NEW FREEDOM COMMISSION ON MENTAL HEALTH

# Subcommittee on Evidence-Based Practices:

## BACKGROUND PAPER

April 2005

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The content of this publication reflects the views and opinions of the Subcommittee on Evidence-Based Practices. Therefore, this paper is a product of the process that advised the full Commission and as such does not reflect the position of the President's New Freedom Commission on Mental Health or any agency of the United States Government.

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# Preface

The President's New Freedom Commission on Mental Health appointed 15 subcommittees to assist in its review of the Nation's mental health service delivery system. The full Commission appointed a Chair for each subcommittee. Several other Commissioners served on each subcommittee, and selected national experts provided advice and support. The experts prepared initial discussion papers that outlined key issues and presented preliminary policy options for consideration by the full subcommittee. The subcommittee reported to the full Commission only in summary form. On the basis of this summary, the full Commission reached consensus on the policy options that were ultimately accepted for inclusion in the Final Report, *Achieving the Promise: Transforming Mental Health Care in America*. Therefore, this paper is a product of the subcommittee only and does not necessarily reflect the position of the full Commission or any agency of the United States Government.

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# Introduction

This background paper of the Subcommittee on Evidence-Based Practices begins with a definition and discussion of the importance of evidence-based practices as reflected in the report on mental health from the Surgeon General (HHS, 1999). After reviewing the opportunities created by the evidence-based practice approach, as well as some of its limitations, this paper describes a series of current initiatives in implementing evidence-based practices. It also covers the importance of having an infrastructure for supporting that implementation activity. Because infrastructure is so critical, it becomes the focus of much of the final section, which consists of the proposed policy options from the Subcommittee.

These policy options are introduced within a conceptual framework, called "overcoming systemic barriers," derived from the final chapter of the Surgeon General's 1999 report (HHS). Each of the eight courses of action suggested by the Surgeon General is discussed in relation to implementing evidence-based practices. These general areas for policy options are then discussed in more detail.

The specific policy options of the Subcommittee are presented in three main subsections identified as Policy Areas 1 (National Leadership), 2 (Advancing Knowledge), and 3 (Financing). The relevant courses of action are detailed within each policy area. Following discussion of a general policy option within each policy area, more specific options are offered. Each policy option also describes a set of possible implementation approaches, offering a brief assessment of the advantages and disadvantages of each approach.

# Evidence-Based Practices

The gap between routine mental health care practice and evidence-based practice represents a significant public health problem. According to the Institute of Medicine, the lag between discovering effective treatments and implementing them in routine practice is 15 to 20 years (2001). Despite the enormous increase in the field's scientific knowledge base and the development of more effective treatments, consumers and their families do not always benefit from these advances.

The main finding of the U.S. Surgeon General's 1999 report on mental health (HHS) is that treatment efficacy is well documented for a range of treatments for most mental disorders. The report encourages individuals who experience a mental disorder or mental health problem to seek help by choosing from this range of treatments to suit their preferences.

**Services and treatment programs based on the latest scientific advances are not routinely available to meet the needs of individuals who have mental illnesses.**

The report alerted the public, mental health advocates, and policymakers to the disparity between the potential for improving treatment and services, and the reality of everyday practice. Services and treatment programs based on the latest scientific advances are not routinely available to meet the needs of individuals who have mental illnesses. The report identified courses of action and called on the field to "ensure the supply of mental health services and providers" and "ensure delivery of state-of-the-art treatments." The Surgeon General's Report concluded that so-called "evidence-based practices" (EBPs) ought to be among the choices offered to individuals who seek treatment for mental disorders with the expectation of moving toward recovery.

In its report *Crossing the Quality Chasm*, the Institute of Medicine (IOM, 2001) states that "evidence based practice is the integration of best research evidence with clinical expertise and patient values." This statement serves as a reminder that there is more to consider in practice than the scientific rigor of the evidence base for these services. It is also important to apply clinical judgment and to respect individuals' choices and preferences. Although scientific rigor is at the heart of the definition of evidence-based practices, there is diverse opinion and some controversy on the standard for defining scientific rigor. For the most part this paper relies on the discussion of this matter in *Mental Health: A Report of the Surgeon General* (HHS, 1999, pp. 9–11).

There are several levels of evidence for determining that a practice is "evidence-based" and therefore demonstrated to be efficacious or effective. Many of the projects and practices described in this paper meet the criteria for the strictest level of evidence. The Subcommittee on Evidence–Based Practices uses a broad definition of "evidence" in its policy options, recognizing the need to be forward-thinking and inclusive of all stakeholders and their ideas about relevance and evidence.

The Subcommittee on Evidence–Based Practices' policy options, however, do not call for any particular practice to be designated as "evidence-based." The options focus on policies that are viewed as needed to promote the implementation of treatments, services, and supports—and they encourage the dissemination and implementation of evidence-based practices, however they are defined.

Evaluations of several national service demonstrations have indicated that although system reforms occurred, the direct impact of

system changes on individuals has been limited (Bickman, Guthrie, & Foster, 1995; Goldman, Morrissey, & Ridgely, 1994; Goldman et al., 2002; Tessler & Goldman, 1982). When system interventions alone proved necessary but insufficient for improving the lives of persons with mental illnesses throughout the life cycle, attention shifted to the content and quality of services. This research identified both the potential benefits of services and treatments and the deficiencies in usual care (HHS, 1999; Torrey et al., 2001).

**Policies create incentives and disincentives that shape the mental health service system.**

Various articles (Bond et al., 2001; Dixon et al., 2001; Drake et al., 2001; Hoagwood, Burns, Kiser, Ringelsen, & Schoenwald, 2001; Mellman, Miller, Weissman, Crismon, Essock, & Marder, 2001; Torrey et al., 2001) have reviewed individual evidence-based practices for adults and children. They describe efforts to implement these practices, highlighting facilitators and barriers, including rules, regulations, and mental health financing policies. Both policies and administrative practices have been identified as specific barriers to the implementation of evidence-based services; policies have also been identified as facilitators.

Policies create incentives and disincentives that shape the mental health service system. A major challenge is to identify policy interventions that facilitate implementation of evidence-based practices but also minimize barriers to implementation.

This paper offers a range of responses to the Surgeon General's call to address this problem. Goldman et al. (2001) have previously suggested a series of specific courses of action for implementing evidence-based practices. This current paper elaborates on these courses of action and considers the specific policy changes that may be necessary to achieve them.[1]

[1] Pages 3 through 17 of this paper are based largely on the article, "Policy Implications for Implementing Evidence-Based Practices," by Howard H. Goldman, Vijay Ganju, Robert E. Drake, Paul Gorman, Michael Hogan, Pamela S. Hyde, and Oscar Morgan (2001), published in *Psychiatric Services*, *52*, pages 1591-1597, and used by permission of the American Psychiatric Association.

# Quality and Accountability

Quality and accountability have become the watchwords of health and mental health services (IOM, 2001). Implementing evidence-based practices has become a means to achieving both ends. In this context "quality" means positive outcomes obtained by using cost-effective services, and "accountability" means documentation of adherence to evidence-based practice. There are many other approaches to achieving quality mental health services; this paper, however, deals only with evidence-based practices.

**Implementing evidence-based practices is a quality-improvement process.**

Michael Hogan, commissioner of mental health in Ohio and chair of the President's New Freedom Commission on Mental Health, refers to a triangular relationship among these three service system elements: quality improvement, accountability through performance measurement, and evidence-based practices. He describes this relationship as central to providing effective mental health services (personal communication, 2001). Implementing evidence-based practices is a quality-improvement process that provides accountability through the monitoring of the fidelity of practices to models that have been demonstrated by research to be effective. Programs that are faithful to the evidence-based models produce good outcomes in general, but not necessarily for all individuals or in all circumstances. Achieving consistently positive outcomes is at the heart of the definition of an evidence-based practice.

With common agreement about the validity and appropriateness of these positive outcomes as policy goals, the quality of mental health services can be continually improved. Measures of fidelity, like other process measures, are a means to an end, not an end in themselves. It is critical that fidelity to a particular model or practice not be regulated in a way that prevents client choice, clinical judgment, or continuing change as new evidence emerges. Yet fidelity should be a goal to which systems and practitioners aspire, with the assumption that the greater the fidelity, the greater the likelihood of good outcomes.

Unfortunately, although the Surgeon General concluded that a range of efficacious treatments exists for almost every mental disorder, for many clinical conditions there is no evidence to support particular treatments or services. For example, although effective treatments are available for schizophrenia and bipolar disorders, many individuals with these disorders have complications and co-morbid disorders that have not been considered in studies of treatment effectiveness.

In many cases, the existing evidence comes from clinical trials that may not be generalizable without adaptation to typical treatment settings—for example, the trials may have been conducted by clinicians with specific levels of training or with homogeneous patient groups.

For some problems with the greatest salience—such as youth suicide, posttraumatic stress disorder, and borderline personality disorder—there is not yet a satisfactory research base to guide policy and practice with clarity, although the evidence base for each of these problems is growing. Rosenberg et al. (2001) have suggested that while we wait for definitive answers to emerge, policymakers hold off on endorsing specific models and instead support studies of comparative effectiveness.

**There continues to be much room for clinical judgment, client choice, and development of innovative treatments and services.**

Not every problem has an evidence-based solution, and not every evidence-based practice that works for a majority of persons who have similar symptoms, history, and needs will work for all such individuals. There continues to be much room for clinical judgment, client choice, and development of innovative treatments and services. However, well-documented evidence-based practices do exist for certain clinical conditions (HHS, 1999).

Yet too often these practices are not implemented, even when their benefits are well understood; when clients, clinicians, and policymakers agree on desired outcomes; or when models exist of successful implementation.

States and local mental health systems, as well as those in the private sector, are moving forward in their implementation of evidence-based practices with varying levels of commitment and success. Many are struggling with the implementation of evidence-based practices that have existed for more than a decade and that have been proven effective in a variety of settings.

Even when service systems or individual providers have had the political and administrative will to implement—or at least have stated an interest in implementing—evidence-based practices, they have not always done so by using mechanisms that ensure adherence to fidelity. And even when evidence-based services have been implemented with fidelity, systems have had to address questions of how these services fit with each other and with other services that may lack a strong evidence base.

Many factors contribute to these implementation problems, including lack of a long-term vision for the service system, lack of agreement on desired outcomes, lack of penalties for practices that are not evidence based, short-term horizons for policy planning, political mandates or competing priorities, and resource limitations. In such a context, administrative practices and policy infrastructure are of paramount importance to overcoming these problems.

# Current Initiatives in Implementing Evidence-Based Practices

A preliminary review of state activities in 2001, based on the reports of 47 states in the National Association of State Mental Health Program Directors (NASMHPD) Research Institute Profiles (NASMHPD Research Institute, 2002), indicates that every reporting state is involved with evidence-based practices in some fashion; most are implementing three or more practices. Some types of evidence-based practices are being implemented by only a handful of states while others are being used by nearly every state.

For example, 16 states use some form of medication algorithm while 43 states are involved in some type of supported employment. States are also implementing evidence-based services for children and adolescents, e.g., 21 states report that they are using multisystemic therapy, while 26 use therapeutic foster care.

Fewer states report that they make use of fidelity measures to assure standardization for quality. For example, only 11 of the 43 states report using fidelity measures for supported employment. Among those states involved with evidence-based practices, implementation is rarely statewide, e.g., in 12 of the 41 states reporting use of assertive community treatment, the practice is reportedly available or being implemented statewide (NASMHPD Research Institute, 2002).

Along with numerous state and local initiatives, there are several important national initiatives in implementing evidence-based practices in mental health services. While described in more detail elsewhere, they are outlined here for reference. A national initiative being run out of South Carolina is designed to implement multisystemic therapy for children and adolescents who exhibit the behaviors referred to as conduct disorder (Hoagwood et al., 2001). This project involves states, counties, and private sector services.

A second example of a major initiative in the public sector is the Evidence-Based Services Project, oriented at adults with severe mental illnesses. This project, based at the New Hampshire–Dartmouth Psychiatric Research Center and sponsored by the Robert Wood Johnson Foundation, the Center for Mental Health Services/SAMHSA, and several other funders, is being implemented in eight states (Drake et al., 2001). Described in detail in *Psychiatric Services* and elsewhere, the project is currently in the second of three phases. Phase 1 developed implementation materials (often referred to as "toolkits") for six evidence-based practices for use in building consensus, training, and ongoing support for a range of stakeholders—consumers, family members, state and local administrators, and clinicians.

Phase 2 is studying the feasibility and effectiveness of these materials and procedures in eight states over the period from 2002 to 2004. Phase 3 will be a national demonstration among the dozens of states already engaged in evidence-based practice implementation, as described earlier in data from the NASMHPD Research Institute.

One key point for policymakers that has already emerged from the early experiences with implementing evidence-based practices is the need to focus not only on state agencies, but also on local mental health authorities and provider organizations. Finding the right balance among these governmental and private organizations is critical to successful implementation.

# Infrastructure to Support Systemic Change

Most observers have indicated the need for a dedicated individual and for infrastructure to support the implementation of evidence-based practices. Infrastructure with continuity of leadership in implementation is important because of the frequent turnover of state and local mental health program directors. This type of infrastructure is also important in efforts to move from research or pilot projects to system-wide implementation.

What may be conceptualized by a clinical or policy leader in an administrative office and supported in the throes of change may become compromised when multiple practitioners, providers, or locations are involved. (See Goldman et al., 2001, for more details.) The sections that follow address this infrastructure need in detail.

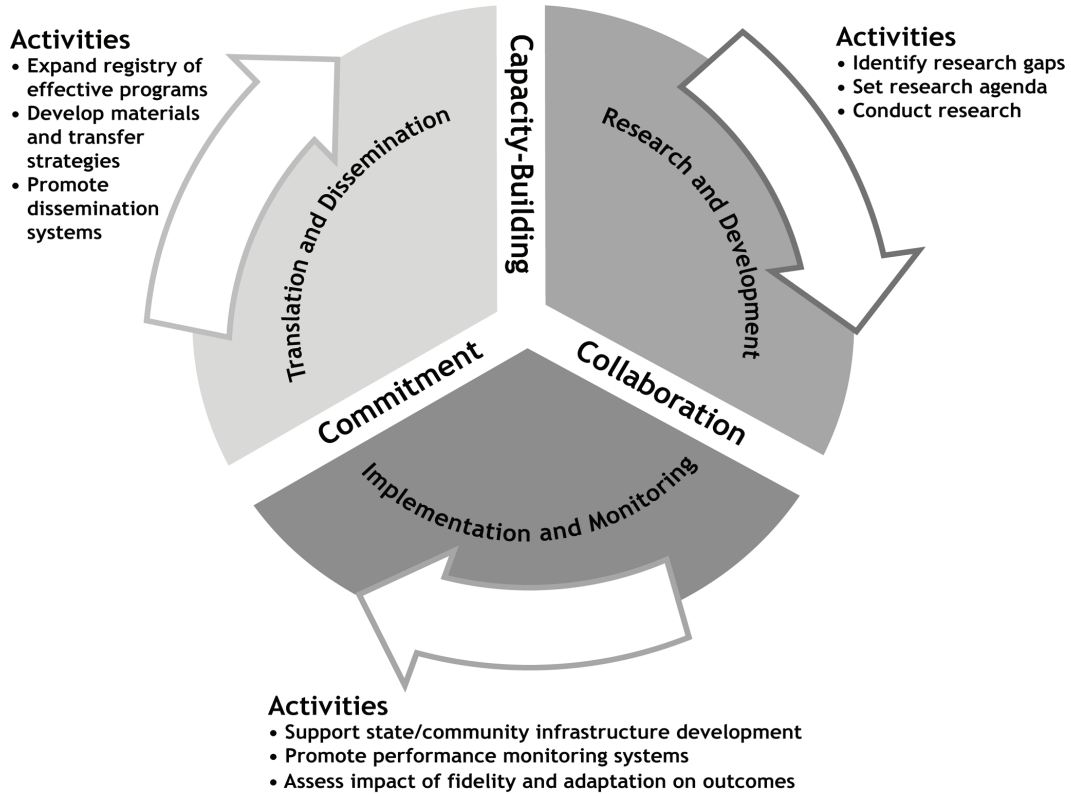
# Overcoming Systemic Barriers

Policymakers cannot ignore the systemic barriers to implementing evidence-based practices. Each of the articles in the literature describing specific evidence-based practices identifies barriers related to organizational policy and financing policy, and some identify strategies for overcoming those barriers and creating appropriate incentives to support implementation. This section is organized around these types of strategies, using the eight courses of action outlined by the Surgeon General (HHS, 1999).

## Continue to Build the Science Base

As we have noted, there are limitations in the research base on the effectiveness of treatments, which helps to define the evidence-based practices. There must not only be steady development of new treatments moving out of the sciences and into everyday practice, but also continued scientific testing of those practices already being used. In other words, there must be research that moves treatments from "services to science" as well as from "science to services." This science-to-services cycle is illustrated in *Figure 1* and detailed in the next section.

**FIGURE 1. SCIENCES-TO-SERVICES CYCLE**




*Source: SAMHSA & National Institutes of Health, 2003.*

## Sciences-to-Services Cycle

*Figure 1* offers a model of the science-to-services cycle and identifies the key activities in implementing each of the three phases in the cycle. (SAMHSA & National Institutes of Health, 2003). The three phases of the cycle are:

- Research and development,
- Dissemination and implementation, and
- Monitoring and feedback.

Strengthening the connections between these phases and their activities requires three types of supports on behalf of all mental health services and research stakeholders:

- Collaboration,
- Commitment, and
- Capacity building.

In the science-to-services cycle, scientific knowledge of effective mental health services (derived through research and development) is translated into actual clinical practice (through dissemination and implementation of these effective services to providers), while clinical practice influences the priorities and further development of the science (through monitoring of services delivered and feedback to the scientific community).

The intended outcome of the cycle is that providers will deliver the most up-to-date and effective mental health treatment to the consumers who seek their help. Achieving the science-to-services cycle will be instrumental in overcoming the barriers to implementing evidence-based practices.

For example, more research is needed to determine whether these practices are effective in all ethnic subpopulations, among persons who have multiple disorders, and in all practice settings—for example, rural as opposed to urban settings. In addition, more research is needed on nontraditional approaches that give clients more control over their own recovery or that utilize professionals trained in nontraditional methods.

Furthermore, although thousands of studies have been conducted on dissemination of innovation and implementation of health and mental health services, there is virtually no definitive evidence to guide implementation of specific evidence-based practices. However, some experts, such as Argyris (1993), warn that the results of experimental studies that involve human interaction may not generalize to any great degree to typical treatment circumstances, because the complexity of social systems cannot be captured in controlled experiments. There is uncomfortable irony in moving forward to implement evidence-based practices in the absence of an evidence base to guide implementation practice.

**There must be research that moves treatments from "services to science" as well as from "science to services."**

Torrey and colleagues (2001) reviewed some of the literature on dissemination and implementation but uncovered more about what we do not know than what we do know. The literature is better at telling us what does not work and what not to do than it is at guiding our work. To better inform future implementation efforts, we need to study the earliest experiences with evidence-based practices to identify significant barriers and successful strategies for overcoming them.

# Overcome Stigma

Few authors writing on evidence-based practices have identified stigma as a special barrier to implementation of evidence-based practices. However, it is possible that the pervasive stigma associated with mental illness and its treatment has resulted in discriminatory financing policies.

As a result of stigma, individuals who are in need may be unwilling to seek care. Those who do seek treatment may experience forms of discrimination that can exacerbate their illnesses. In addition, stigma often produces service delivery systems that view mental health treatment as less valuable or necessary than general health care.

For example, all too often Medicaid does not cover the evidence-based practices or covers them in a way that precludes faithful implementation of the model, thus creating the risk that the positive outcomes documented in the research will not be achieved. Furthermore, there is growing evidence that budgets for public mental health systems are eroding (Lutterman & Hogan, 2001). Numerous researchers have identified financing policies as barriers to implementing evidence-based practices for adults and children (Bond et al., 2001; Dixon et al., 2001; Drake et al., 2001; Hoagwood, Burns, Kiser, Ringelsen, & Schoenwald, 2001; Mellman, Miller, Weissman, Crismon, Essock, & Marder, 2001; Torrey et al., 2001).

# Improve Public and Provider Awareness of Effective Treatments

Although awareness alone is not sufficient for implementation, it is certainly a necessary first step. Consumers and family members can affect the demand for evidence-based services if they are aware of the benefits associated with these services (Frese, Stanley, Kress, & Vogel–Scibilia, S., 2001). Evidence from general medical care supports the effectiveness of raising awareness (Reiser, 1992). Providers—both clinicians and administrators—must understand the new practices and their utility before they can be expected to adopt them. The same, of course, is true for policymakers.

# Ensure the Supply of Mental Health Services and Providers

Ensuring the supply of mental health services and providers, along with the next course of action—ensuring the delivery of state-of-the-art treatments—is at the heart of the matter. Policymakers have a responsibility to ensure that individual clinicians and service providers are available in their mental health systems. This responsibility involves making a commitment to recruiting individuals who have the necessary skills to deliver evidence-based services, creating incentives to attract these individuals to practice in their systems, and training, supervising, and supporting the work of providers of evidence-based services.

Retaining skilled providers and minimizing job burnout are critical to maintaining a workforce that is capable of supplying evidence-based services. According to the Surgeon General and experts on specific evidence-based practices, there is a shortage of trained personnel who are able to provide evidence-based services (HHS, 1999). The erosion of the resources of state mental health programs undermines the ability of mental health agencies to attract and retain competent clinicians.

**To work effectively, all evidence-based practices rely on informed and engaged individuals at all levels of service provision.**

It will be necessary to develop mechanisms for retraining the current workforce and to influence the training of new professionals and paraprofessionals. To work effectively, all evidence-based practices rely on informed and engaged individuals at all levels of service provision—consumers, family members, clinicians, program administrators, and policymakers. Some practices require that consumers, providers, and family members receive special training.

Without these informed and committed administrators and policymakers, no amount of literature or evidence will matter, and no amount of accountability through measurement of fidelity will increase public commitment to seeking or funding mental health care. Adherence to evidence-based practices will give way to whatever clinicians can get paid for, and accountability will give way to whatever questions funders want answered. Program administrators need assistance in understanding the need, making the case, and sustaining the effort to lead systems either to promote evidence-based practices or, at the very least, to not be a barrier to implementation of these practices.

# Ensure Delivery of State-of-the-Art Treatments

Ensuring delivery of state-of-the-art practices is not a trivial matter. Authors on evidence-based practices have repeatedly emphasized the need for leadership in implementation of these practices (Bond et al., 2001; Dixon et al., 2001; Drake et al., 2001; Hoagwood, Burns, Kiser, Ringelsen, & Schoenwald, 2001; Mellman, Miller, Weissman, Crismon, Essock, & Marder, 2001; Torrey et al., 2001). Leaders must make it clear that evidence-based practices are a priority for care.

Architects of the mental health system must organize services with quality improvement in mind, ensuring that regulations do not serve to impede the implementation of evidence-based practices, as they often have. It is not possible to deliver state-of-the-art treatments if, for example, newer anti-psychotic medications are not on the formulary of a program, or if an insurer does not cover family interventions.

Regulations may also create unanticipated barriers. For example, the treatment components of supported employment may not be an approved service for Medicaid reimbursement. Most states cannot afford to offer evidence-based treatments to those without Medicaid coverage. Often, a majority of individuals in public-sector programs are not even eligible for Medicaid.

Organizational and financial barriers to integrated treatment have been identified for supported employment (i.e., barriers between vocational rehabilitation and mental health agencies) and for co-occurring substance abuse and severe mental illness (i.e., barriers between uncoordinated substance abuse and mental health services). This latter issue is a special problem in which Federal mental health and substance abuse block grant funds cannot be mingled to provide integrated care.

Overcoming these agencies' divisions is often an important first step in the effort to provide better-integrated services. On the other hand, some of these programs, such as assertive community treatment, are designed to allow program sponsors to provide the services themselves, eliminating the need to rely on a fragmented service system.

# Tailor Treatment to Age, Sex, Race, and Culture

Although the research base is not sufficient to support use of all evidence-based practices with each of the sociodemographic groups encountered in practice, it is always important to be culturally sensitive and respectful of diversity when designing and delivering services. It is also important to realize that, for the most part, when research on evidence-based practices has been conducted in ethnic subpopulations, the outcomes have been good (HHS, 2001). As emphasized by the Surgeon General, tailoring treatment will be of special importance in situations in which "culture counts" in specific ways (HHS, 2001).

For example, family interventions must take into account culture-specific definitions of family and respect the differences associated with age, sex, and stage of life. Language-appropriate services are critical to successful outreach to consumers, and for encouraging members of linguistic minorities to use evidence-based services. Medications should be used appropriately, with an awareness of ethnopsychopharmacologic variations in physiology and in attitudes and behaviors associated with drug taking. While remaining faithful to program models, designers of evidence-based services must reach out to everyone in a community who might need or benefit from the services.

# Facilitate Entry into Treatment

Except in rare instances, people cannot benefit from evidence-based treatments if they do not seek help. Occasionally, treatment is provided under a court order, but in general the goal is to have consumers receive services on a voluntary basis. Thus, evidence-based services must not only be available and accessible to consumers,

they should also be inviting. The Surgeon General expressed the belief and the hope that evidence-based practices will reduce the need for coercion in mental health services. He encouraged multiple "portals of entry" to services by creating incentives for many service providers to receive referrals and accept all individuals seeking services (HHS, 1999; HHS, 2001).

**There should be no "wrong door" for services.**

With this type of system in place, individuals can be matched with appropriate evidence-based services that are provided by specially trained clinicians, teams, and programs within the service system. Not every service provider will offer all evidence-based services, but every clinician and provider organization should offer choices of some of the evidence-based services that are delivered in their organization or elsewhere in the system. There should be no "wrong door" for services. Awareness of evidence-based practices and of where such services can be received is essential information for the contemporary mental health service system.

# Reduce Financial Barriers to Treatment

No single policy issue received more attention in the literature on implementing evidence-based practices than did financing. Realistically, a service is not available if a person with a mental illness cannot afford to use it or a program cannot afford to provide it for the price offered by payers. It is a simple truism that a service system runs on its financing policies. If evidence-based practices are not covered services, they will not be used, and if the fees paid are below the cost of providing them, they will not be offered.

There are numerous examples of financing policies impeding the delivery of evidence-based services. Until recently, Medicaid policy almost uniformly discouraged assertive community treatment. Federal block grant regulations have complicated the funding of integrated services for individuals who have co-occurring disorders. Payment for multifamily groups is not always covered or reimbursed adequately. The same may be true for various components of self-managed care. Newer medications may not be on the formulary of a pharmacy benefit plan, or co-payments may discourage the use of newer agents. Supported employment may not be reimbursed at a rate that compares favorably with the rate that could be obtained through a sheltered workshop.

Resources are also needed to support the transition to evidence-based practices in agencies that have historically been involved in older practices. It may be difficult for agency personnel to be motivated to learn a new practice if the old practice still generates the agency's revenues. Policymakers and administrators need the tools to shift funding in a logical and incremental manner from old ways of practice to new ways. They also need the resources—both human and financial—to provide technical assistance or quality oversight to ensure that funds are truly being spent to support new ways of practice, rather than supporting old practices with new names. Funds are also needed to offset the opportunity costs associated with learning a new practice.

By and large, the move to evidence-based practices will not be accompanied by a permanent increase in resources. Many successful implementations have occurred when agencies make use of one-time-only resources to support the switch from an older practice, such as brokering case management or rehabilitation-oriented day treatment, to a new practice, such as assertive community treatment or supported employment.

Implementation might be enhanced by better planning among the agencies responsible for financing care—Federal, State, and local authorities—to develop the necessary incentives for implementing and sustaining evidence-based practices. To provide adequate financing, planners also need accurate information about the costs of providing evidence-based services. As with other aspects of the research, cost data from experimental studies often are not generalizable to usual care settings.

**Policymakers and administrators need the tools to shift funding in a logical and incremental manner from old ways of practice to new ways.**

Finally, cutting across all these courses of action is the need for informed leadership from mental health policymakers and administrators—and increasingly from other sectors, such as insurers, the criminal justice system, vocational rehabilitation services, and the education system.

# Policy Options

## Policy Area 1. National Leadership

Policy Area 1 addresses these action strategies of the Surgeon General:

- Continue to build the science base.
- Improve public awareness of effective treatments.
- Ensure the supply of mental health services and providers.
- Ensure delivery of state-of-the-art treatments.

The Federal government needs to partner with States, localities, and the private sector, including consumer advocacy groups, as well as payer, provider, and professional groups, to provide national leadership to move from science to services, as well as from services to science. This partnership will follow four courses of action suggested by the Surgeon General's report (HHS, 1999).

The following policy options will enhance national leadership on mental health policy issues. Furthermore, the policy options are designed to bring together the activities of Federal agencies devoted to science and to services to provide leadership in evidence-based practices.

| POLICY OPTION 1 | Partnership for National Leadership |
|---|---|

The relevant Federal agencies (particularly at the National Institutes of Health [NIH] and the Substance Abuse and Mental Health Services Administration [SAMHSA] but also at the Agency for Healthcare Research and Quality [AHRQ] and the National Institute on Disability and Rehabilitation Research [NIDRR]) should establish a working relationship specifically related to developing and implementing evidence-based practices throughout the life cycle.

They should work with diverse agencies within the Federal Government and within other organizations in the public and private sectors to advance knowledge, disseminate findings, and implement evidence-based practices.

Topics to be encompassed by this process should include the following:

- Expanding mental health outreach partnerships and mental health awareness activities;
- Developing and strengthening quality improvement programs linked to evidence-based practices in the public and private sectors, including licensure, credentialing, accreditation, treatment guidelines, and algorithms;
- Creating a national infrastructure for leadership in evidence-based practices, such as through a renewed staff college operated jointly by the partnership involving NIH and SAMHSA;
- Building infrastructure for a national multidisciplinary mental health professional training program to focus on disseminating and implementing evidence-based practices; and
- Advancing knowledge, including rigorously evaluated service demonstration programs.

Possible approaches to address this policy option include the following:

1. Create a formal working group, chaired by Federal agency heads and including representatives of other levels of government and the private sector, that

would guide a budgeted process for achieving these goals. The intention here would be to develop a national leadership program with financial resources—either new or reprogrammed from existing budgets.

2. Develop an informal ad hoc working group chaired by division-level individuals that would be primarily focused on planning at the Federal level, but would also be in regular contact with stakeholders to promote national attention to evidence-based practices.
3. Give a charge to the agencies involved in this area of planning and development, and provide encouragement to other levels of government and the private sector, to develop their own initiatives and to approach government and private funders for specific support.
4. Create a "national consortium" of organizations interested in evidence-based practices (initiated by the Federal government with its ongoing participation) that would be independent of the Federal government and would have representation from all sectors.

Approach 1 would be favored if it is viewed as appropriate for the Federal government to take the lead in the partnership with its resources and staff—and if formal processes are viewed as essential to initiate this process.

Approach 2 would be favored if it is viewed as essential to have Federal leadership but there is a wish to reduce the direction provided by the Federal government and to rely more heavily on other levels of government for support and initiative.

Approach 3 is a laissez-faire strategy to encourage leadership and provide support in response to field-initiated ideas and processes. This set of issues is probably too urgent to rely on Approach 3 or perhaps even Approach 2.

Approach 4 could provide the power and initiative of Approach 1 without relying on Federal or governmental leadership alone. It should expand public-academic liaison and involve private foundations and representatives of all of the stakeholder groups, including consumers and families.

Selecting from among these approaches will be a matter of Administration and stakeholder preference and will depend in large part on priorities and available budget.

Each of the bulleted areas highlighted above is the focus of specific but brief options that are discussed next. The proposed partnership for national leadership should initiate a strategic planning process that might add or subtract from these options, and will likely produce more detailed options with a greater focus on implementation. The proposed partnership should assess the success of implementing each policy option through performance measures focusing on achieving each objective.

| POLICY OPTION 1-1 | **Expand Mental Health Outreach Partnerships and Mental Health Awareness Activities** |
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There are various organizations and initiatives that have been and can continue to be useful for improving public awareness of effective treatments such as evidence-based practices. Some are sponsored directly and exclusively by Federal agencies, such as the National Institute of Mental Health (NIMH) Outreach Partners Program or several SAMHSA communications contracts, while others are in the private sector and funded by a mix of public and private resources, such as the National Mental Health Association and National Alliance for the Mentally Ill (NAMI) anti-stigma campaign and the National Mental Health Awareness Campaign.

The NIMH Outreach Partners form a network of outlets in each state for NIMH and its science-based messages and information about evidence-based practices. The outlets often are state and local affiliates of NAMI, the Mental Health Association, or the National Depressive and Manic-Depressive Association.

These activities are critical for increasing the demand for evidence-based services, since an informed consumer and family make a powerful source of pressure for implementing such practices. Encouraging the development of programs that collectively create a variety of messages, and that encourage the involvement of multiple organizations, is probably beneficial to achieving the goal of reaching many audiences with solid messages about different evidence-based practices.

What is missing, however, is a point of coordination to reduce fragmentation and promote collaboration and efficiency in the use of scarce resources. In particular mass media awareness activities are expensive to develop and to field. Duplication of effort can and should be avoided.

The national partnership can plan and recommend a coordinating effort for the various mental health awareness activities without precluding the initiative of any member of the partnership. Approaches to implement this policy option include the following:

1. Federal agencies within the partnership could fund a coordinating center and clearinghouse of mental health awareness activities, continue or expand funding for these activities individually, and encourage collaboration among them through use of financial mechanisms (such as contracts).
2. The partnership could encourage and suggest State and Federal financial support for regular regional and national meetings among the awareness groups.
3. The partnership could develop an information-sharing process, such as a web site, to be implemented with a mix of private and public resources.

Approach 3 is close to the *status quo* (although without the coordinating and convening power of the proposed partnership) and may be insufficient to accomplish any meaningful change. It does, however, encourage creativity from the private sector and avoids government involvement.

Approach 1 may involve the Federal Government too much in an awareness process using mass media, but it may be the best way to encourage this process with real resources as incentives. Relying on the partnership may address the concerns of those who want to minimize government.

But Approach 2 might be preferable to those who would like to achieve the objectives in a more *laissez-faire* approach.

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| **POLICY OPTION 1-2** | **Develop and Strengthen Quality Improvement Programs Linked to Evidence-Based Practices in the Public and Private Sectors** |

Quality improvement strategies are an important vehicle for promoting the widespread implementation of evidence-based practices. These strategies take many forms and involve numerous organizations. Mechanisms include licensure, credentialing, and accreditation offered by a range of organizations in both the public sector (governmental licensure) and the private and quasi-public sector (e.g., formal training program credentials and their links to accreditation bodies). Professional associations also develop standards for empirically supported treatments (the American Psychological Association) and practice guidelines (American Psychiatric Association), which include best practices as well as evidence-based practices.

Some degree of diversity is welcomed to encourage multiple perspectives and opinions on what constitutes "evidence" and on who should decide. While perhaps there will never be a consensus, there currently is no national leadership to encourage discourse and collaboration, and to work efficiently to develop quality assurance mechanisms for everyone to use.

The proposed national partnership for leadership should develop and strengthen quality improvement strategies using evidence-based practices. The goal is not to preclude individual initiative, but rather to promote sharing and learning among the partners and to avoid inefficient and unnecessary fragmentation and duplication of effort.

This policy option might be implemented by one of several approaches:

1. A Federal agency, such as AHRQ, collaborating with NIH and SAMHSA, could convene the various organizations (e.g., National Committee on Quality Assurance, Commission on the Accreditation of Rehabilitation Facilities, Joint Commission on the Accreditation of Healthcare Organizations, professional associations) and representatives of state and local governments responsible for licensure to coordinate efforts at quality improvement using evidence-based practices.
2. The partnership could convene the same organizations, but also be given a budget and be empowered to create incentives to base their quality improvement strategies on evidence-based practices.
3. The organizations themselves should be encouraged to follow their natural inclinations to partner in a loosely regulated market.

Approach 1 is probably beyond the scope and reach of appropriate Federal activity and interest; a national partnership (Approach 2) is probably better suited to this activity given current feelings about avoiding government involvement in such spheres. Approach 3 is not likely to produce much change.

| POLICY OPTION 1-3 | **Create a National Infrastructure for Leadership in Evidence-Based Practices** |
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There is a need for an infrastructure at many levels of organization in the public and private sectors to promote the dissemination and implementation of evidence-based practices. Nationally the proposed partnership could sponsor and support a center or collaborative network to review practices and the evidence supporting their effectiveness, to develop quality improvement tools, and to conduct training. In addition, the center could develop training materials, present conferences, and provide ongoing consultation and support to organizations wishing to promote and implement evidence-based practices.

As described earlier, various organizations already have developed centers on implementing evidence-based practices, including NAMI, NASMHPD, and several states, with several of these funded by SAMHSA/Center for Mental Health Services (CMHS). The partnership could form an umbrella organization for these organizations and help to establish new centers. In addition, some activities, such as review of the evidence for various practices, might best be done in a single collaborative consortium of interested parties.

Up until the early 1980s NIMH operated a Staff College that served as a national training and implementation support center for mental health programs. Frequently in discussions of evidence-based practices individuals long-experienced in the mental health field have lamented the passing of this highly valued organization and its functions.

Three possible implementation approaches are presented:

1. The Federal Government could recreate the Staff College, locating it as a joint activity of NIMH and SAMHSA's CMHS, adding functions related to contemporary needs to support the dissemination and implementation of evidence-based practices. It would work in concert with the existing evidence-based practice centers in the public and private sectors.
2. The partnership—with initial funding from the Federal Government—could develop a Staff College or similar national collaborative devoted to evidence-based practices. The entity would involve the direct collaboration of existing centers.
3. Incentives could be used within the current environment (market and nonmarket) to encourage centers to collaborate and new centers to form.

| POLICY OPTION 1-4 | **Revive Infrastructure for a National Multidisciplinary Mental Health Professional Training Program Focused on Disseminating and Implementing Evidence-Based Practices** |
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With the creation of NIMH the Federal Government encouraged the development of the current supply of providers of mental health services through its staff development and professional training programs. These programs have been slowly phased out since the 1980s, leaving this responsibility to the field itself, primarily in the form of professional and post-professional training sponsored by public and private universities, professional associations, and other private entities.

Successful in creating a professional and paraprofessional workforce, the field has fallen down in its efforts to train these providers in newer practices, particularly evidence-based practices. It is not a matter of unwillingness or lack of interest. Rather, many structural barriers exist to learning and implementing evidence-based practices in everyday services.

One barrier is the need for multidisciplinary training in a world that emphasizes single-disciplinary training. Other barriers relate to finances and the structure of the organizations that provide services, many of which are too inflexible to implement new practices. There is a need for new leadership—and the support to go with it—to promote the training of a workforce skilled in evidence-based practices and to offer updated knowledge and skills through quality improvement and continuing education of the existing workforce.

1. The Federal Government—through NIMH and SAMHSA, perhaps in conjunction with the Health Resources and Services Administration—could restore critical aspects of the mental health professional training program. In contrast to the previous program focused on the core disciplines (i.e., psychiatry, psychology, social work, and nursing) training should be multidisciplinary and focused on the capacity to train in evidence-based practices.
2. The partnership could garner private as well as State resources to add to a Federal Government initiative in this area.

Two, rather than three, approaches are presented, as no laissez-faire approach is considered likely to be effective:

Approach 2 is broader and more flexible than Approach 1, although Federal resources are probably key to the success of such an enterprise. Perhaps the proposed training activities to create a supply of skilled providers of evidence-based practitioners should be linked to Policy Option 1–3 and be provided by a Staff College or collaborative under the leadership of the Partnership for Evidence-Based Practices. Ultimately the coordinating activities of mental health and treatment effectiveness awareness suggested under Policy Option 1–1 should also be consolidated with these supply-side evidence-based practice activities under a single center or collaborative.

| POLICY OPTION 1-5 | **Advance Knowledge, Including Rigorously Evaluated Service Demonstration Programs** |
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It is essential not only to continue to add to the science base that leads to the development of new evidence-based practices, but also to understand how to implement them effectively within the service system. Because this area is so complex and so central to the work of the Commission, this paper discusses the issue on its own in Policy Option 2.

## Policy Area 2. Advancing Knowledge

Policy Area 2 addresses these action strategies of the Surgeon General:

- Continue to build the science base.
- Ensure delivery of state-of-the-art treatments.

**POLICY OPTION 2**

**Advance Knowledge, Including Rigorously Evaluated Service Demonstration Programs**

Historically various Federal agencies and private foundations—sometimes in partnership with each other and often in partnership with local providers and mental health authorities—have sponsored mental health service demonstration programs. It is common to evaluate these demonstration programs to add to the knowledge base about the feasibility and effectiveness of innovative service models, and to derive lessons from the experience to pass on to others. Service demonstrations are intended to provide this knowledge to assist in disseminating and implementing new service models. After several active decades of service demonstrations, there is currently a lull in activity in mental health services. The one exception has been efforts to learn how to better implement evidence-based practices in real world settings.

While there have been some initial efforts at service demonstrations, they are just underway, and there are also many more areas for advancing knowledge through service demonstrations that have yet to be planned or developed. For example, although Phase 2 of the project in the public sector for adults with serious mental illnesses (described previously as the "toolkit project" in eight states) has begun, there are several dozen states ready to move forward with the demonstration. It will be difficult, however, for them to organize and fund their efforts, since Phase 3 has yet to be planned and funded.

Projects for children and adolescents with emotional disturbances are just being conceptualized—based on some groundbreaking work with multisystemic treatment from South Carolina. Studies are also just beginning on implementing evidence-based practices for individuals with late-life disorders, such as depression.

Foundations have sponsored private sector projects, mostly focused on treating depression in primary care settings. None of these projects, however, is specifically focused on learning about the process of dissemination of innovation, or the implementation of evidence-based practices throughout the life cycle.

The Federal Government, initially through NIMH and later through CMHS, has taken the lead in planning, fielding, and evaluating mental health service demonstrations. As noted in Policy Option 1–5, a national partnership for leadership in evidence-based practices should take responsibility for coordinating these knowledge-development activities.

This task involves more than designing service demonstrations. It also includes involving all stakeholders in advising research funding agencies about sponsoring research that is more likely to result in services that will move from scientific study into practice. This specific policy option, however, focuses principally on service demonstrations, moving both from science to services and from services to science.

The Subcommittee suggests the following to fulfill Policy Option 2:

1. CMHS (SAMHSA) and NIMH (NIH) should strengthen their collaboration in planning, fielding, and evaluating mental health service demonstration programs in evidence-based practices. They are encouraged to collaborate with other Federal agencies, State and local governments, and private organizations, including foundations. The process must involve all stakeholders in an effort to improve the relevance and generalizability of the research and other forms of knowledge development.

2. The partnership should assume overall responsibility for this area—to include all of the stakeholders listed in Option 1. It should provide each with funding to move the partnership forward in the planning, fielding, and evaluation of service demonstrations on evidence-based practices.

The following are specific possible approaches to further develop service demonstrations on evidence-based practices:

- Private sector implementation of practices such as medication algorithms and collaborative care of depression for adults and Attention Deficit Hyperactivity Disorder treatment of children.
- Further study of implementation of multisystemic therapy, home visiting programs, and therapeutic foster care for children and adolescents.
- Phase 3 of the Evidence-Based Practice project for adults with serious mental illnesses in the states ("toolkit project").
- Expanded, toolkit-type projects with other age and clinical groups across the life span and the diversity of the population.

The approaches will be a matter of preference and priority. The pros and cons of the two main approaches have been discussed previously in the context of Policy Area 1 and are not substantively different for this policy area. Decisions about the Federal role and the partnership for Area 1 will affect the final recommendation for this policy area.

## Policy Area 3. Financing

Policy Area 3 addresses these action strategies of the Surgeon General:

- Reduce financial barriers to care.
- Ensure delivery of state-of-the-art treatments.

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| **POLICY OPTION 3** | **Assure that Existing Funding Mechanisms Will Encourage the Use of Evidence-Based Practices** |

As noted earlier, it is essential to find a range of strategies and tactics to finance evidence-based practices. Many of these issues are discussed in other Subcommittee papers. What follows are specific policy options for financing evidence-based practices:

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| **POLICY OPTION 3-1** | **Modify Medicaid** |

As discussed above and in the background paper of the Subcommittee on Medicaid, there is a need to include evidence-based practices in Medicaid covered benefits. It is also critical that the rates paid to providers create an incentive for them to deliver evidence-based practices. (See the Medicaid Subcommittee's background paper and its policy options for details.)

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| **POLICY OPTION 3-2** | **Modify Medicare** |

As discussed above and in the paper of the Subcommittee on Medicaid, it is essential to cover evidence-based practices in Medicare benefits, particularly the disease management interventions that presently cannot be paid for in their "bundled" form. These practices should be brought to the attention of the Medicare National Coverage Process, with a recommendation that they be added to the list of covered services.

In the case of collaborative care for chronic disease management this step probably requires special attention to how to "bundle" or "un-bundle" the services. (See the specific policy options in the Medicaid, Mental Health Interface with General Medicine, and Older Adults Subcommittee papers for more details.)

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| **POLICY OPTION 3-3** | **Using the Mental Health Services Block Grant to Initiate Evidence-Based Practices** |

In an era of scarce resources, one of the most important existing funding streams available for initiating service innovations is the Federal

Community Mental Health Services block grant. The Federal CMHS within SAMHSA administers the block grant. Originally created in 1981 by the first Omnibus Budget Reconciliation Act during the Reagan Administration, the block grant was designed to bring all Federal funding for general mental health services into a single stream of resources. This legislation repealed the Mental Health Systems Act and the block grant replaced a number of previous programs, including the Community Mental Health Centers Program.

The block grant represents a centerpiece of new Federalism and gives the state mental health authority broad latitude in the use of these Federal funds to pay for community-based mental health services. The block grant spending is subject to state mental health plans and a system of Federal monitoring. States use the block grant for a wide range of mental health services. Some of them are evidence-based, others represent best practices where no evidence-based practices exist, and others are innovations waiting to be tested.

Recent efforts to expand the block grant have been only modestly successful. Legislators are asking for evidence that the appropriations are for effective services and that states can be accountable for the services funded through the block grant. These two characteristics—effectiveness and accountability—are hallmarks of evidence-based practices, with their track record of positive research findings and use of measures for assessing adherence to proven models of care and treatment.

Without increasing the level of funding in the block grant, resources could be used to shift services from existing practices to evidence-based practices. Although the FY 2002 funding is only $433 million (representing at most a few percent of any State's mental health budget), the block grant is a source of flexible financing that would permit funding for evidence-based practices that might not otherwise be part of a State's Medicaid plan.

It also could serve as an extra source of funding to go beyond what is expected by service providers from State and local governmental sources (e.g., enabling the addition of a job coach to a supported employment team or a consumer case manager to an Assertive Community Treatment team). Several of the States already involved in projects for implementing evidence-based practices are using block grant resources for this purpose.

As noted in earlier sections of the paper, it is critical to develop an infrastructure for implementing evidence-based practices within each state. A first step in the Federal–State partnership should be the creation of a State center (or centers) for implementing evidence-based practices. Both centralized and decentralized models exist in several States, often funded with Federal block grant and other discretionary resources, such as from SAMHSA/CMHS. These centers provide leadership and are involved in training, consultation and support, and monitoring programs for ensuring fidelity to the intended model of evidence-based practices.

Some changes in the use of the block grant can be accomplished through guidelines or regulations while others may require legislation. Four possible approaches are offered, each involving a different level of Federal mandate:

1. The Federal Government could mandate that the block grant be used only for evidence-based practices or that a specific proportion be used for that purpose—with services and proportions to be designated by the Secretary of Health and Human Services.

2. The Federal and State governments could enter into a series of partnership agreements on evidence-base practices in which the block grant was targeted for use for implementing evidence-based practices.

3. The Federal Government could encourage States to use their block grant to promote evidence-based practices by creating a system of rewards (e.g., related to future block grant expansion resources) and incentives for doing so.

4. The Federal Government could adopt a hybrid model, combining a mandate to use block grant resources for creating an infrastructure—a center for implementing evidence-based practices—in each state, with voluntary plans related to expenditures for direct services.

Approach 1 suggests a strong Federal role in shaping mental health policy. It is most likely to lead to initial implementation but may encounter resistance in the field in the long run, as well as political resistance from those who would prefer to limit the Federal role in favor of state determination of such policies. Furthermore, this policy approach might require new legislation.

Approach 2 represents a compromise between the interests of the Federal Government and the States. But programs and services might not conform to accepted standards in this more *laissez-faire* approach. Targeting is a good method to improve adherence to quality standards without mandates. Proposed partnership grants have requirements that some directors of State mental health authorities think are infeasible or otherwise undesirable.

Approach 3 is the most *laissez-faire* of the approaches suggested, choosing to use a series of incentives rather than penalties to encourage States to implement evidence-based practices.

Approach 4 is a hybrid approach that has a mandate for what some would view as the most important beginning investment in infrastructure—a center in each State to support implementation efforts—but leaves the rest of block grant use for promoting mental health services to State discretion. The balance of the spending could follow Approaches 2 or 3 above.

# Conclusions

The promise of decades of research must be realized in practice. In his 1999 report, the Surgeon General simultaneously identified this promise and documented the shortcomings that have prevented its realization thus far. That report outlines courses of action for policymakers that should guide us away from service disparities and that support the implementation of evidence-based practices. With the New Freedom Commission on Mental Health, the opportunity exists to combine quality improvement with accountability through performance measurement and the implementation of effective new services and treatments.

The time has come to add to the body of knowledge about implementing evidence-based practices at different levels, including knowledge about policy, program priorities, clinician practice, consumer adherence, and family member support. However, development and implementation of new policies are of primary importance to achieving the goal of widespread implementation of evidence-based practices. The national initiative supporting evidence-based practice implementation is one of the most important innovations on the mental health horizon. It will serve as the testing ground for what can be learned about bridging the gap between science and service.

But this important initiative will not go far if it is not supported by mental health policies—at State and Federal levels—that create the organizational and financial incentives to implement evidence-based practices. In addition, it will be a time-limited activity if it does not also yield lessons about how to adapt to new evidence and on-going systemic changes. Organizations must be flexible and able to learn and adapt.

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