## State Activities in Implementing Evidence-Based Programs for Children, Youth, and Families

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## Purpose

State survey conducted by the NRI Center for Mental Health Quality and Accountability to:

- Obtain descriptive information on State Mental Health Agencies' policies, strategies, and mechanisms for implementing evidence-based practices (EBP);
- Identify models of successful EBP implementation;
- Identify challenges, barriers, and facilitators that influence statewide implementation; and
- Identify needs related to current and future implementation.

## Methods

Questionnaire was composed of primarily open-ended questions covering the following topic areas:

- Types of EBPs and promising practices being planned or implemented
- Integration of EBP initiatives with other major initiatives such as System of Care or Trauma Initiatives
- How EBPs are implemented in rural and frontier areas
- Description of policy, procedural, or programmatic approaches used to integrate EBPs into practice settings
- Financing strategies
- Infrastructure and mechanisms used for training, coaching, and technical assistance
- Strategies used for evaluating and monitoring fidelity and outcomes; and methods for incorporating these data into management information systems

## Sample and Data Collection

- The sample was composed of the 50 states, plus DC and territories. Primary respondents were State Mental Health Agency (SMHA) Directors of Child Mental Health Services. Supplemental information was provided by other personnel such as program managers, evaluation directors, or MIS directors.
- The survey was conducted during December 2003 to June 2004 through telephone interviews lasting 1 to 1.5 hours. Interviews were audio taped and transcribed.

## Results to be Presented

- Types of EBPs being implemented across the states
- Cross-cutting issues faced by most states in implementing EBPs
- Types of strategies being used to implement EBPs (in general and by types of EBPs)
- Next steps

## Evidence-Based and Promising Practices Being Implemented in Different States (N=44)

- Multisystemic Therapy (61%)
- Intensive Home Intervention (27%)
- Functional Family Therapy (30%)
- Wraparound (55%)
- Therapeutic Foster Care (86%)
- Family Support (27%)
- Parent Management Training (9%)
- Respite (23%)
- School-based mental health (46%)
- Clinical interventions (CBT, MDFT) (43%)
- Medication Guidelines or Algorithms (11%)
- Early childhood interventions (18%)
- Trauma interventions (27%)
- Crisis intervention (11%)
- Screening/Assessment/Support (5%)
- Independent living skills (18%)
- Telepsychiatry ( 9%)

## Cross-cutting Issues

- SMHA Governance and Structure of State Mental Health Systems
- Motivation for EBP Initiatives
- Stage of EBP Initiatives and Competing Initiatives
- Promising and Emerging Practices
- Monitoring Fidelity and Outcomes
- Financing Structures

## Types of Strategies

- Leveraging the Legislature
- Leveraging Financial Resources
- Planning Initiatives
- System Reform/Deinstitutionalization
- Nesting in Quality Improvement initiatives
- Nesting in Systems of Care
- Building on Existing Service Platforms
- Relationships with Providers
- EBP Information Dissemination

## Strategies Based in Interagency Collaboration

- Collaboration in Developing Consensus
- Collaboration on Specific EBPs or Promising Practices
- Collaboration in Financing EBPs
- Public-Academic Collaboration for Translating Science to Practice and Training Professionals in EBP
- Collaboration with other state agencies in general

## Strategies/Approaches for Specific EBPs

## Multisystemic Therapy ( n=27 states)

- Initiative/Approach
  - Collaboration with Juvenile Justice or Courts to divert youth from the juvenile justice system or for community re-entry (AZ, CT, NM, OK, PA)
  - Collaboration with JJ and Child Welfare (GA)
  - MH refers to JJ who contracts for MST (Idaho, WA)
  - MST projects in state, but not funded by MH (IL, OR
  - Scope of Projects:
    - Statewide (CT)
    - Regional (AZ, GA, NE, SC)
    - Few pilots or sites (KS, Missouri, MI, MN, OK, PA, RI, TX, VA)

## MST continued

- Financing
  - Medicaid, Juvenile Justice, and State Dollars (SC)
  - Covered under Medicaid regular program, but developing codes and criteria to cover MST as an in-home service. New codes will reflect the actual clinical and case management services, and out of clinic setting (CT)
  - Blended funds through MH, JJ, and CW; and uses Medicaid rehab option for intensive family intervention services (GA, one region)
  - State funds and Medicaid amendment for TFC and MST (HI)
  - Medicaid managed care organization provides an enhanced service package; State general funds for training and supervision (NM)
  - Some MST sites funded by MH; Others by Juvenile Justice (TX)

## MST continued

- Training
  - MST services
  - Original training by MST Services, but transitioning to state training/supervision infrastructure (CT, OH, HI)
  - State Coordinator co-located at MST Services (SC)
  - MH contracts with JJ to do the training (TX)
- Piloted, but no longer in existence or still in existence, but on very small level due to challenges in sustaining resources for training and fidelity (5 states)

## Intensive In-Home Services (n=12 states)

- In-home teams (originally based on Homebuilder Model) enhanced to add components of MST; cognitive behavioral therapy, and social skills training; additional training to meet needs ( suicide screening, and depression). (AL)
- Intensive Family Intervention Services (GA)
- Intensive in home psychiatric services (CT)
- In-home services as wraparound and crisis
- Funding:
  - Medicaid and state funding
  - Part of SOC grant

## Functional Family Therapy (n=13 states)

- Funding by Medicaid, state dollars, county dollars, seed money from grants, juvenile justice
- Training by developer
- In NY: State MH Agency trained clinic and child welfare sites--MH funds the training for clinics; Services funded by Medicaid and other third party payers; in child welfare sites paid by child welfare dollars as prevention services; A state training infrastructure is currently being built for FFT. It will consist of a state coordinator and 3-5 regional trainers, trained by FFT, who will be the supervisors/consultants responsible for ongoing model fidelity.

## Wraparound (n=24 states)

- Vandenberg model most frequently mentioned
- Funding:
  - Pooled from major agencies
  - State MH Agency
  - state general funds, block grant dollars
  - Medicaid (targeted case management)
  - SOC grant
- Training:
  - Certification training provided by state
  - National experts; then training transitioned to state
  - Family members as trainers

## Therapeutic Foster Care (n=38 states)

- 15 states - provided/funded by MH; services generally provided by Child Welfare in other states
- In some states there is a functional/funding difference between therapeutic and treatment foster care
- Model used was generally not named/known
- Sometimes called individualized residential treatment
- Multidimentional Treatment Foster Care (Chamberlain model-4 states)
- Generally accessible through Child Welfare IV-E funding; some Medicaid (Rehab Option)
- In MH funded programs state has significant role in training and certification

## Family Support ( n=12 states)

- No specific EBP model named,but referred to:
  - Family support specialists
  - Parent support services
  - Family support coordinators
- Funding:
  - State dollars,
  - Medicaid and CHIPS planned
  - Joint funding from multiple agencies

## Respite (n=10 states)

- No model generally mentioned, but one state mentioned they are using a model from the ARC for developmental disabilities
- Often funded by combination of funds such as state dollars, Medicaid, child welfare, block grants
- In one state, it is being included under a new 1915C waiver; and in another state, they are planning to fund through Medicaid and CHIPS starting this year

## School-Based Mental Health Services (n=20 states)

- School-based mental health centers (17 in Arkansas)
- MH counselors in schools – In most school districts in SC; training in EBPS in NY)
- Positive Behavioral Intervention and Supports (KY, CT, grant and IDEA funds in NY)
- Sustaining factors in SC – long history, school invited and jointly funds, best practice model, state level coordinator for outreach, training, and supervision
- Funding sources: Block grants, school funding, Medicaid, seed grants

## Clinical EBPs (n=19 states)

- Types of clinical EBPs:
  - Cognitive behavior therapy (11 states)
  - Dialectical behavior therapy (7 states)
  - Coping Cat (3 states)
  - Multidimensional family therapy (5 states)
- Center for CBT through contract with university in Hawaii
- Center for Effective Practices in CT

## Rural Initiatives

- MST training site set up in Rochester, NY to provide focal point for western counties
- Individual adaptations and ingenious ideas for transportation
- Teleconferencing
- System of Care grants assist in developing rural programs
- Providing services in home and school settings
- Programs designed by local leadership

## Trauma Initiatives

- Bringing in specialists for training on impact of trauma and to assist in developing service delivery approaches
- Each MH center has person specializing in trauma
- Special mental health services for 9/11 victims
- Children in state custody are enrolled within 24 hours; statewide assessment tool
- State has large trauma initiative with child components
- Some special funding for children who have been sexually or physically abused
- Children with PTSD are provided intensive services
- Developing a relationship with 4 trauma centers
- Routine trauma assessment, training curriculum, and individual assigned to do training
- Focus on reducing seclusion and restraint and increasing trauma-sensitive work

## Conclusions/Next Steps

- Qualitative survey allowed for a broad brush look at what is happening in the states from the perspective of mental health agencies
- Due to variation in state mental health agency structures, state level MH authorities may not know every EBP being planned, piloted, or offered (especially clinical ones)
- Numbers reported are probably lower than actual if we also surveyed county-level mental health authorities directly
- Most states are still in implementation phases versus dissemination--Exploring, trying out, figuring out how to integrate into service systems

## Next Steps

- Initial qualitative effort to explore strategies will be followed up with more focused studies of specific EBPs and strategies using quantitative methods
- Recommendation to adapt NRI's State Profiles System to collect data on a wider range of children's EBPs--to track dissemination over time
- Dissemination of successful strategies/approaches found in this survey
- Recommendation to develop and implement more focused approaches to knowledge exchange across states