TURNING KNOWLEDGE INTO PRACTICE

2ND EDITION (REVISED)

A Manual for Human Service Administrators and Practitioners about Understanding and Implementing Evidence-Based Practices

Editors, 2nd Edition

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TAC
TECHNICAL ASSISTANCE COLLABORATIVE, INC.

The Technical Assistance Collaborative, Inc. (TAC)

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Notes on the 2^{nd} Edition

Since its initial publication in 2003, this manual has found wide acceptance. In 2009, the Technical Assistance Collaborative, Inc. had exhausted all printed copies of the manual, and the decision was made to undertake a revision to update the manual. While the original work as it appeared in the first edition remains the core of the document, we thought it important to update and revise the manual. The original work grew out of the work of the John D. and Catherine T. MacArthur Foundation's Mental Health Policy Research Network and the work of the American College of Mental Health Administration, and its focus throughout was on mental health. In the years since the first publication, we have learned from direct experience and user feedback that much of the content applied across a broad spectrum of human service environments. The principles of using scientific evidence to drive improvements in practice are largely universal, and implementation issues know no sector. In this edition, we have tried to consistently refer to behavioral health *and other human services* (or some variant of that language), and to use interchangeably 'clinician,' 'practitioner' and 'worker' to reflect that broader perspective. We retained most of the original examples that were drawn from mental health practice, believing that the processes described and the steps identified are transportable across a wide array of settings in which evidence-based practices are implemented.

A more difficult challenge was presented as we sought a method to identify the client or service recipient. In mental health, the current preferred term is 'consumer' for adults receiving mental health services, and so we have used that language frequently. We have also modified many sections to refer to 'service recipients,' 'clients,' 'families,' 'youth' and other references. It is our hope that the reader will comfortably substitute the relevant word or terms that fit with the service environment for which the manual is being used as a guide.

We have updated the bibliography to reflect at least a sampling of new publications and resources that have become available since the earlier edition.

We hope that this revised version proves useful to the field. We have been gratified by the response to the First Edition, and have high hopes for the usefulness of this revised version.

The Technical Assistance Collaborative is grateful for the contributions of all individuals who supported both editions of this manual.

John Morris, Lead Editor, 2^{nd} Edition

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Executive Summary

THIS MANUAL’S PURPOSE

The mission of the authors and sponsors of this manual is to enhance independence, self sufficiency, and community living for people with disabilities through the implementation and approaches of best practice series and segments. This manual was originally intended to support mental health programs for individuals diagnosed with mental and substance use conditions. However, the issues of implementation of evidence-based practices cut across broader segments of human services, and so this 2nd Edition (Revised) is broader in reach. The authors share a belief in the promise of evidence-based practices, but we also know the limitations and realities of translating scientific research findings into the real world of service delivery, therefore this manual has been developed in large measure to provide a practical approach to moving the field forward. It is written with specific audiences in mind: clinicians and other practitioners or workers, administrators in human service provider organizations and their chief partners – primary consumers/persons in recovery, other service recipients, and their family members.[1]

This 2nd edition is built on our past experience; or the current state of evidence-based practice implementation; or feedback on the 1st edition; or common concerns or questions about adopting and implementing evidence-based practices. This edition is organized around a series of questions:

- What are evidence-based practices and why should we use them? (Chapter One)
- How does the movement toward evidence-based practice fit with concepts of recovery, resilience, and cultural competence? (Chapter Two)
- What do the terms used to describe various approaches really mean? (Chapter Three)
- What are some examples of evidence-based practices? (Chapter Four)
- How does a program choose an evidence-based practice to implement, and what is involved in implementing it? (Chapter Five)
- How can we help practitioners change their practice to an evidence-based approach? (Chapter Six)

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[1] *Throughout the document we use the terms ‘consumers’ or ‘persons in recovery’ to refer to individuals (and families of youth, or families of adults as desired) who have not only mental and substance use conditions, but a wide array of concerns, needs and challenges. Readers are encouraged to view the terms as interchangeable.*

- Are there organizational or structural issues that can impact the success of implementing evidence-based practices? (Chapter Seven)
- Assuming we get this started, how can we sustain the progress we are making? (Chapter Eight)

'TRUTH-IN-ADVERTISING'

There are substantial bodies of knowledge underlying the various elements addressed in this manual: The clinical interventions or practices themselves; the technology of knowledge transfer and adoption of innovation; the process and structure of change management; and the increasingly complex issues of financing services and supports for all people with disabilities or who otherwise need the services and supports of our human service providers. The authors have attempted to remain true to that wealth of knowledge, but did not set out to write an academic treatise or an exhaustive review of the total universe of evidence-based practices. Instead, this is intended to be a user-friendly, how-to manual. The Bibliography (Appendix D) can be used as a guide to more detailed exploration of many of the issues.

THUMBNAIL SKETCH OF THIS MANUAL'S CONTENTS

The following few pages capture the highlights of the larger publication so that readers can focus on areas of greatest interest and/or concern to them. These sections may also be useful for giving board members or other stakeholders a quick review of the central issues. We know that not everyone will take the time to study the entire document, but may still want or need to be familiar with the core concepts.

CHAPTER ONE: AN INTRODUCTION TO EVIDENCE-BASED PRACTICES

In this section, we attempt to answer the question: What's the big deal about 'evidence-based practices' and how do they differ from what we're doing already? We come down strongly on the side of using the best that science has to offer in designing and delivering services. While what we're doing already may be excellent, at a minimum we want to make sure that if there is relevant research, we are using it. The perspective of the authors is simple: consumers of mental health and substance-use conditions treatment and other human services recipients have a right to expect that the services they receive are the best possible — that they actually work. Public systems have a special responsibility to purchase services that work, as the resources for safety net programs are chronically limited. We believe that interventions supported by rigorous research offer more reassurances of that level of quality.

What about the question of business-as-usual? Do we have to stop everything we have done in the past? Certainly not! While we see great promise in evidence-based practice, we envision a continuum between the worlds of practice and science. In effect, we believe that practice needs to be informed by science, but that science needs to be adjusted by the real world experience of practice – what some have called 'practice-based evidence.' The key word is 'evidence' in either case, not simply anecdote or opinion. That is, even practice-based evidence requires some systematic effort to understand and monitor the experience of consumers and clinicians with respect to the processes and outcomes of a particular treatment or service.

Why would a provider organization consider modifying practice to ensure the use of evidence-based practices where appropriate? The reasons can be categorized as follows:

Clinical reasons – The bottom line here is matching the needs and choices of consumers/persons in recovery[2]/service recipients to services that will yield the desired outcomes – the ethical responsibility of providers to give the best possible care desired by the service recipients who are their partners in care.

Quality reasons – Increasingly, providers are being asked to demonstrate quality in the services and supports they deliver, and to demonstrate a commitment to continuous improvement in the quality of that care. The use of evidence-based practices furthers that effort because the interventions are spelled out in detail, can usually be monitored, and have track records of effectiveness.

Administrative reasons – Providers are continually bombarded with requests to do more with less, and to serve increasingly diverse community demands. Thinking carefully about which services are most likely to help which individuals enables more strategic planning around the design and delivery of a mix of services, and a mix that does not include science-based interventions will be inadequate.

Financial reasons – When the first edition went to press, care systems across the country – whether public or private, local or regional – were under enormous financial strain. As the second edition is being prepared, the US economy is experiencing what appears to be the most challenging financial crisis since the Great Depression. While the degree of pressure on service systems was extreme for both editions, the experience of demand exceeding supply is scarcely new. The use of evidence-based practices requires the skillful application of technologies known to yield the desired results. This application, in turn, is likely to achieve the maximum return, and maximum return is important to all stakeholders, at any time, and consistent with the fiduciary responsibilities of both public and private administrators.

Political reasons – Here we mean 'political' in its broadest sense. Providers routinely have multiple lines of accountability: to consumers/clients, families, funding sources, government funders and/or regulators, and to accrediting organizations and professional guilds. Data about outcomes for clients served by a care system that uses evidence-based practices can help providers demonstrate their commitment to quality to a range of stakeholders.

Chapter One Summary

While not a panacea, judicious use of evidence-based practices can serve a range of ethical, organizational, and clinical imperatives in the practice of contemporary behavioral healthcare service delivery.

Chapter Two: Recovery, Resiliency and Evidence-Based Thinking

It would be difficult to think of a more profound shift in approaching services for people with mental illnesses than the concept of recovery when speaking of adults, and the concept of resilience when considering children, adolescents and their families. The substance abuse field has a longer history with this orientation, which emphasizes the consumer (or child and family) in the driver's seat of care design and management, and taking personal responsibility for the ultimate direction of one's life. This concept and its implications have gained significant traction in the mental health community, as well, and for all elements of the behavioral health field, this reflects a convergence with general medical care, in which the concept of patient-driven care is an increasingly mainstream concept. In the case of other human services, certainly concepts of resiliency are germane. Families in crisis, youth in juvenile corrections or child welfare — whatever the challenges, we believe that the concepts of recovery and resilience apply.

While there is no single, universally-accepted definition of the word 'recovery,' the authors of

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[2] *'Persons in recovery' was the consensus term identified by the Annapolis Coalition, (The Annapolis Coalition. (2007) An Action Plan on Behavioral Health Workforce Development, a publication funded by the Substance Abuse and Mental Health Services Administration, available at www.SAMHSA.gov or at www.AnnapolisCoalition.org) alternative to 'consumers,' which did not resonate with the prevention community nor with some members of the substance-use disorders treatment community.*

this manual understand recovery/resilience to encompass approaches that: provide hope for achieving the consumer's or client's or family's goals for themselves; honor self- or family-driven choices about services and supports; and are characterized by client/provider relationships that are mutually respectful partnerships leading toward meaningful roles in society for those receiving services.

Many consumers/persons in recovery and other services recipients are concerned when they hear discussions about the implementation of evidence-based practices. They worry that they will be offered cookie-cutter care, that their individuality will not be respected, and that their uniqueness and personhood will be ignored. They also worry that their autonomy and personal decision-making will be undermined by a vague body of 'evidence.' That is, what if the 'evidence' is used to require a certain kind of treatment that they do not want or that they feel will not work for them? When evidence-based interventions are properly used, the reverse should be true. When clinicians and provider systems listen carefully to the needs and desires of the people they serve, they are more likely to offer services targeted to solve specific problems – the very antithesis of the 'these are the services we have, so you'll have to fit in' mindset that has troubled consumers of services and their families for years.

This Chapter also deals with the reality that scientifically validated services do not exist for every condition, and that the amount and quality of science available varies from intervention to intervention. For this reason, we believe that provider systems and clinicians need to adopt a philosophy of 'evidence-based thinking.' This is nothing new but it is hard to sustain. Reduced to its simplest conceptualization, evidence-based thinking reflects an approach that attempts to make sure that treatment works. To achieve that goal, providers have to understand the individual as well as possible (not only by assessing the presenting 'problem,' but culture, language, gender, sexual orientation, ethnicity, age, and integration into community activities – all of the factors that interact to create the personhood of the consumer). Then, providers have to think systematically about what known interventions provide the best match for that individual and the outcomes they want to achieve.

Genuine partnerships thrive when there is a rich, continuing exchange of information about the best way to make things happen. Evidence-based thinking can fortify those relationships and yield results that are meaningful to all participants in the process.

Chapter Three: Different Words for Different Ideas – Definitions that Matter

One of the most frustrating things about evidence-based practice discussions is confusion about language. As often happens – especially in emerging fields – terms are used interchangeably when they actually have distinct meanings. The result is that people confuse and misunderstand each other's intentions and actions. Improving services is difficult enough without introducing another element of confusion. This Chapter serves to counteract the language confusion of the current state of conversation by proposing simple definitions of key terms.

Reduced to the most core understanding, evidence-based practice is defined as the coming together of these elements: the knowledge and skills of the practitioner; the desires and values of the consumer; and the best research evidence that links a particular intervention with a desired outcome.

Within that conceptual theme, there are a variety of other terms that have specific meanings: best practices (perhaps most simply understood as the closest fit between what we know, based on science, and what we can actually do in the present circumstance); promising practices (which covers interventions that are well known and have expert consensus or other support, but which haven't been as rigorously evaluated); and emerging practices (very specific approaches to problems or ways of working with particular people that receive high marks from consumers and/or clinicians, but which are too new or used by too few practitioners to have received scientific attention).

This Chapter also gives an overview of many of the terms routinely used in the science world ('efficacious' versus 'effective' interventions, 'fidelity' to models, 'transportability'). These are presented in layperson's language as an aid in reading and interpreting the scientific literature that is the foundation of evidence-based practices.

This Chapter also presents a simple explanation of the different types of scientific study that produce different levels of confidence – low to high – that an intervention 'works.' This explanation is often referred to as the 'hierarchy of evidence,' with each level yielding a higher comfort level of certainty, from the most basic level of anecdotal or word-of-mouth testimonials to the highest level of scientific study – the controlled clinical trial with random assignment of subjects. The range of 'evidence' can be as simple as a friend's endorsement of a particular over-the-counter pain reliever (anecdotal) to the FDA approval of a new cancer drug (controlled, multi-site, random assignment clinical study over a significant period of time). It is important to note that these same criteria apply equally to all organizations engaged in clinical enterprises, whether they are traditional professional provider organizations or consumer-operated services.

Finally, this Chapter (and a related appendix) gives the reader guidance on reading the scientific literature and interpreting clinical guidelines and protocols, many of which are widely available through the internet or other sources. These sections may be of special utility in assisting all stakeholders to be educated consumers of both services and science about those services.

Chapter Three Summary

Language is important, and understanding the meaning of some core terms is an important initial step in using evidence-based practices. While not everyone needs to be a researcher, some familiarity with research principles and products is a definite plus.

Chapter Four: Examples of Evidence-Based and Promising Practices

In this Chapter, the authors provide some illustrative examples of the categories or types of evidence-based practices, as well as some specific examples of widely accepted practices.

The Chapter begins with a focus on evidence-based practices for adults who are diagnosed as having mental illnesses, then for children diagnosed with behavioral and emotional disorders and for youth whose difficulties place them at imminent risk for incarceration or placement outside of the home, and finally for persons with addictive disorders. The Chapter builds on nationally recognized lists or compendia of evidence-based or promising practices, including those identified by the Substance Abuse and Mental Health Services Administration's (SAMHSA) 'Toolkit' project, and National Registry of Evidence-based Programs and Practices (NREPP), by the U.S. Surgeon General, by state governments and academia, and by the U.S. Department of Justice's review of evidence-based programs for children and adolescents.

Specific examples of interventions and practices are summarized, and the reader is given insight into the selection process used by the organization that chose the models on which the manual comments in this Chapter. Some illustrative tables are provided as examples of how a provider organization might categorize and assess the elements of one practice in comparison to another.

While these treatment, service, and care organization or coordination models have been extensively researched and endorsed by national policy organizations, they do not reflect the full range of options. To various degrees of scientific study, there are numerous emerging and promising practices that bear consideration: System of Care models for improving the accessibility and array of children's services; the National Alliance for the Mentally Ill's family-to-family education model; rural adaptations of models, such as ACT; a range of self-help and peer-support models for adults, including Wellness Recovery and Action Plan (WRAP); select school-based mental health services for children and adolescents; and many, many others. Some of these are identified in this Chapter. Inclusion in this Chapter does not suggest that the list presented here is finite or complete, as that would limit research on emerging and promising practices.

Chapter Four Summary

This Chapter was not designed to be an exhaustive compendium of all best practices, but rather illustrative of the range of practices from which a provider and his/her consumer partner(s) might choose. The authors chose programs that have received significant national attention already, for which there are materials readily available, and which have appeared in some national list or collection of best practices.

Chapter Five: How to Select and Implement Evidence-Based Practices

This Chapter provides a step-by-step approach to selecting and implementing evidence-based practices. Consistent with a recovery/resiliency orientation, the very first step involves thinking about the consumers who are receiving services, followed quickly by the organization's staff and its resources. What do the consumers really want? What services do we have the actual skills to provide? What resources do we have on hand to make it happen?

A closely linked set of questions focuses on what outcomes consumers and the service system want to achieve. If people want to work, can we support them in finding jobs? If people want to live independently but need extra services, can we get them supported housing? If families want to have their kids stay at home and in school, can we support them in doing so?

Answering these questions isn't easy, nor is it a one-time-only task. The needs of service recipients and communities change. As they do, organizations need mechanisms to stay in touch with those changing priorities. The authors recommend assembling and using a group of advisors who represent the consumers of services, including families, routinely when children are being treated, and as appropriate for individual adult consumers, as well as the clinicians who form the primary service partnership.

The next step is to acquire knowledge about the range of evidence-based practices available. There are no reliable shortcuts to obtain some basic knowledge of the practices being chosen, and energy has to be spent here. Spending this energy leads to making an informed selection of practices that can best help you meet the needs you identified in earlier steps of this process.

At this point, a more thorough assessment of the administrative, financial, human resource, policy and procedural demands of adopting a new practice is required. Changes in these areas don't happen magically, and a cold-eyed review of the realities of disruption, cost, and change management is better done earlier than later.

The next logical step is the creation of an action plan, preferably with clear timelines and with specific assignment of tasks to individuals. It is also critical at this early juncture to think about how you will monitor implementation of the new practice and plan for adjustments to the plan. The only thing that can be confidently expected to occur is the unexpected. The initial implementation planning phase should also include as detailed a discussion as possible about how everyone will know that the desired outcomes have been achieved. What data will be used to enable all to agree that success was achieved, if at all, and to what degree?

Part of monitoring the implementation of a new practice involves communication about progress. People need to be reminded about the process, be comfortable that they know when mid-course adjustments are needed and made, and be informed when important benchmarks are achieved.

In essence, one needs to consciously, thoughtfully manage the change process, and there are numerous strategies for planning, implementing, monitoring, and adjusting a new process. One of the most common is the Plan/Do/Check/Act cycle of continuous quality improvement, and we also reflect Prochaska's stages of change in the manual.

Chapter Five Summary

Selecting and implementing best practices should be approached systematically and within the context of the provider organization's mission and service environment.

CHAPTER SIX: HOW TO SUPPORT STAFF IN MOVING TOWARD EVIDENCE-BASED PRACTICES

This Chapter focuses on the important issue of working with the people who will actually deliver the evidence-based interventions: clinicians/practitioners. Change is difficult for all of us, and most provider organizations have had the experience of watching a new initiative die because practitioners, clinical supervisors, and other key participants were inadequately involved in decisions about adopting a new practice, or because they were insufficiently trained and supported in making the desired changes. Success in implementing evidence-based practices at the provider level involves several distinct activities: assessment of program, clinician and support staff readiness; knowledge-development about the chosen practice; assessment of the degree of substantive change required to move from current practice to the new state of service delivery; assessment of barriers to implementation; and supports needed for the change process. These are necessary preconditions for making the change work. Failure to attend to these processes can expose the organization to a painful (and potentially expensive) system change failure.

Assuming that an organization reaches a comfort level with its readiness to proceed, there are specific action steps that focus on clinicians. Engaging clinicians and ensuring they understand and authentically endorse the value of trying the new practice is essential. Practice patterns don't change by fiat, and even if an external authority (a purchaser or state regulatory body, for example) has mandated adoption of a new practice, practitioners need to know the reasons and the expected benefits of the new practice. Providers may be able to work with individuals within the organization seen as opinion leaders to help lead the change process. Respected peers who endorse a new course of action can be invaluable in successful adoption of innovation.

Training and exposure to quality information about the practice is another essential. This may include attention to adult learning and to evidence-based teaching methods, such as mentoring and coaching. Particularly in resource-constrained environments, it is tempting to scrimp on training expenditures, but it is also generally a very bad idea. Provider organizations cannot risk making assumptions about staff reading scientific literature or seeking out materials on the web or elsewhere. A training and supervision model to support clinicians in implementing the new practice has to be thought out, and resources (e.g., time away from billable hours, competency training supports) must be committed. For some interventions, models of supervision and training have been specified and are being evaluated scientifically. For other interventions, this is not the case, and the provider may need to design a training and supervision model consistent with the model used in studies of the intervention, but not yet specified for use in everyday clinical settings. Finally, we know that there is a correlation between turn-over and successful implementation of evidence-placed models: in high turn-over settings, the original training may not be replicated and so the practice erodes, resulting in less robust outcomes.

The organization also must be prepared to look at its own practices and be prepared to modify them. For example, if a child service is moving from a clinic-based model to an in-home or family-based model, productivity standards may have to be adjusted to account for travel time, crisis response, etc. A readiness to identify barriers and surmount them is required. Front line staff will feel much more supported in their movement toward change if leadership demonstrates willingness to hear concerns and respond. For example, if a team is undertaking rural assertive case management, they may need different vehicles and communication devices than urban practitioners. Leaders must make the changes necessary to accommodate the changed practice reality.

Attempts to educate, supervise, or persuade clinicians will be ineffective unless they are accompanied by changes in financing, record-keeping, decision supports, staff roles, outcome monitoring, and other organizational changes that affect the daily flow of business determined by the structure of the organization. Therefore, program managers must look at internal and external organizational barriers as intently — if not more so — as they do clinician behaviors (see Chapter Seven).

Finally, organizations must look realistically at the role of incentives and sanctions. If people in the organization have new levels of skill and are demonstrating significantly improved outcomes, methods of recognizing these new skills should be designed: differential compensation, flexible scheduling, etc. The corollary, of course, is disincentives or sanctions. Sometimes individuals are unwilling to change, in spite of effective supports, and provider organizations have to accept the reality that some folks are unsuited to the new practice and doing what is necessary to move ahead.

Chapter Six Summary

All of these issues are familiar to providers, but moving toward an evidence-based approach does involve significant attention to managing the change process. Long-term changes in practice behavior are made by changing the structure of the practice rather than by simply teaching new skills to practitioners.

Chapter Seven: How to Support Your Organization or Program as it Implements Evidence-Based Practices

While an organization is attending to the role of the front line clinician in adopting and implementing an evidence-based practice, there are program or organizational level issues that need simultaneous attention.

One of the very first issues is the culture of the organization. Is it an organization in which innovation and change are embraced and seen as routine or an organization that has taken pride in its stability and traditions?

Equally important is the community cultural context of the provider organization. As we noted in Chapter Two, consumers have raised serious concern about the applicability of evidence-based practices across racial, ethnic and other cultural dimensions. Failure to reflect the cultural diversity of the community with evidence-based interventions that can be culturally responsive will invite failure from the outset.

Supporting a new practice may require modified billing protocols, blended or blurred supervisory relationships, or a host of other structural elements. It cannot be assumed that the new practice can be inserted into existing structures – a sort of new wine, old wine skins problem. All organizations develop bureaucratic rigidity over time. Sometimes these routine behaviors are invisible until a new approach is initiated. Then, the organizational stability is disrupted, and there can be a flight back to the relative safety of the traditional patterns of operation. A willingness and capacity to determine the difference between excuses and genuine barriers, and to act on that distinction, is characteristic of effective leadership for change.

Paying for best practices may prove a difficult task, especially if the reimbursement system has intrinsic incentives for one approach (e.g., rewards for generating lots of individual service units) and inherent disincentives for others (e.g., reimbursement that doesn't account for travel time in rural areas or for in-home services). These issues are especially important when a provider organization is contemplating changes that it wants to sustain over time (see Chapter Eight).

No organization can ignore the politics of change, and that is certainly true for providers of behavioral health services. With the emergence of a strong consumer and family voice, with trade associations and accrediting organizations asserting their influence, and with an increasingly complex interdependency of funding streams (public, private, and blended), competing agendas are to be expected as part of the daily routine. The provider organization cannot afford to approach implementation of evidence-based practices with naïve faith that it enjoys good will from all quarters. The provider organization must plan accordingly to address the legitimate concerns of diverse stakeholders.

There are some policy questions that are unique to the use of evidence-based models. One of the most vexing is that of 'fidelity' to a chosen model. Most practitioners are accustomed to tweaking, revising, or modifying what they have learned as they apply it in their day-to-day practice. With some evidence-based models, variation from the prescribed activities may undercut the scientifically established predictability of outcomes: in essence, too much variation may 'void the warranty.'

That being said, provider organizations need to be savvy enough to use caution when using a model with a group of people, or in a language or context, for which there may be no science. Ideally, provider organizations will already be building robust systems to track costs and outcomes, which can help assess the results of variation. If a program is 'faithful,' but the costs are out of line or the outcomes are below expectation, there is a problem.

This Chapter describes a well-known model of the stages of change:

- Unaware/uninterested (sometimes called 'pre-contemplation')
- Consensus building/motivating (contemplation/preparation)
- Implementing (action)
- Sustaining (maintenance)
- Improving (continuous quality improvement)

The Joint Commission on the Accreditation of Healthcare Organizations and many other organizations foster the PDCA (Plan/Do/Check/Act) model of continuous change. The Chapter closes with a few examples of how one might tackle some of the most common challenges in implementing evidence-based practices.

Chapter Seven Summary

The Chapter and supporting materials provide concrete suggestions about what questions to ask and what data to collect when planning and implementing evidence-based approaches. The Chapter also highlights strategies for overcoming barriers and building on the organization's strengths, just as clinicians strive to build on the consumer's and family's strengths in designing effective service plans.

CHAPTER EIGHT: SUSTAINING AND IMPROVING ON THE EFFORT

One of the shortcomings of many grant-funded initiatives has been that they create wonderful services or environments, only to have them wither and die at the end of the life of the grant. Implementing evidence-based practices should be a long-term proposition, even though grant funding may help to jump start the process.

If an organization already has a sophisticated performance monitoring apparatus in place, then evidence-based practices can be incorporated into the existing machinery. If, however, this has been a low priority, then the organization may wish to build a more robust accountability system, using evidence-based practices and their monitoring as a template. As mentioned above, data collection is an essential element, both for assessing outcomes, and for monitoring fidelity to the models chosen.

It's also important to be prepared to adjust programs if the desired outcomes aren't achieved, but being prepared means a real commitment to what we're calling evidence-based thinking, and what some have called 'practice-based evidence.' Figuring out why you're getting different results from the research, which could either be more positive results or negative results, will not only benefit your organization, but the field as well.

In the best case scenario, the new practice will yield results that are as good or better than anticipated, in which case it is all the more critical to attend to sustainability. Our review suggests that there are some common themes in programs that flourish over time.

First, feedback is crucial. Practitioners, families and consumers need to know that something is working, and working well. If you are monitoring effectively, you will be looking at outcome data, assessing consumer perception of the quality of care, and taking the pulse of clinical staff and their performance. Make sure that all elements get this feedback regularly, and in a format that is easy to understand.

Clinical supervision is receiving increased attention as stakeholders seek to increase the quality and effectiveness of care, and research findings indicate workplace-based clinical support is needed following training to sustain implementation and achieve desired outcomes. This is a major organizational commitment, as skills in supervising and guiding practice do not occur spontaneously throughout the practice or leadership communities. There is an emerging evidence base here, as well, and provider organizations are wise to use that knowledge.

The change literature often cites the role of 'champions,' people who have credibility among their peers (whether consumers, clinicians, practitioners or administrators) and who can provide important leadership in this process.

Incentives (and sanctions) have a role to play in sustainable change. Creating clear expectations for practice, and managing to those expectations, requires time and effort. Clinicians have to believe that their work is valued, but also that it is understood. Provider organizations must be sophisticated in their development of these strategies to avoid misdirection of effort.

As alluded to earlier, the issue of data collection and management is crucial to sustainability. Since many desired outcomes require data outside the purview of the agency providing the services (e.g., educational success for youth), there is increasing interest in the development of data-sharing protocols and the creation of integrated data systems to monitor progress. While this can be a daunting prospect for an individual provider because of confidentiality concerns, there is hope in the success of some systems to create safe, reliable 'data warehouses' that permit data sharing for case planning, for program development and evaluation, and for policy making, while maintaining protections for individuals privacy.

Another imperative is attention to human resource development. The training, recruitment, and retention of competent, skillful, and qualified clinicians require constant attention. This may impose a requirement on providers to interact much more assertively than in the past in making demands on academic institutions, professional licensing organizations, and other key players who shape the workforce.

We conclude this section with one final piece of real world advice concerning our inter-connectedness with and inter-dependence on other service systems. As healthcare dollars are constrained, and as there is increasing awareness of the numbers of individuals needing behavioral healthcare who are receiving services primarily (and even exclusively) in adult or juvenile corrections, child welfare, or primary health care settings, provider organizations must be prepared to re-tool the services they offer for a constantly changing environment.

Chapter Eight Summary

Having made a commitment to using evidence-based practices and evidence-based thinking, provider organizations must ensure that their investment in time and money yields lasting returns.

APPENDICES

Following the Chapters, there are four important appendices. The first (Appendix A) lists the criteria used by the National Evidence-Based Practices Project (sometimes referred to as the Toolkit Project) to assess the likelihood of success when an organization implements evidence-based practices. These criteria are from the General Organizational Index (GOI). The second (Appendix B) is the Multisystemic Therapy (MST) Site Assessment Checklist, one of several tools used to help a service provider organization and collaborating stakeholders determine whether they are ready to implement an MST program. These examples will help you think about your own organization's ability to implement evidence-based practices and what you need to address before the implementation can be successful.

The third appendix (Appendix C) is a short narrative about how to read research literature. This will help you be a better reader of articles and books about clinical practices and guidelines. Appendix D is a Bibliography, organized by Chapter or topic. This will help you find additional resources to further your study of the concepts of evidence-based practices and of specific practices described in this manual. We hope these resources will help you as you learn more and begin to change your programs and services to be as evidence-based as possible.

Appendix E provides a listing of all of the consultant/advisors who reviewed the First Edition of this manual, and Appendix F gives brief bios of the editors of the 2nd edition.

OVER-ALL SUMMARY OBSERVATIONS

This Executive Summary was designed to provide a fairly comprehensive overview of the contents of its parent document, but also to serve as a quick reference on evidence-based practices for people who may not have direct operational responsibility for implementation or management of these practices. The whole area of evidence-based practice is rapidly changing. In this Executive Summary and the larger manual, we have tried to be general enough to provide a broad perspective but one that is detailed enough to be useful to those who make change happen. This project has been undertaken in the hope that the improvements in services that are derived from evidence-based practices will make a difference in the lives of the people who are served by provider organizations and by individual practitioners or workers.

Introduction: Purposes and Uses of this Manual

Human services organizations are increasingly being asked to prove that they are accountable and that they offer valuable services—and results — for the funds expended. This is true whether the payer is the public, an employer-sponsored or private health plan, or an individual seeking services. The concepts of using evidence and basing practice on science have become critical pieces of this quality agenda. Much work is being done to identify interventions that can be scientifically demonstrated to produce results, and to understand their value to service recipients and to the field. Less has been done to help program directors and clinicians understand how to select, implement, and support evidence-based practices in every day service delivery, and how to support clinicians to engage in evidence-based thinking and to have their practices evolve to reflect emerging scientific knowledge throughout their careers.

Research about the best methods for incorporating evidence-based practices into routine practice settings is beginning. Research about the relationship of these efforts to the concepts of recovery and resiliency, and to the idea of purchasing value in the behavioral health care field, is also beginning. Many times, individuals working in routine practice settings are struggling with insufficient funding for training, professional development and testing new approaches. Sometimes systems and organizational issues actually impede the search for new ways of providing services that are more effective than current methods.

With all the new information available, it is imperative that organizations delivering human services are actively engaged in learning about and implementing new practices. It is also imperative that consumers/service recipients and their families have opportunities to be exposed to new medications, new treatment approaches, and new service and support technologies that will help their individual or family recovery and resiliency journeys.

This manual introduces concepts about evidence-based practices to individuals already working in the field, to human service program leaders, and to individuals who receive human services. It has been developed to provide information, to suggest ways of thinking and getting started, and to point to additional resources as evolving evidence-based practices become a routine part of service delivery and management. It is hoped that the reader finds this a valuable tool to stimulate thinking, to move toward systemic and sustained improvement in the services we provide, so that we do the best we can for the people we serve.

Chapter 1

An Introduction to Evidence-Based Practices

WHAT ARE EVIDENCE-BASED PRACTICES? AND WHAT IS EVIDENCE-BASED PRACTICE?

In the field of behavioral health, clinicians, academicians, and policy makers have often hypothesized theories about the human psyche or about the human condition, which became the basis for any number of clinical practices and service system interventions. These theories have sometimes become treatment, service delivery, organizational or financing approaches that were (and sometimes still are) widely accepted and practiced throughout Europe and the United States. Today, early theories have been significantly modified and expanded but these treatment, service, and system approaches often remain as the treatment or practice of choice for people who experience mental and substance abuse conditions. We also believe that there is relevance for other human services organizations that are closely allied to behavioral health, especially child welfare and juvenile justice systems, and so the 2nd edition reflects this wider audience.

Sometimes, theories grow in popularity and practice not because they are proven to be effective in helping people overcome some set of problems in their lives, but because they are *believed* by clinicians and decision-makers to be effective. Often, these theories and practices come from well-intended efforts to improve the lives of people with problems, and they often do show promise through the experiences of individual clinicians, recipients of services and their families, agencies, or systems. These practices are then taught and incorporated into system designs without critical analysis about the results they produce and under what circumstances they are most likely to be effective. This manual attempts to distinguish between those practices that are developed and implemented, based on theory and belief and those that are evidence-based. **This is sometimes referred to as the gap between what we know and what we do.** This manual then provides information for clinicians, administrators, and consumers and their families about how to think about, discover, develop, and implement practices that are most likely to have positive results, based on the best evidence available.

Evidence-based practices are those clinical and administrative practices that have been proven to consistently produce specific, intended results. These practices have been studied in both research settings, such as in controlled, clinical trials, and in real world environments, such as community mental health programs, child welfare, or juvenile justice systems. In both formal research and *in vivo* settings, study of the practice has shown that it produces the defined, expected outcomes that it is intended to produce. The types of evidence that produce this 'proof' vary in type and strength. They are discussed in Chapter Three of this manual.

Evidence-based practices are very specific clinical or service system approaches[3] that help people achieve the specific goals, or outcomes, that they seek. The desired outcomes are identified first by the consumer/person in recovery/children and families so that the evidence-based practice known to produce those outcomes can be selected. Each evidence-based practice is intended to address specific problems or symptoms of mental and/or substance-use conditions (including co-occurring conditions) or to avoid undesirable outcomes, such as out-of-home placement or incarceration, and to produce specifically identified outcomes. The evidence-based practice used depends upon the condition targeted and what outcomes the individual (or program) is trying to achieve. That is why is it always important to first know what you want to accomplish before you choose which evidence-based practice to implement.

Evidence-based practice describes a specific type of practice or service intervention, and it also describes a way of thinking and of conducting a human services practice.

Many mental health care and other human service programs and practitioners do not use evidence-based practices. Instead, they use clinical approaches or intervention strategies that are widely accepted in their field of practice, and that clinical experience and judgment tell them 'this works.' In many cases, they are right. There are many clinical approaches that work well but have not been studied enough to show that they are evidence-based. Simply put, evidence-based practices are not the only ones that work. However, they are the only ones that are supported by scientific evidence that proves they work to produce specific outcomes when used to treat the disorders or achieve the outcomes for which they were developed and with people who are similar to the service recipients in the clinical trials. This distinction is especially important in using the interventions that were developed in one environment (e.g., urban versus rural) or with one predominant racial, ethnic, or cultural group versus another. The designation of 'evidence-based' allows consumers, family members, clinicians, and program managers the choice of a practice that is both believed *and* proven to be effective. See Chapter Three for a discussion of the difference between what works in a controlled research setting and what works in routine practice settings. Chapter Four will help the reader to determine which practices have more or less evidence to support them and which are supported by the strongest evidence.

Evidence-based practice describes a specific type of practice or service intervention, and it also describes a way of thinking and of conducting a human services practice. Evidence-based practice is about the process of changing the way we think about behavioral health and other human services. For a clinician to have an evidence-based practice, he or she must consider how to engage in evidence-based thinking. This concept is described in Chapter Two.

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[3] *It should be noted that, while there is a growing interest in and capability to develop and implement administrative evidence-based practices for behavioral health and human services programs, this manual is focusing largely on clinical or service delivery practices having a direct impact on treatment or services for consumers and/or their families.*

This means thinking about each individual or type of individual first with that individual's values, history, and desired outcomes in mind. Then, the clinician uses the best knowledge available, whether clinical controlled trials described in the literature, or consultation with other clinicians trying new approaches, to obtain those same outcomes with similar types of individuals. The idea is one of constant learning and the use of interventions or treatment approaches most likely to produce the outcomes that individual wants and needs, rather than a common approach for every client.

Many clinical practices in use today were developed in the same way early theories about behavioral health care came about. A mental health professional, usually a clinician or researcher, develops a treatment approach. The approach is then used in a clinical setting to see if it is useful in helping people reach their goals and reduce their symptoms of a mental illness. If the treatment approach is found to work well in the clinical setting, then the practice is disseminated to the field. This process of developing and disseminating clinical practice has been the standard approach in the mental health field since before the days of Freud. With the emergence of evidence-based practices, the field is committing to a new level of quality and accountability in behavioral health services and programs. The availability of evidence-based practices allows us to expect that before treatment approaches are disseminated to the field, they undergo rigorous examination to prove that they are of value to consumers or clients, and to the field as a whole. Studies of the efficacy and effectiveness of treatment practices prior to wide distribution in the field are establishing a new standard of excellence in clinical programs. The same has been true of approaches to supporting families in crisis and children and youth displaying delinquent behaviors.

Everyone wants to be a smart shopper. Before purchasing a car, we read consumer guides to learn what cars are most reliable, which get the best gas mileage, and which are the best buy for our money. When selecting a health insurance plan, we study plans to see which have the most covered services and how the cost of co-pays compare, and we talk to our friends and co-workers about their satisfaction with their health plan. People want to know the facts about products and services so they can make the best decision before they purchase. It is no different with mental health services. If we, or someone in our family, need mental health services, we want to go to the clinician and program that is going to offer the best and most effective services.

When given the choice between selecting a treatment that is highly recommended by the clinician but not backed by scientific evidence or one that is highly recommended and proven by clinical research to be effective, most of us will choose the one that is backed by scientific evidence. As mental health professionals and administrators, it is our duty to know what evidence-based practices are, which practices have the most or strongest evidence-base, what literature supports them, and how to work to make those services available to our clients and communities.

There are a number of practices for adults, children, and adolescents that have a strong evidence base. You can find an introduction to some of these practices in Chapter Four. The Bibliography (Appendix D) also lists links to other resources that provide more in-depth information on specific evidence-based practices. This manual is not intended to be a training guide on each evidence-based practice but rather to introduce evidence-based practices and evidence-based thinking. The manual illustrates how such practices and such evidence-based thinking are critical to improving quality, and offers an approach to implementing these practices in your program or clinical practice. It is also intended to help consumers and family members make the best choice possible as they seek services that promote their recovery, resiliency, and attainment of their personal goals.

WHY IMPLEMENT EVIDENCE-BASED PRACTICES?

There are several reasons why you or your organization should think about implementing evidence-based practices. Some reasons will be more important to you than others, depending on what it is that you want to accomplish. Since this manual is intended for a variety of different professionals, consumers, and family members, we cover five different areas in which you will find important reasons to implement evidence-based practices. Those areas are clinical, quality and accountability, administrative, financial, and political or policy reasons.

CLINICAL/CLIENT REASONS TO IMPLEMENT EVIDENCE-BASED PRACTICES

People with mental illnesses, emotional disturbances, or other problems in living — and in the case of children and youth, we include individuals who are at risk of involvement in the juvenile justice or child welfare systems – have the right to choose services that are most effective in helping them achieve their personal treatment or life goals and to ensure that they remain focused on their journey to recovery and resiliency (see Chapter Two for more about recovery and resiliency). Individuals and families of children with emotional disturbances often know what they want to achieve when they seek treatment and services. This is especially so when the assessment and treatment planning process actively engages individuals and families in making these decisions. Some people want to manage their mental illness or addiction better so they can stay out of the hospital. Others want to feel less depressed and more energetic. Doing well in school, staying out of trouble, and keeping a job are other goals that people frequently name. When consumers and families enter treatment and state their goals, the clinician or program has an obligation to offer them services that are most effective in meeting those goals. If the clinician does not offer those proven services, then he/she has a duty to refer the consumer to practitioners who do. Consumers and family members have the right to be informed of proven clinical practices and given the opportunity to choose the treatment that works best for them.

Behavioral health and human services professionals (and we include direct service professionals who may not have advanced degrees) have an obligation to know what clinical practices or interventions are available and the literature that supports the practice. There is an abundance of treatment and service approaches. Some approaches consistently work well for most people, some work some of the time or for some people, others are seldom effective, and a rare few may even be harmful. It is the duty of professionals to know which treatment approaches fall into which category. This requires keeping up-to-date with the latest advancements in the technologies of services and supports, knowing the practice literature, participating in conferences and other learning environments, and learning about evidence-based practices. Without knowledge and skills in proven practices, clinicians and program managers cannot fulfill their obligation to offer consumers and families the most effective services. This includes peer service providers, such as consumers and families working with other consumers and families in self-help and educational programs.

Recovery from mental illnesses, emotional disturbances, and other life problems, achievement of resiliency for youth, abstinence or reducing the negative consequences of addictive or delinquent behavior are the ultimate goals of consumers and families and the systems that serve them. Every human service support or intervention that is offered should be done with these goals in mind, and should be conscious of the processes that lead to successfully achieving them. To accomplish this, it is critical that an individual or a child's family determine what specific treatment goals and outcomes they want to work toward, and that the practitioner provides the services proven to be most likely to result in those outcomes. This fundamental understanding between person/family and clinician – that the individual determines the goals and the clinician provides effective services or supports the individual or family in taking actions and changing behaviors to meet those goals – is essential to the recovery/resiliency process. Clinicians and other practitioners must know and be skilled in evidence-based practices in order to fulfill their duties in assisting the individuals and families they serve.

Quality Improvement and Accountability Reasons to Implement Evidence-Based Practices

Quality improvement needs to occur at every level of a service system in order to achieve the highest quality services and produce positive outcomes. As service providers, program managers, and state or local administrators, we all share in the responsibility to promote that level of quality. While each individual's contribution to the system is different, depending upon his or her role and level of responsibility, we each play a vital role in making the system work. Together we are the parts that make up the mental health system. Individually and collectively we are responsible for being accountable to consumers, families, and communities for providing the highest quality and most effective services available. When we provide evidence-based practices and have an evidence-based practice, we are fulfilling a major part of that responsibility.

Evidence-based practices, when used strategically and for those conditions and people for which they were designed, improve outcomes for clients, families, and communities. This basic, scientifically proven fact is one of the most important reasons evidence-based practices should be implemented.

If we know through clinical research what services are effective, then why are those services not widely available? We don't yet have the research needed to help us answer that question very well. One problem is that we have not been very effective in disseminating information about evidence-based practices to the field. Mental health, substance abuse, child welfare, and juvenile justice officials and front line professionals often do not know the current literature on clinical or service system research that describes what services have been proven effective in meeting the goals they and their clients share (e.g., functioning well at home, school, and the community; avoiding removal from the home; or incarceration). This is one source of the disconnect between scientific knowledge and clinical practice. The result is significant variability in the quality and effectiveness of practices in the field. Knowledge of evidence-based practices is needed to decrease the variability of practice that results in a lower quality of care and ability to achieve desired outcomes for many individuals and families. Treatments and services should be standardized to levels of excellence so consumers and families can be assured of quality and effectiveness throughout the systems that serve them. Implementing evidence-based practices is a critical step toward assuring quality and accountability in our human services systems.

> Quality improvement needs to occur at every level of a service system in order to achieve the highest quality services and produce positive outcomes.

Systems of the highest quality are accountable to individuals, families, communities, and payers, and as such are flexible enough to serve individuals with unique needs. Evidence-based practices are embedded in the philosophy that every individual has the right to the most effective services. This includes those exceptional individuals who need a unique kind of care. Thinking from an evidence-based perspective and using evidence-based practices will help clinicians and other human service professionals identify unique treatment approaches that meet the needs of unique individuals (see Chapter Two for more discussion of how evidence-based practices and individual needs work together).

ADMINISTRATIVE REASONS TO IMPLEMENT EVIDENCE-BASED PRACTICES

Why is it that sometimes an individual or organization can have the highest commitment to providing quality services and yet have difficulty achieving that goal? One reason is that organizations and systems can be so complex that there are barriers within the organization to providing the best available services. Evidence-based practices and evidence-based thinking can help identify barriers and complexities that prevent systems from doing their best. When an evidence-based practice is implemented, the protocol for delivering that service must be closely followed to assure that defined outcomes are achieved. If you encounter an organizational problem in implementing the protocol, then you have identified a barrier in the system that needs to be addressed.

For example, if an evidence-based practice you are implementing calls for certain services to be delivered in the client's home, or if you know that your organization can be reimbursed for services delivered in the home but there is no reimbursement to cover the practitioners' travel time to the home or their mileage expenses, then how do you implement such an evidence-based practice when it is costly to your organization? As an administrator, you want to offer the best possible services for your clients but feel that the agency cannot afford to offer services that are not reimbursable. This example highlights how implementing evidence-based practices can help administrators and clinicians identify barriers within their organizations to providing quality and effective services. Chapter Seven is devoted to further discussion of examples of barriers you might encounter when implementing evidence-based practices and strategies for resolving those barriers.

The responsibilities of administrators are enormous. Their decisions and actions impact the organization across many components: clinical, fiscal, quality management, and administrative. At times just meeting the basic obligations of keeping an organization running fiscally sound, fully staffed, meeting the requirements of multiple funding sources, avoiding lawsuits, and keeping clients satisfied, is a monumental job. Nonetheless, a good administrator knows that offering the highest quality and most effective services available is also one of the fundamental obligations of any human services organization. It is the duty of administrators to help organizations to do the best they can, to constantly improve, and to prove their worth and efficiency to consumers, families, communities, and the decision-makers and taxpayers who often fund these services.

FINANCIAL REASONS TO IMPLEMENT EVIDENCE-BASED PRACTICES

State and local administrators constantly struggle with meeting the needs of persons with mental, emotional, or addictive disorders in their communities and states with limited resources. The same is true for other human services. Nationwide, more demands are being placed on systems while fewer resources are being made available to meet those needs. Most states do not have enough money in their budgets to serve everyone at the level they need. These times of tight resources are increasing with the latest budget cuts at federal and state levels, and with the growing inability of employers to keep up with rising health care costs. Given the reality of limited resources, the implementation of evidence-based practices becomes a necessity. We must use our limited funding in the most efficient manner to effectively serve as many people as possible.

Investing in services that are proven to be effective is the smartest and best use of human service dollars. Investing in evidence-based practices offers an opportunity to shift resources away from ineffective or less effective services to those services that are more effective for the people served. That means that not only must we look for ways to implement evidence-based practices, but also ways to stop providing services that are less likely to have proven results. The latter process is particularly difficult in light of the belief that such services work, based on academic training or a long history of providing such services. It is hard to acknowledge that things we have been doing for years may not be the best thing to do in the future.

When requested or required to implement a new evidence-based service, programs and clinicians should think of this as an opportunity to identify those things that are less effective for the targeted client population. This process should not be thought of as just an unfunded mandate that must be 'added on' to existing services. Rather, organizations, programs and individual clinicians' practices must change to meet these new challenges.

Evidence-based practices are driven by the belief that consumers and families have the right to the most effective treatments known, and that human services organizations have a duty to be efficient in the use of limited resources by providing services proven to work. To accomplish this, a commitment to evidence-based practices by consumers, families, behavioral health practitioners, and administrators is required. Consumers, families, and professionals must know which services are effective and educate policy makers and legislators regarding the value of those services. This is critical to assuring that future funding supports the development and implementation of evidence-based services.

Of equal importance is the willingness of human service professionals and administrators to shift funding from old services or practices that have not proven their value to treatment approaches that have been shown to be effective. Generally speaking, most organizations or systems are faced with implementing new services without new dollars. As such, the start-up costs of implementing a new service may seem prohibitive and, in fact, may indeed be so unless funding is deployed to support the new service approach.

Even when practitioners and administrators are committed to shift funding from less effective to more effective services, they may have difficulty in doing so if the outcomes desired by policymakers and funders vary from those of consumers, families, and clinicians. For example, policymakers may be interested in funding more residential services for children and adolescents, while families and clinicians support the development of more community and family-based services. In this case, administrators have to choose between using resources to produce the outcomes desired by policymakers versus those desired by families. Children's services research and child treatment research can help administrators resolve this difficult dilemma by providing the evidence that select intensive community-based services, such as specific models of therapeutic foster care or home-based services have been proven more effective in treating children and adolescents in the long run than residential services. Backed by scientific evidence, administrators may be able to align policymakers with families so that they agree upon the same outcomes and support funding of the evidence-based practice most likely to achieve those outcomes.

As states work to take advantage of favorable federal/state matching dollars offered by state Medicaid agencies, they find Medicaid officials increasingly look to the use of evidence-based interventions as one indicator that quality services are both needed **and** likely to achieve the desired impact.

Political/Policy Reasons to Implement Evidence-Based Practices

In the field of behavioral health and other human services, as with most complex social institutions, it is often politics or the demands of practice reality (e.g., availability of trained staff) more than science that influence service and treatment approaches. For example, a tragic event may generate funding for a specific service that the public perceives could have prevented the tragedy or will prevent future tragedies. There is often neither time nor will to determine whether the service funded is one that will be effective in preventing future tragedies. Therefore, it is important that professionals and state and local administrators know and educate the public and funders on evidence-based practices.

Behavioral health professionals and others must be knowledgeable enough to serve as expert advisors to politicians, legislators, funders, and the media on which treatment approaches are effective for what problem, for which groups of people, and in which particular settings.

Behavioral health professionals and administrators are responsible for the efficient use of public dollars. Evidence-based practices allow us to demonstrate the worth of the system to clients, community members, taxpayers, and legislators. By committing taxpayers' dollars to providing services proven to be effective, we provide a higher level of assurance to the public that a wise and valuable investment of public monies has been made in the behavioral health system.

Chapter 2

Recovery, Resiliency, and Evidence-Based Thinking

In the world of adult behavioral health, the term 'recovery' has become a powerful touchstone. Long a term-of-art among people with substance use disorders, it has gained currency with people diagnosed with mental illnesses as it has become clear that recovery is not only possible, but should be expected. Any adult, child, or family, who encounters disruptive or traumatic life experiences, engages in recovery of some kind. In other areas of human services, the concept of 'resiliency' is more relevant. Some youth, for example those who experience chaos in their families or exhibit occasional delinquent behaviors, may not be diagnosed with a major mental illness nor have life-long problems, but intervention and support is clearly needed to help them lead productive and satisfying lives.

As we noted in the introduction, the concepts of evidence-based practice are not new, but in fact come from the evolving field of evidence-based medicine that, since the early 1980s, refers to the systematic approach to bringing scientific evidence to decision-making at the point of contact between physician and patient. In behavioral health and human services, the concepts of recovery and resiliency are increasingly forming the basis of this clinical relationship. This individualized approach to care is what is sometimes called a person-centered practice. Therefore, it is important to understand what these concepts mean and the role they play in the critical practitioner/client interaction. This chapter describes these concepts and considers how to incorporate them into practice and into evidence-based approaches.

It is also important to understand that not all practices that are evidence-based for a population as a whole are right for a particular individual in a given circumstance presented to the practitioner at a specific point in time. As noted in Chapter One, many practices that appear to be helpful for a particular individual or group of individuals have not been evaluated using the kind of rigorous research necessary to call them evidence-based. It is just as important to utilize evidence-based thinking as it is to implement evidence-based practices so that a given group or individual has the best service options possible, given the presenting situation (clinical and circumstantial) and given the available resources. Evaluating the innovations that germinate on the front lines of practice is a corollary of evidence-based practice, 'practice-based evidence.' The concept and process of evidence-based thinking is also described in this chapter.

THE CONCEPT OF RECOVERY

The concept of recovery from addiction has been a guiding principle in substance abuse services for many years. It refers to the process by which the abusing or addicted individual accepts that they have a problem with alcohol and/or other drugs, that they need help to overcome that problem, and that they must take individual responsibility for overcoming the addiction and the associated problems in life caused by the addiction. The process is considered to be individualized and lifelong; that is, each individual must address the issue according to his/her own abilities and needs, and must commit to working to overcome the addiction and prevent relapse for the rest of his/her life. The goal is often abstinence, although sometimes simply reducing the negative consequences of addiction is considered a success when total abstinence is not possible or as a first step toward abstinence (for example, see the National Consensus Statement on Mental Health Recovery at mentalhealth.samhsa.gov).

There are specific treatment approaches that have been found likely to help the individual be successful (e.g., removing the individual from the environment in which the addiction occurred, changing social habits and friends, learning relapse prevention techniques, taking methadone with urine screening plus counseling, and participating in self-help groups, such as Alcoholics Anonymous). However, the individual must ultimately take responsibility for accessing treatment, changing behaviors, and remaining abstinent while life in a job, with the family, and in the community is rebuilt or continues without the use or abuse of alcohol or other drugs.

In the mental health field, the concept of recovery is relatively new. Some feel it is the cornerstone of person-centered practice, an idea that was described by the Institute of Medicine (IOM) as one of the primary aims of a high quality health care delivery system. Person-centeredness means acknowledging individual differences and characteristics, including different biology, culture, beliefs, values, preferences, history, abilities, and interests. Evidence-based medicine is grounded in this concept of person-centeredness, even if the IOM and others suggest that medicine as a field does not always conform to this principle. Since recovery is described as an individual process directed by the individual rather than by practitioners or others, it has become the guiding principle for many adult mental health systems and provides a context for thinking about how to utilize evidence-based practices. For some, recovery concepts can also guide research efforts to identify those practices most likely to support the recovery process or produce individualized recovery goals and outcomes.

The recovery concept in mental health began as adults with serious and persistent mental illness began to advocate for regaining control of their own treatment process and of their own lives. The consumer advocacy movement began with actions and writings of adults who had experienced an illness and often treatment approaches and settings that made them feel disempowered and out of control of their own lives. They often felt as though decisions were made for them, without their input or even knowledge, and that treatment was often provided involuntarily without explanation and without giving them the information and a chance to understand what was happening to them. Today, some consumer advocates feel that these treatment approaches were in some instances more harmful than helpful. Many feel that treatment and services are more effective when consumers are given information about the services available, about which services are most likely to have the results they seek (e.g., symptom reduction, increased functioning, opportunities for housing or employment, etc.) and about the relative roles they should play and their caregivers should play in achieving those goals (see the Consumer/Survivor Mental Health Information website at mentalhealth.samhsa.gov/consumersurvivor/about.asp).

Sometimes, people who treat individuals with diagnoses of serious mental illnesses are not being realistic when they demand services that help them in their recovery process. These workers think that since mental illnesses are diseases that last for long periods or indefinitely in some, that consumers would be more realistic to think simply about what treatments are most likely to have the greatest impact on the symptoms of their illnesses, with life issues being dealt with in the context of the long-term illness. For consumer advocates, the concept of recovery has evolved to mean the individual process by which an individual consumer comes to grips with the illness and by which he or she learns to cope with the symptoms and limitations the illness causes. Recovery does not imply a cure, but it does imply that the process is critical (i.e., that recovery is a journey – often lifelong – that is best supported by the individual having as much control and responsibility for his/her own treatment and life choices as possible). Recovery is the desired outcome of treatment or services. It is very individualistic; choice and control are central; and hope for a fulfilling life is critical for adults diagnosed with mental illness.

Recovery is often associated with psychosocial rehabilitation. The former is a process and a value-oriented principle while the latter is a specific type of service intervention. Psychosocial rehabilitation is described in Chapter Four and incorporates the concepts of consumer choice, involvement, control, and individualized skills development. Psychosocial rehabilitation is a wide range of service interventions that can support the recovery process. Other treatment and service approaches, including medication administration and individual or group therapies, can support the recovery process as well, depending on the individual consumer's needs and desires.

The critical components of the recovery concept are being more clearly articulated and include the following:

- Choices among good clinical care options
- Peer support and relationships
- Support of family and friends
- Work or other meaningful daily activity
- A feeling of hope, as well as power and control over one's life
- Overcoming stigma individually and collectively
- Productive involvement in the community
- Access to needed resources
- Education about the illnesses and about helpful behaviors to manage symptoms and triggering stressors

PARALLELS ACROSS OTHER PEOPLE WITH DISABILITIES

While the term 'recovery' has special resonance in behavioral health, there are close parallels in other populations. The concept of 'person-centered care' and 'self direction' of care are driving principles of interventions in the areas of aging and work with individuals with intellectual and developmental disabilities and a whole range of human service approaches, and the terms 'consumer choice' and 'consumer control' are relevant for people with physical disabilities.

Recovery-oriented thinking has value for all human services practitioners and workers, as it is fundamentally a strengths-based approach to working with people with problems.

THE CONCEPT OF RESILIENCY

While recovery is a term and a concept embraced by adults with serious mental illness and increasingly by practitioners serving any adult with a mental illness, whether serious and persistent or acute and situational, the term has not always resonated with families of children and adolescents with an emotional disturbance. In some cases, families relate to the concept of recovering skills, capacities, and control. However, since children and adolescents are dealing with developmental issues and just beginning to learn social roles and skills, the emotional disturbance or diagnosis of illness may be disruptive to that developmental process. And, since children and adolescents are by virtue of their age not totally in control of their own lives and treatment decisions, the role of the family or other caregivers is even more important than for adults with serious mental illness. The family may be dealing with its own behavioral health concerns either before or as a result of the emotional disturbance of the child. Siblings may experience even more difficulty in their own developmental process due to the focus of the family on the child. And since school is a fundamental part of a child's social and developmental experience, the role of teachers and other school officials in enhancing or exacerbating the child's difficulties must be taken into account.

Consequently, many child and family advocates think of the concept of resiliency as a better descriptor for the ultimate goal of services for children/adolescents and their families. Resiliency describes a process by which a child can achieve positive outcomes in the face of risks in the environment, the family, or the child him/herself. This means that focusing on protective factors that have been identified in the research literature help the child and the family achieve those positive outcomes in spite of the risks. The same is true for young people and families who come into contact with the child welfare and juvenile justice systems; they need supports and services to strengthen their resiliency, and avoid the adverse consequences of out-of-home placement or incarceration.

Resiliency incorporates the idea that the child/adolescent and his/her family needs the resources, skills, coping mechanisms, and ability to successfully play the appropriate social roles of parent, sibling, and student while supporting the healthy changing development of the child and the healthy functioning of the family as a whole unit. This concept also implies that the family, not just the child, must be part of the treatment or intervention process and must learn how to assist the child/adolescent in developing coping skills and eventually recovering. It also implies that school and peers are critical elements of the success of the treatment. The desired outcome of services for emotionally disturbed children/adolescents is a family as well as an individual that understands the illness or disturbance, the treatment, and service options, and can set goals about school, community, and life functioning appropriate to the developmental age of the child/adolescent. The desired outcome is also a child/adolescent that will be able to transition to adulthood successfully and become a contributing member of society with the ability to direct his/her own life and if necessary, his/her own continuing treatment.

Recovery as a concept has relevance for children/adolescents and their families. Resiliency as a concept certainly has relevance for adults with mental illness and their families. In both cases, these concepts have pushed the field to reconsider the relationship between service deliverers and those served. This relationship drives thinking and implementation of evidence-based practices.

The Relationship between the Practitioner and the Individual or Family Served

Utilizing recovery and resiliency as the ultimate goals of behavioral health treatment or human services intervention, the practitioner becomes more of a teacher and a supporter, with specific expertise in explaining and prescribing medications, conducting specialized therapies dependent on the needs of the client, teaching decision-making or coping skills specific to the diagnosis or life problem and the capacities of the individual or family, or providing case management or psychosocial rehabilitation, based on individually determined desires of the consumer. The practitioner is an expert with information and skills the client needs to make his/her own decisions about treatment and services, not an 'expert' who decides what is best without input from the individual or family served.

Accordingly, the practitioner is obligated to know how to engage the client in determining desired outcomes, discuss the available options and which treatment or service is most likely to accomplish the client's goals. If the goal is symptom reduction, medications, therapy, or therapy plus medications may be the options. If the goal is employment, symptom reduction may be a first step, but the client may know that finding a job is the first step toward reducing symptoms of depression and low self-esteem. Sometimes a client may want to try to reduce symptoms or increase functioning without the use of medications or counseling. Therefore, stress reduction techniques, training about cognitive approaches, peer support, or engagement in skills training or social activities may be options to be discussed with the client or family. In each instance, the practitioner needs to be able to discuss with the client or family what the literature says and what experience has been with the various options for people in similar circumstances. That is, the practitioner needs to be able to discuss the evidence about likely outcomes so the client or family can make an informed choice.

Although person-centered principles cut-across all human services, we need to acknowledge that in some instances other contingencies exist, not least of which are laws governing investigation of child abuse, the role of family or civil court structures, etc. At the most fundamental level, however, there is common ground in that the adult with a problem or the child and family in crisis, and the other players, such as courts or communities **all** want services that will produce better outcomes in the most effective and efficient way.

> At the most fundamental level, there is common ground in that the adult with a problem or the child and family in crisis, and the other players such as courts or communities **ALL** want services that will produce better outcomes in the most effective and efficient way.

Potential Concerns About Access

The concepts of recovery and resiliency have raised the issue for many practitioners and programs that the best services or the services desired by the client may not be available. This may be because the agency does not offer it, because funders will not pay for it, or practitioners who know how to provide the service may not be available in the geographic area. This is important for consumers and families to know, so they can choose among the available options and so that consumers, families, and practitioners can advocate together for these options to become available.

The concepts of recovery and resiliency have also raised issues about whether consumers and families have a 'right' to the services or treatments they want, even if the evidence suggests that these services or treatments are not likely to have a positive outcome. Most of the time, consumers and families who are actively engaged in decision-making and who are given good information about what the evidence says will work with practitioners and programs to choose treatment and services that are most likely to have positive outcomes. However, Sometimes individual consumers and families will make choices that seem to be least likely to achieve positive outcomes, but that will end up being just what that particular individual or family needs. Practitioners and programs need to be open to these unusual approaches, so long as they do not actually harm the clients or other people. These circumstances sometimes become the theories upon which new approaches are developed and that become the evidence-based practices of the future.

Effectively Serving Individuals of Diverse Ethnic and Cultural Backgrounds: What About Evidence-Based Practices?

Many consumers, practitioners, and administrators are skeptical about implementing evidence-based practices with individuals from diverse ethnic and cultural backgrounds. Some argue that 'culturally-specific' treatments are needed for different ethnic and cultural groups. One problem contributing to the healthy skepticism about the applicability and effects of evidence-based practices across ethnic and cultural groups is that although the effects of some evidence-based practices have been adequately tested with ethnic minorities, the effects of others have not.

The promising news for adults and children from diverse ethnic and cultural groups and service providers is that recent reviews of research on the effects of evidence-based mental health treatments indicate a number of them are equally, and in some cases more effective with ethnic groups other than white or Anglo groups. At the same time, there is little evidence that culture-specific adaptations of such treatments are effective, but some data suggesting **evidence-based treatments inherently designed to be individualized are culturally responsive.** Given this state of affairs, what are service providers and administrators to offer consumers from ethnically and culturally diverse groups seeking high quality, effective care? We suggest that increasing the likelihood that a particular practice will be acceptable and effective with consumers from a particular ethnic or cultural background involves engaging in two broad classes of activities: (1) becoming familiar with pertinent evidence on the issue; and, (2) engaging in evidence-based thinking. With respect to the former, the SAMHSA NREPP website site provides an easily accessible venue for learning which practices have been tested with diverse ethnic groups. The NREPP entries are not exhaustive, and the lists are not always current, as there is lag time between the emergence of new data, evaluation of the data for the NREPP site, and site updates. It is, however, a useful beginning place. The National Implementation Research Network (NIRN) website also offers information regarding the accessibility, quality, and effects of services for youth and families. Three scholarly reviews – two pertinent to child and adolescent mental health interventions (Chorpita & Daleiden, 2009; Huey & Polo, 2008) and the third to adults (Miranda et al., 2005) – may also be helpful.

If no scientific evidence is available for the particular practice or ethnic group of interest (i.e., the effectiveness studies for the practice did not include members of the ethnic minority group in question, or included such members but not in sufficient numbers to determine whether the effects were different for them) then a consideration process that reflects evidence-based thinking (described further in the next section) is warranted. This process involves consideration of: (a) the ways members of a particular ethnic minority group differ systematically from the groups participating in the research that demonstrated the effectiveness of a particular practice; (b) the active ingredients of the evidence-based practice in question; and (c) the extent to which the unique characteristics of members of the ethnic group and active ingredients align or misalign. As described further in the next section, this kind of consideration is an example of 'evidence-based thinking,' in which administrators, practitioners, and consumers generate specific hypotheses about what aspects of treatment would need to differ, and why, to increase the odds of success with an individual or family from a particular ethnic group.

There are several ways specific ethnic minority groups might differ from non-minorities, and from one another, ways that may impact the delivery or effects of a particular treatment. One way is through biology. There is, for example, some evidence that members of ethnic minority groups may differ in their likelihood of metabolizing some medications either more quickly or more slowly than others. This difference, however, is only one of proportions. That is, the findings are not that all populations of color are slow metabolizers of psychotropic drugs whereas whites are not. In one study, 15–31 percent of East Asians, 7–40 percent of Africans, and 33–62 percent of Europeans and Southwest Asians had a likelihood of metabolizing medications more slowly. These studies would suggest that evidence-based care would still be appropriate for ethnic minorities, but that dosing will differ by individual characteristics.

Second, cultural norms and values, and culturally specific conceptualizations of mental illness, substance use, or behavior problems could influence engagement in and response to some types of interventions. This may mean presenting select aspects of a particular evidence-based practice differently for some cultural groups. In addition, culturally appropriate outreach efforts may be necessary to engage ethnic minority populations in care. This is consistent with the concepts of recovery and resiliency, and person-centered practice described in this chapter.

EVIDENCE-BASED THINKING

As indicated earlier, not all helpful treatments and services have been thoroughly researched and therefore not all have a good evidence base. That does not make them bad or wrong. Likewise, evidence-based practices do not work equally well for all clients, even if the client's diagnosis, symptoms, and circumstances are similar to those of the population that was studied. Practitioners need to be open to approaching each individual and family uniquely, making the best decision possible for that particular client at that time. Sometimes, starting with a treatment or service that is not as likely to be effective according to the research may be all the client will accept or can tolerate at the moment. In some cases, a less effective treatment will be the most acceptable, and likely to have a positive impact, with a particular client at a particular point in time. As the treatment process continues, the client may be more open to hearing about and trying services or treatment with a higher likelihood of having a good result according to the research in the field.

On the other hand, practitioners and consumers/families seldom have as much evidence as they would like about what will produce the best and desired results in every situation. The behavioral health and human services fields are still evolving, with many desired outcomes for some people unable to be accomplished with current known treatments or services. Practitioners must acknowledge these limitations and help consumers and families to work with the practitioner to try approaches that the literature suggests might work as well as approaches that are simply anecdotal where the known treatments and services are ineffective in the particular situation. Continuing to maintain hope is critical for consumers and their families dealing with the effects of mental illnesses, addictions, and a host of personal and family crises.

Many times, people talk about what treatment or service is most likely to work. It is important to remember that what 'works' is sometimes a matter of opinion, based on the perspective of the individual. For some, 'works' means reducing symptoms or increasing function. For others, 'works' means getting a job, staying in school, having a friend, or getting to live where you want. For yet others, 'works' means keeping out of the hospital or out of trouble with the law. Evidence-based thinking, whether for a practitioner or for a program administrator, starts with a shared definition of 'what works.'

> Evidence-based thinking, whether for a practitioner or for a program administrator, starts with a common agreement about the definition of 'what works.'

As an individual practitioner, it is important to know the individual client, his/her thinking and history about treatment and services, his/her knowledge about the illness, and his/her values about what he/she wants life to be. It is also important to understand the life goals, not just the treatment or service goals of the client at that time. The process starts with the person, not with the diagnosis.

The practitioner and consumer work together to identify desired outcomes. Then, the practitioner must go to the literature, the existing service array in a particular community, to other practitioners, and, of course, to the consumer and family group to determine what options there are for this particular client to achieve his/her specific short and long-term goals. The practitioner must understand and be able to explain the different options and the likely outcomes, along with the strength of the evidence associated with an option.

The kind of evidence (controlled study, evaluation, expert consensus opinion, or anecdotal information from other practitioners or consumers) is also important. For some people, the personal experience of other consumers or families, even though only anecdotal, may be more compelling than a clinical controlled trial. Together, the client and practitioner must pick the best option at that moment for that client, given the client-determined desired outcomes. This process requires that the practitioner be open to all kinds of options for each client, including ones that are only available from other practitioners or programs. This thinking process is what will result in an individual practitioner's clinical practice being as evidence-based as possible.

For program managers seeking to implement evidence-based practices and seeking to encourage clinicians to conduct a constantly-improving evidence-based practice, the thinking process must be similarly open, beginning with a clear description of the population or group the manager wants to or is required to serve. This description will include diagnosis, functioning level, age, and income level. It will also include ethnicity, lifestyles, histories, and beliefs held in common. Then, working with members of that population and with practitioners who will be working with them, the manager must determine what the most frequently desired outcomes are for members of this group.

The scientific literature, professional association publications, meetings, training and discussions, and work with advocacy groups should be undertaken to determine the service approaches with the strongest evidence to achieve the desired outcomes. For example, if employment is the desired outcome, the use of an assertive community treatment team alone is probably not the best approach. Rather, supported employment that uses an individual placement and support approach is more likely to be successful. Or, for some individuals, an individual placement and support approach to supported employment must be combined with the involvement of the assertive community treatment team. If keeping elementary school aged children with behavioral difficulties attending and learning in school is the goal, combining parent-mediated treatments and school-based educational support strategies has a much higher probability for yielding the desired results than individual counseling.

Identifying client or population characteristics, determining desired outcomes, finding out what the evidence says about the intervention approaches that have been tested with similar clients, and then choosing the treatment or service design most likely to produce the desired result is evidence-based thinking. Continuing to provide what a practitioner learned in school or what a program has been doing for the last several years may or may not be the best possible approach. Doing what is comfortable or familiar to practitioners or program managers (or to clients or advocates for that matter) may not be the best possible approach. Evidence-based thinking requires that practitioners continue to learn new approaches to serving clients over the course of their careers, because the evidence base about the treatments, services, and supports will continue to grow and improve. In addition, practitioners use a scientific approach to choosing, tailoring, implementing, and monitoring the effects of intervention strategies they use in partnership with the clients they serve. This means taking a scientific approach to understanding the problems and opportunities the client faces and the outcomes the client desires; the extent to which these problems, opportunities, and outcomes map onto what is known scientifically about similar clients; and the extent to which the intervention options available to the practitioner and client have been demonstrated in research to achieve the client's desired outcomes. Practitioners using evidence-based thinking consider the implications of using, tailoring, or rejecting intervention strategies shown to be effective, and of strategies that may be promising, but for which effectiveness has not been determined. Throughout this decision-making process, practitioners take into account both the individual needs and circumstances of the people they serve in order to get the best results for clients and for the program.

No publicly funded program is without the constraints of limited resources and organizational barriers. Dealing with these constraints while still engaging in evidence-based thinking is discussed further in Chapters Six and Seven of this manual.

Chapter

3

Different Words for Different Ideas — Definitions that Matter

The literature on clinical research is filled with new, old, and evolving terminology. Below are terms you will frequently encounter when reading about evidence-based practices. Many of these words have multiple meanings. For example, the term evidence-based practices itself can mean a narrow group of practices proven repeatedly in rigorous scientific studies to consistently produce good results. It can also mean any practice for which there is some scientific evidence of good results, without determination regarding the strength of the evidence. There is increasing convergence regarding the definitions of the terms described here, although variation in definitions is still common. This is so in part because the dissemination and implementation in practice of scientifically tested mental health and substance abuse treatments, services, and supports tested scientifically is still relatively new.

The definitions here are a guide to help the reader learn about these concepts and begin to explore ways to implement evidence-based practices. They are not definitive statements about the meaning of these terms. It's a good idea to become familiar with these terms and refer often to this chapter as you begin reading the scientific literature and other publications about evidence-based practices.

Once you know how to talk about the ideas described here, it will be helpful to understand how to read scientific literature and how to evaluate guidelines and protocols. Just because it is published does not make it right. And, just because a study was done and written up does not mean that the evidence behind that study is strong or reliable. This chapter will help you know how to be a critical reader and listener when you start doing your own review of various publications and when you hear speakers and advocates talk about practices they support and want you to implement for them or for your program.

AN EXPLANATION OF KEY TERMS AND CONCEPTS

Evidence-Based Practices (EBPs) – There are multiple definitions of the term, but two of the most straightforward might be paraphrased as follows: *evidence-based practice is the integration of best research evidence with clinical expertise and patient values* (Institute of Medicine, 2001)[4]; or, *evidence-based practices are those clinical or administrative interventions or practices for which there is consistent scientific evidence showing that they improve client*

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[4] *The IOM defines clinical expertise as the ability to use clinical skills and past experience to rapidly identify each patient's unique health state and diagnosis, individual risks and benefits of potential interventions, and personal values and expectations. The IOM defines patient values as the unique preferences, concerns, and expectations that each patient brings to a clinical encounter and that must be integrated into clinical decisions if they are to serve the patient.*

outcomes (Drake, et al. 2001). The Evaluation Center at the Human Services Research Institute (HSRI) defines evidence-based practices as an approach to mental health care in which consumers, mental health professionals, and policy-makers use the most appropriate information available to make clinical decisions. This is similar to the idea of evidence-based thinking described in Chapter Two of this manual.

> When approaching the topic, it is wise to have consensus about what exactly all stakeholders mean by the term 'evidence-based practice', and agreeing on a definition is the simplest way to achieve that clarity.

Best Practices – Best practices are the best clinical or administrative practice or approach at the moment, given the situation, the consumer's or family's needs and desires, the evidence about what works for this situation/need/desire, and the resources available. Sometimes, the term 'best practices' is used synonymously or interchangeably with the term 'evidence-based practices', but this is unwise. Sometimes, 'best practices' is used to describe guidelines or practices driven more by clinical wisdom, guild organizations, or other consensus approaches that do not include systematic use of available research evidence — again, it is not helpful to use imprecise language.

Promising Practices – Promising practices are clinical or administrative practices for which there is considerable evidence or expert consensus and which show promise in improving client outcomes, but which are not yet proven by the highest or strongest scientific evidence.

Emerging Practices – Emerging practices are new innovations in clinical or administrative practice that address critical needs of a particular program, population, or system, but do not yet have scientific evidence or broad expert consensus support.

Evidence – Evidence refers to scientific controlled trials and research, expert or user consensus, evaluation data, or anecdotal information that shows or suggests an identified result happened or is likely to happen when a clearly identified practice or protocol is employed for a particular well-described population with similar characteristics.

Scientific Evidence – Scientific evidence results from a study or research project that has a rigorous controlled design (including a clearly articulated hypothesis and rigorous methodology along with controlled conditions and random assignments to various comparison conditions), with experimental and control groups, that includes sufficient subjects to overcome the possibility that the result could have occurred by chance, and is repeated with the same result in multiple sites with different researchers and different experimental and control groups.

Evaluation or Demonstration – These are types of evidence that compare a practice or intervention to the same situation before the introduction of the practice or intervention, or describe the positive and negative results of an intervention or practice, without comparison to other times or conditions. Evaluations and demonstrations can be more or less controlled and more or less rigorous, including experimental design, depending on how they are planned and conducted.

Consensus Opinion – Consensus opinion is agreement among a group of knowledgeable individuals or groups (especially those considered to be expert due to education, experience, or license) about the likely results of a given practice or intervention. Guidelines produced by guilds or associations of practitioners are often based on consensus opinion. Some of these guidelines are based on research literature and controlled evaluation studies where these exist, and some utilize a consensus of experienced practitioners where such studies do not exist.

Algorithm – An algorithm is a decision-making guide that recommends a particular intervention or approach given a specific diagnosis and functioning, with recommendations about what to change about the treatment or approach, based on the consumer's reaction or response to the previous treatment or approach. For example, a medication algorithm might suggest a particular dosage of a particular type of medication upon diagnosis and assessment of functioning, with dosage changes or medication changes, based on whether the consumer's symptoms change in a described way over a specified period of time. Algorithms are often based on scientific evidence that suggests using medications in a certain order or dosage is most likely to have the desired results on symptom reduction.

Intervention – Intervention is a change in practice, policy, financing mechanism, practitioner, setting, environment, approach, or oversight that is hypothesized to produce a change in status (positive results) for the study population.

Practitioner – As used in this manual, a practitioner is anyone who provides services for consumers or their families. A practitioner may be a licensed independently practicing clinician, a supervised clinical staff member, a certified direct service provider, a person who is trained and meets the criteria to provide direct services, or a peer helper, whether in a supervised setting or in an unsupervised self-help program.

Efficacious or Effective? – In early efforts to characterize and help bridge the gap between what is known, scientifically, and what is done, in practice, researchers and research funding agencies often made sharp distinctions between the term 'efficacy' and 'effectiveness.' In fact, however, even the initial rubrics used to characterize the 'strength' of the evidence for mental health treatments, for example, were based on what is actually a continuum, rather than discontinuous categorization, of research. The continuum has at one end the highest possible 'internal validity,' and at the other, the highest possible 'external validity.' Using this continuum, 'efficacy studies' were those in which an intervention was tested in a randomized controlled experimental trial under highly controlled circumstances, and 'effectiveness' studies were randomized controlled experimental trials conducted under circumstances that more closely resembled usual practice conditions. Increasingly over the past 5-7 years, treatment, services, and implementation research is striking a better balance between internal and external validity, through the use of experimental designs in usual care settings.

Efficacious – A treatment that is efficacious provides positive results in a controlled experimental research trial. A study that shows a treatment approach to be 'efficacious' means that the study produced good outcomes, which were hypothesized or predicted in advance, in a controlled experimental trial, often in highly constrained conditions (e.g., specially trained clinicians, university settings, with homogeneous clients, etc.). Clinical practices that are determined to be efficacious are more likely than practices proven not to be efficacious to be effective in the 'real world,' (i.e., in routine practice settings). However, the most efficacious interventions may not always be the most effective, given the situation or conditions in which the intervention is introduced and implemented.

Effective – Effective treatment has been tested in experiments (randomized trials) under conditions that reflect usual or routine care. Effectiveness studies use real-world clinicians and clients, and typical complicated clients (i.e., clients who often have multiple diagnoses or presenting problems and needs). It should also be noted that sometimes the word 'works' is used as synonymous with the word 'effective.' The effects of some treatments have been shown in research to vary significantly for different groups of individuals (e.g., men or women; individuals with greater levels of depression or lower levels of depression; individuals with and without co-occurring substance use problems). Thus, for these treatments, it is possible to talk about 'what works for whom.' Indeed, effectiveness trials often illuminate 'what works for whom' knowing a particular treatment is efficacious, or effective, in treating a particular disorder or problem does not guarantee that treatment will work equally well with each individual having the problem. Indeed, even in the experiments, there is variation in improvement *within* each group of participants – those receiving the experimental treatment, and those receiving a comparison treatment, or usual services. When the treatment or service is found to be efficacious or effective in the trial, though, it means that even with the variation in improvement that occurred for individuals within each group, the individuals in the experimental group were, on average, better off than those in the comparison group. Thus, the odds that a particular individual will experience the benefit of a treatment or service are increased when using a treatment shown to be efficacious or effective, relative to a treatment that resembles those used in the 'comparison' condition in experiments, or that has not been evaluated at all.

Knowledge Diffusion – This is the process of transmitting information from controlled trials to those that are in a position to use the information gained in experimental situations in non-experimental situations. *NOTE:* Knowledge diffusion may or may not result in actual changes in behavior, based on learning the new knowledge. Also, knowledge diffusion and knowledge dissemination are sometimes terms used to convey a similar meaning as transportability. Here, the terms are used more narrowly to mean simply making knowledge widely available rather than putting the knowledge into practice.

Transportability – Transportability is the process of moving information about new research findings from a controlled setting or condition to an uncontrolled, non-experimental setting or condition that is routinely experienced.

Adoption – Adoption is the difficult process of planning, implementing, and sustaining practices or interventions that have some evidence to suggest they are likely to or may produce positive results. This process may include behavioral changes at an individual or an organizational level. Adoption implies attention to fidelity to all the key elements of a proven practice and takes careful planning and sustained effort to achieve in routine practice the results achieved and reported in scientific studies.

Fidelity – Fidelity is adherence to the key elements of an evidence-based practice, as described in the controlled experimental design, and that are shown to be critical to achieving the positive results found in a controlled trial. Studies indicate that the quality of implementation strongly influences outcomes. While there is much discussion in the field about the need to maintain fidelity to the experimental design that produced the positive results, increasingly there is discussion about the need to research and rigorously evaluate practices in routine settings so that the things that are more likely to produce good outcomes in such settings are identified and supported.

Adaptation – Implementing a practice or intervention described in a controlled experimental design without complete adherence to its key elements, necessitated by the situation into which the practice or intervention is introduced, is adaptation. *NOTE:* Adapting a practice for routine care may be the only possible course in some situations (given the constraints or available resources), but may not result in the same positive results that were found in controlled trials. Hence, adaptation may be ineffective and therefore inappropriate. In other cases, adaptation may result in better outcomes than in the experimental design because the adaptation more closely matches the desires, needs and expectations of the clients and practitioners in the situation into which the practice is introduced.

Moving to Scale – Increasing from a few (pilots or experiments) to a large number of situations, number of clients, number of providers/programs or geographic range in which a practice or intervention is implemented, is moving to scale. There are often losses in adherence to fidelity when an experimental or pilot practice or program is moved to scale, with a loss of positive results and creating unique challenges for such processes.

Sustainability – Sustainability is the ability of an organization or individual to continue over time the implementation of a practice or intervention with continuing fidelity to key components that create the positive results.

Stages of Organizational Change or Readiness – These stages involve the knowledge, attitudes, resources and intentions of an organization that describe and will impact whether the organization is willing and able to implement a practice or intervention that has not yet been implemented in that organization or setting. NASMHPD identifies five stages as unaware/uninterested, motivating, implementing, sustaining, and improving. Prochaska & Levesque (2001) identify the five stages as pre-contemplation, contemplation, preparation, action, and maintenance. Sometimes these stages are collapsed into three:

1) contemplation/consensus-building;

2) enactment/implementation; and

3) maintenance/sustaining.

Factors in Individual Readiness – These factors are the issues that affect an individual's willingness and ability to adopt a new intervention or practice. These factors include the complexity of the practice, the amount of difference from the current practice, the approach to suggesting the individual adopt a new practice, the champions or opinion leaders encouraging the change in practice, available supervision and support (including feedback on results), and the influences and barriers to adoption.

Influences and Barriers to Adoption – These are actions or issues that encourage or impede adoption of a new practice or intervention. These may include but are not limited to organizational structure, policies and procedures, payment mechanisms, organizational or individual culture or comfort with change, size or age of the organization, history or experience with other recent changes, mandates or incentives.

Resistance – Resistance is the refusal or reluctance to implement a new practice or intervention, often accompanied by rationalization about the reasons for the refusal or reluctance. Resistance often masks the factors in individual readiness or the influences and barriers to adoption.

How Much Evidence Is Enough? The Hierarchy of Evidence

In addition to knowing about key terms, it is important to know how much evidence to look for when reading research literature. In other words, how much evidence is enough evidence to prove that a service is likely to be effective? In the research world, there is what is called a 'hierarchy of evidence.'

The highest level of evidence is scientific, controlled clinical trials with random assignment of individuals from similar groups to the experimental care or to routine care. Outcomes from such trials that are then replicated in studies outside the controlled environment (routine settings or usual care) provide the highest level of evidence that a practice is both efficacious and effective.

The next level of evidence comes from scientific, controlled studies that have not been proven outside of the constrained environment but, within the constrained environment, have produced good outcomes. Practices that are found to be efficacious are more likely to be effective in the real world than practices proven not to be efficacious, if implemented in routine settings with fidelity to the model studied. However, until an effectiveness study occurs there is no way to know for sure whether an efficacious practice will result in effective care in a real world setting.

Evaluations and demonstrations are types of evidence that can vary in design and method. If designed and conducted rigorously, they can produce strong evidence of the effectiveness of the studied practice. If conducted under less rigorous conditions, they can still show some evidence of effectiveness, but are less likely to be proof that the practice can be replicated in other settings. Evaluations and demonstrations often compare outcomes before and after introduction of a given practice or condition and often do not have control groups for comparison. However, they are more likely to provide information about what happens in routine rather than experimentally controlled situations.

Expert consensus that a practice is effective is another level of evidence but one that is not as high as studies of efficacy and effectiveness. The term 'expert' usually refers to a clinician or researcher in the field who has received recognition for making significant contributions to the mental health or substance abuse field. Members of guilds, such as those issuing practice guidelines and treatment monographs, are also considered to be experts. Consensus documents that incorporate the opinions of consumers, families, and other stakeholders offer important additional information on the worth of a clinical practice. Expert consensus documents can be more or less strong depending on whether the conclusions are based on controlled studies and rigorously designed evaluations or based solely on the individual experiences or opinions of the experts. Sometimes, expert consensus documents simply serve to reinforce what practitioners currently do and what they believe is effective rather than what studies and evaluations have proven to be efficacious and/or effective. However, in the absence of controlled studies and rigorous evaluations, expert consensus documents can be valuable information about what is effective in the circumstances and with the populations described.

The lowest level of evidence is that which consists of individual anecdotal stories or experiences about practices in general or those based upon treatment approaches by an individual practitioner or for a particular individual. Unfortunately, much of the treatment that is provided today is based on this kind of evidence. Practitioners should be cautious about implementing practices based only on this level of evidence. On the other hand, this kind of day-to-day experience of practitioners and of consumers and their families is valuable information in the absence of other evidence. In fact, this kind of evidence for a particular situation may be the best evidence possible and should not be ignored. Treatment approaches that are backed only by this level of evidence often serve as theories for further research.

Such approaches should have much more exploration and research before being disseminated to the field as effective practices likely to produce consistent positive results.

THE IMPORTANCE OF READING THE LITERATURE

Lots of information on clinical research is available through journals, web sites, training seminars, and conferences. Much of it is good scientific research while other information is based on limited evidence. How do you know when you are reading or listening to presentations whether the research is of high quality or sufficient strength? The quality of the researchers, the design of the study, the size of the group studied, the number of similar studies, and other factors may determine whether the study provides sufficient value to use in making clinical or program decisions. The guide to reading the literature in Appendix C and the Bibliography in Appendix D provide some guidance about each of these factors for you to use as you read scientific and other literature about treatment and service approaches.

Looking for a review of research done by a neutral multidisciplinary group or a meta-analysis of research studies in a particular area may be a better place to start than trying to read all available research studies about a particular practice. Some program and clinical leaders have charged selected staff to work with local academic leaders to review the literature, summarize it, update it regularly, and make the summarized results available to staff for decision-making. Being familiar with the literature and available information on effective services is a duty that we have to service participant, families, colleagues, and communities.

As a practitioner, it is critical that you learn to use research and evaluation information and that you apply it to your work. As a program manager, it is critical that you encourage and support the practitioners who work for you in being good consumers of research and evaluation information. Provide them articles and books to read and opportunities to hear from researchers and evaluators. Offer them opportunities to participate in research or evaluation studies, and make it a part of your program's every day operations. While it may seem like a luxury in the face of limited resources and staff stretched too thin, it is critical for survival in the long run. Being a learning organization will allow you to recruit and retain the best staff, provide the highest quality of services, and convince funders of the value of the services you provide. It will also assure that you are offering the best services possible for the people you are in business to help. Generally, organizations that utilize, support, and contribute to research and evaluation efforts are more successful at attracting the resources needed to deliver the services they know will produce better results for the people they serve.

Chapter 4

Examples of Evidence-Based and Promising Practices

INTRODUCTION – ORGANIZATION OF THIS CHAPTER

In this chapter, a few existing sources of information about evidence-based practices are identified and some of these practices are briefly described. As the research and literature on evidence-based practices grow, there is an increasing amount of information available on the effectiveness of treatment approaches. Professional associations, research organizations, and federal and state governments have begun to compile and produce lists of evidence-based practices to inform practitioners, consumers, family members, and the public on various treatment and intervention approaches and their effectiveness. The lists included in this chapter and appendices are designed to educate consumers, providers, and program managers about clinical practices that have been proven to be effective for a particular condition and a particular population. These lists are examples only and do not necessarily provide the most complete or most accurate information about evidence-based practices for a particular population or condition. The further one moves from the publication date of this second edition, the more that new resources are likely to be available.

Information about where to find more on specific evidence-based and promising practices, including other helpful lists, is included in the bibliography (Appendix D).

One of the major advantages of using lists produced by state and federal governments, professional associations, professional journals, and research-based organizations is that experts in the field have already done work to assure that the quality and quantity of the evidence is likely to be reliable and true. However, you should always check the latest evidence yourself to make sure there is support for the practice you want to implement and that the information provided in any list or summary of evidence-based practices is the most recent and accurate available.

This chapter is organized around three groups of consumers: adults with mental illnesses, children with emotional or behavioral disturbances (including delinquent behavior and family disruption) and their families; and persons with substance abuse and addictive disorders. Within the three sections of this chapter on each of these populations, one or more lists from identified sources are used to put a variety of practices in context. Then, a few of these practices and sometimes practices not on the highlighted lists are briefly described. The practices highlighted here are ones that are commonly employed or that show a range of practices that program administrators or practitioners might find of interest.

This chapter does not include all the lists available and does not describe all evidence-based, promising, or emerging practices for these three populations. Instead, this chapter introduces the reader to information that can be useful when researching clinical practices to achieve specific outcomes for a particular population or individual.

The research on what works and does not work in the behavioral health and human services fields continues to grow. As a result, sometimes the evidence on the effectiveness of a treatment approach can shift from 'supported' to 'unsupported' or vice versa, as more research is conducted over time. We are all very familiar with this phenomenon in other areas of research, such as the medical field. For example, we have all had the experience of hearing that a specific pharmacology treatment or medication is recommended for a particular physical condition, based on research, and later hearing that the recommendation has been modified based on the 'latest research.' This is often the result of widespread use that provides a more complete picture of the impact of an intervention on a large population of users, not small sub-sets.

As information technology becomes more accessible and the use of the phrase 'evidence-based' becomes more commonplace, it is increasingly important to sort out credible sources of information about evidence-based and promising practices.

What is important in these situations is that the research continues and that professionals and consumers are provided with the latest and best information on the body of evidence supporting a particular treatment approach — and that they use feedback mechanisms to report on their experiences with various interventions — feedback that becomes part of the body of evidence on effectiveness. As you review lists of evidence-based and promising practices, remember to do your own research to verify that the information you are viewing reflects the most up-to-date information. Likewise, remember that the purpose of the lists in this chapter is to provide examples of information available and not to suggest that the specific recommendations of the lists should be accepted without further input from a variety of sources.

It might be wise to revisit for a moment the definition of 'evidence-based' used in this manual. There is a hierarchy of evidence (see Chapter Three) with more or less strength depending on the type and amount of evidence available to support a particular practice. To be considered the strongest 'evidence-based,' a practice must have been proven efficacious (and preferably effective, see Chapter Three) in several randomized, controlled treatment outcome studies. Studies that are strongly supported by evidence can be replicated in other settings by different researchers. This means that even if the treatment developers are among the authors of research studies showing positive outcomes, they are not the only authors of research studies showing these results.

As information technology becomes more accessible and the use of the phrase 'evidence-based' becomes more commonplace, it is increasingly important to sort out credible sources of information about evidence-based and promising practices. Sometimes a practice is said to be evidence-based when, in fact, there is little evidence to support that claim. For example, on the Internet it is common to find information about individuals who have developed a new clinical treatment. A web page may describe the treatment, the clinical conditions the treatment targets, and outcomes that can be achieved through the use of this treatment. In many cases, the treatment is further described as 'evidence-based as demonstrated through numerous studies.' While this may in fact be true, it is always important to examine the quality and quantity of the evidence before a specific practice is considered to be evidence-based. (See Appendix C: How to Read and Understand the Literature.)

As we noted above, this manual was originally produced with a mental health audience in mind. In preparing the second edition, with its broader focus on human services, the authors decided to retain the following sections that are specific to mental health services for adults and youth, and services for people with substance use conditions, as the basic principles are consistent across any practice setting – these are simply instructive examples from a much wider universe of evidence-based interventions.

THE U.S. SURGEON GENERAL'S REPORT ON MENTAL HEALTH*

An important source of information for all current mental health practices is the U.S. Surgeon General's recent report on mental health (*Mental Health: A Report of the Surgeon General* – See Appendix D). The report has extensive information on mental health and its treatment for adults and for children/adolescents. This comprehensive report was compiled and written by some of the best researchers and academics working in behavioral health today. The report includes an overview of types of mental illness and common courses of treatment, emphasizing those that are known to be more effective than others. The U.S. Surgeon General's report is cited often in this chapter.

Of particular note in the U.S. Surgeon General's report is that a combination of evidence-based practices may be more effective than a single evidence-based treatment used alone. For instance, treatment of depression can be approached through either pharmacology or psychotherapy. Specialized time-limited psychotherapies, such as cognitive behavioral therapy and interpersonal psychotherapy, have been proven effective in the treatment of mild to moderate depressions. Likewise, anti-depressant pharmacotherapy is also known to be effective in the treatment of depression. The U.S. Surgeon General's report notes that depression is often best treated through a combination of these two evidence-based practices, pharmacology and specialized therapy.

The report emphasizes that these options mean that consumers can choose which approach seems right for them. In this chapter, examples of single evidence-based practices are highlighted. It is important to remember that a combination of approaches may be most beneficial for the individual who makes that choice or for programs looking for multiple outcomes. An example of the latter might be assertive community treatment combined with illness management and recovery or with supported employment.

THE INSTITUTE OF MEDICINE'S REPORT ON PREVENTION SCIENCE**

One of the most significant publications released since the first edition of this manual is the report *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. This publication of the National Academies of Science brings together the most current information on scientifically validated prevention strategies, and therefore has broad implications for the entire human services field.

** The Surgeon General has also published reports on mental health for youth and mental health disparities.*

*** The Institute of Medicine has also published several useful reports, including* Crossing the Quality Chasm *and* Quality in Mental Health.

EXAMPLES OF EVIDENCE-BASED AND PROMISING PRACTICES FOR ADULTS WITH SERIOUS MENTAL ILLNESSES

RESOURCES FROM THE FEDERAL GOVERNMENT: SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA) AND THE U.S. SURGEON GENERAL

An excellent source for finding evidence-based and promising practices that support the recovery of adults with serious mental illnesses is the website for the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA is the agency of the federal government that administers and funds behavioral health services across the nation. On SAMHSA's website, there are numerous descriptions of evidence-based mental health practices for adults, including six that are part of a National Evidence-Based Practices Project designed to promote the use of evidence-based practices within the public mental health system. SAMHSA is part of an effort to develop six 'toolkits' to guide implementation of evidence-based practices. These are: illness management and recovery (IMR); family psychoeducation (FPE); supported employment services; integrated dual disorders treatment (IDDT), which focuses on co-occurring mental and substance use disorders; assertive community treatment (ACT); and medication management through algorithms.

Highlighted below are some of the evidence-based practices for adults included in the U.S. Surgeon General's report and/or in the National Evidence-Based Practices Project and listed by SAMHSA as practices proven to be effective for adults with serious mental illness.

Illness Management and Recovery (IMR) – This treatment approach is designed to assist adults with serious mental illnesses improve the skills needed to effectively manage their illnesses and reduce troubling symptoms and episodes of relapse. Illness self-management training is the core component of this evidence-based practice. Consumers develop the skills required to recognize symptoms and signs of relapse, to manage and reduce stress, and to understand the side effects of medications. IMR involves professional input and is oriented toward increasing consumer empowerment in managing the illness.

Four primary interventions are used in IMR: psychoeducation; social skills training; coping skills training; and cognitive therapy techniques.

Psychoeducation provides information to consumers about their mental illnesses, including symptoms, side effects of medications, stress management strategies, warning signs of relapse, and general approaches to treatment. Psychoeducation is the primary therapeutic modality used in the illness management and recovery practice.

Social skills training involves helping consumers execute new skills in social situations and relationships. In coping skills training, individuals learn to perform relaxation techniques, engage in positive self-talk, and use other techniques for coping with persistent psychiatric symptoms. Cognitive therapy helps consumers manage their delusional beliefs, evaluate their beliefs and perspectives against evidence in their environment and then formulate new thoughts that are less stressful or disconcerting.

Outcomes of IMR include the individual's successful management of his/her mental illness resulting in reduced distress from symptoms and relapses.

It should be noted that consumers around the country have developed their own approaches to illness management and recovery that include consumers teaching and supporting other consumers to use mechanisms for setting and attaining goals and managing symptoms and stressors associated with mental illnesses or addictions. (See Self-Help and Consumer-Operated Approaches, described later in this Chapter.)

Assertive Community Treatment (ACT) – ACT is a case management model that employs a multidisciplinary team to provide clinical services in a comprehensive and flexible format. This intervention provides direct service provision in the client's natural living environments with 24-hour responsibility maintained by the team. ACT is employed as a model with individuals who have a serious mental illness that causes persistent psychotic symptoms and significant disruptions in their daily life, including frequent and sometimes lengthy hospitalizations.

ACT differs from traditional case management models that use a 'brokered service' approach, where the case manager links the client to services rather than directly providing them. In the ACT model, caseloads are small in order to allow the delivery of intensive services and the team shares responsibility for the intervention, rather than a client being assigned to one case manager. The ACT model has been found to be most effective, both in terms of therapeutic value and cost-effectiveness, for individuals with a history of lengthy or multiple hospitalizations.

Since its development in the late 1970s, many studies of ACT have demonstrated outcomes, such as substantial reductions in psychiatric hospitalization, decreases in psychiatric symptoms, increases in independent living, and increases in quality of life. Recent studies suggest ACT also produces superior vocational outcomes for consumers relative to traditional services if a vocational specialist is part of the team, or if ACT is combined with a supported employment approach (described later in this chapter).

The bibliography (Appendix D) also provides references to materials about adapting ACT teams to rural areas, which often cannot meet the staffing patterns and ratios of urban ACT teams.

Medication Algorithms (Evidence-Based Pharmacological Treatment) – Medication algorithms are practice guidelines to help clinicians make complex clinical decisions in medication treatment for individuals with serious mental illnesses. The guidelines provide a step-by-step decision-making process for determining appropriate medications and dosages. Research in this area has focused on individuals diagnosed with psychotic disorders, mood disorders, and certain anxiety disorders, such as panic disorder, post-traumatic stress disorder, and obsessive-compulsive disorder. Studies of medication algorithms have shown that when clinicians carefully follow medication guidelines the effectiveness of the medication regimen improves, and consumers are more satisfied and experience fewer side effects.

Outcomes of the medication algorithm evidence-based practice include the reduction of psychiatric symptoms and hospitalizations. For some consumers, the result of this reduction in symptoms leads to increased quality of life, including improved social interaction and employment experiences, and satisfaction with treatment. For others, medication algorithms alone will not increase employment or social interactions. A combination of ACT, medication algorithms and supported employment or peer supports may be necessary to produce these multiple positive outcomes.

Psychoeducational Approaches Involving Families – Education of family members of individuals with mental illness is important to help decrease tension and stress in the family, promote social support and empathy, and establish a collaborative relationship between the treatment team and family. Statistics indicate that between 25 and 60 percent of individuals with serious mental illness live at home. In these situations and others, the relationship between family members and a person with mental illness can have a significant impact on the individual's ability to manage his/her symptoms and illness and on the family member's ability to go on with their lives. That is, the recovery experience and independence of the consumer increase while caregiver burden decreases.

Psychoeducation is a primary component of a family intervention program. By helping family members understand the nature and complexity of the mental illnesses of a family member (including the specific diagnoses, symptoms, and treatments), they can more effectively support their loved one. This model presupposes that the primary consumer approves of and has consented to its use with family members.

Documented outcomes of psychoeducational approaches involving families include evidence of increased knowledge within the family regarding mental illnesses and decreased stress and caregiver burden. Studies also suggest that family treatment programs reduce consumer risk of relapse or re-hospitalization by 25 to 50 percent over a two-year period.

It should also be noted that, as with illness management and recovery (IMR), families have created their own approach to family psychoeducation. An emerging practice is the National Alliance for the Mentally Ill's (NAMI's) Family-to-Family program in which families teach other families about the illnesses experienced by adult family members and about methods of coping and resources available for support. Families who participate in this program feel strongly that the information coming from other families who have the shared experience is critical to the educational and support component of the program.

Psychoeducational approaches involving consumers are a common and effective practice. Some of these approaches have already been described in the earlier section of this Chapter under Illness Management and Recovery. For more information on where to learn about psychoeducational approaches involving consumers, see the bibliography (Appendix D).

Integrated Dual Disorders Treatment (IDDT) – Approximately 50 percent of individuals with serious mental illness are impacted by substance use. Individuals with co-occurring disorders of mental illness and substance abuse have increased negative outcomes in the areas of homelessness, incarceration, hospitalization, and serious infections such as HIV and Hepatitis. Studies have shown that treatment of the two disorders by two separate clinicians in different programs is not as effective as integrated services. The term 'integrated services' means that an individual receives treatment from one clinician (or treatment team) through one program that combines appropriate treatments for both disorders. Individuals with co-occurring disorders tend to drop out of traditional treatment programs while those treated through integrated services are more likely to achieve higher rates of recovery.

Desired outcomes for integrated services for individuals with co-occurring disorders of substance abuse and mental illness include reductions in psychiatric symptomatology, decreased substance use, and a reduction in the negative outcomes associated with co-occurring disorders. Positive outcomes have also been demonstrated in the areas of housing, hospitalizations, arrests, functional status, and quality of life.

Supported Employment – This practice is used increasingly to improve the employment outcomes of adults with serious mental illness. Supported employment is one type of psychosocial rehabilitation (PSR). PSR includes independent living and social skills training, client psychological and social support services, family support services, access to recreational activities, housing, and vocational rehabilitation as well as supported employment services. Typically, adults with serious mental illness may benefit from a combination of psychosocial rehabilitation services rather than just a single service.

Supported employment refers to direct placement of individuals with mental illness in competitive employment with ongoing supports. This practice is considered to be an evidence-based practice for adults with serious mental illness. This practice varies significantly from vocational rehabilitation programs that require extensive assessment, skills training, vocational counseling and/or sheltered work experiences before an individual is determined to be 'ready' for competitive employment. Supported employment assumes that persons with serious mental illness, who are provided with support services specific to the job and work environment in which they find themselves, will gain the skills needed for successful employment on the job, just as most other adults do.

Adults with serious mental illness who are placed directly into competitive employment and who receive ongoing supports are statistically more likely to be successful in achieving competitive work outcomes than adults in traditional vocational programs. A primary distinction between supported employment and traditional vocational programs is that supported employment programs provide ongoing support to the individual after they have been hired. Traditional programs sometimes see their job as helping the person develop the skills needed for employment (such as grooming, social interaction skills, timeliness, attention and focus, etc.) or secure competitive employment and offering limited or no services beyond that point.

Supported employment programs can be implemented from a variety of settings, including community mental health centers, community rehabilitation programs, clubhouses, and psychiatric rehabilitation centers. However, the service must be provided *in vivo*, that is, out in the community where job searches and actual employment occur.

Outcomes for supported employment programs include increased levels of competitive employment, on average from about 21 percent in traditional programs to 58 percent in supported employment programs.

Supportive Housing – Originally developed as a strategy for addressing chronic homelessness, especially for persons with severe and persistent mental illnesses, supportive housing (i.e., permanent housing with an array of supportive services available to residents in the housing) has emerged as an approach with broad applicability. For example, youth 'aging out' of child welfare, mental health, and juvenile justice placements have historically fallen through the cracks because of the lack of age-appropriate housing and services. Historically, different models emerged (sometimes called 'supported' housing), often linked to different populations, such as elders, persons with disabilities, etc. There has been emerging consensus about the common principles that underlie any supportive housing model:

- All groups have a similar need for government-funded housing assistance because of extreme poverty.
- Control over one's environment and housing choice is essential.
- Housing must be permanent, as defined in landlord/tenant law.
- Housing must be 'unbundled' from supportive services and not made contingent on the receipt of services. However, supportive services must be available and accessible if needed and desired.
- Supportive services must be flexible and individualized, rather than defined by a 'program.'

The key to the most successful supportive housing interventions has been the notion of 'housing first'—getting the person into a decent, permanent place to live. Early models made continued residence in an apartment or house contingent on compliance with mandatory services, but the best current models encourage but do not mandate specific support services.

Specialized Therapies – Behavioral therapies are interventions that impact disorders by helping people to change their behaviors. For example, behavioral treatment of depression focuses on helping people with depression engage in activities and interactions with others to help improve mood. Cognitive therapies focus on how thinking affects mental disorders. For example, evidence shows that depressed individuals often think about the world in ways that maintain their negative mood. A depressed person might believe that he/she is a complete failure because his/her marriage was unsuccessful. Cognitive therapy would help him/her to challenge this belief and realize that he/she has been successful in many areas and is worthwhile despite his/her divorce.

These two types of therapy have been combined into Cognitive Behavioral Therapy (CBT). CBT is a brief (often 12 to 20 weeks) treatment that has been shown effective for depression and a number of anxiety disorders. CBT teaches techniques for controlling mood and anxiety and can be effective for preventing relapse. CBT has also been demonstrated to be effective in reducing problems with relationships, family, work, school, insomnia, and self-esteem. CBT is considered an effective treatment for panic attacks, phobias, and post-traumatic stress. CBT has also been used in England in the treatment of schizophrenia. It is a specific therapeutic approach that must be taught and followed specifically to gain these outcomes. Simply using an educational approach in a traditional therapeutic session is not CBT. It also requires specific supervision different from usual supervision of traditional therapy.

Dialectical Behavior Therapy (DBT) is an empirically researched psychotherapeutic treatment employing cognitive and behavioral principles. This practice has been demonstrated to be particularly effective in treating individuals who are suicidal, engaging in self-harm behaviors, or diagnosed with a borderline personality disorder. This therapy teaches consumers behavioral skills for interpersonal relationships and managing stress.

Interpersonal Psychotherapy (IPT) has also been demonstrated to be an effective specialized therapy. This practice focuses on four common areas: role disputes, role transitions, unresolved grief, and social deficits. Like CBT, IPT is a time-limited approach that emphasizes the present rather than the past. IPT also uses patient education as a primary tool. Studies of both CBT and IPT suggested that they may be equally effective in preventing relapses in episodes of depression.

Promising Practices for Adults

Some mental health practices have significant research support while others are what is described as 'emerging' or 'promising.' All are worthy of attention and consideration given the importance of the voice of the primary service recipient. Research about whether illness self-management techniques are best taught and supported by professionals, by peers, or by both is just beginning. Consumer leaders note that consumer supported programs often do not get the same kind of financial and research support as programs developed by professionals in clinical practice settings. Sources of information about these practices can be found in the bibliography (Appendix D).

There is little doubt that peer support and interactions have positive effects for consumers with severe mental illness. These approaches along with professionally provided services and treatment should be considered by programs interested in helping consumers learn to cope with their own illness and its symptoms and offering consumers an opportunity to grow and contribute. Many program leaders feel that any program without these components is not complete and not as effective as it could be for adults with serious mental illnesses.

Described below are some important evidence-based, promising, or emerging practices in this area. Many of these are described in the U.S. Surgeon General's report described earlier in this chapter. It should be noted that some of these are proprietary models, other are public domain.

Self-Help – Consumer leaders throughout the country have developed their own models of illness self-management, based on their own experiences and taught or provided by peers (i.e., consumers who have experienced the illness and utilized the techniques to cope with it). An example of such a consumer-developed practice is Wellness Recovery Action Plan (WRAP), developed by Mary Ellen Copeland from Vermont. WRAP is a recovery-focused practice in which an individual develops his/her own system for monitoring and responding to symptoms in order to achieve the highest possible levels of wellness. WRAP uses the concept that consumers and professionals train and are trained together to encourage empowerment and to help professionals understand consumers' perspectives about their illnesses and their lives. This approach has not been as widely or as rigorously researched as some treatment practices. However, consumers who have experienced or who train using this approach report that it significantly improves their ability to take control of their own treatment and quality of life.

In addition, the Personal Assistance in Community Existence (PACE) model developed by Dr. Dan Fisher and Laurie Ahern of the National Empowerment Center and the Recovery Management Plan process developed by Wilma Townsend, has received national attention and interest. Information on how to learn more about this work can be found in the bibliography (Appendix D).

Peer Support – Peer Support embodies a variety of approaches that are based on the belief that people who share the same illness can help each other through mutual support. These practices or programs are led by peers rather than by professionals. Self-help groups have been in existence for years, and are growing. The few studies examining the effectiveness of these approaches suggest benefits for consumers including fewer symptoms, fewer hospitalizations, and greater feelings of empowerment or satisfaction after participation in peer-support programs (for example, see the National Mental Health Consensus' Self Help Clearinghouse at www.mhselfhelp.org).

Consumer-Operated Services – These programs, run by consumers, include drop-in centers, consumer-operated supported businesses, employment and housing programs, crisis services, outreach programs, and case management programs. The Consumer-Operated Services Program (COSP) Multi-Site Research Initiative is a SAMHSA-funded project to study the effectiveness of consumer-operated services in improving outcomes for adults with serious mental illness. Dr. Jean Campbell of the Missouri Institute of Mental Health is leading this major project. While research on consumer-operated services has been modest thus far, this four-year project involving more than 2,200 consumers is providing extensive evidence about the outcomes of consumer-operated services.*

Cognitive Enhancement Therapy (CET) – Cognitive enhancement therapy is a process of training the thinking patterns and enhancing cognition of adults with schizophrenia. This therapeutic intervention has elements of psychosocial rehabilitation in that it employs skill-building techniques, but is very structured and utilizes computer-aided learning to engage consumers in learning how to engage in social interactions and increase ability to stay focused and respond appropriately to normal social situations. While this therapeutic intervention is based on scientific evidence about the cognitive deficits of those with schizophrenia and has shown promise for many adults with serious and persistent mental illness, it has not yet been sufficiently researched in controlled trials to be considered an evidence-based practice for broad application.

** Additional information can be obtained at www.wltconsulting.com.*

A NOTE ABOUT JAIL DIVERSION AND HOUSING AS EVIDENCE-BASED PRACTICES

Some people benefit from treatments applied in specific settings or through structural changes in the way the services are delivered. For example, jail diversion and housing are important service approaches but are not clinical practices per se. While these approaches are not clinical treatments, they have been demonstrated to have a significant impact on socially or clinically related outcomes. For example, jail diversion is an important approach for some individuals with serious and persistent mental illness whose interactions with others may result in law enforcement intervention.

There are many different kinds of jail diversion approaches; pre-booking, post-booking, mental health courts, drug courts, etc. Research has demonstrated that simply diverting people from jail does not impact psychiatric symptoms. However, receiving services in a community-based mental health system that offers evidence-based practices rather than in the criminal justice system may influence the effectiveness of clinical treatment as well as outcomes such as time spent in jail.

Any program providing behavioral health services for adults will need to address housing issues. These issues are complex and involve financial, legal, and treatment issues. While there has been extensive research about supportive housing for adults with mental illness and specialized housing and treatment settings for individuals with addictions, a distinction between the treatment or service approach and the setting itself needs to be considered. Some suggest that stable housing alone has a positive effect on symptoms and on recovery. Others suggest that it is the supports or services connected to or associated with the housing that have the positive impact.

A complete review of these ideas about housing and jail diversion is beyond the scope of this manual. However, program managers and practitioners are encouraged to examine the evidence that is available about various housing and jail diversion approaches for the individuals they serve.

EXAMPLES OF EVIDENCE-BASED AND PROMISING PRACTICES FOR CHILDREN AND ADOLESCENTS

The MacArthur multi-year, multi-site juvenile justice reform effort known as *Models for Change* (www.ModelsforChange.net) is a primary source of relevant information. This effort, which the foundation has supported with a commitment exceeding $130 million dollars, focuses on specific systemic interventions to improve juvenile justice services. These are:

Aftercare – In a model system, youth returning to the community after a period of residential placement would be quickly connected with the programs and services they need to adjust and succeed.

Community-based alternatives – In a model system, responses to delinquency would be local and informal whenever possible, and all but a limited number of youth would be supervised, sanctioned, and treated in community settings.

Evidence-based practices – In a model system, programs, practices, and services would be based on research, having demonstrated their effectiveness or shown a strong likelihood of success in improving juvenile offenders' behavior or skills.

Juvenile indigent defense – A model system would safeguard the procedural and substantive rights of all youth who come into conflict with the law.

Mental health – In a model system, professionals in the fields of juvenile justice, child welfare, mental health, substance abuse, and education would work collaboratively to meet the needs of youth without unnecessary system involvement.

Racial and ethnic fairness/disproportionate minority contact – In a model system, youth would receive fair treatment regardless of their race or ethnicity.

Right-sizing jurisdiction – A model system would feature individualized and developmentally appropriate handling of young people accused of crime.

RESOURCES FOR CHILDREN FROM STATE GOVERNMENT: HAWAII DEPARTMENT OF HEALTH

An example of information about evidence-based practices offered by state government is a list compiled by the Hawaii Department of Health (DOH) after extensive review of the research literature to determine effective treatments for children and adolescents. The report produced by the Hawaii DOH identifies the level of support for various clinical practices and support services used to treat specific mental health issues. The report is organized around the effectiveness of clinical practices in the treatment of specific mental health areas. The report also includes evidence in pediatric psychopharmacology for the treatment of bipolar disorder and schizophrenia.

The report identifies five levels of support for a practice. Level 1 is 'Best Support,' followed by 'Good Support,' 'Moderate Support,' and 'Minimal Support.' The rating level given to a specific practice depends upon how much evidence there is to show that the practice has been proven effective. Level 5 is 'Known Risks,' as determined by at least one study or review demonstrating harmful effects of a treatment.

The Hawaii Department of Health's review of the literature shows 'Best Support' and 'Good Support' for the following areas of mental health issues.

Multidimensional Treatment Foster Care – MTFC is an intensive and multi-component intervention in which a child with emotional or behavior problems is placed in a specialized foster home. Foster parents in these homes receive specific training to work with children who have emotional or behavioral problems. The costs of therapeutic foster care have been shown to be significantly less than other out-of home placements, such as hospitals or residential treatment settings.

Studies of treatment outcomes for youth placed in MTFC show that these youth had more positive outcomes than youth who were placed in usual community care, or with regular foster families. Outcomes included decreases in aggressive behavior, fewer criminal referrals, decreased hospitalizations, and less frequent post-treatment incarcerations. Youths placed in MTFC also showed increases in positive adjustment at the conclusion of placement and more frequent placements with parents or relatives in the year after treatment.

Note that MTFC is a specific type of therapeutic foster care service. The distinction between a service model and a clinical intervention is important. Sometimes a particular service model (e.g., therapeutic foster care, home-based services, school-based services) is a useful approach for a particular population. The clinical interventions provided for individuals served within those service models still need to be as evidence-based as possible in order to have the best results. So, if an ADHD child is placed in a therapeutic foster care setting without the best medication, the results may not be as positive as a child not in such a setting who is provided those evidence-based treatments.

Stimulant medications and parent-mediated behavioral interventions for children are the most widely tested interventions for children

with Attention Deficit Hyperactivity Disorder (ADHD), the most common psychiatric disorder seen in childhood. It is estimated that it affects three to five percent of school-aged children. ADHD frequently co-exists with other problems, primarily conduct disorder, but also depression and anxiety disorders, conduct disorder, and/or substance abuse.

The evidence-based practices for treating children with ADHD underscore the challenges of selecting specific interventions for particular groups of children and adolescents. Both the National Institutes of Health Consensus Conference and the National Institute of Mental Health multi-site treatment study concluded that medication management with stimulants or related compounds combined with careful medication monitoring are the treatments with the best evidence of efficacy, efficiency, and effectiveness. The multi-site study provides added information that behavioral interventions are an important supplement for those youth with co-occurring depression or anxiety, which are both extremely common with ADHD. Both of these interventions are superior to no treatment or usual medication treatment in the community.

In general, usual treatment for ADHD in the community suffers from the same deficits as other usual practice treatments studied for adults. This includes infrequent medication monitoring, low dosages of medication and inadequately standardized behavioral interventions. However, when evidence-based practices are implemented with fidelity to the essential elements of the practice, children with ADHD demonstrate decreased hyperactivity, improved attention, reductions in anxiety symptoms, improved academic performance, enhanced parent-child relationships, and increased social skills.

RESOURCES FROM THE FEDERAL GOVERNMENT: UNITED STATES DEPARTMENT OF JUSTICE

According to the U.S. Department of Justice (USDOJ), programs that meet the 'gold' standard of proven program effectiveness must demonstrate four criteria:

- An experimental or quasi-experimental design with random assignment or matched control group;
- evidence of a statistically significant deterrent effect on delinquency, drug use, and/or violence;
- replication in at least one additional site with demonstrated effects; and
- evidence that the deterrent effect was sustained for at least one year following treatment.

Based on these criteria, ten programs are identified by USDOJ as being proven effective in preventing violence. These are:

- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Prenatal and Infancy Nurse Home Visitation
- The Bullying Prevention Program
- Promoting Alternative Thinking Strategies (PATH)
- Big Brothers Big Sisters of America
- Quantum Opportunities
- The Midwestern Prevention Program
- Life Skills Training
- Multidimensional Treatment Foster Care

Described below are two of these ten programs that are also discussed in the U.S. Surgeon General's report.

Multisystemic Therapy – Multisystemic Therapy (MST) is an intensive family and community-based intervention for youth with serious antisocial behavior. This treatment approach targets the known causes and risk factors for antisocial behavioral and works to strengthen positive family and social relationships. MST is a goal-oriented treatment that occurs in the youth's natural environment and proceeds through a treatment plan that has been developed in collaboration with family members. MST is a highly individualized intervention that focuses on the unique needs of the individual and targets those factors that are contributing to the youth's antisocial behavior.

MST has been extensively studied and has produced consistently positive outcomes for youth with anti-social behaviors when implemented with fidelity to the MST model. These outcomes include long-term reductions in criminal activity, drug-related arrests, violent offenses and incarceration. Studies have also shown reductions in out-of-home placements and improved family relationships.

Functional Family Therapy – Functional Family Therapy (FFT) is a specific type of family therapy that has been shown in clinical trials to be effective for children involved in the juvenile justice system. This treatment approach generally targets youth ages 11 to 18 that are at risk or present with problems in delinquency, violence, and substance use. This is a time-limited intervention that incorporates specific phases or steps during the treatment. The latest research in this type of intervention is now occurring in mental health systems but findings in this area have yet to be published.

Other Emerging Practices for Children/ Adolescents – There are several other important clinical interventions being researched in children's behavioral health that are worthy of consideration. One is Intensive Family Intervention (IFI) that is a specific short-term, team-based, in-home intervention designed to intervene in a family in which a child is at risk of being placed outside the home due to emotional disturbance and/or behavioral issues of the child or family. The practice helps the family deal with the crisis and learn coping behaviors. The practice is also designed to engage the family in ongoing services and supports to prevent crises in the future. Outcomes include decreased out-of-home care, decreased child abuse, and increased engagement in services.

TREATMENT OF TRAUMATIC STRESS

The identification and treatment of children with traumatic stress is another area in the children's behavioral health field undergoing significant research to determine evidence-based practices.

The most effective treatments to date for youth experiencing trauma-related symptoms emphasize the correction of distortions in thinking, behavioral techniques, including hierarchy-based exposure, social skills training, and in some cases medications. The cognitive behavioral treatments for sexually abused children validated by Judy Cohen and Tony Mannarino and by Esther Deblinger and colleagues in the early 1990s have been integrated into a treatment approach, Trauma-Focused Cognitive Behavioral Treatment (TF-CBT), that can be used with a variety of abuse-related and other types of trauma. More information about this treatment approach and others can be found on the website for *The National Child Traumatic Stress Initiative*. Substance Abuse and Mental Health Services Administration (SAMHSA) at: http://www.nctsnet.org.

Previously in 2003, the U.S. Department of Justice (USDOJ) produced a report evaluating treatments for children traumatized through physical and sexual abuse. The report *Child Physical and Sexual Abuse: Guidelines for Treatment* rated a range of clinical practices used in the treatment of traumatized children, based on a combination of evidence available and consensus.

This report was identification of clinical practices that carry a significant risk of harm. For example, Corrective Attachment Therapy is identified in the report as having questionable theoretical basis and being of substantial risk. The report describes Corrective Attachment Therapy (the Evergreen Model) as "a unique synthesis of many different techniques which are employed to facilitate the development of attachment between child and parent. These are rooted in an understanding of neurobiological factors, the function of memory, the effects of trauma, grief and loss, and the critical importance of attachment to the healthy development of a child. Treatment occurs within the context of a safe, nurturing, and respectful environment."

The report further notes that there have been no outcome studies that demonstrate the effectiveness of this practice. Knowing which practices have little to no theoretical basis, have no demonstrated effectiveness, or may result in harm is as important as knowing which practices are proven effective.

The USDOJ report also identified treatments that are increasing in clinical practice but for which there is an inadequate amount of evidence, or conflicting evidence, to support its effectiveness. Eye Movement Desensitization and Reprocessing (EMDR), which is noted in the above table as being a "supported and acceptable treatment" but with "novel/reasonable" theoretical basis, is described below.

Eye Movement Desensitization and Reprocessing (EMDR) – This is a controversial but promising practice that is increasing in popularity. This therapeutic approach has been reported in some controlled studies to be effective in the treatment of post-traumatic stress disorder. However, it is not yet considered to be an evidence-based practice. Information on where to learn more about EMDR can be found in the bibliography (Appendix D).

SERVICE SETTINGS AND STRUCTURAL CHANGES IMPORTANT FOR CHILDREN AND THEIR FAMILIES

Two well-known approaches to service delivery for children and adolescents are the System of Care model and school-based services. While neither of these are actually clinical practices, both are an important approach or setting affecting service delivery that can influence clinical outcomes.

System of Care (SOC) – The System of Care (SOC) model is an excellent example of a structural approach to arranging the delivery and coordination of services that employs 'evidence-based thinking.' This model arranges a comprehensive array of mental health and other services into a collaborative network of services that coordinate and work together to meet the multiple needs of children and adolescents with severe emotional disturbance (SED). The following principles are key to the SOC model:

- The child and family are involved in the planning and delivery of treatment and services;
- Services are coordinated and integrated;
- Services are community-based in order to maintain the child in the family and in the community; and
- The system of care must be culturally competent in order to be most responsive to the child's and family's needs.

Clinical research have not shown the SOC model to result in significant reductions of symptoms or reduction in impairments over those found in usual care. However, studies have shown that 'system coordination alone' improved access to services, increased child and family satisfaction with services, and reduced hospitalizations or other forms of restrictive care. In addition, other studies have produced positive outcomes in the following areas: improved family functioning; reduced school absenteeism and drop-out rates; and reduced utilization of hospital, residential or other restrictive services. System coordination alone, without the use of evidence-based clinical practices, may have limited use in reducing symptoms of a clinically diagnosed illness in an individual or family, even though social, functioning and system outcomes may be positively affected as described.

School-Based Services – Another approach that is gaining significant attention in the child mental health area is school-based mental health. This is recognition that children are found in schools and much of their lives take place in and are affected by the school environment. As with System of Care, 'school-based mental health' has been used to describe a wide range of services and interventions that show promising results in reducing expulsions and increasing attendance and performance for children and adolescents with emotional problems.

Specific prevention programs target school-aged children and are designed for service delivery in the school health setting. Examples of effective programs include Promoting Alternative Thinking Strategies (PATHS) and FAST TRACK. PATHS is an elementary school-based program to promote social/emotional competencies through cognitive skill building. In a randomized controlled trial, PATHS produced significant improvements in social problem solving and understanding emotions.

FAST TRACK is a prevention program designed to prevent serious antisocial behavior. This program includes interventions with the family, the child, the school, the peer groups, and the community. While a relatively new program, studies thus far indicate significant reductions in special education referrals at school and in aggression at home and at school, for the targeted children.

Once again, it is important to distinguish between a program service, a setting for service delivery and an evidence-based clinical practice. Providing services that are not evidence-based in a school setting may not produce positive results beyond what would be seen in any setting delivering that same care. While positive results may occur for an individual child simply because the child is receiving some care rather than none, that child and others seen in the school setting may show even better results if evidence-based practices are employed.

Some school officials and school health specialists are beginning to suggest that the nature of the school setting may require different practices to be designed and researched to address the unique constraints of that setting. These issues are being discussed and researched by the MacArthur Foundation's *Initiative: Linking Science and Practice to Improve Youth Mental Health Care* (see bibliography, Appendix D).

PREVENTION PROGRAMS FOR YOUTH

A 2009 report of the Institute of Medicine (IoM) of the National Academy of Sciences, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities,* outlines a number of research-supported interventions that are demonstrated to have significant positive impact. For example, the IoM identifies several parenting interventions (Incredible Years, Positive Parenting Program, Strengthening Families Program, and Adolescent Transition Program) that reduce 'aggression, disruptive, or antisocial behavior,' reduced substance abuse, and improved academic success. Other interventions identified in the report were shown to impact reductions in the number of sexual partners for adolescents, reduced levels of aggressive behavior and reduced arrests, and many of the interventions have been demonstrated to have lasting positive effects years after the youth have been involved in the models. Obviously these evidence-based models have potential impacts across the broadest spectrum of human service programs.

EXAMPLES OF EVIDENCE-BASED AND PROMISING PRACTICES FOR PERSONS WITH SUBSTANCE ABUSE/ ADDICTIONS

RESOURCES FROM THE FEDERAL GOVERNMENT: SAMHSA

The National Registry of Effective Programs and Practices (NREPP) was developed by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). NREPP was developed to review, identify and disseminate effective evidence-based practices for substance abuse prevention programs. To date there are approximately forty evidence-based prevention programs that have been identified on this registry.

SAMHSA is now expanding NREPP to include evidence-based substance abuse treatments for individuals with co-occurring mental health and substance abuse disorders and effective mental health promotion and prevention programs.

The NREP lists 'model programs,' which are defined by SAMHSA as programs that are well-evaluated and well-implemented based on rigorous standards of research. SAMHSA's website for this program can be found in the bibliography (Appendix D). It provides extensive information on NREPP and the programs listed in the registry.

SAMHSA, through its Center on Substance Abuse Treatment (CSAT), also produces Treatment Improvement Protocols (TIPS). These are best practice guidelines for the treatment of substance abuse. TIPS cover a variety of topics in the treatment of substance abuse and address the treatment needs of specific populations, such as adolescents, homeless persons, and victims of domestic violence. TIPS can be ordered from the National Clearinghouse for Drug and Alcohol Information (NCADI). See the bibliography (Appendix D) for more details on ordering TIPS.

The National Institute on Drug Abuse (NIDA) has several excellent resources on evidence-based treatment programs for substance abuse. NIDA's publication, *Principles of Drug Addiction Treatment: A Research Based Guide* includes a list of evidence-based 'drug addiction' treatments. Three of these treatment programs are summarized below.

Motivational Enhancement Therapy – Motivational Enhancement Therapy is an evidence-based practice in the treatment of substance abuse. This client-centered approach helps clients initiate behavior change by resolving ambivalence about engaging in treatment and stopping their substance abuse. The treatment involves an initial assessment battery session, followed by two to four individual treatment sessions with a specially trained therapist. There is an immediate focus on facilitating the client's discussion of personal substance use and encouraging self-disclosure. Motivational interviewing principles are then used to build motivation and encourage the development of a desired plan for change. Coping strategies are introduced and high-risk situations are described to help the client predict the need for coping strategies. Relapse prevention in this context has been demonstrated successful with alcoholics and individuals who are marijuana-dependent. Some studies have also demonstrated success with cocaine addicts.

Relapse Prevention – Relapse Prevention, a type of cognitive behavior therapy, is an evidence-based practice that was initially developed to treat alcohol abuse. Like all cognitive behavioral therapies, relapse prevention involves the theory that learning processes are central to the development of maladaptive behavioral patterns. Through this therapeutic approach, individuals learn to identify and correct their problematic behaviors that involve substance abuse. Key to this approach is helping individuals anticipate problems they will face and working with them to develop coping strategies. This treatment approach addresses abstinence and provides assistance for those who experience relapse episodes. After its initial development for the treatment of alcohol abuse, relapse prevention was expanded to the treatment of cocaine addiction and found to be efficacious in clinical research studies.

The Matrix Model – The Matrix Model is a therapeutic approach used to engage stimulant abusers in treatment and help them achieve abstinence. An educational component of this model teaches individuals about addiction and relapse issues and introduces them to self-help programs. Family members also receive educational information regarding addictions. In addition to education, individuals receive support from a trained therapist and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction. Studies have shown that individuals participating in the Matrix Model have significant reductions in drug and alcohol use and show improvements in psychological indicators.

Other Resources for Examples of Evidence-Based or Promising Practices

The examples discussed in this chapter are some of the most well researched evidence-based practices or practices that seem to be gaining in popularity and show some initial promise. Resources that provide more information on each practice are noted in the bibliography (Appendix D). In addition, the information in the bibliography will direct you to additional practices that are considered best practices or promising practices for children, adults, and families with mental health or addiction services needs.

One of the most troubling criticisms of evidence-based practices is that they will stifle innovation. While this manual clearly endorses consideration of and adoption of evidence-based practices, the preceding examples are not exhaustive, nor do they suggest that only practices that have met some predetermined standard of evidence-based practice should be used. Rather, as indicated in Chapters One and Two, practitioners should work with consumers and their families to identify goals for that consumer and then use the best available evidence to provide the best approach for that consumer at that time, given that consumer's preferences, culture, history, and needs. This is a dynamic process and will require constant attention to the individual as well as constant learning as the evidence about various approaches changes over time.

Chapter

5

How to Select and Implement Evidence-Based Practices

The process of selecting and implementing an evidence-based practice takes thought and planning. This chapter describes the steps that should be taken in an ideal environment. The world of health and human services programming and administration is never as straightforward as this chapter implies. Many times, there is neither the time nor the resources to take all these steps as described. Sometimes, you will be directed to implement a given evidence-based practice by decision-makers or funders and in a timeframe and manner over which you have little control. The circumstances will need to be modified to fit the situation you encounter. However, knowing how to think about this process will help you to do the best you can in the circumstances you find yourself. Chapters Six and Seven of this manual describe ways to engage staff and affect the organization issues you may encounter as you begin to implement evidence-based practices.

THINK FIRST ABOUT YOUR CLIENTS, STAFF AND ORGANIZATION: WHAT IS NEEDED?

Evidence-based practices are specific interventions and supports that are designed for specific groups of people in particular settings. When selecting an evidence-based practice to implement, you need to first think broadly about your clients, staff, and organization. Who do you serve or want to serve? What do they need? What type of organization will be implementing the evidence-based practice? What types of services does the organization provide currently and in what settings? What level of experience and clinical expertise does the staff have? In other words, think broadly about what your clients need and the capacity of your staff and organization to meet that need. Identifying the overarching needs of your clients and the capacity of your staff and organization is an important first step in the selection process. Identifying the particular group of clients you want to impact and describing their characteristics will help you determine what evidence-based practice to select and how to implement it effectively. This process should be done in consultation with practitioners and with individuals representing the client group you have identified.

DETERMINE THE OUTCOME YOU WISH TO ACHIEVE

After thinking about your clients and organization as a whole, you need to decide what outcomes you want to achieve for the group of people you have identified. Is your goal to help more adult consumers with serious mental illness find jobs and keep them? Are you targeting persons with co-occurring mental and substance use conditions or families who have suffered significant loss and who are at risk of having their children removed from the home? Are you primarily serving children and adolescents and want better outcomes for youth involved in the juvenile justice system? Start by listing the groups of people you serve by age group and needs. For example, do you serve children, adolescents, or adults? Next ask yourself, what are the needs of the people you serve? Within the populations that you serve, is there one particular population that you feel has priority needs (e.g., are children and youth of color disproportionately represented in your juvenile justice system?). Or, if you have several populations with priority needs, is there a particular population that you feel your organization needs to deal with differently to better meet their needs? If so, is that the population that you want to prioritize for using an evidence-based practice? Again, this exploration process should be conducted with practitioners and consumers, and in conjunction with organizational decision-makers, such as board members and executive management.

> The evidence-based practice you select should be based on the outcome you want to achieve.

Next, you need to think about the outcomes that you want for that population. What is it that the population needs most? What do the clients in the group say they would like as their outcomes? (In most instances, this is the gold standard; why deliver supports or services that are not desired?) Is it stable housing, the ability to get and keep a job, better medication management, control over addictions, or better relationships with and support from their families? Knowing what client outcomes are needed and desired by the population will help you decide which evidence-based practice to implement.

For example, suppose that the priority population within your agency is adults with severe mental disorders who have a history of multiple or lengthy hospitalizations. Now you have to decide what outcomes are needed for this population. The first thing you need to think about is what the clients want as outcomes. If their goal is to reduce relapses and re-hospitalizations, then you might think about implementing an ACT team. If their goal is reducing relapses and increasing peer supports, then you would want to consider the Illness Self-Management evidence-based practice. If they feel that staying on their medications is critical, then you would want to think about implementing a medication algorithms practice. If you, consumers of services, or other decision-makers think that preventing clients from being homeless or getting into trouble with the law are the most important outcomes, you may want to implement supported housing or an outreach team for homeless individuals with mental illness and/or substance abuse. The practice you ultimately select will depend upon the outcomes your program and its clients are seeking and what resources and staff you have to implement the program. For individual clients, the practice utilized should match the outcomes that individual clients want to achieve. Chapter Four gives information that will help you get started in learning about some evidence-based practices and the outcomes they produce for identified groups of people. Information on resources for more in-depth information on each evidence-based practice is listed in the bibliography (Appendix D).

We should note that there is increasing attention to using more than one EBP simultaneously: motivational interviewing, for example, can be used within other intervention strategies. All practices are not mutually exclusive of others, and there are current research efforts looking at blended models.

DEVELOP A GROUP OF ADVISORS FROM THE POPULATION TO BE SERVED AND FROM THE PRACTITIONERS WHO WILL BE DELIVERING THE SERVICE

Successfully implementing and sustaining a new practice requires stakeholder support. Including consumers, families, and community members at the beginning of the process is a critical step. Their input is needed and will be an invaluable tool as you proceed toward implementation and evaluation. The development of an advisory group needs to occur early in the planning process. Stakeholder input on what outcomes should be targeted should be a key factor driving the process. It is critical that stakeholders participate and advise on all aspects of the process, including literature reviews, decision-making, design, implementation, and adjustments as the process evolves.

Sometimes it feels like an advisory group slows down the process. It takes much less time if one person is making the decisions, as opposed to getting consensus from a large group of people, some of whom have different interests and goals. However, the investment of time to engage and partner with stakeholders is well worth the benefits. If you have to adjust your time frame for implementation in order to get full input from stakeholders, then do so. Any amount of time you put in building stakeholder support and advocacy for the practice is worth it.

> Stakeholder involvement and support is absolutely critical to successful implementation and to sustaining practice once implemented.

LEARN THE EVIDENCE-BASED PRACTICE CONCEPTS AND BEGIN TO REVIEW THE LITERATURE

Review the literature and talk with experts to find out what practices are out there and what the evidence base is for achieving the desired outcome(s). You should only start from scratch, designing your own service, program, approach, or instrument, if no existing practices are likely to help you achieve the desired outcomes. If you are not accustomed to reading the literature on clinical or services research, sometimes it is hard to know where to start. Listed in Appendix D are articles, websites, and books that you can check out. Appendix C provides a brief discussion on how to read and understand the literature. The journal Psychiatric Services has a series of articles on evidence-based practices in its 2001 edition that are also a good place to start. Chapter Three of this manual explains some of the terms that you may encounter in reading the literature. If you are familiar with these terms, it will make the reading much more meaningful. A recently public textbook (*Evidence-Based Mental Health Practice*, by Drake, Merrens and Lynde), which is written in such a way as to be accessible to lay and expert readers alike, provides an excellent grounding in many of these issues – although its focus is mental health, it has much broader applicability.

When reviewing literature and publications from a variety of sources, it is important to do in-depth reading about the evidence-based practices designed for your population. The literature should help you understand what specific outcomes you can expect to achieve, required components of the program, and what staffing and other resources you will need to implement the program. Being very familiar with the different evidence-based practices will help you decide which one most meets the needs of your population and what resources and training it will take to implement the practice in your organization. It may also help you identify individuals in other programs with whom you can talk about their experiences in implementing the practice you are considering for your organization.

DETERMINE THE PRACTICE(S) THAT ARE MOST LIKELY TO HELP YOU ACHIEVE YOUR GOALS

What have you done so far?

☒ You have thought about your population and what outcomes you would like to achieve;

☒ You have gotten the input of stakeholders;

☒ Together, you have decided what outcomes you and they want to achieve; and

☒ You have read the literature and are now familiar with a variety of evidence-based practices, what outcomes each is intended to achieve, and what resources are needed for each.

Be realistic as you think about the changes that need to occur within your organization.

Now it is time to select the evidence-based practice(s) you want to implement.

Which evidence-based practice fits the needs of the identified population and works to achieve the outcomes the population wants? If more than one evidence-based practice seems to fit, then the next step may help you decide which to choose.

REVIEW THE ADMINISTRATIVE, FINANCIAL, AND HUMAN RESOURCES PRACTICES, POLICIES, AND PROCEDURES THAT WILL NEED TO CHANGE TO IMPLEMENT OR SUPPORT THE NEW PRACTICE

Now that you have selected the evidence-based practice you want to implement, you should again review what you know about the details of the practice. As you do so, think about your organization's administrative, financial, and human resources practices, policies, and procedures. Will the evidence-based practice fit easily within the structure of your organization or will there have to be some changes made? If so, what are they? Are they major changes or minor ones? Begin to make a list of the supports or changes you will need in the areas of administrative, financial, and human resources. Identify any barriers and brainstorm ways to reduce or eliminate these barriers. Chapter Seven has information that will help you as you think about your organization and changes that may need to occur in order to implement the evidence-based practice. It includes examples of barriers that are frequently encountered and offers strategies for addressing these.

Be realistic as you think about the changes that need to occur within your organization. Look at the strategies in Chapter Seven and think about whether they would work within your organization. Talk to your stakeholders and colleagues to solicit their support for creating the changes that need to occur. You will need to consider the people, laws, or political constraints that are less controllable and that may require others to help change or move them out of the way. If you have identified more than one evidence-based practice that would fit the needs of your population, you may want to start with the one that fits most easily within the context of your organization.

DEVELOP AN ACTION PLAN WITH TIMELINES AND RESPONSIBLE PARTIES

After you have selected the practice you want to implement, you need to develop an action plan for implementation. Be sure to include your stakeholders in the process of developing the plan. Start your action plan by thinking about the major stages that need to be accomplished to assure successful implementation. Your action plan should cover the range of activities from beginning to end (i.e., from initial planning to activities to sustain the practice). Major stages of your action plan will include areas discussed in Chapter Three, such as:

- Consensus building and initial planning activities;
- Implementation of the practice with attention to fidelity (see Chapter Two);
- Monitoring and evaluation of the practice;
- Making adjustments based on the evaluation; and
- Sustaining the evidence-based practice.

After you have listed the major stages of the plan, identify specific objectives for each stage. For example, an objective for the first stage of consensus building could be that 'stakeholders and agency staff consistently express support and advocate for the implementation of the practice.' Clearly identifying what you want to accomplish in each stage is critical to a determination that you have successfully completed that stage.

After you have mapped out your plan, action steps, and objectives, think about what activities and strategies are needed to achieve the objective(s) for each stage. For example, activities and strategies for implementation of the practice might include the following:

- Determine who is in charge or leading the effort;
- Educate and engage agency staff at all levels of the organization to get their support for the practice;
- Educate and train stakeholders on the purpose and benefits of the practice;
- Identify trainers for the staff who will be providing the evidence-based service and for the consumers and families who will be receiving the service;
- Visit other programs that have successfully implemented the practice;
- Determine how you will change the structure of practice (e.g., building decision-support systems into an electronic client record to help avoid medication interactions);
- Schedule trainings that include follow-up coaching and case consultation;
- Determine how you will assure fidelity to the practice model; consider working with a consultant who is experienced in fidelity scales (see below); and
- Determine what outcome measures you will use to monitor the practice and what data you will collect to understand the outcomes you are achieving.

These are just some examples of activities that could be included in your action plan for the implementation phase. The activities and strategies you include will be based upon the needs of the population you are serving and your organization. As you implement your action plan, you may need to add or make adjustments to your activities. Being flexible also allows others participating in the process to make contributions and give input and advice.

DETERMINE HOW YOU WILL MONITOR THE IMPLEMENTATION PROCESS TO DETERMINE IF THE ACTION PLAN IS PROCEEDING AS PLANNED

As your action plan proceeds, it is important that you have some way to determine whether the activities and strategies are working to accomplish the goal. For example, your action plan might include 'Engage agency staff throughout the organization.' How will you know if you are successfully engaging them? What is an indicator that they have been engaged? In other words, what needs to happen for you to know that the staff is supportive of the new practice? By identifying 'indicators' for each activity or strategy, you will then be able to monitor whether your action plan is proceeding successfully.

If an activity in your plan does not result in the indicator you are looking for, then you need to modify the activity. For example, say your strategy to engage staff is to send out weekly updates on the planning process for the practice. You do a great job of communicating on a regular basis about meetings you have had with stakeholders, potential trainers you have spoken to, presentations you have done for the board, etc. The two indicators that you've chosen for this activity are 'unsolicited positive comments by staff about the practice' and 'staff requests to be trained to participate in the new practice.' You notice that in spite of your great efforts to keep everyone informed on a regular basis, neither of your indicators are being met. In that case, you need to consider a different strategy to engage your staff. You may also want to think about whether there are other indicators you did not originally think of that are occurring to show you that staff are engaged. You might want to consider devoting some staff meetings to discussions about the practice or sending staff to visit another agency that has successfully implemented the practice. You may simply want to ask key staff why your efforts have not been successful (e.g., they didn't get the newsletter or they have not been allowed by their supervisors to attend trainings). What is most important is that you continually monitor whether activities are successfully moving the process toward the goal. If not, you need to modify or replace the activity.

DETERMINE HOW YOU WILL KNOW WHETHER THE EBP HAS BEEN IMPLEMENTED AS PLANNED AND WHETHER IT HAS RESULTED IN THE OUTCOMES YOU EXPECTED

An evaluation plan is needed before implementation of the evidence-based practice begins. The evaluation plan should include identification of the outcomes you want to measure, the data you need to collect, and the methodology and frequency of outcome measurement. A review of your organization's current data collection procedures and outcome reports will help you determine what additional data your organization will need to collect for the evaluation of the new practice. It's important to use existing data collection methods, if possible, to avoid additional work for staff. However, current data collection may not capture the outcomes you hope to achieve or the outcomes the evidence-based practice you are implementing suggest can be achieved. Since implementing new data collection procedures can be cumbersome and is often met with resistance from some staff, it is important to work closely with staff so that everyone understands that it is only through the evaluation process that you can know with certainty that the evidence-based practice is improving outcomes for your clients. Staff often have great ideas about how to get this information in the least obtrusive way for staff and clients.

In many settings, the intervention may have impacts outside of your organization or the intervention itself involves a partnership with another organization or organizations. In that case, data collection may involve establishing agreements to share information that will be useful in assessing programmatic impacts. The Child Welfare League of America and the Juvenile Law Center have prepared a toolkit for the MacArthur Foundation's Models for Change juvenile justice initiative (*Models for Change Information Sharing Toolkit: Accelerating Progress Toward a More Rational, Fair, Effective and Developmentally Appropriate Juvenile Justice System, 2009*).

In order to achieve the outcomes the evidence-based practice is designed to achieve, you must closely follow the practice model. Fidelity to the model is the best way to assure that you achieve the outcomes you want. Your evaluation plan needs to address how you will assure fidelity. Using a fidelity scale to measure adherence to the model is the most effective and efficient way of looking at fidelity. You may want to consider using a consultant experienced in developing and implementing fidelity scales to assist you in this aspect of the project. There are also several resources listed in the bibliography (Appendix D) to this manual that can guide you on issues of fidelity to the model.

Stakeholder input in the development of the evaluation plan is critically important. There is likely to be a variety of desired outcomes expressed by your advisory group if your stakeholders represent a broad spectrum of consumers, family members, community members, and policy makers. It is important that you recognize the continuum of outcomes desired and, to the extent to which it is feasible, include them in the evaluation plan. Demonstrating improved outcomes to your stakeholders is vital to sustaining the practice once it is implemented.

IMPLEMENT, MONITOR, AND REPORT THE RESULTS

At last, you are at the point 'where the rubber meets the road.' It is time to implement the practice, monitor the outcomes, and report on the results. These activities will involve a number of different people within your organization so team meetings or other methods of communication will be important. Keeping each other informed, identifying problems as they emerge, brainstorming together to minimize barriers, participating in outcome measurement procedures, and sharing evaluation results are all essential activities during this period. Regular reporting to stakeholders who helped you in the planning process will go a long way to assuring a smooth implementation process and to continued support as you modify and sustain the practice to achieve the best results over time. To the extent it is possible, track the fiscal impact of the intervention on the program – cost-savings, should they accrue, can be a powerful motivator for sustainability.

ADJUST IF THE RESULTS ARE NOT AS YOU PLANNED OR EXPECTED

If the results you get from the evaluation are not what you expected, then you need to determine why. Sometimes issues can arise during the implementation phase that were not foreseen. For example, new barriers can arise that were not predicted that hindered the full implementation of the practice. This can include unexpected resistance from certain groups of people. In other cases, the evidence-based practice was fully implemented but was not completely true to the research/evidence. When the evaluation yields results you do not expect, then you need to identify the specific problems and act to remedy them. It may be that you need to spend more time educating key individuals and soliciting their support for the practice. Or you may need to establish stronger protocols regarding fidelity to the model you are implementing. The evaluation results should help you identify the problems and then plan for resolving the issues or strengthening the practice model.

The ultimate goal is to keep your focus on the people you are trying to serve and the outcomes you and they are trying to achieve. It may turn out that the practice you selected is not the best one to achieve those goals in your particular program. You may need to develop a new practice that you and your stakeholders think will do a better job. If so, be sure to include an evaluation or research component so you can rigorously determine if you are able to meet your goals with this new approach. Partnering with a university or evaluation center can be a helpful and rewarding experience as you contribute to the knowledge in the field. Who knows? Your practice may be the next evidence-based practice disseminated to address populations or issues others are also struggling to address.

Chapter 6

How to Support Staff in Moving toward Evidence-Based Practice

The fact that a practice is evidence-based does not mean that individual staff or practitioners will be excited about implementing it with their own clients. There are a number of reasons why practitioners may be reluctant to change the way they have traditionally worked to implement a practice that is new and maybe foreign to them. This chapter describes some of the barriers a program manager is likely to encounter in working with clinicians and other practitioners to implement evidence-based practices. Techniques for overcoming those barriers are also described.

It should be noted that practitioners are often the ones who want to implement evidence-based practices, but find barriers in the program or organization that make it difficult to do so. These barriers and techniques to address them are discussed in Chapter Seven.

APPROACH AND METHOD OF ENGAGING PRACTITIONERS

Senior behavioral health care clinicians and other seasoned human service practitioners have a wealth of knowledge and experience upon which they draw every time they see a client or deliver a service. That knowledge and experience is based on their own sense of what works and what does not from the multiple clients they have seen and many years of practice. They have seen successes with clients using the techniques they currently use, so they do not necessarily believe that client care needs to be improved. This is especially true when external feedback, such as accreditation surveys, certification or licensure processes, and even customers give them consistent positive feedback about their work and the organization within which they provide care. New employees may have recently left academic programs that have taught them about interventions that may not reflect the most current science, and abandoning what they have just learned may trouble them.

Routine or usual care (as distinct from the use of an evidence-based intervention) is neither homogeneous nor automatically inferior, and some care strategies can produce positive results. The reality is that there are relatively limited numbers of rigorously tested models, so practitioners have to use their so-called 'practice wisdom.' Unfortunately, sometimes clinicians are told to implement evidence-based practices in a way that implies what they currently do is not useful for their clients. Sometimes clinicians are told to deliver a specific practice by researchers, academicians, or policy-makers who may not regularly provide direct care, in such a way that implies the clinicians do not understand services, supports, or treatment clients need and want. Clinicians are understandably affronted by such messages and methods of message delivery. Clinicians who are not using a known evidence-based intervention may also be confronted by consumers, families, or advocates with the suspicion that they are providing inappropriate or even harmful treatment. If we assume that reluctance to change (a most human characteristic!) is *de facto* resistance to progress we will mistakenly communicate that they do not care, are not competent, or do not want to serve clients well. All of these are inappropriate and insensitive messages. In other words, the way clinicians and other practitioners are approached and the message they receive about evidence-based practices may contribute to their willingness, or lack thereof, to embrace a new evidence-based practice.

Likewise, the message bearer may have a big effect on whether practitioners are interested in developing new programs, participating in new program models, or adopting new practices. Clinicians and other service providers are often more willing to hear about new program models or practices from a peer or colleague than from administrators or advocates. This is most likely to be the case when clinicians who are natural leaders or to whom other practitioners look for leadership are excited about and supportive of implementing the new practice. Professional associations or colleagues from other successful programs that are utilizing the new practice and experiencing positive results are important sources of information. In some cases, practitioners are most open to hearing directly from consumers and families about new programs or practices. They are likely to be especially sensitive to complaints of consumers and/or families about the new practice, particularly if they were not predisposed to liking the new practice in the first place.

LACK OF KNOWLEDGE ABOUT EVIDENCE-BASED PRACTICES

Sometimes practitioners are uninterested in or actively hostile to the introduction of a new evidence-based practice because they do not know how to provide it, operate within it, or adjust to its requirements of them. Practitioners, especially those who receive graduate training, are often taught that they have to conduct the assessment, make the decisions about treatment, and monitor the treatment results for any particular intervention. They are not often taught about the role of the clinician in providing interpersonal or instrumental support while the consumer finds his or her own way through the illness or problems they experience. In addition, while clinicians are often taught about their responsibility to constantly learn and incorporate new research findings into their day-to-day practice, the explosion of new knowledge plus the pressure to increase productivity often makes this unlikely to happen.

While practitioners can be taught about new practices, a common mistake is to think that training alone will change the way they deliver care. Research about what it takes to change attitudes and behavior among professionals suggests that training alone is not likely to change clinicians' behavior. For example, Continuing Educational Units (CEUs) in which practitioners are presented new ideas by experts in a single training session may impart information, but have been shown to be insufficient to change clinicians' behaviors. While knowledge about evidence-based practices is critical and necessary, it is not sufficient to guarantee the changes required to implement a new evidence-based practice.

Practitioners have to believe the new practice is better than the current one(s), that it will make the lives of their clients better, and that it will improve their ability to be successful in their work. Practitioners may have heard about the new practice in a manner that suggests to them that it will not work in their program. They may hear that the homogeneous population the practice addressed in the research setting is not the same as the heterogeneous populations they serve every day. They may feel the people they serve have more complex needs or are more difficult to serve than the experimental groups. They may feel that the caseloads, the amount of training and supervision, or the time the technique will take per client are simply not realistic in the real world in which they work.

In fact, they may be right! If these conditions are critical to the success of the experimental practice (that is, if they are important to fidelity to the model), then either practice settings and circumstances have to change to implement the practice, or a different evidence-based or promising practice needs to be selected to match the populations and conditions these practitioners are serving. Otherwise, both practitioners and the program will be set up to fail and are not likely to produce the outcomes promised by the research. Such an experience will only reinforce reluctance to introduce other new practices in the future.

Complexity of the Practice or Amount of Difference from Current Practice

In public sector behavioral health and other social service settings, practitioners often have large caseloads and little support by administrative support professionals to deal with paperwork and documentation requirements. If the new practice that is being suggested or required is more complex, more time-consuming, or more difficult to implement, especially if organizational barriers are not sufficiently addressed (see Chapter Seven), then practitioners are not likely to feel positive about the new practice.

Along with complexity of the new practice, the amount of change from current practice will be a factor in whether practitioners are reluctant or willing to embrace the new practice. Some individual practitioners, just as any individuals, are adverse to change of any sort. Most practitioners, however, are eager to learn new skills and new ways of providing services that will assist the consumers and families they serve to experience better outcomes and lead more satisfying lives. Practitioners have to be given the time and support to learn and apply new skills in the context of the reality of routine practice settings, which are often stressful and highly demanding. For practitioners eager to change, support and opportunity are often enough. For practitioners unwilling or reluctant to change, explaining why the change is necessary and how it will make their jobs better, easier or more satisfying, and engaging them in the change process will be important to successful implementation. Sometimes, incentives may be necessary to overcome reluctance. In a few instances, sanctions for not implementing the new practice may be required to overcome subtle or active resistance.

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Support for and Barriers to Implementation

One of the biggest factors influencing practitioners' unwillingness (or inability) to implement new practices is lack of support to do so. This lack of support can be either past or current experience of practitioners with other changes in the organization in which they did not receive the encouragement, supplies, feedback, or help they needed to implement positive changes. This lack of support can also take the form of implementation of a new practice on top of existing practice expectations so that practitioners experience the new practice as additional work without additional resources. Lack of support can simply be implementation without opportunity for input and without feedback about whether the new practice made any difference.

Lack of support can also be an organizational barrier that practitioners feel helpless to change or frustrated about trying to impact. Changing the structure of practice is critical to success. For example, if supported employment is proven to be effective but clinicians/practitioners are paid/rewarded for day treatment, the latter will be provided regardless of what is determined to be an evidence-based practice. These organizational barriers are discussed in Chapter Seven.

As we noted above, individual practitioners are sometimes said to be 'resistant' to change or to implementation of new practices. This resistance is experienced as refusal or reluctance on the part of the practitioner, often accompanied by rationalization about the reasons for the refusal or reluctance. What is experienced as resistance may in fact mask the factors in individual readiness or the influences and barriers to adoption described above. Program managers should assume that all practitioners want to do the best they can to provide person-centered, culturally competent care for consumers and their families. Program managers should approach anything that looks like resistance as being a problem with the manner in which new practices are being implemented and should work with practitioners and other program staff to identify and ameliorate barriers and help to establish positive influences for the adoption of effective practices.

Techniques to Engage Practitioners to Overcome Resistance and Provide Support

The techniques for engaging practitioners stem directly from the factors in individual readiness and may seem obvious. However, program managers often forget to utilize these techniques and find themselves and the practitioners they supervise frustrated, angry and/or ineffective in implementing new practices.

Approach and Engagement – Use of Opinion Leaders

Practitioners do not like to be told what to do or that what they know from experience is wrong any more than consumers and families do. They want input into and control over their individual professional practices and they want colleagues with whom they can collaborate and share ideas. There are often opinion leaders among any program's practitioners or among the practitioners in a given geographic area who are looked to by other practitioners for guidance, either formally or informally. Identifying these opinion leaders, exploring with them the new practice, and asking them to become champions will help to engage other practitioners and provide them a person or persons from whom to seek advice and discuss concerns.

Including practitioners (opinion leaders and others) in planning groups to decide which populations to address, what the desired outcomes are, and which practices to implement will help to engage the involved practitioners as well as others who will trust that their perspectives are represented. It is often helpful to include the most reluctant or resistant practitioners on these planning groups. Allowing times when practitioners can talk together and with program managers about potential barriers, needed supports and resources, and ways to secure these resources and compensate for these organizational issues will be an important part of the planning process. Providing opportunities for practitioners and program clients to talk together about which practice to implement and how to do so will help both groups to own the changes and commit to making implementation of the process a success.

When practitioners and program managers are faced with a decision made by others to implement a particular practice (e.g., if the state funder has required or the director of the agency has decided to implement Assertive Community Treatment teams), practitioners need to understand why the decision was made, what the decision-makers' expectations are, and how they can be involved in planning the implementation process.

Training and Access to Information about Evidence-Based Practices

Practitioners need access to information and training opportunities about evidence-based and promising practices. In some cases, this can be formal training opportunities. In other cases, this could be informal discussions about articles, publications, programs that practitioners, consumers or families have heard about to improve services, or conferences that staff have attended. Information can be made available in a program library or by providing access to the internet for information and research about programs, practices, and concerns of consumers and families about the limitations of current practices and hopes for improved services.

Identifying programs that are implementing high quality evidence-based practices and allowing as many staff as possible to visit such programs is an excellent way to expose practitioners to evidence-based and promising practices. Many times, these promising practices are nearby so that visiting them can be done without significant expenditure of time or resources.

Simplifying Practices and Easing Difficulty of Changes

Anything that is different from what one currently knows and does can seem very complex in the beginning. The planning process can alleviate this experience of complexity by breaking down the new practice into component parts and discussing each of the parts in planning groups. The experience of complexity and difficulty of change can also be mitigated by planning the implementation in stages. For example, if data collection is going to be part of the new practice and its evaluation, mastering the data collection process before actually implementing the practice can be helpful. When implementing ACT teams, staff might start by working in the team that will eventually be responsible for client care to plan their days, or to practice the daily team meetings before responsibility for consumers actually begins.

The difficulty of potential changes can be addressed best by the planning process that includes practitioners and consumers/families, and specifically brainstorms the likely difficulties and options for overcoming each of them. To the extent that current activities can be replaced with activities associated with the new practice, practitioners may feel the new practice is more doable. It is just as important to stop old practices that are not as effective as they could be as it is to implement new programs and practices that have been proven more effective. On the other hand, not every client will respond well to any particular practice approach. Therefore, options for consumers are important, unless there is evidence that the current practice is actually harmful or so unlikely to be effective as to be inappropriate for the expenditure of funds. To the extent that practitioners are given an option whether to participate in the new program or practice, at least in the beginning, will help overcome concerns that the new practice is unreasonable or will not work. This kind of option may not be practicable or desirable for some practices (e.g., use of medication algorithms).

PROVIDING SUPPORTS AND REMOVING BARRIERS

Practitioners need supports and resources to make the change to a new practice. The support needed by staff may be time to learn and discuss new practices, time to participate in planning groups and develop new program guidelines, and time to learn and practice the skills necessary to implement the new practice. Research suggests that adults also need reinforcement to change behaviors. That is, once practitioners know what the new practice will entail and once they begin implementation, they need reminders (formal and informal) about how to maintain fidelity to the practice elements, knowledgeable supervision, plenty of encouragement, and feedback in the form of data about results and about whether the program or practice is meeting expectations of managers, consumers, and families. They also need opportunities to discuss how implementation is going and what adaptations need to be made to address unexpected difficulties.

One way to provide support is to develop technology that will assist practitioners in quality data collection, in consistency of assessments, in documentation of activities, and as prompts for decision-making consistent with the evidence-based practice. While technology can be a big support, some practitioners will need training in computer skills to take full advantage of this support. Practitioners may see this training and requirement to use technology as an added stress in the beginning. Eventually, most staff find technology a time-saver and a supportive adjunct to clinical practice. Today's technology with wireless capacity and mobile capacity are consistent with many evidence-based practices. To the extent programs can afford these kinds of enhancements, this may be both a support and an incentive for those practitioners willing to implement new approaches.

Programs often make the mistake of implementing a new program or practice with little or no follow up. Later, managers wonder why results were not as expected or why staff gradually drift back to practicing as they did before. Sometimes staff behaviors remain changed from prior practice, but do not stay true to the elements of the practice that are key to obtaining the desired results. Chapter Eight discusses the process of sustaining practices once implemented.

During the planning process and during the implementation, barriers will be identified that are systemic to the program itself or to the organization or system within which the program operates. Examples of these barriers include but are not limited to organizational structure, policies and procedures, payment mechanisms, organizational or individual culture or comfort with change, size or age of the organization, history or experience with other recent changes, and mandates or incentives. Some of these barriers can be mitigated and some will have to be changed in order for implementation of the practice to be successful. In some cases, the barriers can be worked around without directly affecting the identified barrier itself. Program managers, practitioners, consumers, and families will need to determine which barriers are simply irritants and which will prohibit the successful implementation of the new practice. Chapter Seven discusses some of these barriers and possible ways to address them.

USE OF INCENTIVES AND SANCTIONS

There are times when practitioners need to be given incentives to assist the process of getting buy-in and getting the practices performing as desired. These incentives can be anything from reduction in productivity requirements to accounting for time spent planning implementation, to travel funding to visit other programs. Incentives can also be recognition at leadership, board, and stakeholders meetings. In some cases, practitioners will make the case for additional pay to account for the complexity or responsibility associated with additional practice requirements.

This issue must be dealt with in the context of each agency's or program's personnel decision-making processes, taking into account whether increased job responsibilities are in fact a part of the new practice. For example, a psychiatric nurse or case worker who takes on the responsibility of an ACT team may be required to work additional hours, be on call, or have additional job duties for individuals in crisis. However, you should be careful not to have staff think of evidence-based practices as 'extras' for which they must be paid extra. Practitioners must think of the implementation of new practices and practices that have an evidence-base as part of their job and as the expected way of doing business in the future. Working to make the program as a whole a learning organization, used to growing and changing as new research, new ideas, and new technologies emerge in the field, will provide the environment in which to foster this attitude.

In rare instances, practitioners will simply be unwilling to change practice behavior even when involved in planning, when provided opportunities for learning, and when receiving reminders, encouragement, supervision, and feedback. In these rare circumstances, program managers may need to think about sanctions. For example, physicians whose prescribing patterns do not indicate the use of medication algorithms adopted by the program may need to have evaluations that make it clear that this is unacceptable and that employment expectations are that they will begin to use these algorithms. If they persist in not doing so, future pay increases may need to be forfeited. In the worst of all worlds, practitioners who refuse to learn or implement evidence-based practices may need to be asked to leave. This result should be the very last resort. Before doing so, program managers should work with the practitioner to understand the reason for non-compliance and how the program can support the practitioner in adopting the evidence-based practice by changing program and business structures or decision-support mechanisms.

Chapter 7

How to Support Your Organization/ Program in Implementing Evidence-Based Practices

The best planning and implementation at the program level can run into barriers at the organizational or system level that may frustrate program managers, practitioners, and/or consumers and families. These barriers are best dealt with by identifying them early, understanding where they come from, and figuring out how to change them or work around them to provide the best possible care for consumers and their families. This chapter describes some of the barriers that might be encountered, using information from organizational change literature and from the observations of experts who have worked to implement changes at each of the levels discussed here. This chapter also suggests ways program managers and practitioners, along with consumers, families and other advocates, might go about dealing with these barriers.

It should be noted that at times the organization or system will be pushing for changes and for implementation of evidence-based practices and will be helping programs to deal with these barriers. This chapter is written to describe as many of the possible barriers programs and practitioners might face if the impetus for change is coming primarily from the program level.

ORGANIZATIONAL AND SYSTEM BARRIERS THAT MIGHT BE ENCOUNTERED

As program managers and practitioners begin to identify, plan, and implement new practices, based on evidence of effectiveness for the populations they serve, the program itself or the organization within which the program operates may have a culture, structures, ways of doing business, financial issues, and 'political' forces that work against the successful implementation of evidence-based practices. Examples of these possible barriers are discussed below.

PROGRAM AND ORGANIZATIONAL CULTURE

Some programs and organizations are comfortable with change and some are not. For those programs and organizations not comfortable with change, the implementation of evidence-based practices may be a challenge for program managers or for practitioners who work within them. Such organizations and programs are sometimes called 'change-averse.' For a program whose staff and clients are used to and comfortable with change, but which exists within an organization that is not comfortable with change, the introduction of new practices can be especially frustrating. Likewise, an organization that is interested in changes at the program level and that has program managers and staff who are not as comfortable with change may face conflict as pressures are put on the program and its staff to implement new practices.

The reasons for a change-averse culture can vary. The philosophy and leadership style of top level managers or boards, the length of time the organization or the leadership has been in existence, the size of the organization, the context within which the organization operates, the financial stability of the organization, and the history of the organization with other recent change efforts can all contribute to the comfort of the organization or program with the introduction of new ideas.

It is critical that program managers, practitioners, and advocates assess whether the organization is change-averse or is going to be supportive of the introduction of new practices, especially if the new practice will have a significant impact on existing programs or on the perception of the organization within the community. It is also important that persons embarking on changes within a change-averse environment consider carefully the process and pace of change so that the organization, its leaders, and needed colleagues within the organization will not become an impediment to the new practice.

One issue that is critical to the implementation of any new practice is the capacity of supervisors to assist in and reinforce efforts of individual practitioners. Often, behavioral health programs hire or promote clinicians into supervisory roles on the basis of a credential, an academic degree, or longevity with the program. While education and experience certainly help practitioners to be successful supervisors, the process of supervising other practitioners is a skill in and of itself and is often quite different from the skills necessary to provide direct service. Programs often have little or no time and resources to assist supervisors in learning these necessary skills. Sometimes programs do not evaluate and provide feedback to supervisors about their supervision activities. In its extensive research and publication on behavioral health workforce, *The Annapolis Coalition Action Plan on Behavioral Health Workforce Development* (Hoge, Morris et al 2007) has highlighted the critical role of the supervisor and the competencies required to be effective.

Changes at the program level will affect many other people within the organization and the community. Recognizing those effects early and planning for them will assist in assuring that the new practice is successful and sustainable.

Appropriate feedback to practitioners as they are learning new skills or a new practice has been shown to be critical to obtaining fidelity to the model being implemented and to successful outcomes. If supervisors are not given the opportunity to learn the new practice, or if they do not have good supervisory skills, the new practice may be doomed to be less than it could be and in fact to be a frustrating failure to consumers and practitioners alike.

It is important to recognize that change is hard work! It can be exciting and fulfilling, and is, in fact, a necessity for high quality work and for survival in today's world. However, changes at the program level will affect many other people within the organization and the community. Recognizing those effects early and planning for them will assist in assuring that the new practice is successful and sustainable.

Another cultural context that can cause a barrier is the culture of the community in which the program or organization exists. Whether the community is primarily rural, composed of a single or multiple ethnic groups, or is a university town can have profound impacts on the ease or difficulty of implementing new practices. In rural areas, it may be difficult to find practitioners to staff teams or to provide knowledgeable supervision for the new practice. In communities that have a number of different ethnic groups, the cultural specificity of clinical practice can impact the approach to implementing new ideas, as well as the content of the new practice itself. In university or college towns or in locations where community colleges are active, there may be researchers and academicians eager to assist you in identifying practices and barriers, and in evaluating the impact of the implementation of new practices. They may also provide a ready resource for training that may be difficult to find in locations where they do not play a role.

ORGANIZATIONAL STRUCTURE

Sometimes the very structure of an organization or system can be an impediment to change. If all the physicians are supervised by a single Medical Director who is not interested in the new practice, and the new practice requires the involvement and support of physicians assigned to the program, this structure can impede the ability of the program manager and other practitioners to engage those physicians in the change process. If the new practice requires utilizing and accounting for financial or human resources differently than in the past, and the person in charge of financial management or the human resource director is not interested in or actively opposed to these financial and personnel changes, the practice may not be able to be implemented successfully.

In some systems, a local authority (county or free-standing board) has control over the direction of program development, financial planning, payment for services, quality efforts, data collection, training, and/or strategic planning. Any of these processes can impede program development if the decision-makers in the system structure are not interested in or actively oppose the changes proposed by the program or organization.

A good example of such a structural impediment would be a system in which decision-making and resources about substance abuse services or about vocational services are separated from decision-making and resources for mental health services. For a program attempting to implement integrated services for persons with co-occurring substance abuse and mental illness or a program interested supported employment, these structural divisions may present considerable constraints.

BUREAUCRATIC PROCESSES

Individuals wishing to implement a different practice will often find that the ways in which the program, organization, or system is set up to do business are impediments to the new practice. By definition, bureaucracy is the policies, procedures, and requirements by which an organization is operated. These rules of doing business are necessary for the orderly management of public or private resources and activities. In and of themselves, they are not bad. However, they exist to support and organize what is, not what is dreamed of or what is hoped for in the future.

Therefore, any new practice is likely to find that existing policies and procedures, forms, definitions, productivity standards, reporting processes, and other bureaucratic requirements are not supportive of a new way of thinking about practices and personnel deployment. There is much promise in the role of an electronic client record, decision support systems, and information technology in impacting the practice of health and behavioral health care. To the extent resources are available, these should be seriously considered.

It is important to approach these impediments with an open mind rather than a desire to resist and destroy. Program managers and practitioners will need to identify where such processes are true impediments and where they can be easily changed or adjusted. Consumers, families, and advocates participating in the planning and implementation process will need to be helped to understand why existing processes are in place and the process for changing them. Identifying who controls these bureaucratic requirements will also be important. If they are controlled locally (e.g., at the program or organizational level), the process for getting them changed will be much different than if they are controlled at a system level (e.g., the county or state) or if they are controlled through a political process (e.g., legislative rule-making body) or by an independent body (e.g., accreditation or credentialing organization).

These bureaucratic processes are often used as excuses for not implementing a new practice. As simple a thing as a reporting form or an assessment tool can drive activities toward old outcomes, or old ways of behaving rather than allowing new thinking to guide the development of a practitioner's care of an individual client or a program change, based on evidence-based thinking (see Chapter Two). All these processes must be inventoried when a new practice is being planned to determine what will impede or be used as an excuse. Programs often make the mistake of creating more bureaucratic processes, including policies, forms, assessment tools, and reports, rather than adapting or eliminating the current ones. Programs also often make the mistake of avoiding dealing with these current processes to their detriment when reimbursement or evaluations are based on the current processes.

These impediments need not be completely overcome in order to proceed. However, they do need to be actively reviewed to determine what actions must be taken to remove or mitigate impediments, support new ways of thinking, and assure compliance with the active components of the evidence-based practice.

FINANCIAL ISSUES

Reimbursement mechanisms are often driven by service definitions and criteria about who is qualified to deliver services. Sometimes these definitions were developed a long time ago and bear little relationship to the new services or practitioners that are being developed today. This is particularly true for a funding source, such as Medicaid, that now represents a significant portion of the funding for mental health services (especially for children) and an increasing portion of funding for substance abuse services.

> Perhaps the most critical potential barrier to the implementation of evidence-based practices is the way in which services are funded and practitioners are paid.

Financing mechanisms also frequently drive or constrain service delivery changes. For example, if the primary financing mechanism is reimbursement for an individual service for an individual client by an individual clinician in an office or facility-based setting, providing services in a team, by a peer support professional, in a home or community-based setting (such as a restaurant or library) or with a collateral contact becomes difficult. Sometimes payment rates or limitations are identified as reasons why new practices cannot be developed or implemented properly. For example, if a program can produce more revenue through the use of licensed practitioners as individual therapists or clinicians seeing clients in individual or group sessions than the use of these same practitioners as client or family educators or as case managers, nurses, or physicians on an Assertive Community Treatment team, it will be hard for a program to reassign these practitioners to a team-based approach. If a program cannot bill for more than one therapist at a time seeing a client face-to-face, it will be difficult to spend the time conducting a team-based or multi-disciplinary assessment or treatment team-planning session. If a program cannot secure higher cost medications that are necessary to appropriately implement medication algorithms, or if the process for getting authorization for the use of such medications is difficult or time-consuming, it will be hard to convince physicians to utilize such medications and algorithms, especially if case-loads are high and other expectations on their time are significant.

Sometimes these payment limitations are national in scope, as with the Medicaid program, or the various block grants and federal funding streams that have different and confusing requirements and goals. Sometimes these payment limitations are state-imposed system plans and regulations (e.g., the state Medicaid plan, the state vocational rehabilitation plan, the state IV-E plan or waiver, or the state plan for use of TANF monies). Payment limitations can also be created at the county or local authority level where such entities exist and play a role in program design and funding. In the best of all worlds, these payment limitations are organizational or programmatic. The Centers for Medicaid and Medicare Services (CMS) Medicaid regulations have been a moving target in this regard, for a time supporting bundling of rates, then opposing bundling of rates, and as of this edition going to press appearing ready to allow bundling. So it is important to remain current on what is permissible if the new evidence-based practice you are considering will be financed in your state, even in part, by Medicaid reimbursement However, any of these limitations outlined above are not easy to affect if the organization or its leaders or colleagues are not amenable to change for any of the reasons identified earlier in this chapter. Generally speaking, the further away from the program the financial impediment originates and the less knowledgeable and interested those in charge of these decisions are in supporting the implementation of evidence-based practices, the more difficult it will be to change these financing limitations.

Sometimes a program's own decisions about salary and compensation, productivity requirements, and their relationship to financial outcomes of the program or the individual practitioner, and financial support for new endeavors through the seeking of grants and donor contributions will have an important impact on preventing or encouraging experimentation and practice changes. It is not uncommon for bonuses and rewards either directly or indirectly to support only the use of existing practices rather than encourage the identification and utilization of new practice methods.

Financial barriers may be among the most difficult, but should not be considered impossible to overcome. Creativity, advocacy, and persistence may be necessary to create the financial changes to provide incentives to implementation of new practice approaches. The ability to identify and overcome such barriers or to create such incentives is the mark of a true program or clinical leader.

‘Political’ Forces

In this context, we are thinking of the term ‘politics’ in its broadest application, that is the range of competing interests that are present in any organization: workers, management, advocates, etc. (There may also be partisan politics involved, if a governor or country supervisor, for example, makes adoption of evidence-based practices an issue.) There are often advocates and system stakeholders that have reasons to support practices and outcomes that have little to do with evidence-based practices or evidence-based thinking. This behavior may stem from lack of knowledge about new practices, a different perspective on desired outcomes, or personal or group agendas driven by interests other than the best quality of care for consumers and their families. For example, decision-makers responsible for funding decisions (e.g., Congress people or state Medicaid officials), may have little information about behavioral health evidence-based practices and may have responsibilities that make it difficult for them to have the interest or to take the time to learn about the implications of such knowledge on financial decisions. Decision-makers responsible for other systems may have a different mission and, therefore, seek different outcomes for the same individuals or groups. For example, family court judges may see keeping a child safe as their primary mission, and thus, may demand immediate out-of-home placement, whereas treatment professionals may see an in-home, family systems approach as the best treatment intervention for the child's ultimate well-being and healthy development. Both positions are understandable, and a compromise in the pace or extent of program change may be required. Resolving differences requires educating all stakeholders and answering their legitimate concerns.

Sometimes representatives of a group of practitioners may express interests different than evidence-based practice. For example, a union may support facility-based approaches that make it easier to obtain and oversee rights and safety of employees when community-based and in-home approaches have been proven to have better client and family outcomes. A professional association may oppose efforts to utilize peer professionals or new practitioners to do what they have traditionally done, for fear that limited resources will be diluted and their expertise will be less valued. This may make it difficult to engage professionals in teams, in multi-disciplinary activities, or in activities that include peer professionals as part of the overall effort.

It is important to see all these 'political' forces for what they are: legitimate differences of opinion about the outcomes desired for the public resources expended, and legitimate differences of opinion about the best method to effect the highest quality of care. They help identify differences in priorities that will impact the ability of a program or practitioner to change. They also reflect real resource limitations in tax dollars, health care and human service dollars, and time that must be respected in order to impact them. Political forces are a fact of life in any human endeavor, especially those funded largely by public dollars. Effectively managing these forces is the mark of a true leader and will be necessary to be successful in implementing evidence-based practices and evidence-based thinking.

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OBJECTIONS TO THE IMPLEMENTATION OF EVIDENCE-BASED PRACTICES

Objections heard within an organization when a new evidence-based or promising practice is proposed by a program manager, practitioners, or clients are likely to reflect any of the barriers described in Chapter Six or in this chapter. These objections may stem from lack of knowledge about evidence-based practices or evidence-based thinking, misinterpreted professional standards, arguments appealing to tradition of practice or of the organization, *ad hominem* arguments (that is, arguments, based on who or what part of the system initiated the requirement or proposal), arguments appealing to ethics, or philosophy, or values. Any of these objections may mask or reveal individual readiness concerns or organizational barriers. Some may be legitimate and some may be based on fear or excuses.

In any case, those interested in implementing evidence-based practice(s) must figure out what is going on about the practice itself, in the program or organization that is being asked to adopt the practice, and in the nature of the relationship between the diffusing and the adopting organizations. You must also understand why individuals who are identifying or creating barriers are doing so and the legitimacy of their concerns. Resistance of an organization or individuals should never be seen as individual or organizational failure, but rather as opportunities to assess readiness and to provide support and encouragement for a change of thinking toward new approaches to delivery of care that will augment or in some instances replace current practices and result in better outcomes for clients.

A WORD ABOUT 'FIDELITY TO THE MODEL'

In many circumstances, the barriers you face will make it difficult to adopt a practice with complete fidelity to the components of the practice that the evidence shows are critical to achieving the desired outcomes. Maintaining complete fidelity may not be possible due to complexity of the client population; unique conditions within the community; human resource, supervision or financial constraints; or policies and procedures that cannot be changed. Increasingly, researchers and organizational decision-makers are beginning to understand that fidelity to the model being implemented is critical to success for consumers. There is debate in the field about whether adaptation of the model to meet existing conditions is better than not implementing the new practice at all, especially when some of the constraints that inhibit complete fidelity cannot be overcome. Some say there is no evidence to suggest that a practice that is not faithful to the experimental model will produce positive results. Others say that getting as close to the model as possible is all that can be expected in the real world of insufficient resources and bureaucratic barriers. For the latter, the argument is that doing something is better than continuing to deliver practices that do not live up to practitioners' or clients' expectations.

This debate is far from over. You should make your own decision about this dilemma, based on the circumstances in which you find your current program and practice. Obviously, the closer you can come to the model you are trying to implement, the better. If you adapt the model to fit your reality and your constraints, it is especially important that you track results and client outcomes to see whether the practice you implement has the outcomes expected and that you and your clients desire. (The role of outcome tracking and quality management and improvement processes is discussed in Chapter Eight.) However, if you are unable to fully implement a particular model, you should not promote it as if it were. Doing a program that is loosely based on the principles of Multi-systemic Therapy (MST), for example, should not be referred to as MST. In this regard, we think 'truth in advertising' is an appropriate guide.

STAGES OF INDIVIDUAL AND ORGANIZATIONAL READINESS

The strategies employed for overcoming barriers need to be designed, based on the stage of readiness of an organization or group of practitioners. As indicated in Chapter Three, organizations could be in any one of five stages:

- Unaware/Uninterested (or pre-contemplation)
- Consensus Building/Motivating (contemplation/preparation)
- Implementing (action)
- Sustaining (maintenance)
- Improving

If your program or practitioner group is unaware or uninterested in evidence-based practices or evidence-based thinking, efforts to expose staff and consumers/families to these ideas and possibilities may be the best approach. If the program or group is aware and somewhat interested, the level of interest and the level of resistance may suggest differences in approach to building consensus and motivating individuals to change.

Decisions about when a program or group of practitioners is ready to begin implementation may not be entirely in your control. Aside from the level of knowledge, interest and motivation, a mandate from a funding source, a decision-making body, or a program supervisor may leave little room for discussion about implementation timeline or process. In such a case, the strategies for engagement may need to be adjusted and focus more on explaining and assisting staff in understanding what is required and by when, with the work of awareness and consensus building occurring during and after implementation.

Once the practice has been implemented, there are specific strategies that ought to be a part of assuring that the practice is sustained, and that adjustments are made to improve these efforts so that results continue to get better over time as experience provides information and as new technologies and service models are researched and disseminated, either within the program itself or within the field.

Assessing Individual and Organizational Readiness and Identifying Real or Perceived Barriers

Some of the barriers described in this chapter and in Chapter Six can be mitigated. Some will have to be changed in order for implementation of the practice to be successful. In some cases, the barriers can be worked around without directly affecting the identified barrier itself. Program managers, practitioners, consumers, and families will need to determine which barriers are simply irritants and which will prohibit the successful implementation of the new practice. This requires a systematic assessment of potential barriers as part of the planning process before beginning implementation of a new practice.

The American College of Mental Health Administration (ACMHA) refers to such an assessment as a ‘fearless inventory’ of organizational and individual cause and effect of a given policy or practice. The ‘fearlessness’ is necessary to look fully and completely at those things that might aid or hinder the outcomes you are trying to achieve. ‘Fearlessness’ also implies looking at each environmental factor and assuming that anything that is in the way can be changed or mitigated, if enough thought, energy, creativity, or political pressure is brought to bear to address the issue. Persistence is also the key to getting beyond some of the barriers and identifying ways to begin new practices in spite of barriers that may exist or resistance that may grow as practices change. The ability to keep your focus on the desired outcomes and to compromise and keep trying to find ways to succeed is often a critical ingredient to getting the job of change done.

Development of techniques to address barriers depends in part on asking the right questions during the planning process (whether this is a formal or informal process). Just as with services for clients, program and practice changes must start with where the organization, program, practitioners, and stakeholders are, and developing an individually tailored plan to capitalize on strengths and address identified barriers.

To conduct this assessment, work with your planning group of practitioners and consumers, and ask yourselves the following questions:

A. Practitioner/Staff Assessment

1. How many practitioners need to be involved in the new practice?

2. How long have these practitioners been in practice and how long have they been with the program?

3. Have any of them been exposed to or trained in evidence-based practices or the particular new practice to be implemented? If not, are there training, reading, or discussion opportunities that can provide this information?

4. Are there natural leaders in the group to whom the other practitioners look for support and guidance (formal or informal)?

5. Are there individual practitioners that are often interested in new things or who have expressed an interest in evidence-based practices in general or the new practice in particular?

6. Are there practitioners you can expect will be unfavorable about trying something new? If so, who are they and why?

7. What impacts will there be on other practitioners if some practitioners are asked to or requested to be part of the planning of the new practice or its implementation?

8. Is there another group of staff who are critical to the implementation of the new practice (e.g., information services staff, support staff, building maintenance or janitorial staff, transportation providers)?

9. Are there real or perceived limitations on time caused by current caseloads, inadequate financial resources, unfilled positions, or demands on practitioner or program manager time other than client care and program management? Is there a reasonable change in the use and deployment of human resources that can be proposed to affect these perceptions or the reality of these limitations?

10. Are supervisors in the program aware of and competent in the evidence-based practice you are trying to implement? Do they support the introduction of new practices? Are they able to learn the specific information or skills needed to encourage and support line staff in implementing the new practice?

11. Are there rewards or sanctions (e.g., monetary, training opportunities, reduction in reporting requirements or oversight, public recognition, public embarrassment through reporting failure to meet standards or requirements) that can be offered or imposed to encourage and support the implementation of new practices?

B. Stakeholder Assessment

1. Who are the program's current clients? Is the new practice going to positively affect these clients or require that the program's resources address new clients?

2. Who are the advocates for the current program? Will the new practice bring additional advocates or make current advocates feel left out?

3. Who among the program's current advocates are likely to support or resist the implementation of the new program and why?

4. Are there stakeholders in the community that will be interested and excited about the clients served or the outcomes achieved by the new approach?

5. Are there natural leaders or usual detractors that need to be engaged about the changes that will occur?

6. Do the current stakeholders or potential new stakeholders have information about evidence-based practices or the particular practice to be implemented? If not, what ways are there to make this information available to them?

C. Program and Organizational Assessment

1. How old is the program and the organization that is being asked to implement the new practice? What is its history of responding to new technologies and practice improvements?

2. Have there been recent attempts at change that have been successful or unsuccessful? If so, what factors contributed to the success or failure of that earlier effort? How long ago was it, and are staff, stakeholders and decision-makers still talking about the success or failure of that effort?

3. Is there a structure in place at the staff, leadership, or organizational (board or owners) level responsible for planning, innovation, or quality management?

4. In what ways does your organization or program engage staff and clients in planning processes? What are the expectations about involvement in planning and decision-making processes?

5. How big is the program or organization in terms of budget, clients, types of programs, and staff? Does the size make it more or less difficult to implement new approaches to care?

6. Does the program or organization have current threats or strengths that will make it more or less likely to want to change? Are there other new requirements or changes that are taking the attention of the program or organization that will make it hard to focus on the new practice?

7. Are there structures either within the program or within the organization that make it difficult to align all the staff, resources, and stakeholders to accomplish the identified task? If so, is there any way to work around those structures or to suggest changes that would support the new practice (e.g., a combined child/family task force to oversee TANF-funded programs and mental health/substance abuse programs for children or a combined substance abuse and mental health task force)?

8. Are there factors in the program's or organization's environment that either make it difficult or will help to align all the staff, resources, and stakeholders necessary to accomplishing the plan to implement the new practice?

9. Are there other things in the program not directly involved in the new practice that will need to change (e.g., the client assessment process or tool, the client intake protocol, the process of who is on-call after hours and how those staff interact with existing crisis services in the community)?

D. Financial Assessment

1. How are services currently funded at the program and organizational levels?

2. Will the new practice fit within the current funding mechanism? If not, exactly what changes will be needed or what questions will need to be clarified to assure the new practice can be funded?

3. Who controls the answers to each of the questions – the program, the organization or a system decision-maker or funder outside the organization?

4. Does the organization or system have experience with multiple funding mechanisms?

5. Have funding decision-makers been willing in the past to be creative or work with programs to change or clarify service definitions, units, provider qualifications, or financing mechanisms to support innovation? If so, who has been instrumental in that process? If not, who has been unwilling to do so and why?

6. Are there any ways to work around financial definitions, processes, or mechanisms by changing the way the program or practice is designed, delivered, or documented?

7. Is there anyone who has authority or influence over financial decision-makers who is interested in the new practice, the population the practice will affect, or the outcomes to be achieved?

8. Are there non-traditional financing sources that might be willing to help with funding pilots or those parts of the practice that cannot be readily funded with traditional funding sources (e.g., businesses willing to fund adjunct services for persons who are homeless with co-occurring disorders; an electronics store willing to provide laptops, cell phones, or handheld devices for mobile teams; local or national foundations willing to fund a pilot that would identify the pros and cons of a new service approach; a TV station or university willing to provide videoconferencing equipment for telemedicine approaches for rural areas)?

9. Is there a creative financing mechanism that can be proposed to decision-makers that will provide the flexibility to implement the new practice but that will not cost more (or may even cost less to funders) than current approaches? Can this mechanism and program design be proposed as a pilot with financial analysis, as well as client outcomes as part of the evaluation criteria?

10. Are there funds currently provided for a less effective activity or practice that can be redeployed in whole or in part for the new practice?

E. Policies and Procedures Assessment

1. Review current policies and procedures and determine which of them support and which prohibit or impede the introduction of the new practice in whole or in part. Specify what would have to change to remove the impediments.

2. Review service unit and definitions and determine which of them are consistent or inconsistent with the services in the new practice (e.g., systems of care or multi-systemic therapy versus individual therapy sessions for behaviorally involved children). For those that are inconsistent, specify how they would have to change to support the new practice.

3. Who controls the policies and procedures and service definitions? Are they easily changed? If not, is there anyone who controls these changes that has exhibited an interest in supporting innovations in the past or who might be interested in the populations or outcomes the new practice is meant to affect?

4. What forms are consistent or inconsistent with the new practice (e.g., assessment tools, intake forms, documentation forms, reporting forms)? If inconsistent, specify how and what it would take to make them consistent.

5. Who mandates the use of these forms? Are they easily changeable or eliminated? If not, can they be done in a way that minimizes their impact on the program or practice?

6. Are there computer screens in use that make the implementation of the new practice difficult? Are there computer screens or programs that could prompt or assist practitioners in using the new practice? Who controls these decisions?

7. What is the history and purpose of each of these policies, procedures, definitions, forms, and computer screens/programs? Are there champions of these current processes that will object to changing them? If so, why?

8. Are there program staff or stakeholders committed to the new practice willing to offer time or expertise to make necessary changes? Are they able to propose policies and procedures, service definitions, forms or computer programs that will encourage and support the new practice while also providing the organization the controls or information it needs?

F. Political Assessment

1. Who will benefit and who will not benefit or who will be perceived as losing something in the change to the new practice?

2. Who are the decision-makers at the organizational and system levels that have a stake in what the program does and who it is for?

3. Are there people in positions to make decisions affecting the program or barriers to implementing the new practice that have different ideas about what the appropriate outcomes are for persons to be served (e.g., legislators who believe less taxpayer money should be spent on mental health and substance abuse; county commissioners who believe putting behaviorally involved children or adults in facilities where they and the community can be safe should be the primary goal of treatment; officials who believe service dollars should be used primarily by licensed practitioners in office-based settings)?

4. Are there individuals or groups who know such people personally and to whom such people will listen about the value of evidence-based practices, the value of person-centered planning and outcomes, and the wisdom of the outcomes expected from the implementation of the new practice?

5. Are there communication outlets that might be sympathetic to the process you are undertaking? Are there places you, supportive practitioners, or influential stakeholders can speak about these ideas that will reach those whose opinion needs to be swayed?

6. Are there influential individuals or associations (advocacy, guild, trade, business, unions) that will be your allies in getting the new practice implemented and barriers removed or mitigated?

7. Who is likely to be opposed and why? Is there any way you can work to reduce that opposition from the beginning by including those individuals or groups, or by understanding their opposition and working to implement in a fashion that will ease their fears and concerns?

8. Is there anything you can trade for support or reduced opposition? That is, is there something the potential allies or opponents want that you can help them with in exchange for them helping you to achieve your goals in the process of implementing the new practice?

TECHNIQUES FOR OVERCOMING IDENTIFIED BARRIERS AND CAPITALIZING ON STRENGTHS

The assessment questions suggest ways to overcome identified barriers and capitalize on the strengths of the program, the organization, its stakeholders and allies. Techniques to accomplish the task of implementing a new practice are almost endless, depending on the answers to the questions above and the unique situation each program encounters. However, a few examples may help you to think about how to put these techniques together to fit your particular needs. These examples are simplistic for the sake of illustration. Your situation is likely to be much more complex, and will require the use of multiple techniques to implement and sustain new practices.

EXAMPLE ONE: IMPLEMENTING A REQUIRED EVIDENCE-BASED PRACTICE FOR ADULTS

You have been told that your major funding source is interested in implementing Assertive Community Treatment (ACT) teams for adults with serious and persistent mental illnesses (SPMI). Each agency that serves a significant number of such individuals will be required to have at least one such team. The funding for these teams will come from usual billing and funding mechanisms, that is, billing Medicaid, private insurance, private pay, and general funds for the delivery of mental health services.

Your agency serves many more adults with SPMI than can be served by one ACT team. Additionally, your local consumer group has already begun to advocate against the use of ACT teams, since they consider them to be overly structured and coercive. Your local NAMI chapter has embraced ACT teams and helped to lobby the funding authority to implement this required new practice.

You have heard a great amount about ACT teams, and read some of the literature about them. However, you are not sure about all the elements of these teams, or how they differ from regular case management with treatment teams for SPMI clients. You have been told that the funding authority will be expecting agencies to keep track of outcomes of those clients served by ACT teams, including days in the hospital, days in stable housing, and treatment/medication compliance.

Your program now has therapists that see clients for individual or group counseling, in the office at scheduled times, although you do have drop-in hours for emergencies. You also have case managers who provide in-community services for SPMI clients, primarily during business hours and sometimes on weekends in special circumstances. You do not currently offer after-hours crisis services. The emergency room of the local hospital provides for such care, and either holds clients until your agency opens the next business day or admits clients if they meet the criteria for hospitalization, and if they have a payment source. Otherwise, the hospital sends crisis cases to the state hospital about 25 miles away.

Your clinical supervisors are Masters-prepared social workers with many years of experience in office-based therapy services. Your staff is generally happy with the way things work now, and consumers who come to your agency like being able to see the same therapist for many sessions. They indicate that they look forward to coming to see their therapist every week, indicating that they appreciate having someone to talk to about their problems.

Therapists have productivity requirements, that is, they are expected to see and bill face-to-face client time at a set number of hours per week. These productivity requirements are crucial to keeping the revenue of the agency sufficiently high to pay for salaries and operations of the agency. In fact, these productivity requirements have increased in the last couple of years as costs have increased and rates for services have decreased. No shows (i.e., individuals who are scheduled for an appointment but who do not come) are a big problem for therapists and for the agency as a whole since they negatively impact the productivity performance of therapists.

TECHNIQUES TO ILLUSTRATE

- Learning about the EBP
- Engaging reluctant staff; finding champions
- Working with consumers to understand their concerns
- Identifying the clients most likely to benefit from this EBP
- Implementing outcome measures
- Helping supervisors change and support staff to change
- Managing changing finances
- Changing relations with community partners
- Organizing work in new sites
- Advocating for changes in implementation requirements to meet the needs of consumers and the agency

Here are some ways you might think about proceeding:

Think about the practitioners and other staff in your organization/program. Do they know about ACT teams? Who has been most interested in finding new ways to serve the high risk, high cost clients who do not do well in the community and/or are often readmitted to the hospital? First identify a staff person or two who has shown such interest or often thinks creatively and is willing to try new things. Then think of a staff person or two who are most likely to be unwilling to change the way services are currently provided. Talk with each of these individuals and ask their help in guiding this new service. These will be your champions (although other 'natural' champions may arise as the process of implementing the program occurs.) Sometimes, people who are most unwilling to change can be best engaged by including them from the outset in the process of doing what must be done. Find out what these individuals think will be needed to make it successful, and listen to the concerns about what might get in the way. Ask them to present the issues to the staff at the next staff meeting and lead a discussion about how to proceed. Sometimes, an ally in this process may be outside the program. That is, the information technology leader or the quality management leader may be important to bring to this initial meeting and to engage as a champion.

During the staff meeting, be prepared (with your chosen champions) to talk about the requirement to implement ACT teams, the benefits that are likely to accrue from such a program and what research says about the value of ACT teams for adults you serve. Ask the staff to read a review or a study that you provide for them about ACT teams and be ready to discuss it at the next staff meeting or a brown bag lunch set up for this purpose. Also at the staff meeting, ask the champions and then staff members to talk about what the positive results of this change can be for consumers, for the program, and for the community. Ask the staff to identify what they feel they need to know about ACT teams and the challenges they feel will need to be overcome. Ask them what questions they have about what this change will require of staff and the organization, as well as the consumers to be served. While it is important to let staff brainstorm issues, it is also important that this session not be a session to say why ACT teams 'won't work here.' Rather, it is important that the session end with assignments for individuals or groups of staff to come back with information about ACT teams and their value for what kinds of consumers or suggestions about how to meet the challenges that will be posed.

Have a separate meeting with supervisors about the new practice. Ask them to identify specifically what they will need to do differently as supervisors to support the new practice, and what they need to know to do this well. Asking a supervisor from an existing ACT team to share techniques and sources of information may help this process. Make sure supervisors have a comfortable and regular place to come to convey feelings of uncertainty or just to ask questions about how to approach supervision when staff are not all in one place or are doing things that seem less like the traditional therapeutic skills taught in clinical training.

You will need to be ready to identify the clients that will be eligible for, or likely to benefit from, an ACT team approach. To do this, someone should be charged with learning enough about the research on ACT teams to know what type of consumer is likely to benefit and what outcomes can be expected, if ACT teams are implemented with fidelity to the model of ACT that has been shown to produce the result. Staff may need to identify what data is currently being collected and what data will need to be collected in order to assure that the outcomes being sought are in fact those that ACT teams have been proven to produce, and that these outcomes are in fact achieved. The program will need to show this to the funder, board, or community.

A consumer group, either existing or specially created for this purpose, should be convened shortly after the staff meeting to talk about their interests, hopes, and concerns about implementing this new approach. Consumer representatives should be identified by the group to work with the staff champions to identify issues, work through solutions, obtain input from other consumers, and provide information to consumers as the process unfolds. Some consumers may feel that ACT teams are too restrictive or 'coercive' as they read about some consumer groups' opposition to this practice. Listening to how you can make sure the teams are not coercive, but rather supportive and how consumers would like them to be developed can help to alleviate this concern. It will be more effective if the staff and consumers work together as a group to guide the implementation of this new effort.

In this example, the local NAMI chapter will be a big ally if you can engage them without making them the 'other' perspective. That is, it will be important to have family members, consumers, and staff work together and respect each others' views and concerns. Ask the NAMI chapter to lead discussion groups with consumers and truly listen to their concerns. Ask them to bring back suggestions agreed to by consumers and family members about how to assure concerns and fears are addressed in the implementation process. Perhaps the NAMI group will be willing to help identify and raise resources for training, equipment, consultants, trips/visitors, etc., that would otherwise be unfunded during this process. Also ask the NAMI group to help you when you tell funders about barriers you need their help in resolving.

The staff/consumer/family champion group should identify where the organization will need to change to support this new effort. For example, do human resource policies about work hours need to change? Will the staff involved in the ACT team need new technology, such as laptop computers, pagers, or cell phones? If these do not now exist, how can the resources for this equipment be obtained? Will the funding mechanisms of critical staff need to change? For example, if physicians are now paid for each client seen and it is expected that the physician will see 20 patients per day in a clinic setting, how will the physician be paid if he/she is working at least one half time with an ACT team? If ACT team staff is expected to be available for crisis calls during the evening, how will they be paid? If staff is used to working in an office setting and they are now expected to see clients mostly in the community, what will that mean to their productivity calculations? How will staff and consumer safety be considered? If the program's forms and reports are set up for individual rather than team reporting, how will these need to change?

One issue that often arises is that staff selected to be part of the new ACT team may have never seen such a team in operation. It is one thing to read about such teams, it is another to operate them. Arranging for a visit to an existing and successful ACT team, with the ability to have ongoing interactions as the project unfolds will be helpful. Consumer and staff representatives should visit together to learn how ACT teams function, issues they have to address, and techniques they have used to be successful and to track their success.

Finally, externally required new programs often do not account for barriers that make it difficult to implement smoothly. Brainstorm with staff and consumers how to have a process that identifies issues as they arise, and focus these issues toward solutions needed rather than reasons the process cannot continue. Talk with the funders or those requiring the change and ask that they come to the program at regular intervals to listen to staff, consumers, and managers about the issues that have been identified and about potential solutions the program has identified to overcome those issues, with the help of the funder or entity requiring the change. If approached in a positive manner, this kind of advocacy that says 'here's the problem, and here's how we can make this work – with your help' is much more likely to result in real solutions.

Finally, make sure you begin early to provide regular reports to consumers, staff, funders, and community and organizational leaders about the status of the implementation. It is important to convey this activity as progress and as a process leading toward better outcomes for consumers. Finding out what these stakeholders want to hear from you and the program as it is implemented is one way to engage them in your change process. Giving them updates and eventually data (i.e., facts) about the positive changes for the consumers served will go a long way to gaining support.

EXAMPLE TWO: IMPLEMENTING A NEW PRACTICE TO ADDRESS THE NEEDS OF A PARTICULAR TYPE OF CONSUMER (CHILDREN)

In this example, you have identified within your program a group of consumers for whom the program is not as successful as you would like it to be. This might be a group of consumers you find difficult to keep engaged in services; a group that uses most of the resources and staff time, thereby taking away time and resources from other consumers; or a group that is a priority for your organization, community, or funder, but for whom the outcomes are not good (for example, children who exhibit more truancy or behavior problems, have less success in school, are more likely to be taken out of the home for care, are more likely to have interactions with police and juvenile authorities). These consumers may be identified by staff, other consumers, funders, organizational leaders, the community, families, school officials, or juvenile judges.

Even though you and your staff can almost name the children/adolescents that are in this group, you cannot exactly say what the common characteristics are of the group as a whole, or even if there are commonalities across the whole group. You have staff that does not want to work with some of these children/adolescents, and you have growing concerns expressed about the value of your program, since it cannot meet the needs of these individuals. You have some staff that are 'blaming' the children/adolescents and suggesting that the program stop serving these children/adolescents. You have some community leaders or funders indicating that if you cannot help find a solution for these consumers, your program will not continue to be funded at the same level (that is, they will find someone who can!)

TECHNIQUES TO ILLUSTRATE

- ❖ Describing the problem to be solved
- ❖ Identifying the outcomes to be achieved
- ❖ Engaging staff and consumers in picking a practice to try
- ❖ Understanding, implementing, and measuring fidelity to the model
- ❖ Convincing the organization and funders to support the efforts
- ❖ Determining whether the desired results were achieved
- ❖ Reporting results to staff, consumers, organizational leaders, and funders

HERE ARE SOME WAYS YOU MIGHT THINK ABOUT PROCEEDING:

First, think about the problems that are being identified by you, staff, funders, or the community. Write down the problem as you believe it to be from their point of view. Check out your understanding of the problem with a representative you trust from each group. If the issue is simply one you have identified, ask trusted staff or advisors if they have the same concern.

Once you have identified the problem and a couple of individuals who agree with you about the nature of the problem, begin to identify the consumers that are the subject of the problem. For example, you might have a group of children and their families who do pretty well in therapy or programs you offer until they reach 12 – 15 years old. Then the children begin to exhibit increasing behavioral difficulties and substance abuse, families become less able and less willing to deal with them, criminal justice interactions increase, school work declines, willingness to engage in mental health treatment declines, and many of these children/adolescents end up in out-of-home placements or in juvenile detention facilities. Eventually, many of these children are identified as serious adolescent or adult offenders and are incarcerated or become homeless as young adults.

It is important to write down the characteristics of these children/adolescents. Look at the clinical records for the children you know. Do they share common diagnoses, common family interactions or histories, or common behavior patterns? Do they have similar educational statuses (e.g., they are often in special education for learning disabilities or behavioral issues)? Do they come from a similar school district or type of school environment? Is there something about their age, gender or sexual experiences or orientation that make them similar?

As you begin to identify the children/adolescents you know about, review the records of other children/adolescents your agency has served to determine if other children and their families have similar characteristics but did not come to your attention because they dropped out of treatment, ended up in adult treatment settings or are still in your program but not really progressing (e.g., they have been in therapy for an exceptionally long time but exhibit the same functional concerns or symptoms). It is important to sort through important clinical differences with similar exhibiting behaviors to make sure you pick a program or service approach that is likely to be successful for the children/adolescents you are trying to serve. You might want to talk with other child-serving agencies to see if they have similar patterns of clinical presentation or behavior in their caseloads as well.

Now try to describe, in writing, the problem and the potential consumers and families you think need a new approach. Write the outcomes you want to see, as well (e.g., less difficult behaviors, more family satisfaction and willingness/ability to work with the youth, less criminal involvement, less substance abuse, better outcomes in school, more days in school, less out-of-home placement, etc.). Identify stakeholders who you believe want to see these same outcomes. Meet with a group of staff, consumers, families, and community members (especially juvenile judges or their staff and school officials) and talk about the problem as you have described it and the outcomes you would like to see. Ask them to help you refine the description of the problem and the outcomes. Ask for volunteers to work with you to research program options in order to achieve such outcomes. Make sure the group knows that it is likely you will have to start small and will need help to identify resources to try to make a difference. Ask for their help in identifying others in the community or organization who might want to join in making this difference.

Once your volunteer group learns about possible program models (by going to conferences, looking on the internet, reading reviews, calling national advocacy groups or trade associations, talking with academicians, etc.), think together about what it would take in your program or community to implement one of these models. What are the core components that have made the model a success (that is, what would it take to be faithful to or have fidelity to the model that has produced the positive outcome elsewhere)? What barriers will you face in trying to obtain the resources and staff and change the program or organizational structures to support implementation of such a model? Are there options, that is, are there different models to choose from? If so, what are the pros and cons of each? Which one is most likely to be fundable, given the sources and rules of your potential funding streams?

Ask your group of volunteers to keep an open mind until you have all discussed and analyzed the models together. It is critical to be certain that whatever model you choose has actually been shown to produce the results you are seeking for the population or subpopulation you describe. Implementing a program for children/adolescents with conduct disorder may not work the same as for children/adolescents with ADHD, even if both groups of adolescents have difficulty in school, at home, and in the community.

Talk with your organization's executive leadership and the governing board to describe the problem you have identified, the clients you want to impact, and the results you want to achieve. Talk about the model(s) you have identified that might be successful in achieving these results and what it might take to implement such a model (including time, staff, money and other resources). Ask if you can pursue a small grant to bring in the developers of the model(s) or someone in the country who has successfully implemented the model to talk with community stakeholders, staff, and consumers/families. See if you can find a local foundation, business, chamber of commerce, or other funding source that will be positively impacted by the outcomes you want to achieve to fund the visit and perhaps a small planning phase for the program.

Begin to identify potential funding sources for the program. Can you continue to bill your existing sources (e.g., Medicaid, federal block grant, school sources, private insurance) for the program? Will you need special start-up funds? Will funding sources have to change? If so, how can you frame the changes needed as a pilot to see if the new program will achieve the positive results? Will the changes needed be difficult for the funder or can you propose relatively easy solutions? For example, can you provide a suggested service definition that will work for Medicaid and analyze the potential cost if the state plan amendment is made, or can you show how providing a flexible case rate for the described children might actually save the funder money if you agree to keep the children/adolescents out of state-operated or state-funded facilities? You may be able to project savings to managed care companies who are at risk for higher levels of care for such children/adolescents.

As you develop the program design and identify the funding for the initial implementation, remember to set up methods with staff to measure how close to fidelity to the model you are staying and to measure the outcomes expected and achieved. If the outcomes you are getting are not what you expected, go back to the description of the consumers and their families and make sure the model you chose is consistent with their characteristics. Look to see if your program is being implemented true to the components of the model that you selected to implement. Make adjustments as needed, using an advisory group of stakeholders (including consumers and their families) to help you monitor the results of your process. Make regular reports to organizational leaders, governing body, community leaders, and funders about your success. Be sure to report openly when the results were not what you expected and what you are doing to change those results.

Do not be afraid to analyze where the process of implementation may have gone wrong. Do not be afraid to say that the model did not work as you wanted, therefore another model needs to be tried to achieve the results you and stakeholders were seeking.

Remember that these processes are dynamic and should include ongoing improvements as you learn what works and what does not, and why. This is at the heart of implementing evidence-based practices and at the heart of having a dynamic evidence-based practice in your organization or program.

A Final Thought

The examples given above are greatly simplified. Your experience is likely to be more complex and messy. That is okay. It is a learning experience. You are creating a learning environment, able to change, and willing to monitor results and act when they are not what you want them to be. Also remember that changing or implementing a new practice is not as simple as just telling staff to do it or even just providing them the training or skills to do it. The structure of their practice will need to be adjusted. The organization and program will probably need to change, too. Financial policies, reporting policies, forms, data collection, supervision processes, human resource policies, and interactions with community, consumers, and funders will all be impacted.

Think about what you are trying to achieve. Track it to see if you did. If you did not, ask why and make adjustments. Do not assume initial positive results will continue. It takes as much effort to sustain a new practice as it does to implement. Chapter Eight discusses what it takes to keep evidence-based practices going over time.

Chapter 8

Sustaining and Improving on the Effort

No matter how well planned and executed the implementation of a new practice, it is not likely to be sustained without specific plans and efforts to do so. That is because human and organizational nature is to return to what is familiar and comfortable in the face of what is sure to be unforeseen obstacles as implementation proceeds. This chapter provides some ideas about how to think about the sustaining stage of the process and how to incorporate ongoing improvements as your program gains experience with the practice.

MONITORING THE EVIDENCE-BASED PRACTICE AND THE RESULTS IT PRODUCES

As indicated in previous chapters, it is critical to know exactly what you are trying to achieve – that is, the population you are trying to impact and the outcomes desired by and for that population – before you select a new practice to implement. In the process, a clear written program description is a good idea. This program description should include the population's characteristics, the program or practice design, the critical components of the practice to which you will try to stay true (fidelity to the model), any deviations from those components you are doing and the reasons why (to address unique things in the environment or population and to deal with barriers), and the outcomes you expect to achieve, based on the research and literature about the practice. These outcomes should be specific and measurable with anticipated and realistic targets for different stages of implementation.

> No matter how well planned and executed the implementation of a new practice, it is not likely to be sustained without specific plans and efforts to do so.

The process of developing this program description should be part of the planning process described in Chapter Five. It will also help you identify issues you want to monitor as implementation progresses. The two most important are the fidelity to the model or components you have described and the outcomes you are achieving. It should be noted that while client outcomes are the bottom line, there may be program performance indicators that you also want to track. For example, you may want to know the overall cost of medications while using a medication algorithm, the costs per seriously mentally ill adult or severely emotionally disturbed child served, or the number of appropriate referrals to other programs or systems.

Part of your planning process should be determining how you will collect information about the fidelity to the described components (and to the researched model if these are different, to determine if these differences affect the expected outcomes either positively or negatively). There are established fidelity scales for some evidence-based practices; an example is provided in Appendix B. Sources of information about fidelity scales and people who are expert in developing these scales are also included in the bibliography (Appendix D). You may want to work with local researchers or evaluators to establish fidelity scales for practices that do not have such scales already established or for promising practices that do not yet have a complete array of scientific evidence to support their use. This process will not only help you and your program, but will help the field as your experience with the promising practice becomes known.

You should also plan on how to collect information about client outcomes. In many programs, there are existing methods for collecting client outcomes, although these outcomes may or may not be the ones you expect or desire or the ones the evidence-based practice you are implementing are targeted to produce. To the extent possible, using existing data collection methods and forms will prevent resistance from staff who may see this as extra or duplicative work. Involving staff who will be doing the data collection in the process of designing data collection tools and methods will help in making this process doable and in obtaining buy-in from these staff early in the process. If your organization has a quality management department or person, involving those leaders will also be critical to ongoing success of the monitoring process.

Finally, a critical part of monitoring as you introduce a new practice is reporting and discussing what is happening and why. From the beginning, you and your planning team should be developing reporting formats and setting expectations about how often and where those reports will be developed and discussed. Should this be with the planning group, a program advisory body, the management or leadership team, the organization's board, the local authority or state system leaders, or other stakeholders? It is probably important to do the reporting early at the program level and expand the reporting in strategic ways as the reports and results become clearer. Part of the discussion early on should be about the completeness, accuracy, and validity of the data. Part of this discussion should also be about the implications of what the data shows and why the results are what was expected or are better or worse than what was expected. Until the data are widely accepted as accurate, low performing organizations or groups will challenge the findings because of the validity of the data. You may need to include incentives (or possibly even sanctions after a period of time) for practitioners or other staff to ensure that reports or information are timely and accurate.

Be sure to use the data! That is one of the best ways to encourage staff to pay attention to data collection, given all the other pressures they have in their jobs. There is nothing more frustrating than having to fill out forms or report data and then never see it again or never hear about whether or how it was used. If the data are not used or discussed, you can rest assured that it will be inadequate to make sound program decisions.

MAKING ADJUSTMENTS BASED ON THE REPORTED RESULTS

If the results you expected and desired are being produced (more satisfaction, fewer out-of home placements, better performance in school, fewer hospitalizations, more jobs, fewer interactions with police and courts, more independent living, fewer suicides, reduction in symptoms, etc.), don't stop there. Find out why. Is it because the new practice was true to the components that the research said was critical to success? Is it because you have discovered a new practice by adapting a well-researched one that seems to work for your unique population or community? Or is it simply because your staff was more energetic in working closely with clients and their families since they were implementing a new and fresh approach? Or did the program select individuals who were most likely to succeed, rather than individuals who needed the service the most? Were there positive outcomes (or program performance) that you did not anticipate, but that occurred while the new practice was being implemented? Sometimes data alone do not tell you why success happens. Looking at anomalies, such as persons or practitioners for whom the new approach did not seem to be as successful, can sometimes tell you why successes happen. Discussion helps, not only with persons involved in the practice but with persons who are outsiders, such as researchers, evaluators, or other systems' staff who may be able to see something in the data you do not.

If the results are not what you expected, it's important to try to understand why. Again, discussion with involved stakeholders and knowledgeable outsiders is important. Is it because the population served is not the one for whom the practice was designed? Was fidelity to the model not followed? If not, what components were changed? Were the outcomes not the ones that should have been expected from the practice you implemented? Are the data collection and reporting process giving you the right information? Is there something in the process of implementation that got you off track and presented barriers that were unanticipated? Did the practice affect allied systems that are now having an impact on the outcomes (e.g., police, courts, families, schools)? Are there barriers in funding, policies and procedures, forms, or organizational structure or politics that you did not anticipate that are getting in the way?

Identifying the reasons will help in making the necessary adjustments. It could be that the practice itself needs to change. The way clients are identified for the practice may need adjustment. The outcomes expected may need to be redefined. Administrative or political barriers may need to be addressed. The important thing is to keep making changes until you achieve the outcomes and program performance you desire. It may be necessary to stop and start all over or to seek help from the decision-makers who required the implementation of the practice in the first place to get back on track.

Including Evidence-Based Practices in Ongoing Quality Management and Improvement Processes

It is important to continue to 'shine a light' on the new practice and on the outcomes you want to achieve. This can be done best by including the fidelity measurements and the outcomes and performance results in the ongoing quality management and improvement processes of the program or organization within which you work. If the organization has no quality management process or if it is focused largely on monitoring the results of things required by accrediting and funding bodies rather than things desired by consumers and families, the implementation of evidence-based practices can be an opportunity for including consumer and family driven outcomes in the quality improvement process.

Building the new practice and the results it is intended to achieve into ongoing quality improvement processes helps to make the new practice a routine part of the program. Building the new practice into funding, regulatory, political and clinical environments, including the routine reporting and management of these aspects of the program, will assure that the new practice becomes the routine — the new 'business as usual.'

Understanding that sustaining new practices, and then being willing to and having the capacity to change those practices, is fundamentally what evidence-based thinking and ongoing quality improvement is all about. Change is inevitable, and necessary for the survival of all human service programs. More importantly, constant additions of new practices to the repertoire of practitioners are crucial to consumer and family success in conquering the effects of severe and persistent mental illness, emotional disturbance and addictions, or a wide range of problems that reduce productive living. This is the reason publicly funded programs exist and is, therefore, the bottom line task of all programs serving persons with these illnesses and conditions.

> It should be noted that any new practice, if incorporated into ongoing program operations, will soon become the routine practice that needs to be changed as new evidence-based and promising practices come along.

ISSUES IN SUSTAINABILITY

Some key operational issues have been identified in the literature and research about implementing and sustaining organizational change (and therefore, new evidence-based or promising practices). First, feedback is essential. As indicated above, practitioners, staff, and consumers/families will not know how they or the program is doing without clear and consistent feedback. This feedback must be provided as aggregate reports as well as reflection on individual performance.

Second, supervision for individual practitioners has been shown to be critical in the implementation and sustaining of new evidence-based practices. Simply telling practitioners what to do differently and asking them to do so will not change their practice behavior. They need supervision that is knowledge- and skills-based that will reinforce and provide an anchor for their own practice and for the expectations the program has of them. Supervision is not often taught, but is often assumed for persons who are responsible for other practitioners' performance. Spending time on the fundamentals of supervision, as well as on the specifics of supervising the particular new practice being implemented, will reap considerable dividends. Helping supervisors know how to learn new skills themselves, and how to support other practitioners in learning and implementing new practices, is a skill in and of itself that should be taught and nurtured. For more on these issues, see the work of The Annapolis Coalition on the Behavioral Health Workforce (www.AnnapolisCoalition.org) and also the National Direct Service Workforce Resource Center (www.DSWResourcecenter.org).

Third, ongoing champions that continue to keep the light shining on new practices are as critical as early leaders who provide the cheerleading and leadership to get the new practice off the ground. Ongoing champions for the new practice and for the concept of changing practices as new knowledge suggests changes in approach are important. These peer leaders among practitioners and consumers, families and advocates should be supported and encouraged.

Fourth, as indicated earlier, incentives to reward new behavior and to prevent old behavior that the program wants to see changed play a significant role in initial changes and in sustaining the new approaches. Incentives take the form of pay, bonuses, public recognition, additional opportunities for training and presentation, and alleviation from other onerous duties. When all else fails, sanctions may need to be employed and include withdrawal of pay or lack of increases, required training, and increased supervision or oversight. In the worst of all cases, staff who consistently fail to conform to expectations about new practices after all other efforts have been tried may need to face the consequences of negative performance evaluations and job related actions. The goal should be to expect, encourage, and assist all staff to perform as expected and provide the kinds of outcomes desired by clients and the program. However, these expectations may not be realized if there are no teeth in that expectation and if bad or ineffective practices are allowed to continue without repercussion. It may be just as important to set the standard for expected performance and to stop practices that are ineffective or harmful as it is to implement and encourage good performance as new practices are researched and prove promising in client care settings.

Finally, the complexities of human resource management must be taken into account in efforts to sustain new practices. In many publicly financed behavioral health programs, turn-over is high and practitioners do not come to programs knowledgeable of new evidence-based or promising practices. This means that a single training or roll-out of a new practice will not be sustained unless attention is given to incorporating the new expectations into ongoing training efforts for new employees and into on-the-job training and supervision. Programs may need to work with community colleges, local universities, and other training programs to assure that they are incorporating new thinking into their curricula to produce practitioners who are able to learn and change throughout their careers. Programs can help to instill this construct into the employees they recruit and hire by making a discussion of evidence-based thinking and ongoing learning a part of the hiring process. Credentialing and privileging processes can also be an opportunity to convey the message that ongoing learning and constantly changing and improving practices are the expectation of a high quality program today, but only if the processes reward learning and performance of effective and high quality service. That is, a credential or privilege, based on outdated criterion, or provides a 'lowest common denominator' of safe (but not necessarily effective) care is likely to be a poor reinforcement of practice improvement and high quality care.

IMPACT OF OTHER SYSTEMS

Programs cannot afford to be insular in today's world. The impact that stakeholders' agendas, leadership turnover within local and state systems, and the requirements of other allied systems will have a profound impact on how money is used and the outcomes sought for clients and families. It is important to recognize these influences and to seek to affect them by participating in planning processes, leadership selection processes, financial decision-making processes, and regulatory processes that impact the delivery of services and the outcomes for clients served by behavioral health care programs. Systems and organizations, such as Medicaid, child welfare, vocational rehabilitation, schools, social security, accrediting bodies, and advocacy groups all play an increasingly important role in how behavioral health care services are designed and implemented. In each of these systems or groups, helping decision-makers to understand the role and importance of evidence-based thinking and practices will serve to improve outcomes in the long haul.

Appendix

A

General Organizational Index (GOI) Criteria[5]

Some years ago, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed a tool for use in implementing evidence-based practices. It may be useful for users of this handbook, and so we have excerpted elements of the GOI below:

G1. PROGRAM PHILOSOPHY

The program is committed to a clearly articulated philosophy consistent with the specific evidence-based practice selected, based on the following five sources:

- Discussions with the Program Leader
- Discussions with the Senior staff (e.g., Executive Director, Chief Financial Officer, Clinical Director, Medical or Psychiatric Director, Supervisors)
- Discussions with or Survey of Clinicians/Practitioners and Key Staff Within the Program
- Discussions with or Survey of Clients and/or Family Members
- Written materials (e.g., Brochures, Program Descriptions, Quality Improvement Plans, etc.)

G2. ELIGIBILITY/CLIENT IDENTIFICATION

All clients with a specifically identified need or set of characteristics in or to be served by the program are screened to determine whether they qualify for the selected EBP using standardized tools or admission criteria. The program tracks the number of clients screened, the number of eligible clients, and the number of clients receiving the EBP, in a systematic fashion.

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[5] *The authors are grateful to the National Evidence-Based Practices Project for use and adaptation of these criteria. The Project uses these criteria to deter mine the relative success of the states participating in the Project to address factors likely to be related to success of EBP implementation. More about this assessment tool can be found at www.mentalhealthpractices.org. Source: Substance Abuse and Mental Health Services Administration. Assertive Community Treatment: Getting Started with EBPs. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008.*

G3. PENETRATION

The maximum number of eligible clients is served by the EBP, as defined by the ratio:

$$\frac{\text{\# clients served by EBP}}{\text{\# clients eligible for EBP}}$$

These two items coded based on all clients in the outpatient/community support services; all other items refer specifically to those receiving the EBP.

________ *Total # clients in target population*

________ *Total # clients eligible for EBP* *% eligible:* ________ %

________ *Total # clients receiving EBP* *Penetration rate:*________

G4. ASSESSMENT

A full standardized assessment of all clients who receive EBP services is conducted, including history and treatment of medical/ psychiatric/substance use disorders, current stages of all existing disorders, vocational history, any existing support network, and evaluation of bio-psychosocial risk factors.

G5. TREATMENT PLAN

For all clients served by the EBP, there is an explicit treatment plan related to the EBP for individualized treatment, consistent with the assessment, and that is updated as specified by the specific EBP.

G6. TREATMENT

Each client receives EBP services consistent with his/her individualized treatment plan related to the EBP.

G7. TRAINING

All new clinicians receive standardized training in the EBP (at least a two-day workshop or its equivalent). Existing clinicians receive annual refresher training (at least one-day workshop or its equivalent).

G8. SUPERVISION

Clinicians/practitioners receive weekly face-to-face supervision (individual or group) from a clinician experienced in the particular EBP, in sessions that explicitly address the EBP model and its application.

G9. PROCESS MONITORING

Supervisors and program leaders monitor the process of implementing the EBP every three months and use the data to improve the program. Monitoring involves a standardized approach, (e.g., fidelity scale, training and supervision activity, service/attendance data).

G10. OUTCOME MONITORING

Supervisors/program leaders monitor the outcomes for EBP clients every three months and share the data with EBP clinicians/practitioners. Monitoring involves a standardized approach to assessing a key outcome related to the EBP (e.g., psychiatric admissions, substance abuse treatment scale, employment rate, parent satisfaction with treatment, performance in school).

G11. QUALITY IMPROVEMENT

The agency has a Quality Improvement (QI) Committee with an explicit plan to review the EBP, or components of the program, at least every six months.

G12. CLIENT CHOICE

All clients receiving EBP services are offered choices; the EBP clinicians/practitioners consider and abide by client preferences when offering and providing services.

Appendix

B Multisystemic Therapy (MST) Site Assessment Checklist[6]

PROVIDER: ______________________ **PREPARED BY:** ______________________

SITE: ______________________ **TRAINING DATES:** ______________________

OVERVIEW OF THE COMMUNITY SERVICE SYSTEM

✓ Identify organizations and agencies affected by the MST program (e.g., schools, social services, juvenile justice) that need to be 'on board' to ensure the successful implementation of the MST program.

✓ Develop an invitation list for the Monday of the 5-Day Orientation training. This list will include representatives from all agencies that need to be 'on board,' including management, front line staff, and critical 'opinion leaders.'

✓ What evidence exists that these organizations and agencies are 'on board'? Please include copies of any memoranda of agreement regarding the support of the MST program in terms of collaboration, referrals, or reimbursement.

✓ Confirm that the provider organization will be able to take the 'lead' on cases with the buy-in of other organizations and agencies (i.e., MST Therapists will be able to 'take the lead' for clinical decision making on each case). The organization sponsoring the MST program has responsibility for initiating collaborative relationships with these organizations and agencies. Each MST Therapist sustains these relationships through ongoing, case-specific collaboration.

✓ Describe the funding sources for MST program (e.g., program funding, fee for service, case rate, capitated rate, performance contract).

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[6] *Used by permission of the authors. The checklist can be found in Strother, K.B., Schoenwald, S.K., & Swenson, M.E., (1998). Multisystemic therapy organizational manual. Charleston, SC: MST Institute. See Bibliography (Appendix D) for more references about Multisystemic Therapy (MST).*

✓ Identify any potential financial disincentives for referral sources to use MST program (i.e., referral source must pay for MST but not for placing the youth in an out-of-home setting).

Overview of Sponsoring and/or Provider Organization or Agency

✓ Describe the factors contributing to the interest in MST (e.g., significant public sector policies or initiatives, federal or state level funding for training, third party payer and/or managed care's impact on the service environment).

✓ Include the provider organization's statements of mission and service philosophy (attaching a recent annual report or program brochure may be an easy way to accomplish this objective).

MST Program 'Goals and Guidelines'

✓ Define the target population for the MST program (ages, defining 'labels,' problem profiles, etc.).

✓Establish written, measurable goals for the MST program.

✓ Discuss how will program-level outcomes be measured.

✓ Establish written referral criteria (inclusionary and exclusionary).

✓ Document the details of the referral procedures (step-by-step details, names, phone numbers, etc.).

✓Confirm that a 'Goals and Guidelines' document will be completed prior to the 5-Day Orientation training.

Implementation of 'Required' Program Practices

✓ MST Therapists will be full-time Master-level or highly competent, clinically skilled bachelor-level professionals assigned to the MST program solely.

✓ MST Clinical Supervisors will be either Ph.D. level or experienced Master-level professionals.

✓ Confirm that the MST Clinical Supervisor will have credible authority over the MST clinicians. Describe the clinical and administrative lines of authority.

✓ MST Therapists will operate in teams of no fewer than two and no more than four therapists (plus the supervisor) and use a home-based model of service delivery.

✓ MST Clinical Supervisors will be assigned to the MST program a minimum of 50 percent time (full-time carrying a partial case load is also an acceptable option) per MST Team to conduct weekly team clinical supervision, facilitate the weekly MST telephone consultation, and be available for individual clinical supervision for crisis cases. Supervisors carrying a partial caseload should be assigned to the program on a full-time basis.

✓ MST caseloads will not exceed six families per therapists with a normal range being four to six families per therapist. A normal caseload consists of three or four 'active' cases.

✓ The expected duration of treatment is three to five months.

✓ Confirm that MST teams will have access to a good quality speakerphone, a fax machine, a computer with Internet access for administering adherence measures.

✓ MST Therapists will be accessible at times that are convenient to their clients and in times of crisis, very quickly. Issues to be addressed in this area include:

- ❖ the full-time and dedicated nature of the MST Therapist role;
- ❖ the use of flex/comp-time;
- ❖ policies allowing for the use of personal vehicles to transport clients; and
- ❖ the use of pagers and/or cellular phones.

✓ The MST program will have a 24 hour/day, 7-day/week on-call system to provide coverage when MST Therapists are on vacation or taking personal time. Professionals who know the details of each MST case and understand MST must staff this system.

✓ Discuss outcome-focused personnel evaluation policies, including the strengths of contract formats that make incentive bonuses for therapists possible.

✓ Confirm that there is an organizational understanding that accountability for client outcomes begins with the therapists but clearly lies within the entire organization, including the team, supervisor, and administration.

CLINICAL PRACTICES

✓ Confirm that supervision practices can conform to the following format: weekly MST group consultation, weekly group clinical supervision, and individual supervision only as needed due to case crises.

✓ Confirm that discharge criteria will be outcome-based rather than being focused on treatment duration or other criteria.

✓ Discuss how after-care referrals will be made. Will such referrals be carefully managed and limited to those that target specific, well-defined problems? MST assumes that most cases should need minimal 'formal' after-care services.

QUALITY ASSURANCE AND PROGRAM EVALUATION

✓ Confirm that the program administration has a clear understanding of the MST quality assurance process, including the ongoing assessment of therapist adherence, supervisor adherence and program outcomes.

✓ Identify an individual or individuals that will be responsible for weekly telephone calls to families for purpose of tracking adherence of therapists, and for prompting therapists on a bi-monthly schedule to complete the Supervisor Adherence Measure.

✓ Confirm that all staff members with responsibility for data entry, including therapists, supervisors, and administrative staff, will have access to the Internet for data entry on the MST Institute website.

TRAINING

✓ Discuss the administration's expectations for the training program and outline specific objectives for the training program. (Outside of developing an effective team of MST therapists, organizational expectations or desired outcomes of the training program need to be clearly articulated and built into the implementation plans or they will not be meet.)

✓ A test will be administered at the end of the 5-Day Orientation Training. We recommend that clinical staff retake the test if they score below 70 percent.

- ❖ Do you want clinical staff to be retested if they score below 70 percent?

  ☐ Yes ☐ No

- ❖ Do you want the test results used for any formal purposes? If so, what are these program specific uses of test results: ______________________________

✓ Who is the appropriate contact person for coordination of the 5-Day Orientation training (list of attendees, space/AV needs, lodging, directions, etc.)?

Name: ___________________________________

Phone: ___________________________________

Fax: ____________________________________

✓ Initial estimate of attendees for the 5-Day Orientation training (numbers to be used for advance shipment of training materials only):

❖ **Monday Overview:**

Estimated Total Number of Attendees for Monday Only: ____

❖ **Entire week:**

Number of Supervisors: ______

Number of Therapists: ______

Number of Open Spaces: ______

Estimated Number of Other Attendees: ______

Estimated Total Number of Attendees for Entire Week: _____

Appendix

C How to Read and Understand the Scientific Literature

As indicated in Chapter Three, lots of information on clinical research is available through journals, websites, training seminars, and conferences. Much of it is good scientific research while other information is based on limited evidence. How do you know when you are reading or listening to presentations whether the research is of high quality or sufficient strength? The quality of the researchers, the design of the study, the size of the group studied, the number of similar studies and other factors may determine whether the study provides sufficient value to use in making clinical or program decisions. This section provides basic information about each of these factors for your consideration before you begin reading the literature listed in the bibliography (Appendix D) or other literature you may obtain from your own reviews or from conferences or workshops.

The Bibliography provides a starting point for you to learn about specific evidence-based practices, about recovery/resiliency, and about related concepts.

QUALITY OF THE RESEARCHERS

Look carefully at who conducted the research. Are the researchers experienced in conducting such research? For newer researchers, are they associated with more experienced researchers? Are they affiliated with an institution that supports the development of newer researchers and/or has a track record of good research? Do the researchers themselves have a track record of producing high quality unbiased research? Do they have any reason to be biased (for example, are they selling a product or do they have reason to need to find a particular outcome in order to keep their job)? Who paid for the research? Was there any bias (for example, a company selling a particular medication may have a reason to pay for research that will show their product in the most favorable light)? Did the researchers utilize consumers or family members as advisors or as participants in the research process?

DESIGN OF THE STUDY OR EVALUATION

A critical look at the design of the study or evaluation is important to understanding whether the outcomes achieved are likely to be replicated in your program or with your clients. Research design is a complicated process that takes much study and experience to learn and master. However, you can ask yourself whether the characteristics of the group being studied are sufficiently described and whether they are like the clients you serve. By definition, research tries to find a relatively homogeneous group to study in order to isolate effects of the experimental condition. Your clients may not be so homogeneous. Have the researchers excluded individuals you are likely to be serving (e.g., persons who speak only Spanish, or persons with co-occurring diagnoses)? Are the conditions under which the study was conducted like yours or can you create conditions like those studied (e.g., the amount of training and supervision, the case load size, the regularity of interaction with the clients)? Are the data collection methods and the data sources reliable? Are the instruments used to collect information about research subjects ones that have been validated or standardized? Additional information about research design can be found in some of the references in the bibliography (Appendix D) of this manual.

Sample Size

While some studies with very small numbers of individuals studied can produce good results and good information, smaller sample sizes sometimes make it difficult to determine if the results observed can be replicated. On the other hand, a large sample size may allow for finding statistically significant results (e.g., a one day difference in length of stay) that may or may not be relevant for the outcomes you are seeking. Ask yourself if the sample size seems big enough for the results the research claims. If many different conditions are being studied or if many different observations are being made, especially if there is a desire to understand the interaction of different influences, the sample size needs to be bigger. However, a small sample size may be sufficient for some conclusions. Guidelines about sample size can be found in some of the references listed in the bibliography (Appendix D) of the manual.

Control Groups and Assignment to Conditions Studied

First, look to see if there is a control or comparison group of any sort. Sometimes, studies and evaluations simply look at outcomes before and after the implementation of a given practice. This is valuable information, but does not provide the strength that a study using a control group for comparison does. If there is a control or comparison group, how were they selected? Are the group studied and the group compared alike in all relevant ways? Are there characteristics that the researchers did not control that might affect the outcomes? It should be noted that a control group is a group selected in exactly the same manner as the experimental group with random assignment of individuals to the control and experimental conditions. A comparison group is a group in which individuals are selected to approximate the same characteristics as the group being studied. These different groups are utilized for different purposes, but considering the selection and similarities of the two groups is important in evaluating the value of the study.

Number of Similar Studies

While a single study or evaluation may tell us a lot about potential positive results of a given practice, it is important to look for additional studies that replicate the results to be sure there were no other factors not studied that contributed to the outcome. Often, research or evaluation results from a single program or study are the basis for clinical or programmatic decisions without the benefit of understanding whether the results can be replicated to other settings and conditions. Ask yourself: are there studies of the practice in different jurisdictions? Are there studies by other researchers using the exact same practice and the same research design or the same research instruments? Have the results been replicated in situations that are different from the situation in which the study occurred?

CONCLUSIONS OF THE RESEARCHERS

All studies have limitations. It is critical to look at the conclusions drawn by the researchers or evaluators themselves to see if they acknowledge the limitations and if the conclusions they reach are justified by the actual research findings. If the conclusions are too broad or global and if the limitations of the research are not acknowledged, it will be important for you to consider the limitations yourself from the design of the research or evaluation. Asking other researchers or evaluators to help with this process can provide valuable information. While limitations are a given, that does not mean the limitations make the research unusable. On the contrary, understanding the limitations may help to ask the right questions as you use the research or evaluation to design a program or an intervention for your agency or client.

VALUE OF REVIEWS AND META-ANALYSES

Sometimes, reading original research studies is difficult and tedious for those who are unaccustomed to scientific methodology and statistical analysis. It may be hard to assure that one has read all the relevant studies without a great amount of time and effort – resources behavioral health program managers and clinicians often do not have. One thing to look for is a review of research studies or a meta-analysis that will help glean the salient points from a variety of research studies about a particular topic. Reviews do simply that – review the existing research and describe the findings of a variety of studies. Meta-analyses go one step further and combine the data from various studies so that conclusions can be drawn from bigger samples or with greater confidence than from one study alone. These meta-analyses, just as with research studies, should be carefully conducted by unbiased and knowledgeable reviewers who understand the 'science' behind such meta-analyses.

Both reviews and meta-analyses can help the lay reader understand the results of a body of research faster than searching and reading the literature from each study. However, the reader needs to assure him/herself that there is no bias in the studies reviewed, the journals in which they are reported, or the data analysis process used, and that no relevant studies are excluded either unknowingly or purposely. Knowing the reputation of the author is one way to assess the objectivity and quality of the work, and reading more than one review or reading some of the original literature behind the meta-analysis might be helpful. If in doubt, asking for assistance from a person knowledgeable of research methods and literature reviews will help the lay reader to assure they are learning what they want to learn from these types of articles or books.

HOW TO EVALUATE GUIDELINES/ PROTOCOLS

It is also important to know how to evaluate guidelines or protocols that you are thinking of following. To be assured of their credibility and usefulness, ask yourself the following:

1. Who wrote them? Was it a professional organization or guild with a particular perspective about who should and should not be allowed to practice? Or did payers or providers trying to live within regulations and funding, etc., develop them?

2. What is the purpose of the guidelines or protocols? Is the goal simply to reduce cost? To improve clinical decision-making? To improve ultimate outcomes of intervention?

3. What is the evidence-base upon which they were developed? Is it scientific studies, consensus opinions, etc.?

4. What is the process by which they were developed, reviewed, updated, etc.?

5. Is the population or client you are trying to serve similar to the ones for whom the guideline or protocol was developed and intended? Is the population for whom the guideline or protocol is likely to be effective clearly described?

6. Were consumers or families involved in the development of the guideline or protocol? Did they have a role in identifying the sources of information upon which the guideline or protocol was based? Did they participate as advisors or as writers of the guideline or protocol?

Learning the language of clinical research and how to approach the literature and be an informed listener can feel overwhelming at first. It takes practice to become comfortable with the literature and scientific presentations, and to begin to feel knowledgeable about current research. Don't get discouraged when you start reading. Start with a few basic articles on subjects that interest you and refer frequently to the terms defined in Chapter Three. Talk with others who know the literature or who are interested in learning it. The most important thing is to keep reading and listening.

Appendix

D Bibliography

This Bibliography is intended to be a resource for learning more about evidence-based practices. It is divided into sections corresponding to the chapters of the manual. The sections are: resources on evidence-based practices in general (Chapters One and Three); recovery and evidence-based practices (Chapter Two); resources about specific evidence-based practices for adults and children (Chapter Four); implementing EBPs (Chapters Five and Six); organizational factors and supporting and sustaining change (Chapters Seven and Eight); and information about reading scientific literature (Appendix C).

The research and literature on evidence-based practices continues to grow. The resources cited here are only a starting point for learning more about evidence-based practices.

CHAPTERS ONE AND THREE: RESOURCES ON EVIDENCE-BASED PRACTICES IN GENERAL

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WEBSITES

(see also Chapter Four – Lists with Information on Proven and Unproven Treatments)

http://www.psych.org/clin_res/prac_guide.cfm. American Psychiatric Association Practice Guidelines.

http://www.apa.org/divisions/div12/rev_est/index.shtml. American Psychological Association Division 12 (laypersons' guide to empirically supported treatments).

http://www.ahrq.gov/clinic/index.html. The federal Agency for Healthcare Research and Quality.

http://www.cochranelibrary.com. The Cochrane Collaborative reviews research and evidence about a variety of evidence-based practices.

http://ww.doh.gov.uk/mentalhealth/treatmentguideline/. Clinical practice guidelines (psychological therapies and counseling) from the UK Department of Health.

http://www.mentalhealthpractices.org. The website of the National Evidence-Based Practices Project (Toolkit Project).

http://guideline.gov. The National Guideline Clearinghouse has diagnostic, assessment, and treatment guidelines.

http://www.nasmhpd.org/ntac/. The National Association of State Mental Health Program Directors (NASMHPD) has a website that provides extensive information on best practices and links to other resources.

http://www.nri-inc.org. The NASMHPD Research Institute's website provides information about a variety of data and practices relevant to states and programs wishing to implement evidence-based practices.

http://tecathsri.org/knowledge.asp. The Human Services Research Institute website for evidence-based practices is a product of The Evaluation Center at HSRI.

CHAPTER TWO: RECOVERY, RESILIENCY AND EVIDENCE-BASED THINKING

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Lists with Information on Proven and Unproven Treatments

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http://modelprograms.samhsa.gov/nrepp.cfm. *National Registry of Effective Prevention Programs (NREPP)*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

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TREATMENT GUIDELINES

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OTHER USEFUL WEBSITES WITH INFORMATION ON SPECIFIC EVIDENCE-BASED PRACTICES (SEE ALSO CHAPTERS ONE AND THREE FOR OTHER GENERAL WEBSITES)

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http://casatweb.ed.unr.edu/cgli-bin/WebObjects/Step6.woa/wa/getList. Western Center for Application of Prevention Technologies.

http://www.nga.org/center/divisions/. National Governor's Association, Center for Best Practices.

http://www.cdc.gov/ncipc/dvp/bestpractices./htm. Best practice for youth violence prevention.

http://www.mentalhealth.org/cmhs/childscampaign/practices.asp. CMHS system of care best practices series.

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TREATMENT FOR ADULTS WITH SERIOUS MENTAL ILLNESS

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ASSERTIVE COMMUNITY TREATMENT (ACT)

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CHAPTERS FIVE AND SIX: IMPLEMENTING EVIDENCE-BASED PRACTICES AND WORKING WITH PRACTITIONERS

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APPENDIX C: HOW TO READ AND UNDERSTAND THE LITERATURE

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Appendix

E Consultants/Advisors for Edition One

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F Biographical Sketches of the Authors

STEPHEN DAY, MSW

Stephen L. Day is co-founder and Executive Director of the Technical Assistance Collaborative, Inc. (TAC). Over the past sixteen years Steve has provided consultation and technical assistance to over 100 state and local jurisdictions, and numerous national policy and advocacy organizations. The results of these consultations include comprehensive analyses of public mental health and human services systems, multi-year strategic plans; service system improvement and financing strategies, outcome and performance measurement systems, and organizational and human resource development plans.

Prior to joining TAC, Steve was Deputy Commissioner of the Massachusetts Department of Mental Health for seven years, and as such has a deep appreciation of both the opportunities and barriers associated with multi-system, interagency planning and implementation efforts in the public sector. At TAC, Steve has worked directly on state level service planning, implementation and financing initiatives in Arizona, Connecticut, Delaware, the District of Columbia, Georgia, Florida, Hawaii, Iowa, Louisiana, Maine, Maryland, Massachusetts, Missouri, Montana, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, Oklahoma, South Carolina, Texas, and Washington.

Steve was among the senior consultants providing technical input and support to the President's New Freedom Commission on Mental Health, authoring a technical monograph on Medicaid's role in public mental health services, and assisting to draft recommendations related to state-level mental health system master planning and on linking mainstream service resources to supportive housing for people with mental illness. He has contributed to other major national policy initiatives related to state level system improvements, including publishing monographs on *Olmstead and Supportive Housing: a Vision for the Future and Turning Knowledge into Practice: a Manual for Behavioral Health Administrators and Practitioners about Understanding and Implementing Evidence-Based Practices.*

Steve specializes in the implementation and financing of best practice mental health and human services, organizational development and management, interagency service coordination and integration strategies, strategic planning, and consumer-based outcome and performance measurement. In addition to his experience in the fields of mental health, substance abuse, Medicaid, aging and related human services topics, he was a Commissioner of a public housing authority, and participated in the development and management of HUD and state-funded housing programs for elders, families with children, and people with disabilities.

John A. Morris, MSW

John Morris is Director of the Human Services Practice of the Technical Assistance Collaborative, Inc., a national not-for-profit consulting group based in Boston, MA. He is also Executive Director of the Annapolis Coalition on the Behavioral Health Workforce, which in 2007 published a national action plan for workforce development in partnership with the Substance Abuse and Mental Health Services Administration. At the time of this edition, he was serving (2008-2010) as Chair of the Board of Directors of Mental Health America (formerly the National Mental Health Association), which celebrated its Centennial in 2009; the South Carolina affiliate of MHA recognized John with its Distinguished Service Award. John is a past president of the American College of Mental Health Administration and of the ACMHA Foundation, and in 2006 he was awarded the Saul Feldman Lifetime Achievement Award, ACMHA's highest honor. In 2010, he was named the recipient of the Vincent I. Howery Award by the National Association for Rural Menal Health. He is a member of the National Advisory Council to the Georgetown University Technical Assistance Center for Children's Mental Health, the Texas Health Institute's National Advisory Board for Community Collaboratives, and the National Leadership Forum on Mental Health and Criminal Justice. He is a past-President of the SC Action Council for Cross Cultural Mental Health and Human Services, and was a member of the Mental Health Policy Research Network of the John D. and Catherine T. MacArthur Foundation from 2004-2009; he is also a consultant and member of the National Resource Bank for the MacArthur Foundation's multi-site *Models for Change* juvenile justice reform project.

John retired in 2007 as Professor and Director of Health Policy Studies in the Department of Neuropsychiatry and Behavioral Sciences at the University of South Carolina School of Medicine; he retains an appointment as Clinical Professor of Psychiatry. Prior to joining the University, John spent more than twenty-five years in the public behavioral health field as a clinician, administrator, researcher, and educator. He started his career in public mental health as a ward attendant at the state hospital, and prior to his move to the University he served a two-year interim appointment as State Director of Mental Health in South Carolina. A 1968 graduate of St. Mary's Seminary and University in Baltimore, he graduated from the George Warren Brown School of Social Work at Washington University in St. Louis in 1978, then returned annually as Visiting Professor of Mental Health Policy between 1991-2004, and was named a Washington University Distinguished Alumnus in 1996. From 2004-2008 he served as Senior Policy Consultant with Comprehensive NeuroScience, Inc. (CNS) of which he was also formerly a Vice President and the founding editor of *Prescriptions for Progress*. He is a member of the editorial boards of *Administration and Policy in Mental Health and Mental Health Services Research* and *The American Journal of Orthopsychiatry*, a member of the National Board of Editors of the College of Direct Support (University of Minnesota) and is a reviewer for *Psychiatric Services* and *PsyCRITIQUES*. He lives in Columbia, SC, with his wife Jennie; they have two grown sons, Dan and Paul.

SONJA SCHOENWALD, PHD

Sonja K. Schoenwald, Ph.D., is Professor of Psychiatry & Behavioral Sciences at the Medical University of South Carolina and was Associate Director of the Family Services Research Center there from 1994 – 2004. Dr. Schoenwald is among the leading clinical services researchers in the country on issues relating to the transportability, implementation, and dissemination of effective community-based treatments. She pioneered the development, refinement, and empirical testing of the quality assurance protocols used to transport Multisystemic Therapy (MST) to diverse communities. In addition, Dr. Schoenwald has collaborated with leading treatment, services, organizational, and economics researchers and community stakeholders in the development of federal, state, and foundation-funded research focused on taking evidence-based treatments for youth and families to scale. Dr. Schoenwald has published numerous peer-reviewed papers and book chapters, and has co-authored three books and several treatment manuals and monographs for diverse stakeholder groups focused on supporting the implementation of effective treatments in communities nationally and internationally.

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