Best Practice Implementation in Kentucky's Public Mental Health & Mental Retardation System

Louis Kurtz, MEd
Best Practice Coordinator
&
Vestena Robbins, PhD
Research Coordinator

Training, Research, Evaluation & Dissemination
Division of Administration & Financial Management
Department for Mental Health &
Mental Retardation Services
Frankfort, KY

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Context & Purpose

Despite a growing body of research about "what works" and a general consensus that consumers deserve the most effective treatments available, there is limited evidence to suggest that empirically-supported health care practices are translated into routine clinical care. The health care field has long been characterized by inconsistent, idiosyncratic practices primarily based on personal clinical experience, intuition, and/or tradition rather than scientific findings. First coined in 1990, the term "evidence-based medicine" was used to describe the systematic use of scientific evidence in clinical decision making. Not surprisingly, the expanded use of science to inform practice in the medical field prompted parallel efforts in the behavioral health arena (Drake, Torrey, & McHugo, 2003). Defined as "the integration of the best research evidence with clinical expertise and patient values" (IOM, 2001), evidence-based care holds the promise of recovery, resiliency, and inclusion for individuals with mental illness, addictions, brain injury, and/or mental retardation. The evidence-based movement is based on the philosophy that every individual has the right to choose and receive the best health care services that science has to offer.

Fueled largely by a series of independent reports describing myriad problems within America's health care system, including the behavioral health system (IOM, 1999, 2001; CSAT, 2000; President's New Freedom Commission on Mental Health, 2003; Office of the Surgeon General, 1999), the concept of evidence-based care is receiving increased attention from consumers, providers, managers, payers, policy makers, and regulators as a means of improving poor outcomes. These reports decried the "chasm" between care that consumers could receive (i.e., practices demonstrated through research studies to be effective) and that which they do receive (i.e., practices provided in routine clinical settings) and called for efforts to identify and implement care based on empirical evidence.

Heeding this call, a number of evidence-based care initiatives have been undertaken. For example, APA's Division 12 Task Force on Promotion and Dissemination of Psychological Procedures identified empirically-supported treatments that led to the development and dissemination of highly specific treatment manuals (Task Force,

1995). The efforts of the Task Force served as a catalyst for a public sector evidence-based initiative for child and adolescent mental health disorders in Hawaii (Chorpita et al., 2002) and later in other states. Other examples include the development of evidence-based treatment guidelines by the American Psychiatric Association (2003), the US Surgeon General's call to ensure the delivery of state-of-the-art treatment (USPHS, 1999), a recommendation for the delivery of excellent care and the acceleration of research by the President's New Freedom Commission on Mental Health (2003), compilations of the effectiveness and efficacy literature by diverse national constituencies (e.g., National Registry of Evidence-Based Programs and Practices), and the establishment of state infrastructures to support evidence-based practice initiatives, such as Centers of Excellence in Ohio and Practice Improvement Collaboratives in New York and Iowa.

The evidence-based movement has placed particular emphasis on the identification and dissemination of effective *practices* for specific disorders, defined as those clinical and administrative practices for which there is consistent scientific evidence showing that they improve client outcomes (Hyde, Walls, Morris, & Schoenwald, 2003). However, consensus has not yet been reached as to *what kind* of evidence or *how much* evidence is needed to deem a practice as evidence based. Critics of the evidence-based practice movement argue that significant aspects of the treatment process, particularly the provider-client subjective experience, have been ignored in lieu of an emphasis upon identifying effective treatments. Messer (2004) contends that sole reliance on the identification of empirically-supported treatments fails to take into account studies that show the significance of relationships between the therapist and the client (see Norcross, 2002). In fact, Wampold and Bhati (2004) maintain that the type of treatment delivered accounts for very little of the variability in outcomes, while variance due to the quality of the therapeutic alliance, therapist empathy, and agreement and collaboration around therapeutic goals can be a strong predictor of outcome. It is likewise important to consider evidence-based care within the context of the recovery and resiliency movement. That is, the needs and choices of consumers must be matched with services that will result in the desired outcomes. Thus, it appears that "the best care results from the conscientious, explicit, and judicious use of current best evidence and knowledge of patient values by well-trained experienced clinicians" (IOM, 2001).

Driven by federal calls for systems transformation and recognition of the need for a state infrastructure to support the adoption and implementation of evidence-based practices, the Kentucky Department for Mental Health and Mental Retardation Services met with a small group of administrators representing the community mental health system to dialogue about state-level strategies to support local-level adoption and implementation.

A recommendation of this group was to conduct a statewide assessment of evidence-based practice implementation throughout the public mental health and mental retardation system. To that end, *Listen and Learn Visits*, as they came to be called, were conducted with each Community Mental Health/Mental Retardation Center to ascertain:

- Best practice planning strategies
- Perceived status of adoption and implementation of evidence-based practices
- Perceived barriers and facilitators (internal and external, local or state) to the adoption and implementation of evidence-based practices
- State strategies that would facilitate adoption and implementation of evidence-based practices at the local level

The primary purpose of the *Listen and Learn Visits* was to compile information and recommendations to guide the development of a state infrastructure to support continued adoption and implementation of evidence-based practices throughout Kentucky.

Methodology

Visits were conducted with the 14 Community Mental Health/Mental Retardation Centers between June and October 2005. A letter from the Commissioner of Mental Health and Mental Retardation Services was sent to the Executive Directors relaying the context for and purpose of the *Listen and Learn Visits*. These visits were not intended to be evaluative in nature, but rather a means of promoting dialogue and information sharing around best practices. Sample interview questions and a proposed agenda were forwarded to Center staff. Department staff contacted each Center to schedule a one-day visit (typically 10:00am to 3:00pm). Two individuals from the Department conducted all interviews. In some instances, a Center's Board or Regional Liaison from the Department participated in the visit. Following each visit, interview responses were transcribed. A post-visit letter identifying strengths and areas for follow-up was sent to the Executive Director.

A semi-structured interview format was used to allow a rich understanding of the topic area and the ability to adapt the interview process to meet the individual characteristics of Centers. A group interview format was used to increase the efficiency and flexibility of the interview process while allowing for a diversity of perspectives.

Interviews were conducted with four groups of individuals at each Center: (1) the Executive Director and Upper Management, (2) Clinical Directors of primary programmatic areas, such as Mental Health, Substance Abuse, and Mental Retardation; (3) Nonclinical Personnel, such as those responsible for training, management information systems, financing, information technology; and (4) Program Directors, such as therapeutic rehabilitation, case management, emergency/crisis services. A semi-structured interview protocol was developed for each of the four respondent groups. The interview was designed to capture information about the agency's organizational structure, planning processes, stakeholder involvement in decision making about best practice adoption and implementation, quality assurance and improvement strategies, training and workforce development, university and other agency interface, and information technology. Best practices planned, adopted, and/or sustained in specific program areas were captured. Respondents were asked to describe any perceived barriers and facilitators to best practice implementation and sustainability as well as recommendations for state-level strategies.

Findings

Findings from the *Listen and Learn Visits* are presented in two ways: (1) a description of themes that emerged from the responses and (2) a listing of strengths identified for each Center. Together, these findings illustrate trends emerging across the state as well as unique practices and strategies undertaken by Centers.

EMERGENT THEMES

Organizational Structure

- *Formation of Medical Services Units*. Typically headed by the Medical Director, these units focus on improving the quality of medical services in areas such as medication prescription and administration, diagnosing, and alignment with recognized practice standards.

- *Integration of Services Across Population Groups*. This "breaking down of silos" is being attempted by cross-training staff, assigning staff (e.g., case managers) to serve individuals from multiple population groups, providing services (e.g., supported employment) to multiple populations, and organizing supervisory structures around service clusters.

Community Collaboration

- *Increased Focus on Collaboration*. A concentrated focus on collaboration with other community service organizations that serve a mutual clientele is a strategy to increase access to a broader array of needed services. All Centers have formal or informal agreements with jails, schools, and local Department for Community Based Services offices. Outreach to these sister organizations is accomplished in unique ways, such as hosting one-hour brown bag informational sessions, lunches for partner groups (such as police), or regularly scheduled meetings focused on training, case review, or planning.

Training

- *Training Coordinators.* The majority of Centers have employed or are planning to hire a full-time training coordinator, primarily housed within the Human Resources Department.

- *Localized Training*. In response to increased travel costs, loss of billable time, and an interest in controlling content to better meet needs, trainings and professional development activities are increasingly being offered by the Centers or in their respective region. Limited funds are available for critical training offered outside the region.

- *Advanced Technology*. Training is being delivered in a variety of formats using advanced technology, such as the development of computer training labs, web-based or CD-ROM-based instruction, teleconferencing, and E-Learning.

- *Cross-Training*. Staff are being cross-trained in mental health, substance abuse, and mental retardation.

- *Orientation*. Human Resources provides an agency orientation for new staff, ranging from 1 to 5 days. The remainder of the orientation is typically carried out by the program supervisor through a variety of methods (e.g., mentoring, shadowing, additional classroom training).

Workforce

- *Planning for Retirement Window*. Planning is occurring related to the anticipated exodus of long-term staff at the next retirement window.

- *Public Sector Training*. Graduates, both Bachelor's and Master's level, are being trained in a private practice model rather than a public sector model. This training fails to adequately prepare them to work effectively in a community mental health/mental retardation center. Thus, the Centers are serving as the major training ground for graduates through internships, practica, and on-the-job training.

Workforce (continued)

- *Recruitment of Qualified Staff*. Critical staff shortages exist for psychiatrists, specifically child psychiatrists. Centers are investing a great deal of time and money to fill vacant positions. Staff recruitment is typically done by hiring interns or practicum students. One Center has developed a comprehensive structured interview tool and rating criteria that is used in the hiring process to assess core competencies.

- *Assessing Staff Readiness*. A few Centers have assessed clinician readiness to adopt evidence-based practices using an instrument developed by Greg Aarons in California. Results are being used to specify training and supervision needs.

- *Staff Evaluations*. Position descriptions are developed based on required competencies. Performance evaluations are linked to these competencies.

- *Credentialing*. Credentialing committees or professional service organizations are established to assure that staff have and maintain proper credentials, primarily for billing purposes. There are problems, however, with certification board regulations as to initial and ongoing training requirements for obtaining and maintaining licensure.

University Linkages

- *Influence on Curricula*. There is very little services research being conducted in the public sector. While Center staff teach in university settings, there is little formal input into the design of university curricula (e.g., training in evidence-based practices). Some management staff participate on higher education advisory committees.

- *Lindsey-Wilson College*. Lindsey-Wilson College has developed unique Bachelor's and Master's programs in at least seven (7) regions. This is the result of a formal partnership between each Center and Lindsey-Wilson College.

Quality Assurance

- *Accreditation*. The value of accreditation appears to be waning among Centers. While a handful maintain full JCAHO accreditation, others have dropped their accreditation because of associated costs, the fact that accreditation is not required by the Department and other funders, and it does not result in "deemed status".

- *Oversight Structures*. Most Centers have established formal Quality Assurance Committees that are linked to the required Program Planning and Evaluation Committee of the Board of Trustees. Chart reviews, data analysis, and reviews of performance indicators are common activities of these Quality Assurance Committees. These committees are typically positioned to promote the introduction of new practices or procedures within the agency.

- *Treatment Protocols*. Many Centers have developed diagnostic-specific treatment protocols or guidelines. One Center has developed cluster-specific treatment protocols based on symptoms.

Adoption of Evidence-Based Practices

- *Clinician-Level*. The majority of clinicians are allowed to adopt practices and approaches that fit the clientele served. Some Centers are attempting to raise clinician competency by developing Master Clinician programs, rolling out specific practices (e.g., dialectical behavior therapy, cognitive behavior therapy), or creating clinician training modules. A focus for supervisors is teaching clinicians to choose evidence-based practices within the context of the individual consumer (i.e., preference, multiple needs).

- *Program-Level*. There has been some adoption of the SAMHSA Tool Kits and other system-oriented evidence-based practices, but very few are being implemented with fidelity. The practices that are being adopted are those that require less funding and are most easily merged with existing practices (e.g., Illness Management and Recovery in TR programs). There is a strong belief that evidence-based practices must be adapted to meet local needs, particularly in rural areas, and that strict adherence to the model or approach as it was implemented in the research setting is less important.

Adoption of Evidence-Based Practices (continued)

- *Agency-Level*. Most Centers believe they have been implementing best practices for many years but have not been acknowledged as such.

- *Incentives*. One Center restricts the use of elective clinical training funds to evidence-based practice topics.

- *Most Commonly Used Practices*.

  In the area of Mental Retardation, the most commonly reported best practices were person-centered planning, supported employment, cross-training in mental health/mental retardation, consumer-directed options, and supported living.

  In Mental Health, the most commonly reported best practices were brief solution-focused therapy, cognitive behavior therapy, dialectical behavior therapy, motivational interviewing, illness management and recovery, parent-child interaction therapy, and wraparound.

  In Substance Abuse, the most commonly reported best practices were integrated treatment for co-occurring disorders, motivational interviewing, brief solution-focused therapy, cognitive behavior therapy, recovery dynamics, drug courts, and Seven Challenges.

Performance-Based Contracting

- *Incentives*. The majority of staff interviewed perceive the Department's performance-based contracting process as a "disincentive" as opposed to an "incentive". They uniformly understand the rationale for performance-based contracting; however, rewarding positive performance through incentive funding or other methods is preferred.

- *Best Practice Training Requirement*. While the response to this performance-based contract item has been primarily positive, some Centers have chosen to develop their own training materials while others are using the Department-developed slides with some adaptations.

Technology

- *Electronic Medical Records*. A few Centers are forging ahead with the development of an electronic medical records system. The majority reported awaiting funding and uniform standards from the Department.

- *Hardware*. The majority of Centers have well-developed technology plans that call for equipping all clinical staff with either desktop or laptop computers. Most are well along in securing the necessary hardware but are faced with connectivity challenges, securing resources to hire staff to provide technology support, and upgrading obsolete hardware.

- *Telehealth*. Most Centers have access to videoconferencing equipment that would allow the delivery of behavioral health services through a "telehealth" network. There appears to be a consensus that this system is under-utilized, the rules for payment are not well understood, and that the Department needs to take lead in learning to better utilize this technology and to work with Medicaid to develop clear guidance about the delivery of behavioral health services through this modality.

Consumer and Family Involvement

- *Advocacy Organizations*. The majority of Centers have at least one National Alliance for the Mentally Ill (NAMI) chapter operating within their region. Where one is not present, development of a chapter is underway. While the majority also have active Association for Retarded Citizens (ARC) groups operating, these are less well developed than the NAMI chapters in some regions.

- *Best Practices*. NAMI's Family-to-Family Program is the primary best practice to which clinicians from the CMHCs refer families. NAMI also promotes the establishment of Crisis Intervention Teams (CITs) in local communities. While there is very little evidence of active consumer-run organizations operating within the regions, there is some level of peer support services. The evolution of the SCL Waiver to a Consumer Directed Option (CDO) model is the major policy change initiative on the horizon.

Consumer and Family Involvement (continued)

- *Level of Involvement*. Involvement in the development of treatment plans, completion of consumer satisfaction surveys, participation in consumer and family focus groups, attendance at consumer conferences, and membership on Regional Planning Councils are the primary ways in which families and consumers are involved with the CMHCs. One CMHC has established an Office of Consumer Affairs (ombudsman role).

CENTER-SPECIFIC STRENGTHS

Four Rivers

- Mentoring program for Qualified Mental Health Professionals
- Interview tool used in interviewing and selecting new clinicians
- Movement of Therapeutic Rehabilitation Programs to an Illness Management and Recovery Model
- Agency-wide assessment of clinician readiness for adoption of evidence-based practices
- Strong Person-Centered Planning process in MR/DD service sector
- Integrated treatment approach to serving individuals with co-occurring mental health and substance abuse disorders
- Interest in integrating physical health with mental health through application for a Federally Qualified Health Center (FQHC)
- Use of tool for assessing fidelity in IMPACT Program

Pennyroyal

- Use of Person-Centered Planning process across disability areas
- CARF-accredited Therapeutic Foster Care program
- Continued development of Best Practice Policies and Procedures
- Training in MR/DD to crisis staff and Therapeutic Foster Care parents
- Interest in promoting greater use of technology (EMRs, telehealth, E-Learning, computer access)

River Valley

- Integration of services across populations (e.g., case management)
- Annual self-assessment survey conducted across disability groups
- Use of satisfaction survey results to guide program improvement
- Development of an Office of Consumer Affairs
- Comprehensive agency disaster plan
- Cluster-specific treatment approach in children's hospital
- Focus on employment issues at consumer conference

LifeSkills

- Peer Support Program
- Information technology infrastructure
- Move to Supported Employment for individuals with mental retardation and downsizing of work centers
- Interest in implementing two of the SAMHSA toolkits: Illness Management and Recovery and Family Psychoeducation
- Strong consumer-operated organizations (e.g., BEST, Inc. and LINK)
- Specialized Intensive Case Management (SICM) program
- Commitment to use of motivational interviewing approach in substance abuse services

Communicare

- REDI (Re-engineering, Empowerment, Developing, Implementation) Process
- Operationalized and reliable use of Global Assessment of Functioning (GAF) in determining Level of Care
- Collaboration with regional advocacy groups (e.g., NAMI, ARC)
- Pilot project in Bardstown for elderly individuals with MR/DD
- Use of wellness groups to provide outreach to individuals who miss appointments
- Integration of Hardin Memorial Hospital, Adult Crisis Stabilization Unit, and adult Targeted Case Management services
- Best practice protocol used in Community Medications Support Program resulting in substantial cost savings
- Mentoring program to be used in conjunction with performance evaluation system
- Drug court program in Hardin County

Seven Counties

- Promotion of a best practice culture throughout organization, with interest in both administrative and clinical best practices
- Development of a strong infrastructure to support the adoption and implementation of best practices (e.g., Promising and Emerging Practices Group, Best Practice Team, Outcomes Team, data warehouse, etc.)
- Strong university research linkages
- JADAC Training Institute
- Engagement in studies focusing on implementation of and outcomes associated with evidence-based practices (e.g., KYMAP, MST, FFT)
- Strong focus on best practices in prevention

NorthKey

- Active utilization of grant resources from the Greater Cincinnati Health Foundation, including studies to examine best practice implementation and associated outcomes
- Strong connections with Xavier and Northern Kentucky University
- Investment in training through recent hiring of full-time training coordinator
- Strong substance abuse prevention efforts
- Youth Substance Abuse Treatment Collaborative
- Substantial grant funding to support development of an integrated treatment approach for adolescents with co-occurring mental health and substance abuse problems

Comprehend

- Agency-wide assessment of clinician readiness for adoption of evidence-based practices
- Partnership with Lindsey-Wilson College in providing Bachelor's and Master's level programs in Maysville coupled with tuition reimbursement for agency employees
- Utilization of grant resources from the Greater Cincinnati Health Foundation for planning and program development
- Collaboration with Lewis County Primary Care Center
- Focus on maintaining model fidelity in adolescent substance abuse IOP
- Utilization of evidence-based models throughout children's program, particularly school-based service delivery
- Recovery Kentucky project for men proposed for Maysville

Pathways

- Strong Quality Improvement Program, including Practice Guidelines Committee
- Nationally recognized Prevention Program
- Comprehensive crisis program (800 number, walk-in, mobile, residential)
- Strong emphasis on collaboration with community partners (e.g., monthly meetings in local communities)
- Use of Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocols
- "Working on Wellness" program used in TR Programs
- Partnership with Lindsey-Wilson College in providing Bachelor's and Master's level programs in Ashland coupled with tuition reimbursement for agency employees

Mountain

- CSRS Program for adults with severe mental illness and focus on psychiatric rehabilitation principles
- One hour response time for individuals in crisis
- Upgrading facilities throughout region
- Specialized Intensive Case Management (SICM) program
- Lane House residential substance abuse program
- Annual regional children's mental health conference

Kentucky River

- Securing a number of federal grants to advance best practices
  - Pathways to Recovery Project introducing rapid change cycles throughout agency
  - Reclaiming Futures Project designed to unite system of care around delivery of evidence-based practices to youth with substance abuse and mental health problems involved with juvenile justice
- Formation of Juniper, a Federally Qualified Health Center, and focus on integration of physical and behavioral health services
- Focus on trauma services with a vision for embedding trauma-informed care in all services
- Agency-wide assessment of clinician readiness for adoption of evidence-based practices
- Cross-training of staff in mental health and substance abuse
- Development of a drug court treatment protocol
- Focus on prevention of prescription drug abuse

Cumberland River

- Integrated treatment focus in mental health and substance abuse
- JCAHO accreditation
- Implementation of evidence-based practices throughout children's system of care (e.g., schoolwide positive behavior supports, wraparound, parent-child interaction therapy, adventure-based treatment)
- Strong family support network (e.g., COPE House in Williamsburg)
- Focus on wellness at the New Beginnings TR Program in Manchester

Adanta

- Emphasis on Quality Improvement, including dissemination of an Annual Quality Improvement report and conference and Pride Reviews
- Level of service integration across disability groups (e.g., case managers serving adults with SMI and those with MR/DD)
- Relationship with community partners (e.g., monthly meetings in local communities, staff serving on local boards and committees)
- Development of treatment guidelines for medical services
- Peer support program
- Adult day health program
- Mentoring program for new staff
- Development of handbooks/manuals for clinical staff, therapeutic rehabilitation programs, therapeutic foster care programs

Bluegrass

- Well developed training curriculum supporting integrated treatment focus across disability groups (mental health and substance abuse, mental health and mental retardation)
- Training coordinator and comprehensive training for clinical staff
- Development of treatment protocols
- Comprehensiveness of proposed electronic medical record
- Centralized access and jail triage program

Recommendations

Based on the emerging themes from the visits, the following recommendations are offered to guide the KDMHMRS in its efforts to support the CMHCs in their continued provision of high quality services.

Organizational Structure

Continue service integration efforts by

- supporting the co-occurring disorders work group
- developing a cross-disability case management training curriculum
- creating mechanisms for joint planning across branches and divisions
- Creating staff positions that focus on integrated services as well as specialty areas (e.g., elderly mental health and substance abuse)

Collaboration

Strengthen relationships across agencies that serve mutual clientele around specific transformation activities, e.g., physical/behavioral health interface, cross-agency information and data sharing, development of model protocols among community agencies such as the CMHC jail triage protocol

Training

- Continue development of centralized training coordination and curriculum development
- Transform Mental Health Institute into a comprehensive conference focusing on best practices across populations
- Develop training curricula that meet identified local needs (e.g., cultural competency, MH/MR, MH/ABI, MH/SA, etc.)
- Continue opportunities for cross-learning and cross-training among department staff (e.g., Brown Bags)
- Decrease staff travel time and costs by increasing use of diverse technology formats for training and information dissemination
  - TRAIN
  - Web-based
  - Listservs
  - CDs and DVDs

Conclusions and Recommendations

Workforce

- Revitalize workforce subcommittee of HB843
- Identify and catalog existing practicum and internship possibilities at CMHCs for marketing to university training programs; provide guidance to supervisors at CMHCs to become exemplary practicum and internship sites
- Establish CMHC recruitment program for rural/underserved areas and specialty areas (e.g., ARNPs, child psychiatrists); examine recruitment strategies used in other states
- Facilitate the alignment of master level training programs to licensing standards
- Work with licensing boards to adopt CEU requirements based on evidence-based practices

University Linkages

- Through NIMH EBP Planning grant, develop science-to-service collaboratives between providers and university researchers to increase services research initiatives focusing on administrative, clinical, and financial best practices in the public mental health sector
- Catalog existing research efforts taking place in Kentucky and assess areas of research interest and need across providers, consumers, family members, and the KDMHMRS
- Where research and practice expertise does not exist in Kentucky, create linkages with purveyors from other states
- Identify core community mental health competencies to incorporate into existing training program curricula, e.g., evidence-based administrative, clinical, and financial practices, client relationship and alliance building strategies
- Partner with universities to establish a Master's level training program in Community Mental Health Counseling; identify and review existing Community Mental Health Counseling curricula from other university preparation programs
- Consider supporting an endowed chair at a state university whose sole focus is on best practice implementation in community mental health settings

Conclusions and Recommendations

Quality Assurance

- Create an evidence-based culture within the KDMHMRS that promotes evaluation of implementation, outcomes, and cost effectiveness for all funded programs
- Provide deemed status for monitoring of CMHCs or other contractors who are accredited by JCAHO, CARF, or other appropriate national accreditation body
- Create mechanisms to support the development and sharing of quality improvement strategies across CMHCs, e.g., diagnosis-specific treatment guidelines
- Provide data to CMHCs (who have made a request) to allow their own analysis of data
- Increase transparency of CMHC data to promote quality improvement initiatives

Adoption of Best Practices

- Support infrastructure development and action plan for KDMHMRS around best practice identification, adoption, and implementation through the NIMH EBP State Planning Grant
- Develop consistent mechanisms for dissemination of best practice information, e.g., quarterly newsletters, listserv, one-day focused workshops, best practice library
- Develop specific best practice training modules that are easily integrated with existing department-sponsored training
- Work with purveyors to identify best practice components already aligned with current practices, including billing and encounter structures (e.g., job development is currently nonbillable so the task would be to discover how to provide this service within current practice structures)

Recommendations

Consumer and Family Involvement

- Raise awareness of evidence-based practices among consumers and family members by sponsoring Consumer and Family EBP Forums in concert with NIMH EBP State Planning Grant
- Continue to support the involvement of family members and consumers at multiple levels within the system, including policymaking, advocacy, research, and evaluation activities

It is our hope that the findings and recommendations from the *Listen and Learn Visits* will be used by Department leaders and planners to create and sustain an infrastructure to support the adoption of best practices throughout Kentucky's public mental health and mental retardation system.

Please contact Vestena Robbins or Louis Kurtz to request copies of the following:

- Site Visit Protocol
- Sample on-site agenda
- Interview Questions

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