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The Role of State Mental Health Authorities in Promoting Improved Client Outcomes through Evidence-Based Practice

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ABSTRACT: The role of state mental health authorities (SMHA) is critical to implementing and sustaining evidence-based practices. This paper describes the seven major tasks of SMHA's that comprise that role and provides examples from states which have been actively pursuing evidence-based practices.

KEY WORDS: mental health administration; evidence-based practice; mental health policy; state mental health authorities.

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The national movement to improve client outcomes through implementation of evidence-based practices in routine mental health settings continues to gain momentum (New Freedom Commission, 2003). The difficulty of the task is underscored by studies showing that most consumers with severe and persistent mental illness do not receive evidence based practice services (Lehman et al., 1998) and the poor record of system reform (Bickman, Guthrie, & Poster, 1999; Goldman, Morrissey, & Ridgely, 1994; Tessler & Goldman, 1982). While barriers have been identified at multiple levels of the service system, unsupportive mental health authority (state, local, federal) administrative practices and policies seem to be particularly important (Corrigan et al., 2001; Rosenheck, 2001). Goldman et al. (2001) identified the most prevalent as:

> lack of a long-term vision for the service system, lack of agreement on desired outcomes, lack of penalties for practices that are not evidence-based, short-term horizons for policy planning, political mandates on competing public-sector priorities, resource limitations, and uncertainty associated with change and untoward events (p. 1593).

This paper describes the seven major tasks of state mental health authorities in seeking to facilitate improved client outcomes through the implementation of evidence-based practices. The goal of any practice or policy should be to improve client outcomes, which refer to desired improvements in a client's life. Evidence-based practices are those interventions that have been shown to improve client outcomes through rigorous research conducted by multiple investigators, in multiple sites and with rigorous methods (McHugo & Drake, 2003).

The framework for the paper developed from the authors' four years of experience in the National Evidence-Based Practices Implementation Project. This project is investigating the factors and strategies relevant to implementing five EBP's in eight states. The five are supported employment, assertive community treatment, family psychoeducation, illness self-management and recovery, and integrated dual diagnosis treatment. Discussions among the participating commissioners of mental health and senior project researchers highlighted the critical role of state mental health authorities (SMHA) and the specific tasks that are facilitative of implementation. Seven task clusters emerged from those discussions although diverse strategies were used within each task cluster.

TASK 1: STRATEGIC PLANNING

Strategic planning is a set of procedures that help organizations and communities to align their priorities with changing conditions and new opportunities (Berman, 1998). Clarifying mission, goals and objectives is often an early step in the process. The State Mental Health Authority (SMHA) is in a unique position to articulate where the mental health system needs to go and that the implementation of evidence-based practices is not just an "add-on" to current service configurations but a part of the indispensable core of the system. Strategic planning also includes "awareness building among stakeholders, education about new quality initiatives, structured and clinical improvements that result in incorporation of quality measures into practice, and continual improvement and support that monitors quality measures while providing for continuous upgrading." (Carpinello, Rosenberg, Stone, Schwager, & Felton, 2002).

States have adopted one of two broad strategies. The first can be viewed as a marketing approach whereby interested providers can apply to be an evidence-based practice (EBP) site. Training, on-going consultations, fidelity reviews and often some modest financial incentive is offered. Providers apply by various means ranging from a formal "request for proposal" mechanism (e.g., Maryland, Oregon) to merely submitting a letter of interest and being interviewed (Kansas). At the early stages of states' efforts to implement EBPs, the use of "volunteers" who are often the more progressive providers and early adopters of many innovations helps establish the visibility and desirability of the EBP in the state and acts as a training resource for second generation adopters.

The second broad approach is regulatory whereby the state mandates the adoption of an EBP. For example, New York and Indiana established a statewide licensing/credentialing protocol for assertive community treatment programs (Carpinello et al., 2002; Moser, Deluca, Rollins, & Bond, in press). Most states are sequencing the two approaches whereby a marketing approach is used initially as a prelude to system-wide regulations and mandates.

In Oregon, the SMHA is in a unique position. In 2003, the Oregon legislature passed SB267, which requires the state to implement EBPs with increasing gradations of funding be allocated to EBPs each year. With this mandate in place, the SMHA is working with stakeholders to develop the elements and plans necessary for meeting the requirements of the legislation.

TASK 2: INVOLVE STAKEHOLDERS

One of the elements and purposes of strategic planning is to build support among often disparate individuals and organizations; to shape different points of view. Moving a service system towards evidence-based practices requires changes in current policy but efforts to alter policy occur in a turbulent environment of often conflicting interests and demands. Stakeholders include elected officials, provider agencies, employee unions and guild organizations, related state agencies or departments, universities, and the media. Consumers and families are particularly important. The Vermont SMHA used a full year for discussions among stakeholders to build consensus before implementing several EBPs. In Indiana, the trade organization for CMHC directors was initially opposed to the state's funding for ACT because center directors feared that ACT funding would reduce state funds allocated for general CMHC services. Lack of stakeholder involvement in the planning process and consequently a lack of stakeholder commitment to change led to some EBP sites in the National Project to drop-out of the effort.

Involving important constituencies in a variety of systems development and system operation activities has increasingly become the modus operandi of state mental health authorities. In the case of EBP implementation, the purpose of stakeholder involvement is to "rally interest and support for the evidence-based practice" (Torrey, Finnerty, Evans, & Wyzik, 2003, p. 886). Goldman and Azrin (2003) aver that "informed consumers and families make a powerful source of pressure for implementing EBP" (p. 980).

In the area of evidence-based practices, a common proposed strategy is creating state-wide task forces involving a variety of stakeholders in monitoring and setting the outcome benchmarks. Other proposed strategies target specific stakeholders group, for example, working with consumer and family groups to increase the demand for evidence-based services. As Carpinello et al. (2002) state: "The National Alliance for the Mentally Ill has demonstrated in many states that family-based advocacy can result in new programs and funding streams and has proved that it is possible to generate demand for evidence-based services and improved performance" (p. 155). Collaboration between the mental health authorities and the state department of vocational rehabilitation, in the case of supported employment, is considered critical (Dellario, 1985; Drake et al., 1998; Rogers, Anthony, & Danley, 1989).

Suggested strategies have included: co-sponsoring statewide conferences (Drake et al., 1998), combining funding streams (Becker, Torrey, Toscano, Wyzik, & Fox, 1998; McCarthy, Thompson, & Olsen, 1998), establishing common missions and goals, and jointly reviewing applications for EBP service funding. New York packaged multiple strategies in their EBP Awareness Campaign that sought to enlist champions across stakeholder groups. Commissioners of SMHA's often need the support of the governor and legislative leaders to pursue on EBP initiative. For example, the state of Texas has required that its SMHA only deliver a core of evidence-based interventions effective September 2004. Similar legislation passed last year in North Carolina.

TASK 3: FOCUSING ON OUTCOMES THAT CLIENTS VALUE

Recovery is more than controlling symptoms. It denotes developing a satisfying life beyond the mental health system (Ralph, in press). As Pat Deegan (1988) penned:

> The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution (p. 15).

While the goals of each individual are unique and nuanced, people with severe mental illness desire the same core outcomes (Rapp, 1998a, b):

1. to live independently in a place we call home,
2. to have a job that enhances our income, provides a means to make a contribution, offers a place to receive recognition,
3. to insure education whether for career enhancement or personal growth,
4. to avoid the spirit-breaking experiences of hospitalization, incarceration, homelessness, victimization and substance abuse.

The bedrock of policy makers efforts is the establishment and codification of client outcomes. They are the ends for which the service system is designed and for which consumers, providers and others work. "Achieving consistently positive outcomes is at the heart of EBP" (Goldman & Azrin, 2003, p. 901).

Client outcomes are the bottom-line for mental health, like profit is in business. No successful business person would assume that the business was profitable merely because the enterprise was producing a lot of widgets (e.g. cars, clothes) or employees were working hard. In mental health, process or productivity measures such as number of counseling sessions or number of clients served tell us very little (if anything) about the results on clients and their welfare.

This fact has led to a broad-based call for outcome measurement and management by outcomes. The Surgeon General's Report on Mental Health highlighted the important connection between incentives and outcomes: "Current practices often provide little incentive to improve quality... Outcome assessments...are particularly important in mental health area" (U.S. DHHS, 1999). The Quality Improvement System for Managed Care released by the Health Care Finance Authority in 1998 mandates that health care contractors report client-level outcomes in order to continue to receive federal funding. According to Hamilton (1997):

> ...assessments of process and structure are no longer enough; all managed care plans with Medicare or Medicaid contracts must demonstrate improvement in patient's health and functional status (p. 368).

In 2002, the National Association of State Mental Health Program Directors established an Office of Evidence-Based Practice. Goldman et al. (2001) stated that, "quality and accountability have become the watchwords of health and mental health service.....quality means positive outcomes obtained from using cost-effective services" (p. 1592). In fact, Chapin (2000) avers that the central challenge of human services financing is to "design reimbursement systems that support the policy and program goals [consumer outcomes] of a service system" (p. 201).

TASK 4: REGULATORY STANDARDS: DESIGN AND TASK SPECIFICATION

Program design and task specifications are the prescriptions that are most likely to lead to the specified client outcomes and the mechanisms by which policy makers promulgate them. Evidence-based practices are those with the best information on interventions that produce good outcomes. Therefore, they should be the focal point of these prescriptions.

Policy makers' have various methods at their disposal to promulgate these expectations including vision statements (Jacobson & Curtis,

2000), state-provider contracts, licensing regulations, design of RFP's and grant funding decisions, the use of quality improvement plans, varying publications (e.g., newsletters, press releases), and speeches and presentations. The next three tasks also serve as ways of promulgating and reinforcing the expectations.

A primary basis for these prescriptions are fidelity measures (Bond, Evans, Salyers, Williams, & Kim, 2000; Mowbray, Holder, Teague, & Bybee, 2003). Fidelity measures identify the active ingredients of each evidence-based practice and provide scales for measuring the degree of adherence. These measures can be used to establish clear standards, monitor programs over time, improve performance, and document the relationship between model adherence and outcome (Bond et al., 2000). In fact, systematic auditing of practices and providing feedback are influential in effecting practice changes (Thomson O'Brien et al., 2002). In many ways, they address the issue of quality of care that is prominent on the agenda of many stakeholders.

TASK 5: CREATE INCENTIVES AND DISINCENTIVES

The success or failure of many social policies resides in the incentive structure built into the policy (Rapp, 2002). At its most fundamental level, an incentive structure is comprised of the nature of the incentive (consequences) and the behavior or performance to be consequated. The power of incentives in business (Stajkovic & Luthans, 1997) and public administration (Osbourne & Gaebler, 1992) is well documented. A meta-analysis of the research on incentives in service organizations found that financial rewards produced a significantly stronger average effects than non-financial interventions (Stajkovic & Luthans, 1997).

The central challenge of policy makers is how to provide the most effective services and improve client outcomes within limited budgets. This needs to occur in a service system where few services are provided directly by the state but rather through a variety of reimbursement methods to private non-profit and for-profit providers. While the variations are extensive, the two current dominant methods are fee-for-service and managed care.

Imbedded in all reimbursement schemes are incentives and disincentives that greatly affect the behavior and performance of the providers that comprise the service system. For example, most fee-for-service arrangements encourage providers to increase the amount of service provided, especially those services that are reimbursed most

generously compared to cost. For example, the ubiquity of day treatment, despite limited evidence of its effectiveness, has been due to the relatively high Medicaid reimbursement rates in many states. In early managed care options, financial (dis)incentives led to a reduction of state hospitals and other forms of expensive care, under-serving some clients, and cost shifting to other entities (e.g., nursing facilities, jails, police, etc.) (Rapp, 2002).

One of the most critical elements involved in the successful implementation of incentive structures is the ability to accurately measure that which will be rewarded (Hatry & Wholey, 1999). Client-level outcomes (e.g., hospitalization, competitive employment and independent living rates) represent the best and most accurate measure of service effectiveness (Hamilton, 1997) but accurate data are rarely available. In South Carolina, the Governor has adopted an "activities-based" funding approach that requires programs and services to be tied directly to outcomes. In lieu of outcomes, states could reward the attainment of high fidelity. Indiana used this approach in implementing ACT. New York used ACT fidelity measures to renew licenses, with longer-term licenses linked to higher fidelity scores.

Once performance targets and benchmarking (Cohen & Eimicke, 1998) are established, performance above or below these targets would trigger the consequence. Schemes for triggering financial incentives include the milestones method used in Oklahoma, Alabama, and New York (Gates et al., 2004); outcome-based incentive financing used in New Hampshire and Colorado (Rapp, 2002; Rapp, Huff, & Hansen, 2003), or performance contracting (Behn & Kant, 1999). Ohio doubled the rate of employment by providing financial incentives tied directly to employment (Hogan, 1999). Oregon has been moving towards allocating block grant funds on an outcome-basis. Aligning incentives also requires that Medicaid service definitions include evidence-based practices and that Medicaid rates are set as to be advantageous to providers in relation to services and practices that have little empirical evidence of effectiveness (see the Indiana case example at the end). While financial consequences are the most powerful, others could include recognition and awards, development of quality improvement plans, and so forth.

TASK 6: MAXIMIZE FUNDING

Organizing funds in a way that provides incentives for providers is one order of business. The "funding" task level, in contrast, focuses on

strategies for maximizing available funds for evidence-based practices and pursuit of improved client outcomes. Medicaid is the funding foundation for much of community mental health. Medicaid often either fails to cover EBPs or else covers them in a way that makes faithful implementation of the model impossible (Goldman & Azrin, 2003, p. 904) and the lack of fit between Medicaid requirements and evidence-based practice principles is one of the primary reasons for problems in implementing and sustaining EBP. Maximizing Medicaid is particularly critical. Among the strategies are the inclusion of evidence based practice-defined services in the state Medicaid plan, negotiating a higher Medicaid rate for integrated dual diagnosis services, and application for various Medicaid waivers. One approach to maximize available Medicaid funds used by New York, Oregon and Kansas is to describe for providers how the existing fee-for-service billing structure can be used to fund EBPs. For example, the use of the Illness Management and Recovery EBP technology or motivational interviewing interventions can be covered through case management services or ACT services. Block grant funds can also be used as a flexible source of support for EBPs not part of the state's Medicaid Plan.

Since dramatic increases in mental health funding are rarely possible, reallocation and reconfiguring of existing funds is often the major task at this level: Moving funds from ineffective practices to EBPs. There are services and methods without a sufficient empirical base of effectiveness yet seem to be contributory to recovery-based client outcomes based on anecdotal or non-experimental evidence. Promising practice examples would include consumer-run organizations, supported education (Mobray & Collins, 2002), Wellness-Recovery Action Planning (Copeland, 1997), and supported housing (Ridgway & Rapp, 1977; Rog, 2004). There are other services and methods however, where there is evidence and it is overwhelmingly negative. Three prominent examples are day treatment (Hoge et al., 1992), brokerage model case management (Rapp, 1998), and sheltered workshops (Greenleigh Associates, 1975). Despite the evidence, these services are among the most ubiquitous. Reallocating funds from these inert or harmful interventions seems particularly promising. For example, three quasi-experimental studies show that converting day treatment to supported employment programs produce consistently positive outcomes without iatrogenic consequences (e.g., increased hospitalization, incarceration, drop-outs) (Bailey, Ricketts, Becker, Xie, & Drake, 1998; Becker et al., 2001; Drake et al., 1994, 1996; Torrey, Becker, & Drake, 1995). The

conversions also led to cost savings (Clark, 1998). Government budget staff and many legislators put a premium on funding "what works" and want information on the "return for their investment."

South Carolina is an excellent example of reallocation of existing funds to support EBPs. The SMHA included a mandate to move toward EBP implementation by the community mental health centers as part of a five year plan. By the third year, over 40 new EBP programs were in place. Most of the funding was redirected from programs that were less effective and efficient.

TASK 7: PROVIDE WORKFORCE DEVELOPMENT

Workforce development involves building the necessary knowledge, skills, and capacities required by different participants so that they can fulfill their roles in increasing outcomes and implementing evidence-based practices. This layer includes both specification of the core competencies (e.g., knowledge and skills) for each party and the mechanisms for imparting them. A common mistake made by organizations or systems is to do training as a surrogate for the hard and politically complicated work of reallocating resources, rearranging incentives and sanctions, etc. In general, passive educational approaches (e.g., didactic presentations and dissemination of practice guidelines) are ineffective at producing changes in practice (Bero, Grilli, Grimshaw, & Russell, 1998; Grimshaw et al., 2001).

The mixed results of training in improving skills palls in the face of evidence that training does not improve job performance, which is the ultimate test of training. The research on change in health care consistently shows the educational efforts alone do not strongly influence health care provider practice behaviors (Davis, Thompson, Oxman, & Haynes, 1992; Oxman, Thomson, & Davies, 1995). Curry, Caplan, and Knuppel (1994) estimates that only 10–13% of skills taught are transferred to the work environment. Farkas, Cohen, and Nemec (1988) studied 40 community mental health centers that purportedly were implementing the psychiatric rehabilitation model as developed by Anthony. They found that significant elements of this model, such as client involvement in treatment plans, were not being implemented. Seekins and Fawcett (1984) studied the diffusion of behavioral approaches and suggested that only 6 to 29% of a method's critical components will be implemented as designed. Given this, training is viewed a necessary but not sufficient condition.

The likelihood of dissemination leading to high fidelity is enhanced when the previous task sets (e.g., regulations, incentives) are in place prior to training, and the training is well-designed and targeted at multiple levels. Even then, dissemination is enhanced by on-site technical assistance focused on guiding a particular site through the barriers of implementation (Sullivan & Rapp, 1991). In New York, a combination of regulation, training and on-site technical assistance increased ACT team fidelity scores. *In situ* supervision of front-line workers seeking to implement an EBP seems particularly important. The experience of the eight states involved in the National Evidence-Based Practice Project (Torrey et al., 2003) has underscored the importance of front-line supervisors to high fidelity implementation. Kansas requires supervisors to complete a two day training that includes content on managing by outcomes and enhancing EBP fidelity.

While the SMHAs in some states have taken direct responsibility for organizing and implementing the training and technical assistance (e.g., Oregon, New York), many states have developed partnerships with universities (e.g., Maryland, Indiana, Vermont, Ohio, New Hampshire, Kansas). A comprehensive approach to workforce development would also include altering university curriculum to include content on EBPs so that graduates would have relevant knowledge. The New York State Office of Mental Health has partnered with the New York State Social Work Dean's Consortium to introduce an EBP course into five social work graduate programs (expanding to eight in 2004–2005). Field placements on EBP ACT teams and in supported employment settings are also included. The larger issue of how one influences the training curriculum for professionals across the mental health field needs to be actively addressed on a national level. Mental health professionals in social work, psychology, nursing and psychiatry are being trained in programs which never address evidenced based practices. Not addressing this issue on the level of the accreditation of these programs will by-pass an entire generation of professionals.

Another example of a workforce development strategy is the The National Evidence-Based Project, which is investigating the implementation of five evidence based practices in routine mental health settings (Torrey et al., 2003). The implementation kits from this project include training manuals, videotapes, access to model program sites, and access to expert trainers. Furthermore, training resources are available for multiple levels of the system: front-line workers, supervisors, program leaders and policy makers' staff. There are even

resources available for consumers and families. On-site consultation is built into the supports provided to each demonstration site.

INDIANA AS A CASE EXAMPLE

As part of the National Evidence-based Practice Implementation Project, Indiana compared the implementation success of two practices: Assertive Community Treatment (ACT) and Integrated Dual Diagnosis Treatment (IDDT) (Moser et al., in press). All eight ACT sites had made significant progress in implementation. In contrast, only two of six IDDT sites had done so. This sharp difference in successful implementation can be understood in terms of SMHA actions.

Indiana had many years of activities focused on the client outcome of reducing the use of psychiatric hospitalization. In the case of ACT, Indiana also had 15 years of experience with a variety of demonstration projects. These projects produced evidence of effectiveness within Indiana, the mental health community was already familiar with ACT, and many CMHCs had experience with it or with key elements of the practice. In contrast, IDDT was largely unknown in Indiana at the onset of the project and clarity of outcomes was absent.

Indiana's SMHA began developing standards for ACT prior to the launch of the National EBP Implementation Project. The ACT standards ultimately adopted as Indiana Administrative Code are very prescriptive. They include detail on required staffing patterns, organization of services, hours of operation, intensity and types of services, and admission criteria. Community mental health centers must satisfy these standards to be certified as ACT providers and be eligible for Medicaid reimbursement. In contrast, IDDT did not benefit from any state-sanctioned regulations, guidelines or standards.

Another sharp difference between ACT and IDDT implementation concerned funding. In each year between 2001–2003, the state authority provided a special (and limited) set-aside fund of $333,000 annually per CMHC for enrollment of the first 37 clients into certified ACT teams. CMHCs have competed vigorously for this funding. DMHA has designated only a limited number of CMHCs each year to be eligible to receive this funding, including the eight sites in the National EBP Project. Once selected for this initiative, CMHCs are required to meet the standards for certification before they received the funding. The incentive fund had its expected tangible impact on CMHCs. All eligible CMHCs have applied for and received certification. In June

2004, ACT has became a covered service under the state's Medicaid Plan thereby providing an on-going funding stream tied to a rigorous EBP-based certification process. Unlike ACT, no incentive funding has been earmarked for IDDT, nor is it recognized as a treatment reimbursable under Medicaid.

The implementation of ACT benefited greatly by the presence of the ACT Center of Indiana located within the Psychology Department at the Indiana University–Purdue University Indianapolis. The ACT Center was created in 2001 through a contract with DMHA to provide training and technical assistance to the state and local providers. This also included disseminating written materials and videotapes, advising DMHA on ACT policies, publishing a newsletter, and facilitating a list service. The ACT center was comprised of people with extensive experiences in ACT who were well regarded within the state. The training resources for IDDT, in contrast, were limited to one trainer whose recruitment was problematic because there was no history of IDDT in Indiana. A person was eventually hired who did not have experience in the IDDT model.

In this case example, the SMHA systematically implemented several of the strategies noted above for one EBP, while none were addressed for the other EBP. Thus, it is no surprise that implementation has gone so much better for the former.

DISCUSSION

This paper adopts a teleogical perspective on the role policy makers play in improving client outcomes through the implementation of EBPs. It proposes defining and measuring client outcomes as the ends to which all other efforts are directed. With client outcomes defined, policy makers would then prescribe the most effective means to that end (evidence-based practices), arrange the system's incentives to reward client outcome achievement and fidelity to the EBP, secure adequate funding for its implementation, and develop partnership with stakeholders. Training and technical support are then focused on the skills and knowledge needed to successfully carry-out the mandate.

From a purely rational perspective, policy makers would progress sequentially from strategic planning and defining outcomes through training with stakeholder involvement in each stage. One cannot specify the prescriptions (designs and tasks) without knowing the ends to which they are to be applied. Since performance standards are

needed to trigger consequences, policy makers need to know the outcomes and practices that are to be reinforced. Consequating outcomes without clarity of the best ways to achieve them often leads to "gaming" the system. It makes little sense to apply additional resources if the outcomes, tasks and contingencies are not in place. Otherwise, the policy makers are in danger of just throwing money at a problem in which there is no clear solution that will lead to improved client outcomes. The research on training effectiveness suggests that maximum power is achieved once the previous six tasks are in place (Rapp & Poertner, 1992).

On the other hand, the complexity of turning around a service system towards an explicit focus on client outcomes and evidence-based practice is in truth like turning the proverbial battleship around. The work goes on, not in a cozy laboratory insulated from outside stimuli, but rather in a turbulent, ever-changing, noisy and distracting environment. This environment is endemic with competing demands on policy makers. In reality therefore, sequencing is neither possible nor desirable.

The initial results of the National Evidence Based Practice Implementation Project suggest that EBPs can, in fact, be implemented in routine mental health settings. It is also becoming clear that state mental health authorities have a powerful effect on that implementation and the diffusion of EBPs throughout the system. An instrument has been designed to assess SMHA performance in these areas. The State Mental Health Authority Yardstick (SHAY) is a 15-item instrument formatted like an EBP fidelity scale (e.g., five point scales, multiple sources of information used) (Finnerty, Rapp, Bond, Lynde, & Goldman, 2004). Early analysis has found a strong relationship between SMHA ratings and EBP fidelity scores.

It is hard to imagine a state or county maximizing client outcomes in their jurisdiction without policy-makers attending to the tasks identified in this paper. It seems axiomatic that organizations or systems, from Girl Scouts to the military that tightly focus on a few result areas will inevitably achieve those results. Similarly, the service systems with the best client outcomes will be those that have developed the tightest confluence of regulations, incentives, funding and training.

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