implementing EBPs so that this can be used by state mental health agencies and other organizations in budget requests and justifications for incorporating EBPs in their systems.

PERFORMANCE MEASURES: STATUS AND RECOMMENDATIONS

Environmental Scan

Evidence-based decision-making was identified a “rule” in the *Crossing the Quality Chasm Report* and the previous section has attempted to reflect specific activities that need to be undertaken to address this area for mental health systems. An important component of “evidence-based decision-making” is the availability of data and performance measures in a timely and user-friendly fashion so that necessary adjustments and modifications can be made. The IOM Report also identified the incorporation of performance and outcome measurements as a challenge that needs a more focused and innovative approach. This section identifies specific issues and activities that apply to the development and implementation of performance and outcome measures for the mental health field.

Over the last ten years, mental health performance measurement has made tremendous strides. Accreditation agencies such as the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) have implemented performance measurement systems that explicitly include a behavioral health component. Several organizations such as the Institute of Medicine and the American College of Mental Health Administrators (ACMHA) have proposed performance indicators for mental health, although these have neither been defined as measures nor have they been implemented.

Progress in the public mental health system, largely supported by SAMHSA’s Center for Mental Health Services, has been the most enduring. The MHSIP Consumer-Oriented Report Card performance measures had a major impact on state performance measurement systems. Built on the MHSIP work, the NASMHPD Framework of Performance Measures both extended and refined the MHSIP measures. Subsequently, the NASMHPD Framework was the basis of the federally-sponsored five-state feasibility study and the sixteen-state performance indicator project. These projects, in turn, shaped the current Block Grant reporting tables and the objectives of the state data infrastructure grants. The NRI Behavioral Healthcare Performance Measurement System for state hospitals (developed to meet JCAHO requirements) is also a major achievement, in terms of its comprehensive coverage, its standardization of definitions, and its quality improvement reports both for the public mental health system and for pilot work with private psychiatric hospitals.

Many lessons have been learned through these various implementation efforts and each initiative has built and refined its measures using the experiences of the previous ones. More recently, the *MHSIP Quality Report* (which updates the MHSIP Consumer-Oriented Report Card and NASMHPD Framework) offers measures related to recovery and cultural competence, and is the latest iteration of this progress.

There is consensus and remarkable consistency across jurisdictions and stakeholders regarding the outcomes that mental health systems and services are intended to achieve: improved functioning; reduction in symptom distress; building social supports; community participation; improvement in work or, in the case of children and adolescents, school performance or age-appropriate functioning; reduced hospitalization; well-being and positive health; and decreased contact with criminal and juvenile justice systems. Over the past few years, states, with only modest federal support, have worked to develop performance measurement systems along these lines. A handful of states – Ohio, Texas, Colorado, Washington, and Oklahoma among them – have implemented systems to obtain these data on a statewide basis, but the majority of states are currently in the process of building such systems.

But implementing these systems is not just a matter of administrative fiat or will. Identifying and implementing measures for uses such as planning, budgeting, monitoring, and quality improvement is enormously complex, expensive, and labor intensive. Resources are necessary to update or, in some cases, create information technology systems that would enable states and counties to collect, access, link, and analyze the relevant data. Investing in infrastructure at a time when budgets are being slashed and public mental health systems are already failing to provide needed services and supports can be problematic for states. Training administrators, planners, and clinicians to make optimal use of these new performance measurement systems is also lacking.

This suggests the critical role that the federal government must play in helping to enhance and expand performance measurement systems: first, in consultation with stakeholders, toward developing meaningful measures and definitions; second, ensuring the dissemination and implementation of these measures; and third, funding states and counties that are creating performance and outcome measurement systems, particularly to the extent the measures are federally mandated and designed to present a national picture. To date, the federal commitment has been minimal, with states receiving grants of between \$100,000 and \$150,000 per year to move billion-dollar systems. To be sure, SAMHSA and the states, through changes to the mental health block grant program, are making progress by placing greater emphasis on performance and outcome measures, but SAMHSA must be sure that the data it is requiring the states to report are of value not only to the federal government, but also to the states and counties in planning, quality improvement, and contracts management.

Major issues that still confront mental health performance measurement include: standardization, appropriate benchmarks, the identification of performance measures for particular uses, such as planning, program monitoring and quality improvement, and outcomes measures that are both appropriate and easy to implement. In summary, while worthwhile advances have occurred, there are several critical areas that remain to be

addressed, such as the lack of research related to performance measures. We know very little about whether performance measures reflect the reality of systems adequately or whether specific measures are monitoring the concern they are intended to represent in an optimal fashion.

Federal Initiatives

The MHSIP and NASMHPD, and numerous other performance measurement initiatives and attempts to standardize measures across states have all occurred with federal support from SAMHSA (though, as pointed out below, these federal initiatives have leveraged far greater investments by the states to develop coherent performance measurement systems).

With the introduction of the Data Infrastructure Grant (DIG) program in 2001, the federal orientation to state performance measurement systems development underwent a subtle shift. Previously, performance measurement initiatives were focused on developing systems that reflected the *states'* needs and priorities. These efforts, however, had limited value at the federal level because the data did not result easily in aggregation at the national level, making it difficult to produce national reports to Congress.

The DIG program was an attempt to address this gap. For this purpose, elaborate data tables with considerable detail were developed. These included *basic* tables (that a majority of states could report) and *developmental* tables (that addressed measures for which there was a lack of clear operational definition and which most states at the time could not report). This initiative is currently in its last year and many of the operational issues persist and have not yet been resolved. Recently, a new DIG grant has been announced which emphasizes and requires reporting on these data tables with an additional component of support to the local level.

State Initiatives

Often, with federal support as an impetus, state mental health agencies have developed performance measurement systems which they are using for planning/budgeting, legislative reporting, contracting, Medicaid managed care, state hospital operations, and quality improvement. Many of the state systems have incorporated outcomes measures proposed in the NASMHPD Framework.

However, with budget shortfalls, many of these performance measurement systems have been eroded. For example, the exemplary system developed by Virginia has been largely dismantled. Other states are curtailing the frequency of reporting and surveys. As a result, many states are focusing their efforts on data collection and reporting of the measures in the DIG tables. Increasingly, states are turning to sample survey methodologies to obtain outcomes measures rather than obtaining these on a system-wide, person-to-person basis. As this tendency grows, the utility of these measures for internal state purposes could decline.

At the same time, several states are moving forward with initiatives related to evidence-based practices, recovery/resilience, cultural competence and integration with

general health systems, and collaboration on mental health initiatives with other state agencies. However, as these are not the primary emphasis of federal support, this places an additional onus on the states to fund and support these separate initiatives.

Performance Measures: Recommendations

1. **There is a need for standardized mental health performance and outcomes measures that are in the public domain and reflect public values.**

A multiplicity of approaches and measures are currently being used in the public sector to measure the same constructs. Even though there has been considerable progress in standardization efforts coordinated by the Center for Mental Health Services – through the Performance Measurement Forum, the 16-state performance indicator feasibility study, the MHSIP Consumer-Oriented Report Card and the more recent Data Infrastructure Grant – this continues to be an ongoing problem. While there is convergence on the areas that need to be monitored, the actual measures and the methodologies for their measurement remain diverse. This creates issues related to both the credibility and the comparability of mental health performance measures.

Accreditation agencies such as the National Committee on Quality Assurance (NCQA) have made progress on the standardization front but have been able to do so for a relatively limited number of indicators that do not adequately cover the range of concerns that need to be monitored. In general, the successes in standardization have occurred where the application is limited to similar organizations that have comparable mandates. The implementation of standardized measures across populations and/or settings has been limited. An inherent danger in the push for standardization is the adoption of the least common denominator where what is standardized is determined by the ease of reporting rather than the validity and reliability of the measure.

The lack of standardization is especially true in the areas of outcomes measures. Standardized clinical symptoms and functioning measures are being used but there are no instruments that definitively reflect the outcomes that mental health systems are intended to achieve.

Recommendation: SAMHSA/CMHS should develop and validate standardized measures that can be related to the key concerns and constructs being monitored by performance measurement systems. If multiple measures (or methodologies) are being used, the equivalences among them should be defined.

Recommendation: NASMHPD/NRI and SAMHSA/CMHS should jointly coordinate the development of outcomes instrumentation for adults and children and adolescents to reflect public sector values and priorities.

2. **There is a need for performance measures (and the data collected for performance measures) to be developed for use by a multiplicity of stakeholders including consumers, family members and providers of care.**

Performance measures have largely been used for accountability purposes (that is, to report to funders and purchasers of care) and to a lesser degree for quality improvement purposes at the organizational level. A major impediment to the use of performance measures is that the performance measurement enterprise has not been perceived as helping or supporting clinicians and case managers providing the data for the performance measures. In fact, providing such data has often been viewed as a burden and as impeding the delivery of services. As one proceeds with inculcating “evidence-based decision-making,” a critical aspect using data and measurement to support consumers and family members in their decision-making and providers in the delivery of appropriate and timely care.

The implication is that defining performance measures and implementing systems to collect the needed data are not enough. Performance measurement and outcomes systems must be implemented so that their advantages are realized and perceived by all parties involved. A mechanism for this is to marry performance measurement systems to Web-based systems and new technologies so that the needs of a multiplicity of audiences can be addressed in a timely and useful manner. (An important aspect of this is to be able to provide feedback to consumers, family members, clinicians and other providers of care so that outcomes can be monitored and adjustments and modifications be made, if needed.)

Recommendation: Technologies should be developed so that performance measures are integrated in a supportive and timely fashion into the delivery of care.

Recommendation: Appropriate training and education materials should be developed to support consumers and family members and providers of care in the value and uses of performance and outcomes measures.

3. **There is a need to develop an evidence base related to the validity, use and implementation of mental health performance measures.**

Recommendation: NASMHPD/NRI, SAMHSA and NIMH should jointly develop a multi-year program to develop the “science” related to

performance measures instrumentation, definitions, validation, implementation and use (e.g., planning, monitoring and improving care).

4. **In federal initiatives related to performance measures, an appropriate balance is needed to support both state and federal priorities in performance measurement activities.**

While there is convergence in priorities related to performance indicators across both state and federal initiatives, federal support for such initiatives have shifted to emphasize federal needs. A federal program which could perhaps serve as a model of a partnership in PM implementation is the Maternal and Child Healthcare Block Grant program where clear guidelines and operational definitions were developed by the federal program, states participated on a “volunteer” basis and considerable federal support was devoted to technical assistance to enhance state capacities for reporting and addressing state needs. The program included both federally proposed outcomes and state-specific outcomes. The federal programs also supported the development of journal articles and publications by states.

Also, current federal initiatives do not reflect the Commission’s priorities related to recovery, resilience and cultural competence adequately. These are increasingly priorities for consumers, family members and states. Initiatives such as the MHSIP Quality Report that incorporate measures related to such priorities should be put on a fast track.

Recommendation: NASMHPD/NRI should work jointly with SAMHSA/CMHS to develop a five-year strategic plan for the development and refinement of performance measures, reporting requirements and mechanisms to support and provide technical assistance for individual state initiatives. The *use* of measures must be emphasized. A major aspect should be identifying the minimal set needed for federal reporting.

Recommendation: NASMHPD/NRI should work with SAMHSA/CMHS to develop, define, and test performance measures related to Commission priorities. One mechanism is to explicitly endorse and support the MHSIP Quality Report Initiative which will be proposing and testing performance measures for different populations and settings, and will include measures related to recovery, cultural competence, and revised versions of the MHSIP surveys, including those for children/adolescents.

SYSTEMS TRANSFORMATION: NEEDS AND RECOMMENDATIONS

The previous sections have focused on evidence-based practices and performance measurement as essential requisites for the transformation of mental health systems so that they can be learning organizations moving forward with a quality and accountability agenda. However, one of the lessons learned from the various initiatives is that singular activities related to evidence-based practices and performance measures work optimally when ensconced within adequate systemic context. In fact, without such systemic readiness, the broad, sustained uptake of either evidence-based practices or performance measurement systems is unlikely. Some factors that have been identified as critical to the successful implementation of evidence-based practices and performance measures are:

Consensus Building. Inconsistencies in perspectives and associated apprehensions have undermined many potentially worthwhile initiatives. Fundamental to the sustained, ongoing incorporation of innovation, whether programmatic or administrative, is the need for both perceived advantage and buy-in by all the relevant stakeholders, including consumers, family members, providers, funders/purchasers of services and policymakers.

While everyone recognizes this as an important need, the mechanisms and models for such consensus building are lacking.

Infrastructure Readiness. Critical aspects related to system transformation is the condition of the infrastructure including training mechanisms, information systems development and the organizational culture that embraces change and innovation. Instruments to assess the readiness of systems in these areas are needed. Without such assessment and adequate preparation, initiatives related to EBPs and performance measures have a greater likelihood of failing.

There are examples scattered throughout the country on how some of these aspects have been addressed but there is no systematic national impetus to move these areas forward within the mental health field.

Interagency Collaboration. Although SAMHSA and state mental health authorities must be looked to for their leadership at this time, it should be noted that the resources they control are dwarfed by the myriad programs and supports that serve adults and children with mental disorders in other systems, such as criminal justice, housing, Medicaid, Medicare, child welfare, vocational rehabilitation, special education, and SSI and SSDI. Transforming mental health systems will require broad changes in social services. If SAMHSA and state mental health authorities are to be tasked with promoting recovery and resilience, then they must be able to work collaboratively with all of the other systems and agencies whose policies affect consumers and their families.

In short, focusing on SAMHSA and the state mental health agencies and requiring reporting of performance measures in their programs, without at the same time

looking to the performance of other programs will merely perpetuate the fragmentation in the public mental health system and do little to advance the goals of the Commission or address the aims of the IOM Report. If we are serious about recovery and about improving the outcomes for adults and children with mental disorders in all systems, we must implement processes that encourage collaboration and consistency across these systems.

Systems-Level and Programmatic Leadership. This is key to many of the changes being proposed but, with the aging of the current workforce and the inability to support a coherent approach to workforce development, there is potentially going to be a greater need in this area. Clearly, workforce development initiatives are in the process of being developed and recommended but these are long-term solutions. In the short run, training programs and self-assessment capabilities should be promoted to address needs in this area.

Alignment of Funding and Incentive Systems. Perverse incentives undermine the ability of systems to move forward with the needed changes to improve quality and accountability. Also, the planning and budgeting models that exist are not supported by adequate research related to the “business” case for quality or innovation.

Many of the presentations made to the IOM Committee on the adaptation of the *Crossing the Quality Chasm Report* to mental health and addictive disorders have addressed these areas adequately and in line with any recommendations this report would make. But as John Iglehart, the editor of *Healthcare Affairs*, puts it, “Quality is a complex, multidimensional issue that won’t necessarily be solved in piecemeal steps.” (Iglehart, 2003).

Unfortunately, we – as a field – are proceeding in piecemeal steps, addressing these different issues in different silos and under different auspices. The way these different activities are staged, managed and integrated to “transform” the system is not clear. Fortunately, there are models of change management from business that mental health systems are attempting to adopt for such transformation. These should be monitored and documented. More specific guidance in this area could be extremely helpful.

A second aspect related to these critical components is that there is a lack of data and well defined measures for these components. The focus of performance and outcomes measures has been on people receiving services and/or the services themselves. Measures related to leadership, the degree of consensus among key stakeholders, interagency collaboration, adequacy of information systems, and the adequacy of financing have not received the necessary attention. Data and measures in these areas are needed.

Finally, there are the areas for which there are no clear funding sources. For example, while everyone recognizes the need for ongoing training, funding streams for such activities are limited and rely more on ingenuity than on being an inherent integral part of mental health system operations. Similarly, funding for activities such as consensus-building, system readiness assessment, and leadership development are not

easily funded through the mechanisms that currently exist. Once again, these are areas in which the federal government can, and must, play a critical role. These are areas in which the federal government must provide not only leadership and guidance but also develop a programmatic agenda to ensure that quality and accountability are the expectation and not just a slogan or a vision in some plan or report.

Recommendation: The IOM Report should provide explicit models of change management and system transformation that define how the different recommended activities can be staged and integrated so that they result in systemic transformation rather than disjointed piecemeal activities and projects.

Recommendation: Instruments for monitoring key components such as the training infrastructure, leadership, adequacy of financing, adequacy of information systems, and consensus development should be developed and tested.

Recommendation: Funding streams to support the development of a quality and accountability infrastructure should be identified and implemented for public mental health systems.