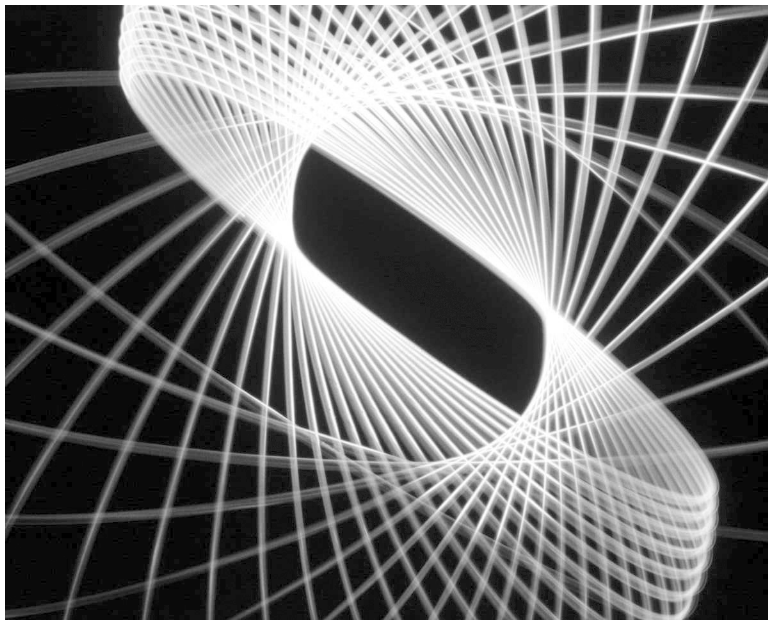

Toward Effective Mental Health Practices

A Strategic Work Plan to Develop Organizational Capacity for Incorporating Values and Science Into Mental Health Practices

CALIFORNIA INSTITUTE FOR MENTAL HEALTH
NOVEMBER 2003

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California Institute for Mental Health

TOWARD EFFECTIVE MENTAL HEALTH PRACTICES

A Strategic Work Plan to Develop Organizational Capacity for

Incorporating Values and Science Into Mental Health Practices

November 2003

EXECUTIVE SUMMARY

Summary Statement

The California Institute for Mental Health (CIMH) values the use of scientific information in mental health system planning and service delivery. A key component of this process is the promotion of "evidence-based practices," a term that has many meanings. CIMH recognizes that science is not the only determinant of the worth of a mental health practice, and maintains that evidence-based practices are relevant only when various levels of scientific evidence and stakeholder values are factored together.

For purposes of this document and the work that CIMH conducts, CIMH will emphasize the incorporation of the values of the California mental health delivery system and evidence-based practices to promote: *Values-driven, evidence-based practices*.

Values-driven, evidence-based practices are defined as *practices that reflect key values of the California Mental Health System Stakeholders—such as recovery/resiliency and cultural competence—and which are supported by an identified level of scientific evidence*.

Introduction

The California Institute for Mental Health (CIMH) strategic goals identify the need to develop organizational capacity to assist county mental health program and other local system personnel understand, develop and implement *values driven evidence-based mental health practices*[1]. As a result, CIMH leadership, staff, board members, constituents and consultants have worked together to develop this agency plan.

The California Institute for Mental Health

CIMH grew out of, and remains responsive to, county mental health systems. Consequently, the values, visions and missions of the California Institute for Mental Health and the California Mental Health Directors Association share common themes. These themes include:

- A commitment to consumer and family-centered planning and services;
- A belief in the community as the right locus of care and living;
- A belief in the recovery and resiliency for adults and children/adolescents with psychiatric disabilities;
- An understanding of the critical nature of cultural differences and cultural competency; and
- A commitment to quality, including the discovery and implementation of those service and administrative practices that are supported by the strongest evidence available, with a commitment to tracking and improving client outcomes.

Since 1993, CIMH's projects—driven by the needs of county mental health systems and the consumers and families they serve—have grown. However, project funding often influences the Institute's activities and

[1] Subsequently called values/evidence-based practices or evidence-based practices.

agendas. As a result, CIMH conducts a multitude of programs, training sessions, and projects, each responsive to its own funding source. This Strategic Work Plan is part of a series of CIMH activities designed to unify its many projects with some common themes, and to set priorities for future services and programs, while still retaining the organization's critical strength: responsiveness to county mental health systems and to issues of immediate import for California's evolving mental health delivery system.

Why a Strategic Work Plan About Values-Driven, Evidence-Based Practices?

During the 1990s, the drive toward quality and accountability in public-sector mental health care, coupled with new research on mental health service delivery technology, increasingly prompted researchers and policy-makers to use this research in mental health system planning and service delivery.

In order to participate effectively in this process, CIMH itself must become a learning organization, willing and able to change as new technologies develop. CIMH must identify, utilize, and promote development of effective practices based on the best available scientific evidence regarding the Institute's primary functions (i.e., training, providing technical assistance, initiating policy discussions and development, conducting research and evaluations, and disseminating information.) CIMH must know which administrative and service delivery practices are evidence-based, and how to best support local implementation of these practices. CIMH will support the identification of practices that are promising and will provide technical assistance, evaluation and research to help build the scientific knowledge base. This Strategic Plan is intended to help achieve those objectives.

The Strategic Planning Process

In the spring of 2002, the David and Lucile Packard Foundation funded a CIMH organizational development proposal to increase the Institute's capacity to promote evidence-based mental health practices. The Institute established a staff and board leadership group and engaged a consultant[2] for the project. The consultant conducted a number of key informant interviews, and convened a series of meetings with CIMH staff members and key stakeholders during the summer and fall of 2002. The resulting Strategic Work Plan draft was reviewed by CIMH staff members, the CIMH Board of Directors, and key stakeholders, as well as by national consultants with expertise in evidence-based practices. A draft of this Work Plan was presented at the CMHDA Full Association meeting in April 2003. The CIMH Board of Directors approved the final draft in September 2003.

Relationship of This Plan to Other Key CIMH Initiatives

In addition to this values-driven, evidence-based practices initiative, CIMH has other initiatives under way to encourage improvements in the delivery of mental health services in California. Two key initiatives involve cultural competence and recovery/resiliency. Each of these three initiatives embodies unique philosophies, ideas, and agenda recommendations. However, they share commonality in the fundamental values that distinguish all CIMH projects. Tensions between these initiatives help to drive the ongoing evolution and improvement of CIMH's work in each area. Proponents of cultural competency and recovery/resiliency have expressed concerns about the lack of scientific evidence supporting mental health practices such as peer support services or traditional healing ceremonies that incorporate these core values. Likewise, current practices that have strong scientific support rarely have been tested specifically with different ethnic groups to verify that they are unilaterally effective among all populations. Hence, each of these initiatives will contribute to, and benefit from, the others.

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[2] Pamela S. Hyde is an attorney with considerable administrative experience with public mental health and social service agencies including but not limited to tenure as the director of the Ohio State Department of Mental Health, Ohio State Department of Human Services and Seattle Department of Housing and Human Services. Her experience in private nonprofit behavioral health management includes serving as the president and CEO of COMCARE, and Ms. Hyde has held the position of senior consultant to The Technical Assistance Collaborative, Inc.

Key Terms and Concepts

CIMH is interested in helping California's mental health system to develop evaluative mechanisms to assure the effectiveness of all its services and administrative practices. The need for accurate evaluative processes becomes most apparent when practices, supported by a range of identified levels of scientific support, are considered in context of the values to which the public mental health system is committed. Therefore, this Work Plan uses the term **values-driven, evidence-based practices** to reinforce the integration of these two concepts in identifying and promoting effective mental health practices.

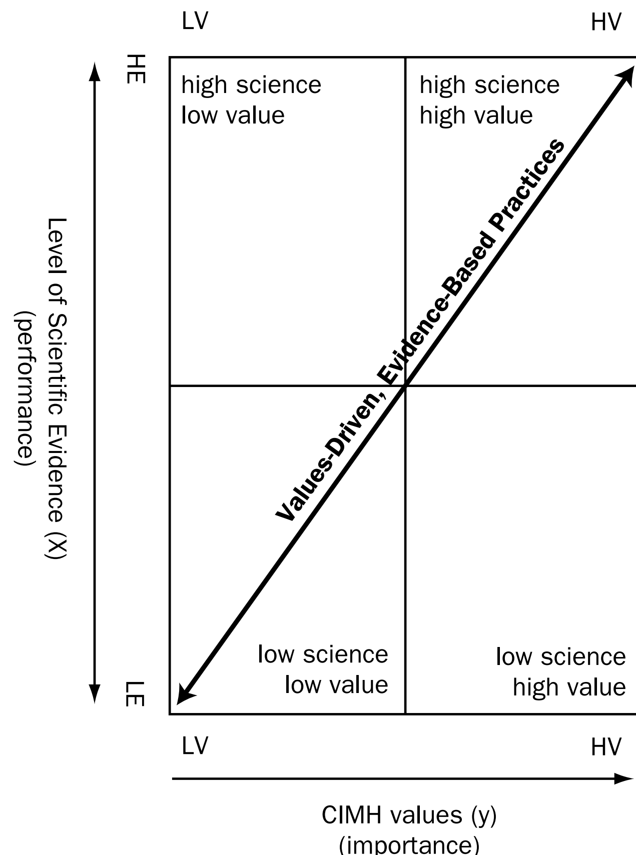
The concept of values-driven, evidence-based practices first posits that stakeholder values must drive the research and implementation of evidence-based practices. Priority must be given to those practices with a high level of scientific support that are also consistent with the recovery/resiliency vision and principles of cultural competence. Similarly, we must identify practices that embody the recovery vision and cultural competence that have not been adequately investigated, and must promote their inclusion in the scientific agenda. CIMH will promote research models that are consistent with recovery/resiliency and cultural competence, and are intended to increase understanding of consumer self help, family partnership programs, and other important traditional healing practices.

Values-driven, evidence-based practices theory next assumes that a broad definition of ***evidence*** encompassing different levels of evidence must be identified when describing scientific support for practices, to allow research information to respond to key stakeholder values. CIMH relies upon the concept of a ***hierarchy of scientific evidence*** to acknowledge the existence of numerous types of scientific evidence ranging from rigorously designed research trials to systematic observations, including those that are a part of a structured continuous quality improvement process. The level of evidence in this hierarchy supporting a practice determines the relative strength of the scientific evidence for that practice.

The matrix (at right) illustrates the approach by which CIMH will assess practices.

CIMH also promotes the concept of ***evidence-based thinking*** to describe a process by which practitioners stay abreast of all levels of scientific evidence and integrate this understanding with key values, in order to best serve consumers and families in achieving the outcomes they desire. Evidence-based thinking is consistent with Sackett's definition of evidence-based practices in the physical health care field—"the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients." This definition establishes that program administrators or practitioners must be cognizant of a) who they are trying to serve {the salient characteristics of the individual or population, including culture, history, support system, diagnosis and symptoms}; b) the outcomes they are trying to achieve {determined with the individual/family or representatives of the population to be served}; and c) the strength of the evidence available—whether from controlled trials, evaluations, observations, or consensus opinion of professional or stakeholder groups—about what might be effective in achieving those desired outcomes.

Matrix of Values-Driven, Evidence-Based Mental Health Practices



Objectives and Strategies for FY 2003–2005[3]

CIMH has developed four objectives and related strategies which are described below. The time frame indicated after each strategy relates to the date on which CIMH expects to *begin* work. "Immediate" means within six months; "mid-range" means within 12 to 18 months; and "long-range" means 18 months or longer.

Objective One: To increase CIMH's capacity to provide leadership in the identification and implementation of values-driven, evidence-based mental health practices.

Strategies:

A. Increase the CIMH staff's knowledge of concepts related to research, science, and dissemination and diffusion clinical and administrative practices considered to be evidence-based. **[Immediate]**
B. Assure that all CIMH staff members understand the stages of organizational change, how to identify and eliminate barriers, and how to use incentives to improve the implementation of effective mental health practices. **[Immediate]**
C. Identify and catalogue evidence-based service and administrative practices in use within the California public mental health system, including promising and emerging practices, for use by CIMH staff members and stakeholders. **[Mid-range]**

Objective Two: To increase CIMH's capacity to include values-driven, evidence-based practices content in its work and to apply evidence-based approaches to knowledge exchange and skill development in CIMH's consultation, training, and technical assistance activities.

Strategies:

A. Require all CIMH staff members to understand the range of evidence-based practices concepts (for example, effective, efficacious, promising, and emerging) and incorporate them into the design and methods for training sessions, technical assistance, and information dissemination activities, while applying principles of adult learning styles and organizational behavior change. **[Immediate]**
B. Assure that evidence-based practices concepts and content are incorporated into every CIMH project. **[Mid-range]**

Objective Three: To increase CIMH's capacity to help personnel of county mental health systems identify and remove barriers and create incentives to support adoption of values-driven, evidence-based mental health practices in California.

Strategies:

A. Identify barriers interfering with implementation of evidence-based practices capable of producing person-centered, culturally competent assessment, treatment planning, and service delivery. Targeted impediments could include financial, structural, clinical, political, philosophical, human resource or other barriers. **[Immediate]**
B. Sponsor discussions with public mental health stakeholders intended to build strategies to overcome identified barriers and create incentives for implementation of evidence-based mental health practices; identify specific action steps, responsible personnel, and time lines for each action step. **[Mid-range]**
C. With public mental health stakeholders, develop options for introducing disincentives to mental health practices proven through research to be ineffective in producing constructive consumer/family outcomes; develop specific recommendations to induce discontinuation of practices that have been proven to be ineffective or harmful. **[Long range]**

Objective Four: To increase CIMH's leadership capabilities in the evaluation and research of mental health practices in California.

Strategies:

A. Infuse the CIMH staff with the knowledge and capacity to conduct research and to review, analyze, and utilize research literature and findings. **[Immediate]**
B. Develop an action agenda for needed research about values-driven, evidence-based mental health service and administrative practices in California. **[Long range]**
C. Identify research and evaluation priorities to advance effective practices, including promising and emerging practices within California. **[Long range]**

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[3] Each of the strategies identified here has numerous associated specific action steps to assure they are accomplished and that success can be measured. Once these strategies and action steps are finalized, time lines and responsible parties will be identified as part of the final Strategic Plan.

INTRODUCTION

Summary Statement

The California Institute for Mental Health (CIMH) values the use of scientific information in mental health system planning and service delivery. A key component of this process is the promotion of "evidence-based practices," a term that has many meanings. CIMH recognizes that science is not the only determinant of the worth of a mental health practice, and maintains that evidence-based practices are relevant only when various levels of scientific evidence and stakeholder values are factored together.

For purposes of this document and the work that CIMH conducts, CIMH will emphasize the incorporation of the values of the California mental health delivery system and evidence-based practices to promote: ***Values-driven, evidence-based practices.***

Values-driven, evidence-based practices are defined as *practices that reflect key values of the California Mental Health System Stakeholders—such as recovery/resiliency and cultural competence— which are supported by an identified level of scientific evidence*.

The California Institute for Mental Health (CIMH) strategic goals identify the need to develop organizational capacity to assist county mental health programs personnel understand, develop, and implement *values-driven, evidence-based mental health practices*[4]. As a result, CIMH leadership, staff, board members, constituents and consultants have worked together to develop this agency plan.

This plan is the result of the efforts of CIMH staff and board members, constituents and consultants, and is designed to increase CIMH's incorporation of concepts and processes that identify and support evidence-based practices services; to identify the objectives that CIMH personnel need to enhance their knowledge and capacity about evidence-based practices service and administrative practices; and to decide upon strategies and action steps CIMH will take to achieve these objectives.

This plan has three purposes: 1) to document the history of CIMH's planning process; 2) to identify and describe key concepts and terms and CIMH values related to the implementation of evidence-based mental health practices in California; and, 3) to provide a reference point for the objectives, strategies, and actions that CIMH has determined it will undertake to develop its capacity to help county mental health systems in California incorporate values-driven, evidence-based practices. This process will support efforts by administrators of public mental health systems to understand, implement, and evaluate services and programs that are effective in helping mental health consumers and their families achieve better outcomes and lives that are meaningful and satisfying.

This document evolved as CIMH has pursued its planning efforts, and is written for two different audiences. Firstly, it is meant for internal use by CIMH Board and staff members. Secondly, it is intended to supply CIMH stakeholders and colleagues with supporting documentation about evidence-based practices.

[4]Hereinafter referred to as values/evidence-based practices or evidence-based practices interchangeably.

THE CALIFORNIA INSTITUTE FOR MENTAL HEALTH

CIMH History

The California Institute for Mental Health (CIMH) was established in 1993 at the behest of the California Mental Health Directors Association (CMHDA) to provide training, education and research support to the public mental health system in California. CIMH was established as a tax-exempt 501(c)(3), non-profit organization, able to receive foundation and governmental funding. Initially, the CIMH and CMHDA Boards of Directors shared the same membership. In 1999, CIMH established a separate Board of Directors with broader membership representing mental health consumers, family members (of both children and adults), and persons representing the public interest. County mental health directors continue to have a strong presence on the Board of CIMH.

Because CIMH grew out of, and is still responsive to, county mental health systems, the CIMH mission and vision statements must be viewed in the context of those of CMHDA.

CMHDA's mission is to assure:

. . . *the accessibility of high-quality, cost-effective mental health care for the people of California. Principal goals are to*

advocate for high-quality mental health systems of care that are culturally competent, consumer-guided, family-sensitive, and community-based.

CMHDA's values can be expressed in eight statements:

1. Healthy families require healthy communities; healthy communities are built through the partnership and collaboration of the public and system stakeholders.
2. Community collaboration assures that a safety net is in place and that no one falls through the cracks of the system of care.
3. Consumers, families/caregivers, and advocates form the nucleus for the design, operation, and governance of the public system.
4. Services will be consumer-guided, culturally competent, recovery[5]-oriented, and planned and delivered with the participation of families/ caregivers in age-appropriate systems of care.
5. Services will be clinically of high quality, developed according to evidence and best practices, and organized to assist consumers to achieve satisfactory outcomes, including goals related to physical health, housing, education, employment, and other activities.
6. Services will be provided with the engagement of the client, and with dignity, respect, and choice of services, regardless of the setting in which services are delivered or the legal status of the consumer.
7. Measurement and reporting of consumer satisfaction and system achievement of outcomes will be routine services delivery components.
8. Service systems will promote public understanding and awareness of mental illness, the damage caused by stigma and discrimination, and the public benefit of high-quality care.

CIMH Vision, Mission, and Values

CIMH's vision is "a culturally competent mental health service system, within communities that sustain and support families and children, support resilience, recovery and self-determination for persons with psychiatric disabilities, and which promote mental health and wellness."

[5]See discussion later in this plan regarding the concept of recovery and the related concept of resilience.

CIMH's mission is:

To promote excellence in mental health services through training, technical assistance, research, and policy development.

CIMH's values can be expressed in 10 statements:

1. Consumers, family members, providers, and policymakers must work in partnership to assure that services enhance each individual's integrity and dignity.
2. Healthy communities are measured by the extent to which persons with psychiatric disabilities can lead meaningful and productive lives free of stigma and discrimination.
3. Mental health systems must be culturally and linguistically competent in order to be effective.
4. All people, regardless of resources, must have access to necessary mental health services.
5. Mental health systems must be organizations in which people are valued, safe, eager to work, and which funders are proud to support.
6. Excellence in mental health services is grounded in capacity building and support to local systems and their partners.
7. Collaboration of the mental health system with the community and with other human services is essential to the resilience, recovery, and wellness of adults and children with mental illness and emotional disturbance.
8. Mental health systems must be accountable, cost effective, and must achieve beneficial outcomes.
9. The California mental health system must reflect and promote the values and needs of individual consumers, families, and local mental health systems.
10. Scientific information must be utilized in mental health system planning and service delivery with a focus on positive consumer outcomes. However, evidence-based practices are relevant only when various levels of scientific evidence and stakeholder values are factored together.

CIMH Strategic Goals

In the fall of 2001, CIMH established 10 strategic goals to guide its work in the foreseeable future. These position statements, which CIMH updated in September 2003, are:

GOAL 1: Utilize constituent partnerships throughout CIMH activities to promote integrity and

dignity, eliminate stigma and discrimination, and promote community involvement in mental health and wellness.

GOAL 2: Work to build healthy communities and reduce stigma and discrimination by supporting resilience, recovery, and self-determination for people with psychiatric disabilities.

GOAL 3: Support the continuous development of a mental health system that sustains effective practices for people who are diverse in race, culture, ethnicity, language, gender, sexual orientation, disability, and life span.

GOAL 4: Promote a mental health system that is accountable and that enhances providers' knowledge and skills of effective outreach, engagement, treatment, support, and retention practices.

GOAL 5: Support the ongoing training and recruitment of culturally competent human resources personnel dedicated to improving quality in the workplace.

GOAL 6: Identify high-priority subjects for training sessions, technical assistance, research, and policy analysis that will improve the local mental health systems.

GOAL 7: Maintain, develop, and strengthen partnerships with the community and with other human service agencies in order to define and enhance shared values and goals and to collaborate in the development of CIMH projects.

GOAL 8: Help mental health systems and their partners achieve continuous quality improvement (CQI) through the dissemination and diffusion of effective programs and practices.

GOAL 9: Enhance the effectiveness of local mental health systems and their partners by actively participating in national initiatives.

GOAL 10: Conduct research, training, technical assistance, and policy development programs that have a strong base of evidence and reflect CIMH values.

These goals have themes in common with CMHDA's and CIMH's values, visions, and missions. These themes include:

- A commitment to consumer and family-centered planning and services;
- A belief in the community as the right locus of care and living;
- A belief in recovery and resiliency[6] for adults and children/adolescents with psychiatric disabilities;
- An understanding of the critical nature of cultural differences and cultural competency; and
- A commitment to high quality, including the discovery and implementation of service and administrative practices that are supported by the strongest evidence available, with determination to track and improve client outcomes.

These themes reflect the driving values, beliefs, and commitment that motivated CIMH to undertake this Strategic Planning process to encourage use of science and research information promoting evidence-based mental health practices; and to inform CIMH technical assistance, training, research, and information dissemination activities.

The Importance of This Strategic Work Plan

Since 1993, CIMH's projects have been driven by the needs of county mental health systems and the consumers and families they serve. These projects have been supported by public and private grant funding, as well as by training fees charged to public mental health agencies. The funding for these projects has tended to drive the agenda and the activities of CIMH, which consequently established a multitude of programs, training sessions, and projects, each responsive to its own funding source. This Strategic Work Plan is part of a series of activities through which CIMH is unifying its projects with common themes, and setting priorities for future services and programs. CIMH is committed to retaining its responsiveness to county mental health programs and to issues of immediate import for California's evolving mental health delivery system through this process.

CIMH has grown rapidly, from 1.5 staff positions in 1993, to approximately 25 full- and part-time staff members in 2003. It has developed a reputation within the California mental health system for high-quality work. CIMH is respected and seen as a critical component of the public mental health system, well-suited to providing leadership within that system and objective information about mental health issues within the California Legislature and other key funding and policy-making bodies.

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[6]See the discussion of these terms and concepts later in this plan.

At the same time, CIMH has recognized a need to increase the connectivity and consistency between its projects. CIMH staff members and constituents acknowledge that its attempt to administer numerous projects for many constituents and funding sources sometimes results in attempts to be "all things to all people." CIMH also has identified the need to better incorporate the themes of cultural competence and recovery (a term used especially for adults and elders) or resiliency (a term sometimes used for children/adolescents and their families) into its many projects. Even though these issues transcend the scope of this Strategic Work Plan, it takes them into account through specific action steps. CIMH hopes to use the objectives and strategies identified in this plan as part of a foundation that enhances organizational quality and efficiency while specifically increasing capacity in service and administrative practices that are grounded in research.

WHY A STRATEGIC WORK PLAN ABOUT EVIDENCE-BASED PRACTICES?

No one disputes the need to assure that services and administrative activities within California's mental health system result in the best outcomes possible. Controlled research trials, evaluations, demonstrations, observations, and anecdotal evidence increasingly confirm the most and least effective everyday practices in the mental health field. "Evidence-based practices"[7] is a concept that has received significant national attention in public and private health and behavioral health systems in the 1990s and early 21st century. The relationship between this concept and mental health systems derives from a much longer tradition in evidence-based medicine.

Information identifying efficacious practices (those shown to achieve beneficial results in controlled research settings) and how to incorporate these practices into routine or non-controlled service delivery settings has increased exponentially during the last two decades. Likewise, the body of research investigating practices yielding beneficial outcomes in the complex and varied routine or usual care settings of publicly funded mental health care is growing more rapidly than ever before. New research and evaluations, more robust efforts to disseminate this information, and advanced technology's contribution to the availability of this information combine to create momentum for these efforts. However, this rapidly evolving research and information about evidence-based practices is not reflected in mental health system planning and service delivery.

This move toward quality and accountability, coupled with new research has resulted in a desire by researchers to see this new knowledge used by practitioners and decision-makers, along with a desire by policy makers to access and utilize this new knowledge. Often, misunderstandings of the research and misapplication of evidence-based practices impede this translation of research to practice.

Many publications have documented evidence-based practices and the gap between what we know and what we do in both physical health care and in the delivery of mental health services. The United States Surgeon General identified this gap as one causative factor resulting in inadequacy of mental health care for millions of Americans. Charles Curie, the administrator of the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), likewise speaks repeatedly about SAMHSA's commitment to the "science to services cycle." The National Institutes of Health (NIH) and particularly the National Institute of Mental Health (NIMH) are making renewed efforts to identify ways to improve the adoption of new service delivery technologies that arise from NIMH-funded research.

The National Association of State Mental Health Program Directors (NASMHPD) and its NASMHPD Research Institute (NRI), in collaboration with the SAMHSA Center for Mental Health Services (CMHS), has adopted the implementation of evidence-based practices as one of its cornerstone projects for the next few years. That policy reflects the deep commitment of state mental health commissioners to the infusion of evidence-based practices throughout publicly funded mental health systems of care in the United States. Likewise, the National Council of Community Behavioral Healthcare (NCCBH) represent-

[7] See discussion later in this plan about the meaning of this and related terms.

ing provider and county programs throughout the nation, and the National Association of County Behavioral Health Directors (NACBHD) representing county-based behavioral health program directors through the country, have decreed the implementation of evidence-based practices as a key goal of their associations.

Private foundations, such as the MacArthur Foundation, the Anne E. Casey Foundation, the Robert Wood Johnson Foundation, and the Center for Healthcare Strategies, have been leaders in identifying evidence-based clinical and administrative practices as critical to their health and mental health funding strategies. The prioritization of evidence-based practices results in their desire to fund those programs of research, evaluation and policy development that will be likely to achieve the best results for persons with mental disabilities.

In spite of, or as a result of, this growing recognition of the importance of evidence-based practices, researchers, administrators, funders, and policy-makers are recognizing that little is known about the most effective ways to assure that organizations and practitioners understand, accept, and adopt newer service delivery technologies. In fact, some researchers are now turning their attention to a review of general knowledge transfer and adaptation literature in manufacturing, marketing, and health care. These researchers are beginning to design and conduct research utilizing some of these concepts in the behavioral health care delivery system.

In this context CIMH has determined that implementation of evidence-based practices is a strategic goal for California's mental health delivery system and for its own efforts. CIMH has further resolved that building its capacity to help personnel in California's publicly funded mental health systems comprehend, identify, and adopt evidence-based practices is an important strategy toward reaching that goal. This means that CIMH itself must become a learning organization, willing and able to change as new technologies develop. CIMH must identify and utilize techniques based on the best available evidence about what it does (i.e., train, provide technical assistance, facilitate policy discussions and development, conduct research and evaluations, and disseminate information) as a part of its own learning process to better serve publicly funded mental health systems in California. Further, CIMH personnel must understand the level of evidence upon which administrative and service delivery practices are based and how to embrace practices that are promising and infuse them in technical assistance and evaluation/research programs to help to build the scientific knowledge base. After studying these concepts, CIMH leaders became resolved to development of this Strategic Work Plan to advance CIMH and CMHDA values, visions, missions, and goals.

THE STRATEGIC PLANNING PROCESS

Having identified cultural competence, recovery/resiliency, and evidence-based practices as important values and goals, CIMH utilized support from the David and Lucile Packard Foundation for an organizational development effort. The proposal aimed to strengthen CIMH leadership capacity to influence improvements in the quality of mental health services in California through the implementation of evidence-based practices (EBP). The proposal would increase CIMH's capacity to:

1. Identify and implement evidence-based and promising practices in the field of mental health;
2. Apply evidence-based practices and promising approaches for knowledge exchange and skill development in the provision of consultation, training, and technical assistance; and
3. Evaluate and research mental health practices in California.

The objectives are:

1. To assess CIMH's organizational capacity and readiness to provide leadership regarding knowledge and implementation of EBP in California;
2. To provide a basic training/presentation on EBP core concepts for CIMH staff and Board members, and critical colleagues;
3. To establish a process and criteria by which to evaluate CIMH's current and future projects in order to assure that the content and methods for conducting the project are as consistent with EBP as possible, and that CIMH is able to determine and report the results and outcomes of its work;
4. To develop a strategic work plan to prepare CIMH to provide leadership in identification, implemen-

tation, evaluation, and research of mental health EBP in California, using methods that embody EBP concepts to the greatest extent possible;
5. To identify or begin development of EBP materials and approaches for CIMH's use internally and in its work throughout California.

Project activities included: identifying leadership and advisory committees; preparing a bibliography and materials; holding a first meeting of CIMH leadership and constituents; drafting the initial Strategic Work Plan; holding a second meeting to review and revise the Work Plan; beginning to develop criteria for review and evaluation of projects, tools for assessing outcomes, a logic model for potential project success markers, and other materials; finalizing the Work Plan; and implementing the Strategic Work Plan.

Consistent with this proposal, a staff and Board leadership group and primary consultant[8] were identified in the spring of 2002. The consultant conducted key informant interviews of staff and Board members and CIMH constituents, facilitated planning meetings, and submitted draft Work Plans for review and comment. Two national consultants—Kimberly Hoagwood, Ph.D., director of Child and Adolescent Services Research, New York State Office of Mental Health, and Robert Drake, M.D., Ph.D., director of New Hampshire Dartmouth Psychiatric Research Center—reviewed and commented upon drafts of the Work Plan. The CIMH staff and Board began implementation of the plan in the winter and spring of 2003. The CIMH Board adopted the final Strategic Work Plan in September 2003.

As part of this planning process, key indicators of success were identified. These will be monitored, and progress on each indicator will be discussed with the CIMH Board over the life of the Strategic Work Plan. Adjustments will be made to objectives, strategies, and action steps, as well as to timelines, based on these monitoring reports.

[8]Pamela S. Hyde is an attorney with considerable administrative experience with public mental health and social service agencies including but not limited to tenure as the director of the Ohio State Department of Mental Health, Ohio State Department of Human Services, and Seattle Department of Housing and Human Services. Her experience in private nonprofit behavioral health management includes serving as the president and CEO of COMCARE, and Ms. Hyde has held the position of senior consultant to The Technical Assistance Collaborative, Inc.

RELATIONSHIP OF THE INITIATIVE TO PROMOTION OF RECOVERY AND CULTURAL COMPETENCE

CIMH adheres to core values that place importance on recovery and cultural competence. As a result, CIMH has key initiatives under way intended to improve its own performance in incorporating these values and to influence mental health services in California to better incorporate these values. Each of these initiatives is rooted in its own philosophy, ideas, and agenda, but all share crosscutting values that are not specific to any particular CIMH project or fund source. CIMH believes that unless evidence-based practices incorporate the concepts of cultural competence and recovery/resiliency, they will not be optimally effective nor will they be effective for all Californians served by the public mental health system.

Recovery and Resiliency

For adults with mental illness, the goal of any service or program should be to promote and support the individual in his/her recovery process. In order to accomplish that goal, services must be: a) person-centered—that is, individualized, taking into account the unique interests, strengths, culture, and history of each individual; b) consumer-directed—that is, based on the life goals the consumer wants to accomplish rather than on the treatment goals a professional or service delivery team might decree best for the individual; c) focused on helping individuals gain the skills necessary to manage their own services and find their own path to quality of life, utilizing the naturally occurring resources in the communities in which they live; and d) reaffirming existence of reason to be hopeful that individuals can regain a sense of self and of control over their lives and can achieve the goals they set for themselves, in spite of dealing with a major mental illness.

The California Statewide Wellness and Recovery Task Force has paraphrased CMHDA's[9] description of recovery as follows:

[9]Adult System of Care Framework, adopted by CMHDA on September 14, 2000.

a deeply personal and individual journey where people with a psychiatric disability can choose to partner with providers to achieve employment, obtain affordable and decent housing, create social and family supports, maintain a healthy lifestyle, achieve symptom and behavior management, have meaningful roles in their lives, and quite possibly enhance spiritual beliefs as an option for healing. . . . The important facets of recovery are: hope, empowerment, meaningful roles in life, spirituality, self-responsibility, medications, and peer education and support.

The concept of recovery does not always resonate with children/adolescents with serious emotional disturbance (SED), and their families. Serious emotional disturbance is conceptualized as a developmental condition, for which the concept of "recovery" may not be appropriate. The relationship of children/adolescents to their families or caregivers, and the role of family members or caregivers as "consumers" of mental health services, create qualitative differences among mental health service needs of children, adolescents and adult consumers.

Research shows that risk and protective factors can be identified and reduced or enhanced to promote beneficial outcomes for children/adolescents. Research further supports mental health interventions that are strength based, and suggest that outcomes are significantly improved when family members and/or caregivers are partners in service planning and delivery. This process has been described as helping the child/adolescent and his/her family gain resiliency to respond positively to all that life offers. Others have referred to this process as discovery.

Whatever the term, the idea of successful and productive living in the community as the goal is common to the idea of recovery for adults with mental illness and for children/adolescents with SED. In this Strategic Plan, CIMH uses both terms to include adults and children/adolescents in its planning.

Recovery/resiliency advocates are concerned that "evidence-based practices" (EBPs) will limit consumer choice. Some advocates fear that EBPs are delivered solely by professionals and result in professional-driven, or medical model, outcomes (i.e., symptom reduction, appropriate service utilization, and compliance with professionally prescribed treatments). Consumer advocates are often concerned that outcomes such as hope, empowerment, quality of life, and individualized goal setting and accomplishment usually are not measured in research. Some advocates also are concerned that EBPs will result in standardized services that allow no room for consumer choice or preferences. They express the concern that "science" (at least as practiced in university systems and as invoked to drive service design and availability) is too rigid to accommodate recovery/resiliency ideas that are holistic in nature and respond to the needs of the whole person, not just to medical or behavioral health needs. They perceive science and EBPs as emphasizing quantitative measures while viewing recovery as a subjective and qualitative process.

They also are concerned that effective practices that are consumer-driven, such as mutual aid, peer support, family/professional partnership or consumer-operated services, rarely receive attention from researchers or funding for research that would scientifically prove their worth. Few acknowledged consumers are among the ranks of academic researchers, and few researchers are focusing upon these practices.

CIMH is committed to overcoming these concerns by: a) working with consumer and family advocates to understand and respond to their concerns; b) helping consumers and families understand the value of identifying practices that are likely to be most effective in supporting recovery and resiliency so that science can be used to enhance, not limit, consumer decision making; c) identifying consumer-involved and consumer-accommodating research methods; d) assuring that outcomes of concern to consumers and families are included in research designs; e) focusing on and supporting research of consumer-driven practices. CIMH would like to engage consumers and families in determining which research questions need to be answered and in helping consumers and families learn how to use the results of scientific research to make truly informed choices about their care and services.

Cultural Competence

CIMH is committed to incorporating cultural competence within all of its work and to helping personnel throughout the California mental health system to understand the value of cultural considerations in service design and delivery. CIMH's efforts are spearheaded by its Center on Multicultural Development and currently include a statewide initiative funded by

The California Endowment to identify culturally specific practices in California, and to determine practices that are effective, promising, and emerging for ethnic subgroups.

CIMH and CMHDA held an initial statewide convention, and subsequent meetings at the state and regional levels to help identify subsequent steps for cultural competency in California. CIMH used the findings from those meetings to produce a draft plan to guide incorporation of cultural competence throughout California's mental health system. The document was titled *Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health—A Report to the Community*. CIMH has identified leaders in academia, mental health administration, communities of color, and mental health advocacy to advise their work on cultural competence. CIMH wants to assure that its work on multiculturalism is consistent with its work to support evidence-based practices. And, it wants to assure that its work identifying and supporting the implementation of evidence-based mental health practices recognizes the importance of culture in determining what is effective for different populations and for individuals within diverse populations. In fact, CIMH believes that person-centered assessments of strengths and needs, as well as services planned and delivered, cannot be effective unless they reflect an understanding of the individual's culture and history, and the role of that culture and history in the course of the mental illness/serious emotional disturbance and in the process of recovery and resiliency.

The Statewide Wellness and Recovery Task Force cautions that:

> *it is also important to remember the importance of cultural competency as a part of the healing process. This includes the cultural identities and world views of consumers that help to shape health and healing beliefs, practices, behaviors, and expectations of recovery. Each individual and each cultural group therefore uniquely defines wellness and recovery.*

Many advocates of cultural competency also have expressed concern about evidence-based practices. Similar to the consumer stance articulated earlier, these advocates speculate that the research community does not include diverse populations in studies, that it cites results of research in the absence of clear descriptions of the limitations associated with the ethnic/cultural/racial makeup of the study populations, that it does not conduct research investigating nontraditional healing practices, and that it promotes developing practices and outcomes that do not reflect cultural values and beliefs. For example, research outcomes have not historically reflected cultural considerations. Independent living has been considered a positive outcome in most adult mental health research. However, that outcome may not be as critical for persons of Asian or African American cultures that place a high value on the interdependence of family members. Cultural variability may require different research methods that incorporate representatives of communities studied, acknowledge unique views of science, and respect the value communities place upon the different ways they view the world. Cultural competence must drive research to identify evidence-based practices for diverse populations.

Recovery/Resiliency, Cultural Competence and Evidence-based Practices

Cultural competence and recovery/resilience are core values that must be incorporated within any practice with scientific support to assure the best outcomes possible. And specific practices that support cultural competence and recovery/resilience are in need of a stronger evidence base. Each of these three CIMH initiatives share challenges, and in some cases similar strategies, that will enable CIMH to be more efficient in creating internal as well as external organizational change. Hence, each of these initiatives will strengthen and benefit from the others.

KEY TERMS AND CONCEPTS

The Term "Evidence-based Practices" — Effective and Efficacious Practices

The term "evidence-based practices" has both a broad meaning (i.e., any practice that has some level of scientific, consensus or anecdotal evidence of having worked better than something else) and a narrow meaning (i.e., those practices that have met the criteria for strict scientific evidence of efficacy in clinical controlled trials with comparison groups sufficiently large to illuminate meaningful differences among sub-

jects). Dr. Robert Drake, a leader in the field of mental health evidence-based practices, defines the term as "interventions or practices for which there is consistent scientific evidence showing that they improve client outcomes" for specific targeted populations with specifically identified outcomes.

The Institute of Medicine, in its recent groundbreaking report on the quality of health care in America, *Crossing the Quality Chasm*, presents perhaps the best definition of this term. Evidence-based practice is the integration of the best research evidence with clinical expertise and patient values.

This definition combines the idea that practice should be based first on a consumer's or family's desires for their own recovery and resiliency process, and then should be driven by the best research evidence. In each case, the consumer, family member, and clinician's judgment and expertise will jointly guide the service delivery process. This shared decision-making is critical to the success of treatment. This process combines a commitment to recovery and resilience, a respect for the family or person-centered service planning, and an understanding of the value of culturally specific service delivery.

In this document, CIMH uses the term "evidence-based practices" to mean practices that have some level of scientific research support (see discussions of the hierarchy of scientific evidence and evidence-based thinking later in this plan). Acknowledgement of the level of scientific support, and consideration of the relationship of all practices to the values embraced by stakeholders of the mental health system, are important.

What is a Practice and Who Are Practitioners?

Practices are activities, services, or programs implemented to assist consumers and families achieve better outcomes and a more satisfying quality of life. Practices may be administrative—for example financial management, human resource development, or information system design and management. Practices also may be clinical, delivered by clinicians, lay staff members or volunteers, or consumers, families or peers.

Any person from any of these groups is a "practitioner." CIMH uses the term practitioner as broadly as possible.

The Terms "Science" and "Evidence"

Some people disparage the term "science," equating it with only the most rigorous of randomized controlled research trials with comparison groups, often conducted by university-based researchers, and documented via established refereed journals. While this is certainly an important form of scientific investigation, CIMH considers the term "science" to be much broader. In fact, "science" can refer generally to any attempt to investigate the causes and effects of various practices and is really the process of that investigation. A scientific method simply investigates what will happen (often based on previous observations or anecdotes) if a given practice is implemented in a specified way, with a specific group of individuals, in a specific set of circumstances.

Various approaches to investigating questions are forms of scientific inquiry and are all types of "evidence." Some approaches and methods are more likely than others to isolate what really makes a difference for a given population, and therefore can be replicated to yield the same beneficial effect. The investigative process encompasses what is called a "hierarchy of scientific evidence."

Hierarchy of Scientific Evidence

CIMH personnel, along with its consumer, family, practitioner, provider, and public authority stakeholders, believe that all types of scientific evidence about what is effective for service recipients and their families or for communities are important and should be considered in deciding the best practice to implement at a system level or for a given individual or family.

A "hierarchy of scientific evidence" is a range of types of evidence from the most controlled experimental designs (randomized assignment to test condition and control groups, multiple sites, and large number of subjects) to anecdotal evidence (the experience of a practitioner, consumer/family or organization). The strength of the evidence is judged by the degree to which it approximates or deviates from the most scientifically controlled studies. It is important to note that this does not mean that other forms of scientific inquiry or other forms of evidence are unimportant or

wrong. Rather, differing types of evidence provide variable means to evaluate the strength of the causal relationship for the population studied. A practitioner, consumer or family member can be assured that a practice supported by more rigorous and numerous studies will likely achieve similar beneficial results when delivered in a similar manner to a similar population. Even so, that does not negate the fact that individual practitioners or consumers/families may experience desirable results with other kinds of practices based upon other kinds of evidence.

To describe the hierarchy of scientific evidence CIMH will adopt the following terminology: effective practices, efficacious practices, promising practices, and emerging practices.

Effective and Efficacious Practices

Effective practices have the strongest scientific support. An effective practice or program is one that has been found to be effective in at least two independent, methodologically strong studies (e.g. random assignment) in usual care settings. When implemented with fidelity, with similar clients, these approaches have the greatest likelihood of achieving similarly beneficial results. Efficacious practices and programs have the same strength related to research design, but have been studied only in research settings with tightly controlled populations. An efficacious practice has been found to be effective in at least two independent, methodologically strong studies (e.g., random assignment) in controlled settings. The successful implementation of these approaches in a usual care setting has not been tested.

Promising and Emerging Practices

Promising and emerging practices are terms to identify practices with less rigorous levels of evidence supporting them. CIMH uses the term "promising practices" to refer to services or administrative practices that are supported by some level of scientific evidence, but which have not yet been tested in randomized controlled experimental designs with comparison groups, replicated by multiple researchers in multiple sites. For example, practices supported by research based upon quasi-experimental models, such as time series design, pretest post-test design, and non-equivalent control group research design are promising practices.

An "emerging practice" is often an innovation that has strong rationale supporting it but does not yet have much evidence beyond anecdotal, unsystematic observations, a single evaluation, and/or expert consensus to support the claim that it improves outcomes or performance.

Evidence-Based Thinking

CIMH maintains that incorporation of values-driven, evidence-based practice will require a systemic culture change that instills the process of evidence-based thinking into system planning and service delivery. Sackett defined evidence-based practices in the physical health care field as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients." The National Institute of Mental Health (NIMH) has utilized this same definition in its Request for Applications (RFA) to Implement Evidence-Based Practices to State Mental Health Authorities (SMHAs). Sackett's definition describes an evidence-based thinking process when dealing with individual patients or consumers/families. That is, program administrators or practitioners must be cognizant of: a) who they are trying to serve {the salient characteristics of the individual or population, including culture, history, support system, diagnosis and symptoms}; b) the outcomes they are trying to achieve {determined with the individual/family or representatives of the population to be served}; and c) the various evidence available, whether from controlled trials, evaluations, observations, or consensus opinion of professional or stakeholder groups, about what might be effective in achieving those desired outcomes. We believe that a similar process must be applied to system development and service delivery.

Evidence-based thinking calls on all practitioners and administrators to stay abreast of effective, efficacious, promising and emerging practices, to enable them to assist consumers/families in achieving the outcomes they desire. Evidence-based thinking also requires a continuous quality improvement process to measure the service fidelity to the model and the outcomes achieved, and to determine what influenced the outcomes and to identify which changes may produce better results. Evidence-based thinking takes into ac-

count the realities of the often under-resourced, complex public system of care and the vagaries of the various geographic settings in which programs and practitioners work. However, evidence-based thinking is more than just "doing the best you can with what you've got." It is a structured process through which the best available evidence is brought to bear in each individual situation (whether for a particular individual/family or a population group) to create the best possible chance for desired outcomes as defined by that individual, family or group.

Relationship to Quality Improvement Processes

Linking effective practices to a system's quality improvement processes is of critical importance. The quality improvement process requires a predetermination of anticipated outcomes and the processes that achieve those outcomes. These methods may include implementation of a new practice or provision of additional training or supervision to assure that the practice emulates the service model as clearly as possible . The quality improvement process must determine the data that will generate the information necessary to measure outcomes, and the manner in which the data will be collected and reported.

When evidence-based practices deviate from the model (i.e., without fidelity), outcomes are much less predictable at best and may be much poorer at worst. A strong quality improvement process allows systems to determine whether or not an evidence-based practice is conducted with fidelity to the model, and whether or not outcomes are consistent with research. It also can allow some assessment of the impact of an adaptation of the model that better reflects the needs of the consumer or system.

CIMH is committed to working with DMH, CMHDA, the Statewide Quality Improvement Council (SQIC) and stakeholders to support the integration of evidence-based practices and fidelity monitoring to enrich the quality improvement process.

Knowledge Dissemination and Diffusion

Awareness and understanding of evidence-based practices are by themselves insufficient to change service delivery. Enacting evidence-based practices is a difficult and complex process. Little is known about ways in which to successfully promote the introduction of evidence-based practices with fidelity in routine or usual care settings.

Many terms are used in this process. For example, NIMH distinguishes between "diffusion" ("the intended or unintended spread of information and/or treatments through the health services field") and "dissemination" ("the targeted distribution of a well-defined set of information"). Sometimes the term "transportability" is used to reference the process of moving research findings from a controlled setting to a non-experimental or usual care setting (see Hoagwood, et al.).

Adoption, Adaptation and Moving to Scale

Mental health services personnel must recognize that effective or efficacious practices are sometimes "adopted" (the process of planning, engaging, and sustaining new practices that may include behavioral changes at an individual or organizational level), while other times practices are "adapted" (that is, implementing a practice without complete fidelity to the model). When a practice is adapted, monitoring outcomes is of even more critical importance to determine whether the adaptation affects the outcomes achieved. If not, implementation of an adapted practice may not be effective.

Another important concept in a system is "moving to scale." This is the process of moving a practice from a pilot or experiment in an easily controlled environment to control to a large number of situations, geographic locations, clients, or practitioners. Losses in adherence to fidelity often occur when practices are enacted on a large scale, with a reduction in desirable results. Careful planning and monitoring of outcomes are critical in such circumstances.

Organizational and Individual Readiness to Implement and Sustain New Practices

Organizations and individual practitioners are not equally ready or able to engage evidence-based practices. Organizations must progress through developmental stages to successfully initiate new practices. NASMHPD identifies five stages of organizational change: unaware/uninterested, motivating, implementing, sustaining, and improving. Prochaska & Levesque (2001) identify the five stages as precontemplation,

contemplation, preparation, action, and maintenance. Sometimes these stages are collapsed into three:

a) contemplation/consensus-building;

b) enactment/implementation; and

c) maintenance/sustenance.

Sustainability of a new practice references the degree to which an organization or individual continues to implement a practice, especially with fidelity. Assessment of, and attention to, the stage of the organization into which a new practice will be introduced will be crucial for CIMH to assure successful infusion and sustainability of evidence-based practices. The use of continuous quality improvement, as discussed earlier in this section, is important for this process.

Just as organizations may be more or less ready to adopt changes in practice, individual practitioners will have issues that affect their willingness and ability to adopt a new practice. Factors affecting individual readiness include the complexity of the practice, the skills of the individual, the difference between the new and current practice, the motivation for the adoption of the new practice (i.e., voluntary, compulsory), the champions or opinion leaders encouraging the change in practice, and available supervision and support (including reaction to results). Organizational variables that can influence individual adoption of a new practice include, but are not limited to, organizational structure, policies and procedures, payment mechanisms, organizational or individual culture, comfort with change, size or age of the organization, history or experience with other recent changes, and mandates or incentives.

Individual practitioners are sometimes said to be resistant to change or to implementation of new practices. Resistance or reluctance may reflect factors of individual readiness or the systemic influences and barriers to adoption described above. CIMH assumes that all practitioners want to provide effective person-centered, culturally competent care for consumers and their families. CIMH will work to support practitioners and systems to identify and ameliorate barriers, and promote incentives to adopting evidence-based practices.

OBJECTIVES, STRATEGIES & ACTIONS—FY 2003–2005

Wherever population or age references are made or implied, CIMH intends to enact these action steps with attention to the specific and unique needs of men and women (or girls and boys), toddlers, children/adolescents, transition-age youths, adults, and elders. Steps unique to any population will be identified.

Finally, note that the "immediate" reference means that as of December 2003, CIMH will have begun enacting the strategy or is scheduled to do so within six months; "mid-range" means CIMH planned to begin the strategy within six to 18 months; and "long range" means CIMH planned to begin the strategy sometime after 18 months from the final adoption of this Plan.

Objective One: To increase CIMH's capacity to provide leadership in the identification and implementation of evidence-based mental health practices.

Strategies:

A. Increase CIMH staff's knowledge of concepts about evidence, effective and efficacious practices, and related concepts, and about those clinical and administrative practices considered to be effective. **[Immediate]**

Action Step 1.A.1: Develop and conduct a mandatory training curriculum for all CIMH staff members on EBP core concepts and terms.

Action Step 1.A.2: Catalogue all available research literature on service and administrative practices in the mental health and related human services areas in which CIMH is working; incorporate into abstracts information about recovery/resiliency-related outcomes, ethnic groups involved or culturally competent research methods, age and gender references, and type and strength of the evidence to help CIMH staff members understand the usefulness of the research literature and its limitations.

Action Step 1.A.3: Develop a resource library, to make available abstracted information with references to additional documentation about evidence-based practices, for CIMH staff members and the public sector mental health field in California; as-

sign staff members to maintain and manage the resource library to assure its currency and usefulness.

B. Assure that all CIMH staff members understand the stages of organizational change, how to identify and eliminate barriers, and how to use incentives to improve the implementation of evidence-based mental health practices. **[Immediate]**

Action Step 1.B.1: Develop and engage a mandatory training curriculum for all CIMH staff members describing stages of organizational and individual change, incorporating the concepts of barriers and incentives.

Action Step 1.B.2: Assess for CIMH as an organization and for each CIMH staff person the organizational and individual barriers and possible incentives for learning about and incorporating evidence-based mental health practices and educational and implementation practices in their work; develop an action plan to remove barriers and create incentives for such learning and utilization of evidence-based practices.

Action Step 1.B.3: Develop protocols for assessing organizational and individual readiness for implementation of specific new evidence-based practices.

C. Identify and distinguish for CIMH staff and Board members (and ultimately for stakeholders) CIMH's priorities and cross-cutting principles. **[Immediate]**

Action Step 1.C.1: Engage in a discussion with CMHDA staff and Board members and with DMH regarding the respective roles of CIMH, CMHDA and DMH in supporting the identification and implementation of evidence-based mental health practices throughout California.

Action Step 1.C.2: Create a matrix of CIMH priorities and cross-cutting principles (including but not limited to recovery/resiliency, cultural competence, and use of evidence-based practices) illustrating how they will be expected to interact within each priority or project.

Action Step 1.C.3: Disseminate information to stakeholders on the draft priorities and solicit their reactions and principles matrix; refine the matrix based on their responses; review and revise the priorities and principles matrix annually and redistribute.

Action Step 1.C.4: Utilize the matrix for the Board's review of projects and of the Executive Director's performance, and for management staff's use in determining what projects to seek out or undertake and which to forgo; also use the matrix for evaluation of each project leader's performance in incorporating cross-cutting principles.

Action Step 1.C.5: Distinguish between the various types of training and technical assistance provided by CIMH; create a framework that identifies the differences between instruction, demonstration, mentoring, coaching, investigation, recommendations, technical assistance, needs assessment and other functions, along with guidelines specifying when each type of approach should be used based on the desired outcomes of the CIMH project or activity.

D. Identify and catalogue evidence-based practices service and administrative practices in use within the California public mental health system, including promising and emerging practices, for use by CIMH staff members and stakeholders. **[Mid-range]**

Action Step 1.D.1: Develop criteria for determining effectiveness of service and administrative practices that incorporate recovery/resiliency and culturally specific outcomes.

Action Step 1.D.2: Ask staff members and stakeholders to assist in identifying practices that work or are effective in supporting the recovery of children/adolescents with emotional disturbance and adults with mental illness, using criteria developed in Action Step 1.D.1.; survey California public mental health system programs and providers as necessary to identify such practices.

Action Step 1.D.3: Using criteria developed in Action Step 1.D.1., catalogue each practice identified as effective, efficacious, promising, or emerging, with a common format for describing the practice, the population for whom the practice is meant, the proven or expected outcomes or performance results, summaries of the sources of information about the evidence that supports the practice including any fidelity scales available, and references for finding out more about the practice; make this catalogue available electronically to CIMH staff members and stakeholders.

Objective Two: To increase CIMH's capacity to include evidence-based practices content in its work and to utilize effective approaches to achieve knowledge exchange and skill development in the provision of CIMH's consultation, training, and technical assistance activities.

Strategies:

A. Assure that all CIMH staff members understand and can incorporate evidence-based practices concepts (including promising and emerging practices) into the design and methods for training sessions, technical assistance, and information dissemination activities, utilizing knowledge of adult learning styles and ways in which behavior changes occur in organizations. **[Immediate]**

Action Step 2.A.1: Review research on adult learning styles and training methods, identifying which approaches work best in which settings and circumstances, with which audiences, and with which anticipated outcomes.

Action Step 2.A.2: Develop and conduct mandatory training on this research for all staff members.

Action Step 2.A.3: Develop guidelines regarding the methods and approaches to use with particular audiences; distribute guidelines for use by presenters.

Action Step 2.A.4: For each training, workshop, conference, technical assistance session, and document or policy paper, identify the intended audience, the pre-requisites or skills expected of audience members, and what the audience can expect to learn or accomplish.

B. Assure that all CIMH projects are conceived, implemented and reviewed to achieve optimal results. **[Immediate]**

Action Step 2.B.1: Develop a format and protocol for project descriptions that will require articulation of project goals and/or learning objectives, audiences or affected groups, approach or method (based on audience), community resources, and collaborators to develop the content of the project or training; identification of expected measurable results and the people or organizations that are involved, and the evaluation/review method and timeline that will be employed to determine if the expected results materialized.

Action Step 2.B.2: Review, reassess and revise the audience evaluation instrument and methods to reflect the desired results of the training or project offering; conduct follow-up evaluations that include questions about actions that trainees or participants/users took as a result of the training or project.

C. Increase understanding of and commitment to effective, efficacious, promising, and emerging practices, diffusion, transportability, and related concepts by public sector mental health systems in California. **[Immediate]**

Action Step 2.C.1: Host a series of discussions about these concepts including consideration of barriers to and incentives for implementation of evidence-based mental health practices; include a dialogue about organizational and individual readiness criteria and roles of CIMH, county mental health systems, contract providers, practitioners/guilds, consumers, families, state government agencies, advocates, and other key stakeholders in supporting identification and implementation of such practices and in identifying and removing barriers and implementing incentives.

Action Step 2.C.2: Produce and widely disseminate proceedings of these dialogues, including non-traditional dissemination methods such as newspaper articles, radio talk shows, guild and organizational newsletters, and other news media avenues.

Action Step 2.C.3: Provide a series of training sessions annually (e.g., an "Effective Mental Health Practices Symposium" series) focusing on two or three key service and administrative practices that have been proven to be effective, or that are promising or emerging practices for adults, for child/adolescents, and for effective administration of mental health systems and services.[10]

Action Step 2.C.4: Develop training and guidelines regarding the role of quality management and

[10]Examples might be Assertive Community Treatment (ACT) and Illness Self-Management/Recovery (IMR) or Wellness Recovery Action Planning (WRAP) for adults; multi-system therapy (MST) and family focused therapy (FFT) for children/adolescents; 360 Degree Performance Evaluation™ and consumers as employees for administration; and the difficulties with transportability and assessing readiness for implementation of effective practices.

improvement (QM/I) processes and data collection and analysis in monitoring and sustaining evidence-based mental health practices; develop training and materials to assist county mental health systems in evaluating their own programs and services within the context of their quality improvement processes; keep all CIMH staff members informed about the state Quality Improvement Council (QIC) activities.

Action Step 2.C.5: Work with relevant stakeholders to adopt and disseminate a consistent framework for measuring and reporting results in key domains such as access, consumer and family outcomes, and system performance[11]; work with CMHDA to obtain acceptance of the framework and commitment to utilization of the framework in all quality management and improvement activities.

Action Step 2.C.6: Work with California legislators to identify and seek passage of legislation to advance or support the development and enactment of evidence-based mental health service and administrative practices.

D. Assure that the concepts of evidence-based practices and content about evidence-based practices are incorporated into every CIMH project. **[Mid-range]**

Action Step 2.D.1: Develop a set of talking points or script delineating effective practices and related concepts of effective, efficacious, promising, and emerging practices, and CIMH's commitment to the implementation of evidence-based mental health practices; use these talking points as an introduction and consistent message for all training sessions, policy papers, CIMH documents, technical assistance, and research proposals; include explanation of the relationship to cultural competence and recovery/resiliency and/or create separate talking points about each of these concepts with consistent heed to effective practices.

[11]Attention should be given to the QIC's efforts to utilize the six aims identified by the Institute of Medicine's (IOMs) *Crossing the Quality Chasm* report (safe, effective, person-centered, timely, efficient and equitable) and the American College of Mental Health Administration's (ACMHAs) three performance indicator areas of access, process, and outcomes.

Action Step 2.D.2: Develop a set of criteria and review all existing and future CIMH projects to identify and articulate the evidence base of the project's content and approaches; identify areas in which more evidence is needed to strengthen the content or the approach of continued and newly started projects.

Action Step 2.D.3: Create a "vetting" protocol and list of criteria for selecting consultants, trainers, and presenters for CIMH use and for referral to county mental health systems to assure that knowledge and capacity is as evidence-based as possible; include multi-ethnic individuals and consumers/families, recognizing their unique contributions over and above traditional experience and credentials.

Action Step 2.D.4: Create an orientation package for presenters and trainers, and for purchasers or clients wishing to determine how to initiate or derive the greatest benefit from a project or training relationship with CIMH.

Objective Three: To increase CIMH's capacity to identify and assist county mental health systems in removing barriers and creating incentives to support enactment of evidence-based mental health practices in California.

Strategies:

A. Identify barriers to evidence-based practices, including but not limited to financial, structural, clinical, political, philosophical, and human resource barriers. **[Immediate]**

Action Step 3.A.1: Review national literature regarding organizational change and mental health evidence-based practices to identify examples of organizational and individual barriers impeding evidence-based practices.

Action Step 3.A.2: Work with relevant stakeholders to correlate those examples with specific barriers in California's mental health system.

B. Sponsor dialogue(s) with public mental health stakeholders about how to remove identified barriers and create incentives for engagement of evidence-based mental health practices. **[Mid-range]**

Action Step 3.B.1: Identify incentives for organizations and individuals to encourage removal of barriers, and to engage and sustain evidence-based practices

Action Step 3.B.2: Publish and disseminate results of the dialogues as a "Guide to implementing and sustaining evidence-based practices" for county mental health systems.

C. Develop specific recommendations leading to discontinuation of consumer/family mental health service practices that have been proven to be ineffective or harmful. **[Long range]**

Action Step 3.C.1: Review national literature and information sources and work with relevant stakeholders to develop criteria to identify administrative and service practices that are ineffective or less effective than other proven practices; ask stakeholders to assist in identifying a small number of clearly ineffective or minimally effective practices.

Action Step 3.C.2: Sponsor discussions with relevant stakeholders to identify reasons why the identified practices continue, and suggest methods to eliminate them and replace them with more effective practices; publish and disseminate the results of these dialogues.

Objective Four: To increase CIMH's capacity to provide leadership in the evaluation and research of mental health practices in California.

Strategies:

A. Assure that CIMH staff members have the knowledge and capacity to conduct research and to read, analyze, and utilize research literature and findings. **[Immediate]**

Action Step 4.A.1: Develop mandatory training and guidelines for CIMH staff members explaining how to conduct a literature review and how to read literature to determine the strength and value of the evidence presented.

B. Develop an action agenda for research needed in California about evidence-based mental health service and administrative practices. **[Long range]**

Action Step 4.B.1: Review national literature and sources of information about existing research in cultural competence and recovery/resiliency approaches, with attention to research that has identified and explored culturally specific populations and outcomes and recovery-oriented outcomes.

Action Step 4.B.2: Work with relevant stakeholders (especially the Cultural Competence Advisory Work Group, ethnic services leaders, the Statewide Wellness and Recovery Task Force, consumer and families' leaders, and CMHDA) to identify: a) current practices meant to promote desired outcomes in specific ethnic communities or to promote recovery/resiliency; b) gaps in knowledge about practices that support and promote cultural competence and recovery/resiliency; and c) the relevant research questions and outcomes that mental health systems need for the next decade.

Action Step 4.B.3: Using the practices identified in Action Steps 4.B.1 and 4.B.2, determine gaps in knowledge about evidence-based practices and implementation of known effective and efficacious practices in California; determine a limited number of high-priority promising or emerging practices currently in practice that need additional research to move them into the category of effective or efficacious practices; identify a limited number of high-priority populations (with attention to age, gender and culture) and service or administrative situations requiring additional research investigating the best ways to meet their needs or manage them effectively.

Action Step 4.B.4: After identification of gaps and needs, regularly promulgate a written research agenda for California's public mental health system and disseminate this research agenda to colleges, universities and funders throughout California and the nation.

Action Step 4.B.5: Build a coalition of academic experts, current and potential researchers, consumers and family members, and other key stakeholder groups to determine courses of action to begin concentrating on the promulgated research action agenda, with attention to the role of consumers, family members and ethnically diverse researchers; schedule regular discussions with DMH, CMHDA, foundations, universities, and county mental health systems representatives about how to obtain the data and resources to validate and engage the research action agenda , and about the barriers to desired research.

C. Identify evaluation priorities and conduct research to advance evidence-based practices, including promising and emerging practices within California. **[Long range]**

Action Step 4.C.1: Identify one or two promising practices from the promulgated research agenda, identify potential funders, and develop projects, proposals and/or partnerships within California and nationally to close this evidence gap; identify components of these practices that are critical to attainment of beneficial results and creation of fidelity scales.

Action Step 4.C.2: Identify one or two emerging practices from the promulgated research agenda, identify potential funders, and conduct an initial evaluation or demonstration to more clearly identify the population for whom the practice is designed, expected outcomes, and the research questions and hypotheses that need to be resolved to convert emerging practices to promising practices.

Action Step 4.C.3: Identify one or two transportability and adaptability issues from the research action agenda; seek resources and conduct studies on factors for successful implementation.

Action Step 4.C.4: Identify, support, and where necessary develop validation criteria for culturally specific individual and organizational assessment methodologies currently in use in California.

Action Step 4.C.5: Publish the results of CIMH evaluation and research efforts in refereed journals.

APPENDIX A—GLOSSARY OF TERMS

Adaptation: implementation of a practice or description of a practice in a controlled experimental design without complete adherence to its key elements.

Adoption: planning, implementing and sustaining practices that some evidence suggests may be likely to produce desirable results.

Consensus opinion: agreement among a group of knowledgeable individuals or groups about the likely results of a given practice. Such opinions may be based on strong, weak or no scientific evidence.

Diffusion: intended or unintended spread of information and/or treatments throughout the health services field. [NIMH RFA]

Dissemination: targeted distribution of a well-defined set of data (e.g., information about treatment of a specific disorder or illness). [NIMH RFA]

Effective: characterization of beneficial results in randomized controlled experimental research trials in usual or routine-care settings.

Efficacious: producing desirable results in randomized controlled experimental research trials in a controlled setting.

Emerging practices: innovations in clinical or administrative practice that respond to critical needs of a particular program, population or system and which seem to produce good outcomes, but are not yet validated by sufficient scientific evidence to show whether these initial results would be replicated among other groups.

Evidence-based practices (EBPs): a) used narrowly, this term refers to the clinical or administrative practices shown by consistent scientific evidence to improve specifically identified client outcomes (Drake, et al. 2001) for specific targeted populations; b) used more broadly, this term means “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients (Sackett et al. 1996).” [NIMH RFA] The Institute of Medicine says it best as follows: “evidence-based practice is the integration of the best research evidence with clinical expertise and patient values.”

Fidelity: adherence to the key elements of a practice.

Hierarchy of scientific evidence: a range of types of evidence including, a) the most rigorous randomized controlled experimental designs with control groups, multiple sites, and large numbers of subjects; b) quasi-experimental evaluations and demonstrations; c) systematic and unsystematic observations or anecdotal reports of an individual practitioner, organization or consumer/family based on general observations and impressions from a history of practice or experience. The strength of the evidence is judged by the degree to which it approximates or deviates from the most rigorous randomized controlled experimental designs.

Implementation: the process of introducing or modifying a practice for use in a specific local setting. [NIMH RFA]

Moving to scale: increasing from a few (pilots or experiments) to a large number of situations, number of clients, number of providers/programs, or geographic ranges in which a practice is implemented.

Practice: a service, policy, financing mechanism, setting, environment, approach, or supervisory authority.

Practitioner: an individual who engages or conducts a practice.

Promising practices: clinical or administrative practices for which considerable supporting scientific evidence exists and which show promise for improving client outcomes, but which have not yet been tested under the most rigorous form of scientific inquiry—that is, multiple randomized controlled trials.

Readiness: the willingness and/or capacity of an organization or an individual practitioner to adopt changes in practice. The willingness and ability of an individual to adopt a new practice are influenced by numerous factors including the complexity of the practice, the amount of difference from the current practice, the approach to suggesting adoption of a new practice, the champions or opinion leaders encouraging the change in practice, available supervision and support (including feedback on results), and the influences and barriers to adoption. Factors in organizational readiness include the culture of the organization, the commitment of the organizational leader, recent experience in implementing other changes, and barriers to adoption.

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

Scientific evidence: results from the evaluation of practice.

Stages of organizational change: the knowledge, attitudes, resources and intentions of an organization that influence whether the organization is willing and able to implement a practice for the first time. NASMHPD identifies five stages of organizational change—unaware/uninterested, motivating, implementing, sustaining, improving. Prochaska & Levesque (2001) identify the five stages as precontemplation, contemplation, preparation, action, and maintenance. Sometimes these stages are collapsed into three:

1. contemplation/consensus-building;
2. enactment/implementation; and
3. maintenance/sustaining.

Sustainability: the ability of an organization or individual to maintain a practice with continuing fidelity to key components that create beneficial results.

Transportability: the process of applying information about new research findings from a controlled setting or condition to an uncontrolled routine clinical setting or condition.