

**FACTORS ASSOCIATED WITH SPONSORSHIP
OF EVIDENCE-BASED PRACTICES BY STATE
SUBSTANCE ABUSE AGENCIES**

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PROJECT DESCRIPTION AND BACKGROUND

The Federal government has a legitimate interest in understanding and optimizing the performance of its own agencies and those it funds. In public substance abuse funding, Federal funding accounts for almost 2/3 of the funding total (SAMHSA Expenditures Report, 2005). Via the Substance Abuse Prevention and Treatment Block Grants, as well as discretionary funding, SAMHSA allocates money to the state substance abuse agencies. The second critical funder is the state governments themselves, followed by county and municipal funds. In order to improve the service delivery performance of the state substance abuse agencies, both State and Federal government have emphasized performance and outcomes measurement. Less attention, perhaps, has been given to what determines the level of agencies' varying performance on different dimensions of functioning. There is a strong organizational literature in sociology and political science, as well as business, that indicates that under conditions of environmental and market stress and change, such as those conditions that pertain in 2006 with a national economy in partial recovery and states still dealing with deficits and legislative and organizational change, a public agency's ability to survive and to perform optimally, including its ability to model and sponsor innovation, are affected by its ability to work with stakeholders and its positioning within its own organizational network. In these circumstances, stakeholder relations and positioning and all they affect, may well be as important, if not more important in times of turbulence, than traditional factors such as leadership, staffing, or internal structure.

External structural variables such as how the agency relates to its sister agencies, to the Governor and Legislature and to its sisters agencies, as well as where in the State bureaucracy the state substance abuse agency is positioned, to what agency or authority the agency reports and at what level, as well as the agency's visibility and degree of autonomy in the bureaucracy have been shown in prior Avisa Group qualitative studies of 12 states to have an impact on organizational performance (Gelber and Rinaldo, Avisa Group, 2004 and 2005, www.avisagroup.com). Other key organizational features such as agency leadership, stability, funding, and ability to mobilize organizational networks to accomplish tasks appear to be related to positioning and to one another. It is logical, then, to see adoption and sponsorship of evidence-based practices, an aspect both of leadership and of innovation, as potentially affected by these variables as well. This key stakeholder qualitative analysis sought to examine the impact of organizational placement and the other variables noted, as well as the effect of the presence or absence of a NIDA-supported CTN node, on state substance abuse agencies' abilities to be adopters and sponsors of the use

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of evidence-based practices in State/county substance abuse treatment and prevention provider agencies. This is an exploratory analysis based on results from eight States. All eight States approached for participation in this analysis agreed to take part, providing a very high response rate. The results of this and earlier studies affirms that there is a relationship between stakeholder relations and organizational positioning and leadership on state substance abuse agencies to improve their performance by modeling and sponsoring evidence based practices. Of course, in order to determine the precise importance the factors noted here have on performance and on modeling and sponsorship of evidence-based practice, a multi-stage explanatory model would need to be tested on a larger number of states (cases) with the inclusion of hypotheses drawn from this work and the literature, using both quantitative and qualitative data beyond what is available here. However, the fact that these three qualitative studies suggest similar influences and effects makes it more likely that these phenomena exist and influence organizational performance including sponsorship of evidence-based practice and other collaboration-related performance domains.

Results of SAMHSA-Funded Review of 12 SSAs (11/2005, CSAT)

As noted, this new analysis for NIDA builds on the foundation provided by the Avisa Group's 2004-5 studies of 9 and then 12 Single State agencies (SSAs)¹. The earlier studies found that **effective collaboration** between the substance abuse agency, its key stakeholders and multiple other State and community agencies is required in order to establish and maintain effective substance abuse services and policies. **The organizational placement** of a State substance abuse agency is a critical factor in the ability of a State substance abuse agency to engage in effective collaboration because collaboration is only possible if substance abuse agency is sufficiently visible within State government. **Gubernatorial appointment or sub-cabinet status** of State substance abuse agency directors adds significantly to the inter-stakeholder credibility, status and ability of agency and its Director to collaborate effectively. That review also observed that there is an ongoing **trend nationally to restructure SSAs** internally and to **merge or move** them within other, sometimes unrelated State structures to achieve what are described as savings or synergies. State substance abuse agencies that are completely **merged within other State agencies** or submerged too many levels down from the Governor's office reported difficulties with stakeholder relations, legislative affairs, executive recruitment/staffing, funding, interagency collaboration, compliance with funding

¹ Suzanne Gelber and David Rinaldo, State Substance Abuse Agencies and their Placement Within Government: Impact on Organizational Performance and Collaboration in 12 States, The Avisa Group, November, 2005 http://www.avisagroup.com/images/Phase_II_Final_November_11-16-05.doc.pdf

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requirements and reporting requirements, management, staff retention and overall effectiveness. **Stable and nimble leadership** is critical to SSA performance and inter-stakeholder collaboration and can offset some of the potentially disabling consequences of a poorly conceived merger under certain conditions but the ability of the agency to endure and lead may end with the departure of the leader who retires or leaves the agency. Support for the SSA from a **“drug czar” / Executive Office** or **strong partnership** with the adult and/or juvenile criminal justice systems facilitates SSA effectiveness and ability to collaborate with state agencies, Governor’s Office and other key stakeholders.

Substance abuse agencies require **close working relationships with providers and key advisors** and **need specialized policy, fiscal and contracting staff** to work with them effectively. These staff are being lost in the wave of mergers taking place that move these functions to higher level “host” or “superagencies, ” in part because business consultants advising Governors often feel these functions will be less expensive if centralized. However, in fact the loss of specialized SA fiscal and contracting expertise can significantly degrade ability to work with providers and advisors, threaten agency leadership, create contract compliance problems; disrupt funded initiatives and collaboration, stifle innovation such as the sponsorship of evidence-based care and evaluation/research, and degrade overall agency performance. **Strong support from positions superior to the SSA Director** can contribute significantly to the collaborative clout and overall innovation, accountability and effectiveness of the substance abuse agency. Finally, the impact of often constant and sometimes ill-conceived **organizational changes** in State government, impelled by a desire to manage crises or create administrative efficiencies in other, larger agencies, has frequently been negative for SSA performance.

CURRENT ANALYSIS

Project Goals

Building on the work of that earlier report, this current NIDA-funded analysis has two principal goals:

1. To identify key factors that State substance abuse agencies can employ to enhance their ability to model and **sponsor** adoption of EBPs and to promote a culture of continuous improvement; and

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2. To examine how the use of evidence-based practices in substance abuse prevention and treatment is affected by the following:
 - a. Key enabling and disabling factors (discussed below)
 - b. The organizational placement and stakeholder-relationships of State substance abuse agencies
 - c. The presence or absence of a NIDA-supported CTN node that has a close relationship to SSA

Sponsorship may be defined as active promotion and collaboration by the State substance abuse agency of EBPs. It can entail a variety of specific strategies. Change and innovation are facilitated by active sponsorship of such innovations and improvements.

Project Approach and Design

Eight varied states were selected from the two earlier State report panels; five States had an existing CTN Node and three lacked a CTN Node or had a Node so new (i.e. created during the current funding year) that no impact would yet be expected. All eight States contacted for this analysis agreed to participate:

- California
- Florida
- Georgia
- Maine
- North Carolina
- Oregon
- Texas
- Washington State

Semi-structured discussion guides based on the earlier Avisa instruments were developed and sent to key-informant respondents from each State who were then interviewed by telephone. Three broad categories of respondents were interviewed:

- Directors of State substance abuse agencies
- Principal investigator(s) of CTN Node (where present in a State)
- External stakeholders (e.g. executives of State provider associations)

Because NIDA wished that the preliminary results of this analysis could be presented at the June 2006 NASADAD meeting and the analysis was funded in March 2006, the interviewing had to be accomplished relatively quickly. No assertion is made here, therefore, that every key stakeholder whose perceptions

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should be included was available or willing to take part on such short notice. Nevertheless, every state agreed to participate and most of the key stakeholders who could be available did in fact take part in interviews. No collection of quantitative data were possible in this timeframe, nor is this analysis to be understood as going beyond what can be determined in rigorous qualitative interviews with background information supplied. To the extent possible, sources were triangulated to provide varying perceptions of differing stakeholders. A true test of the model factors suggested here awaits a longer time period, specification of hypotheses based on these preliminary studies, and a larger and more comprehensive set of data. Nevertheless, the patterns noted below are of interest.

Analysis Focus and Participants

The focus of the Discussion Guide (attached) were designed to identify the specific activities undertaken by State substance abuse agencies to sponsor use of evidence-based practices such as the ones noted below amongst agencies or providers to whom they supply funding. The discussion items were grouped into five categories of issues:

- What activities have been and are planned in the future to sponsor the use of three specific EBPs in which NIDA has invested?
- What resources have been and are planned in the future to design and implement a strategy to further sponsor EBPs?
- What other activities have been undertaken by the SSA to improve the quality and effectiveness of substance abuse treatment and prevention?
- What specific activities were undertaken with the ATTC?
- What specific collaborative activities were there with the CTN node?

Conceptual Framework: The Underlying Model

A multi-level set of enabling / disabling factors discussed in the introduction to this analysis were identified from the organization-environment and market transactions research literatures. A multi-level framework or model is necessary in order to comprehend the factors that critically affect (enable or disable) State substance abuse (and/or behavioral health) agencies to become adopters and sponsors of evidence-based practices ("technologies" and information/data flows) in substance abuse prevention and treatment. Six levels of organization were identified, each level containing a specific set of enabling / disabling factors:

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- Systems/Community Level
- State Inter-Organizational Level
- State Agency Level
- Technology and Information Level
- Individual Practitioner Level
- Client Level

HIGHLIGHTS FROM PARTICIPATING STATES

CALIFORNIA

Organizational Placement of SSA:	One level down from Governor's Office; autonomous but located within DHHS; equivalent to mental health; SSA Director has significant tenure and visibility at SSA and within State agencies
CTN Node Status:	Two CTN Nodes in State

- California State SSA agency is located within the Department of Health and Human Services, but has substantial autonomy; Director's appointment is made by DHHS Secretary but approved by Governor and Director has direct access to the Governor and the Executive Office staff members
- Primary key initiative at this time is the refinement and evaluation of California's Proposition 36 (Substance Abuse and Crime Prevention Act, a voter initiative), which includes substantial SA treatment access improvements and some new judicial discretion for the criminal justice-involved SA clients. This new focus has led to suggestions for treatment effectiveness improvement; for example – California needs to make methadone/other medication-assisted treatment such as buprenorphine more available to these Proposition 36 clients and others involved with the criminal justice system. As opposed to local option, it has provided a statewide data collection and evaluation opportunity, somewhat unusual in this State with powerful and autonomous counties.

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- The second key EBP-related initiative has been CAL OMS (Outcomes Management System). This informational database will serve as the evidence base for continuous outcomes improvement activities that will, the SSA hopes, involve enhanced uptake and sponsorship of EBPs by counties and providers.
- The state SA agency intends to publish a Practitioners' Desk Reference, in conjunction with scientific experts, focusing on EBPs, but needs to find staff and funding to do epidemiological/needs assessment to focus EBPs where they are most needed. This is one area in which NIDA and SAMHSA could be very helpful, according to the SSA Director.
- ATTCs are perceived as not reaching out enough by the SSA, which feels the current ATTCs are under-funded and too academic; they not useful for policy and practice improvement as currently conceived and operated.
- CAL OMS has forced adoption of rigorous assessment as a standard practice; there is a choice of instruments.
- Prevention efforts are required by the SSA to prove they are evidence-based by 2007.
- Despite the state efforts, many CA traditional SA providers are skeptical of EBPs and see them as inconsistent with the "social model" orientation of many treatment agencies in CA. This is an obstacle to sponsorship of the EBP's at the local level.
- There has been relatively little interaction with either of the two CTN nodes (and little outreach from CTN nodes to SSA) except for continuing individual and collegial, relationships with three researchers affiliated with CTN's and the SSA Director and her staff.
- Statewide provider association is supportive of SSA and EBPs but has been somewhat preoccupied with funding and organizational restructuring challenges and pending Proposition 36 reauthorization, which was signed by the Governor but is being held up by court challenges from certain advocates.

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FLORIDA

Organizational Placement of SSA:	FLA has State Drug Czar appointed by Governor; SSA Director is Deputy Director of Office of Drug Control; Agency is within DCF but equivalent to mental health with a behavioral health director over SSA, who was the previous SSA Director; SSA and ODC have new directors; current Corrections Director was Drug Czar
CTN Node Status:	CTN Node in State

- The Director of Florida SSA is not a gubernatorial appointee, but is part of Florida Office of Drug Control (ODC) and has close relationship to Executive Office through ODC. Director of ODC is appointed by Governor. Current and previous directors are ex-military officers with an interest in substance abuse treatment and drug control.
- There is a history of strong high-level state support for SA agency in the past five years in Florida but previously, the agency reported to mental health and it has also dealt with previously reduced funding and organizational status.
- All prevention programs in Florida are currently required to use EBPs in order to qualify for public funds.
- Clinical peer review and agency mentoring program are used as an instrument of quality improvement and are jointly sponsored by SSA, ATTCs, and Florida's prominent provider association
- The relatively recent placement of an ATTC in Florida itself rather than a neighboring state has significantly contributed to promotion of science-based practices and innovation, according to key stakeholders and staff/SSA Director. The ATTC is led by the former executive VP of the statewide provider association and therefore has a strong connection with providers; the ATTC also has developed a partnership with State's licensing and certification board to address workforce issues pertaining to EBP training and practice.

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- The ATTC Director sees the SSA as a “key customer” and is positive about the SSA’s EBP and performance initiatives; the ATTC has a long history with and close relationship to the SSA.
- The ATTC supports the voluntary clinical peer-review process noted earlier, with reviews based on comparison to seven specific evidence-based practices; EBP trainings are readily available and are offered statewide.
- The Florida ATTC, also in charge of Alabama, has produced a compendium of a wide variety of EBPs and placed it on its website (www.scattc.org). The statewide provider association (FADAA) has previously implemented a provider resource center on EBPs. The SA and MH statewide provider associations are collaborating on EBPs. The SA provider association is currently founding a learning community with the SSA to include strong regional provider associations
- The CTN node director serves on the ATTC advisory board.
- Most Florida SA providers have bought into evidence-based practices, as opposed to some other states where they are still skeptical.
- An intensive licensure review process in Florida has been a longstanding quality improvement initiative that has promoted the adoption and sponsorship of EBPs.
- An important current initiative for quality improvement led by the SSA is to make clinical supervision, for the purpose of increasing fidelity to EBPs, reimbursable by the State and Federally. This initiative is strongly supported by Florida SA provider association. Providers also support the Beacon product, a quarterly publication of the ATTC designed to synthesize some of the latest research on a variety of topics related to addiction treatment and adoption of new practices.
- Another important quality EBP-related initiative is the Florida Learning System, which brings the statewide SA provider association, the ATTC, the SSA and other stakeholders together for the development and implementation of an ongoing strategy focusing on improving practice.
- A key quality initiative currently being undertaken in Florida is to create a Performance Management Unit within the SSA. This unit will bring together data from large variety of sources within agency, including licensure surveys, contract monitoring, peer-review, administrative data, as well as others.
- Another quality EBP-related practice initiative in Florida is collaboration between child welfare system and the SSA; there is now a position of Family Intervention Specialist within each District SA team.

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- Florida looks to SAMHSA/NIDA/Federal agencies for identification of EBPs but also cultivates a close relationship with NIDA-funded/other experts.
- Florida regards NREPP as a fundamental resource for prevention; the SSA sees great potential in NREPP in the prevention arena if it were also to incorporate mental health.
- The new Florida-based ATTC is considered effective by FADAA and it has assigned mentors to new executive directors of SA agencies.
- According to the statewide provider association and other key stakeholders, NREPP should be revised to incorporate substance abuse and mental health EBPs.
- In Florida, the ASI is required for ATR but not for other programs as yet. The SSA would like to mandate evidence-based screening tools overall.
- Medication-assisted treatment is in the strategic plans of the ATTC, the SSA, and the Florida provider association. Florida is planning to promote depot-naltrexone and has strong methadone and buprenorphine providers.
- Key Florida SA providers have collaborated amongst themselves to create the “New Century Institute” for purpose of clinical quality improvement and dissemination of EBP’s; this effort is supported by the ATTC and SSA.
- Staff from the Florida Mental Health Institute and the University of Miami were embedded in the SSA as epidemiologists as a response to previous years’ State budget cutbacks. This enables the State to do needs-based research and evaluation related to EBP’s and other major policy initiatives.
- Florida legislature has Office of Program Policy Analysis, which has a longstanding relationship with SSA and is staffed by the FL Mental Health Institute (Tampa). This office also researches EBPs and evaluates other major health initiatives for the State government.
- The CTN is part of several SSA work groups.
- The CTN collaborates with the SSA and with Florida provider associations. Last year, the CTN co-sponsored the national NIDA Blending Conference with the SSA.
- There is frequent collaboration and interaction between the CTN and the SSA.

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GEORGIA

Organizational Placement of SSA:	SSA is three levels down from Governor; within DHR; SSA has an active new director
CTN Node Status:	No CTN Node in State

- In January 2005, a new Office of Addictive Diseases was created in the Georgia Department of Human Resources; it is staffed by a new Director.
- EBPs have been used by Georgia for youth SA treatment and prevention since 2004.
- Georgia's numerous Community Service Boards will be required by the State to use some EBPs beginning in July 2007.
- Georgia will use a State Incentive Grant to hire a Child and Adolescent Coordinator to enable the SSA to focus on developing EBPs for this population.
- The Georgia SSA has convinced providers to offer EBPs to adolescents. The SSA supports provider training in EBPs.
- A significant obstacle to broader adoption of EBPs is insufficient funding for training practitioners in the state.
- The relationship between the SSA and the ATTC is described as "weak" and there is no CTN relationship at this time.

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MAINE

Organizational Placement of SSA:	SSA is three levels down from Governor; within DHHS; the Office of Substance Abuse was recently merged into the larger agency and lost autonomy and finance/contracting staff; however, the SSA Director has significant tenure and is linked to the provider association, the Legislature and the Governor's Office
CTN Node Status:	No CTN Node in State

- Maine's major quality initiative in 2004-05 included both juvenile and adult drug courts, which improved access to and quality of treatment for the population involved with the two criminal justice systems;
- Maine has created a behavioral health department and behavioral health managed care is in the planning stages, with its launch delayed to allow more time for analysis, input and planning
- Maine also focuses on co-occurring disorders via its COSIG grant (SAMHSA)
- Maine defines evidence-based practice as a treatment or practice modality that is designed and proven to achieve optimal outcomes based on careful research and testing in field sites. There is no formal way for the State to designate such practices in Maine
- The SSA uses TEDS for data collection.
- Maine participates in NIATx
- Maine's provider buy-in on EBPs is challenged by lack of funds and staff, a downgrade in the status/visibility of the SSA since merger of SA into DHHS, which is "very challenging" for the SSA and the providers
- The closest ATTC office is in RI, not Maine – it is described as not "visible" to SSA
- All SA agencies that are funded by the SSA are required to use the ASI.

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- Further science-based initiatives await grant funds and future SAMHSA/NIDA announcements; this State has a Medicaid deficit/crisis and a pending behavioral health managed care system that may or may not include SA.
- One hospital (Mercy, Mark Publicker, MD) in Portland, Maine is participating in the NIDA CTN but Maine has no node. This is the only hospital or agency involved with the CTN; the SSA Director was involved with this hospital when it began to work as part of the CTN.
- For Maine, NREPP is of limited use due to its "emphasis on prevention and lack of treatment, administrative, or policy emphasis".
- Maine has actively promoted buprenorphine and other medication-assisted treatments but almost completely lacks funds for such efforts, despite its extensive opiate addiction issues, especially in rural areas of the State.
- The Maine SSA has promoted MI and MET, but fidelity to these models by practitioners is not monitored and may be questionable. Maine's SSA would like to research this and fund clinical supervision around EBPs but has had funding and does not have the resources to do so without external help.
- Maine's SSA has strong relationships with the Governor's Office (there is a Gubernatorial election in November 2006) both parties in its Legislature, there are also strong links with the provider association, which has been oriented towards supporting SSA autonomy (but did not achieve this goal) rather than an extensive focus on EBP initiatives.

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NORTH CAROLINA

Organizational Placement of SSA:	SSA is three levels down from Governor; within Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Office of Community Policy Management. No separate identity for SA agency but highly visible. There is longstanding tenure of NC's SSA Director, who is also the SSA for Mental Health.
CTN Node Status:	CTN Node in State

- There are three levels between Governor's office and the SSA; the SSA Director is appointed by the Secretary of HHS (no Governor's confirmation needed) and she works closely with the Legislature and the Governor's Office, as well as having close ties to the criminal justice systems (adult and juvenile).
- Significant stakeholders mentioned also include the Partnership for a Drug Free America, the Director of CTN Node, and the University of North Carolina School of Social Work for SA workforce development.
- NC's quality initiatives included longstanding efforts to identify and support data and research, including EBPs, and to retain key staff who participate in this effort; NC expects its outcomes measurement system key to promote the use of EBPs; EBPs should now be studied for outcomes and fidelity in the field, according to the SSA Director (but current studies lack resources for comparison/control groups).
- NC staff developed descriptions of EBP services, including SA IOP, psychosocial intervention and MST, which were then implemented statewide. NC's Practice Improvement Committee also encouraged use of EBPs, as did the North Carolina Treatment Outcome and Program Performance System (NC-TOPPS), tracking changes, and outcomes for clients.
- NIDA, SAMHSA, CMS and the Robert Wood Johnson Foundation have provided support to NC to develop/disseminate EBPs. The CTN was key

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- to this effort, as was National Development and Research Institutes (NDRI) for ten years. NC's CTN Director is now at NDRI, affiliated with NC State; the CTN node director has closely worked with NC's SSA for many years in previous positions.
- New EBP-related initiatives:
 1. Continuing the work of NC Practice Improvement Collaborative, which recommends EBPs to implement and disseminate to DHMDDSAS (Department in which SSA is located). This collaborative is a partnership amongst consumers, clinicians, and researchers.
 2. Continuing efforts by SSA to train correctional staff to use CBT and MET and to have juvenile justice staff use MST for youth with conduct disorders and/or co-occurring disorders (MH/SA).
 - NCTOPPS client data is used to measure quality and outcome indicators – (no detail yet on exactly how this is used).
 - NC Practice Improvement Collaborative (NCP/IP) meets quarterly to review and discuss the evidence base for each service/program suggested as an EBP (in conjunction with Governor's Institute on Alcohol and Substance Abuse) and it makes recommendations to DMHDDSAS, along with codified service descriptions for programs to follow and to be purchased by the State.
 - NC is developing contracts with national EBP experts to provide supervision and oversight of fidelity of implementation (UNC Chapel Hill).
 - NREPP is used as a resource for prevention initiatives.
 - MI and MET are being used in NC's prison system, which also has CBT from trained corrections staff and TASC staff post-parole (TASC has developed and extended an offender management model, supported by RWJF and NIDA).
 - NC is also sponsoring TELE, Matrix, TASC and SBIRT initiatives.
 - NIDA's NC CTN node is extremely active; CTN sees treatment improvement, not just research, as its mission. The CTN meets regularly with NC's SSA, prepares materials, and is involved in all SSA activities.

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OREGON

Organizational Placement of SSA:	SSA is two levels down from Governor; merged with mental health, within DHS; Oregon has had serious funding issues for both MH and SA, Medicaid deficits
CTN Node Status:	CTN Node in State

- Oregon SSA is merged with MH agency in a larger department headed by the former SSA Director
- Legislation requiring State purchase of EBPs was enacted in 2003 and implemented in 2005. The MH/SA agency created an EBP unit within the agency to facilitate implementation; it is staffed by a longtime staffer.
- Oregon has a legislatively established definition of EBPs and has developed a list of practices that meet the definition and has posted this information on the web. There is a formal statewide process to identify and EBPs and update the posted list.
- Oregon uses NREPP to identify EBPs for prevention. At this time NREPP is not considered useful for treatment.
- Oregon's most important initiative for 2006 – 2007 is to request more budget dollars to quadruple training and workforce development.
- ATTCs are considered useful. However, a stakeholder identified a disconnect between the ATTC, which relates to the SSA, and the Counties and their managed care plans, which actually deliver (or contract for delivering) services.
- No ASI requirement is in place; ASAM placement criteria are required.
- Oregon has no buprenorphine initiative; it provides some methadone treatment but that is no longer reimbursed by Medicaid because it was an optional benefit under Medicaid and it was dropped; extensive SA funding cuts have occurred in the last two years, up to the present.
- The State is not sure about fidelity to its MI/MET model.
- The Director of Oregon's EBP unit communicates regularly with its CTN node principal investigator.

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- The CTN is active within Oregon; there is a multi-faceted and longstanding relationship between individuals in the CTN and State SSA staff.
- Nevertheless, Oregon has suffered significant cuts in SA funding, resulting in constrained ability to implement EBPs, despite the legislation. The State's EBP legislation lacked funding for training, data and research, and systems change needed to institutionalize most EBP's.

TEXAS

Organizational Placement of SSA:	Substance Abuse is two levels down from Governor; combined with mental health, within Dept. State Health Svcs and headed by former SSA director, now Deputy Commissioner of the larger DHS
CTN Node Status:	No CTN Node in State (One was very recently established, but is too new to have had any impact)

- Texas, a state with constrained funding, must constantly shift resources to more effective practices and approaches in order to provide state-of-the-art services; Texas uses the U of T Addiction Research Center, extensive data systems, and discretionary grants to do this.
- Former SSA Director (who also has MH experience) is now deputy commissioner of merged behavioral health division within State Department of Health Services
- Texas has ATR, Co-Occurring, and SBIRT grants; there is a brand new CTN node but it is not having impact yet
- There is reportedly no legislative or gubernatorial interest in SA issues except as they affect CJ/Corrections; external stakeholders/providers are not considered strong or active as a force re EBP's or other issues.

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- Texas is using Duane Simpson's (TCU) process improvement model, in conjunction with CTN, also moving to EHR's to help track and implement improvements.
- The emphasis in Texas is in on process improvement, not on the promotion of any specific methods or EBPs
- The Texas SA provider association is supportive of EBPs but not active in promoting them.
- ATTCs are perceived by SSA to be extremely useful (U of T).
- The ASI "lite" is built into EHR's; Texas uses ASAM criteria as well.
- Texas recently changed provider contracts to promote use of buprenorphine (methadone is little used)
- MI/MET are now part of regular statewide provider trainings sponsored by the SSA.
- Texas is working on the Star SI-RWJF project.
- Texas has an umbrella Initiative: all SA clinics required by contract to participate and use instruments (org readiness to change; CEST) in process improvement activities
- There is a heavy emphasis on data for MH and SA (combined now); Texas is adding cw, ss, cj data to better coordinate and improve SA client services and outcomes.
- Specific EB practices are thought to have some effect on outcomes but the environment, client, therapist, and other factors are considered more significant – hence this SSA's emphasis on databases, process improvement and structured quality improvement (there is reportedly some tension between providers and State on purpose of EBPs)
- Spontaneous dissemination of MI/MET occurred via the State's annual training institute, with State travel grants given for CME attendance
- NIDA could identify core elements of EBPs, develop a matrix showing EBPs by client population and defining the aspects of SA problems the EBP addresses.
- NIDA could better communicate everything it funds or mounts as an initiative to the state agencies, according to Texas researchers.

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WASHINGTON STATE

Organizational Placement of SSA:	SSA is three levels down from Governor; within Dept of Social and Health Services; SSA recently merged into Medicaid agency and there is a new Director
CTN Node Status:	CTN Node in State

- The Secretary of DHHS appoints the SSA director; WA has a new Director now.
- WA State has mandated common, evidence-based diagnostic and screening tools.
- WA State is engaged in major treatment continuum expansion that has absorbed much of its staff's time but the Legislature appropriated \$26M in new funding due to good data/results and the close SSA relationship to the legislature
- This State has a fulltime research director and an EBP website; WA State has many SAMHSA grants and EBP projects
- WA SSA is now part of the State Medicaid agency, on a par with MH but may lose contracting and financial people/other staff – significant layoffs possible despite new treatment \$ from legislature
- U of WA has best practices website associated with its Alcohol and Drug Institute; accessible to providers but use is not mandated by the SSA
- There are no mandated EBPs but NREPP is used by DASA and agency prevention staff
- Provider buy-in is good to EBPs, which are not mandated
- The ASI is in use since 2000
- ATTCs are not a key resource currently
- The State has a Bup/methadone initiative, MI/MET via training and clinical supervision for fidelity.
- The SSA has its own research committee (Research Advisory Group) that meets quarterly and includes the CTN; the CTN responds to SSA outreach

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- but not the other way around (SSA pushed U of WA to become CTN Node);
- WA's CTN is part of the WA information/data strategy (but SSA now has new Director; former director is now in charge of MH transformation grant)
 - DASA has longstanding focus on data collection for use in evaluation, improvement, policy and planning – but that now considered at some risk due to DASA absorption into Medicaid agency, with threatened cutbacks in staff that will reduce ability to test and promote EBPs.
 - DASA's Target database is event driven, client focused with assessment and use of the ASI at intervals; the ASI is part of State data requirements for provider agencies
 - The SSA strongly supports methadone and wants to increase selected evidence-based medication-assisted treatments but lacks specific funding to do so
 - There are CTN meetings with DASA quarterly during Research Committee meetings and there are some interactions with CTN but no intense partnership

Major Findings and Key Factors Affecting Implementation of EBPs

This analysis found the following key enabling and disabling organizational factors that affect the effectiveness of implementation of EBPs by State substance abuse agencies:

- Critical Enabling Factors Associated with Sponsorship of EBPs
 - Effective and continuous agency leadership
 - Agency visibility and autonomy within the State government
 - Availability of administrative resources including fiscal and contracting staff who understand the grants and funding supporting EBP's
 - Strong partnerships with CTN nodes and ATTCs

 - Sufficient autonomy to initiate and collaborate on interorganizational issues
 - Strong partnership with CTN Node, ATTCs and providers
 - Sufficient resource levels and availability of funding and staff
 - Substantial Executive Office of Governor support
 - Good information and data and ability to use it to advance the SSA and EBP's
 - Active and sustained collaboration and outreach strategies
 - Organizational scanning and "permeability" strategies to keep aware and current on trends in data and in science
 - Organizational flexibility around initiatives
 - Relative ease and low cost of implementation of specific EBP

- Critical Disabling Factors Associated with Lack of Sponsorship of EBPs
 - Complete agency submersion within a host or merger agency, "super-agency" submersion
 - Organizational instability
 - Severe lack of administrative and fiscal resources at the State level
 - Wholesale merger with another State agency, especially one not committed to or understanding of the SSA's mission and Federal requirements
 - Changes in leadership above SSA level, combined with major system or organizational restructuring undertaken for non-SSA reasons
 - Severe lack of administrative resources/talent
 - Lack of strong intergovernmental and interorganizational support / stakeholder support for the SSA

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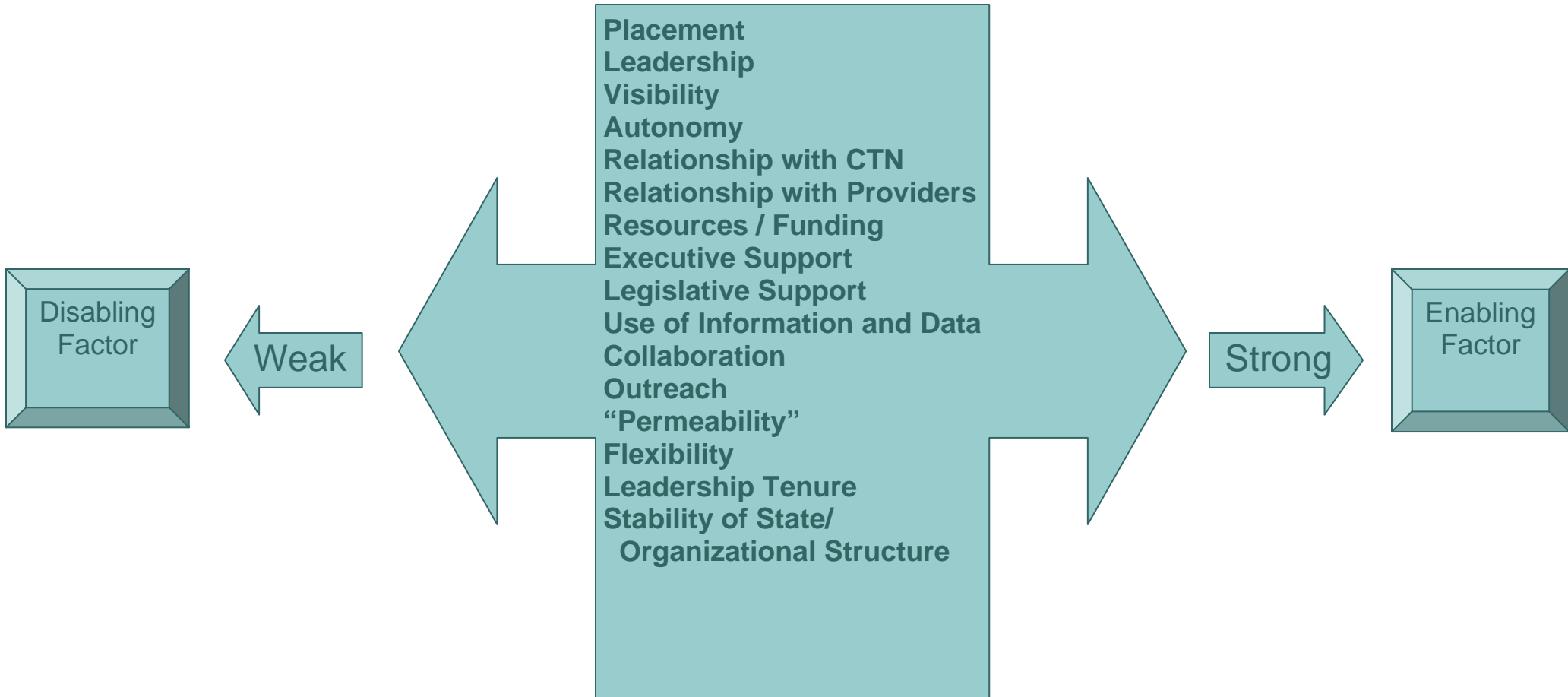
- Inability / lack of interest at the SSA in scanning for and implementing new approaches
- Lack of commitment to continuous quality improvement at the top of the SSA and its host agency

The following model illustrates how these factors can enable and/or disable the implementation of EBPs:

MODEL OF ENABLING AND DISABLING FACTORS

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With respect to the various levels identified in the research literature, these factors can be categorized as follows:

LEVEL	FACTOR	STRATEGY
Systems / Community	Sufficiency of SA funding Community awareness Drug Czar Coordinated initiatives among national stakeholders	Stakeholder outreach Outreach to legislative and key executive/ agency stakeholders
State Agency	Agile and stable leadership Agency placement Environmental scanning Information systems Collaborative relationships Engagement of policymakers Access to expertise	Information dissemination Data improvement Designation of specific staff for collaboration and scanning Stakeholder outreach Outreach to legislative and key executive/ agency stakeholders Outreach to CTN and ATTC
Inter-Organizational	Managed Permeability Pro-Activity Flexibility Continuous Improvement Inter-Organizational relationships	Designation of specific staff for collaboration and scanning Stakeholder outreach Information dissemination
Technology and Information	Ability of current systems to prove effectiveness of SSA Alignment of information with agency mission Resources required for upgrade	Information dissemination Data improvement Training in use of information
Individual Practitioner	Proportion who are early adopters Desire for professional advancement Professional development activities Alignment of EBPs with personal goals Trust in SSA	Provider and provider association outreach Information dissemination

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LEVEL	FACTOR	STRATEGY
Client	Commitment to therapeutic relationship Alignment of EBPs with personal goals Receptivity to innovation Community and family support	Stakeholder outreach

The analysis had four other key findings:

1. State agencies most active in sponsorship of EBPs had the strongest partnerships with their CTN Node(s) / ATTCs and statewide provider associations. Characteristics of these partnerships included regular and frequent communications at multiple levels via multiple media
2. Absence of a CTN Node in a State appeared to be associated with a lower level of activity in promoting EBPs
3. Major treatment expansion initiatives tended to divert some State agency resources from immediate sponsorship of EBPs but SSA Directors tended to see these initiatives as evidence-based in terms of having a complete continuum of prevention and care so as to optimize engagement, retention and client outcome, per the research literature
4. ATTCs and CTNs were reported to have greatly varying levels of effectiveness in working proactively with States and seeing them as “customers”. Either these relationships were intense, close and ongoing partnerships or they were at the other extreme, mostly disassociated with the SSA and one another (U-shaped curve)

Levers and Sources of Leverage Available to State Substance Abuse Agencies

In addition to identifying enabling and disabling factors associated with implementation of EBPs by State substance abuse agencies, this analysis identified the levers used by State agencies and the sources of leverage available to them. Essentially, State agencies use one or all or none of four levers available to them to sponsor the use and dissemination of EBP’s:

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1. Mandates for Specific Practices
2. Financial Incentives
3. Continuous Improvement Requirements / Performance Management
4. Other Incentives (Awards, Reduced Oversight, Etc.)

Each of these levers has specific advantages and disadvantages. Although mandates for specific practices may appear to be a straightforward lever that would require implementation of particular EBPs, at least for any services funded by the State, managing and monitoring adherence and fidelity to such a requirement is a resource-intensive activity. For example, monitoring compliance with a requirement to provide motivational enhancement therapy (MET) requires some mechanism for auditing and providing improvement training regarding these counseling approaches. Although other EBPs may appear to present fewer such issues, such as use of the Addiction Severity Index (ASI), even the ASI exists in a large variety of formats, well or poorly adopted from the standard versions. These modified formats, which have not been subjected to the same scientific review as have the standard formats published by the University of Pennsylvania Treatment Research Institute, have been developed on a practical but not necessarily scientifically rigorous basis to address specific issues, such as length of time required for administration and adolescents / youth, that have been identified with the standard versions. These states reported that failure to address these and other such issues would make degrade the effectiveness of universal use of the ASI. With all EBP's, there could be political costs of requiring specific practices that may be perceived as difficult or costly to follow.

Financial incentives for use of EBPs may be more acceptable to providers than mandated use, but the fiscal consequences to the State and the providers must be considered. A budget neutral set of financial incentives could in theory be developed and adopted, paying less than currently for non-EBP services and more than currently for EBP services, but calculation and prediction of the rates that would both produce the desired behavior and be budget neutral would not be a trivial exercise. Two small a difference between the two rates could result in an insufficient rate of adoption of EBPs and too great a difference – if budget neutral – could be perceived as unfair and essentially equivalent to a mandate.

A requirement for continuous improvement and documented performance management is an indirect mechanism used by states in implementing EBPs. Rather than requiring specific practices, instead providers are usually required to improve their performance with respect to specific measures on an ongoing basis. Presumably, providers will adopt EBPs in the course of such improvement,

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as EBPs are assumed by sponsor agencies to lead to better client outcomes than other practices.

States have also used other incentives such as awards, recognition or reduced oversight to encourage use of EBPs. These “softer” incentive mechanisms may also be used in conjunction with other levers.

State agencies have a number of sources of leverage. The most obvious is probably federal funds from the State Block Grants. These funds constitute the majority of State funding for substance abuse services in most States (and in some states they constitute 100% of the funding for public sector SA activities). In addition, most States contribute some of their own funds, both directly to the State substance abuse agency as well as through their State Medicaid program. Linking funding to use of specific, well understood EBP's is a major lever.

Contracts and purchasing requirements are also potential sources of leverage; EBPs may be treated as contractual matters and referenced in various State purchasing arrangements. Licensure and certification are additional sources of leverage. For example, knowledge of and training in EBPs could be required for licensure and certification, on an ongoing basis. State quality management or quality improvement regulations may also be a source of leverage for adherence to EBPs. Data submission specifications and requirements may also be used to require use of specific EBPs. For example, providers could be required to submit data for each client admission that would include data elements from the ASI. Finally, the State substance abuse agency can collaborate with other State entities so as to have them actively sponsor use of EBPs for clients with substance abuse issues.

Actions States Can Take Facilitate Implementation of EBPs

This analysis identified a number of actions that can be undertaken by States to facilitate the implementation of EBPs. The first is to **designate specific staff and/or resources** to build or intensify system / stakeholder outreach and inter-organizational collaboration and provide staff training and support for collaboration and policy initiatives. This does not necessarily imply that specific staff need to be assigned to full-time stakeholder outreach; although that is one possible strategy, many States have undertaken this strategy through recognition of a portion of a larger number of staff members' time in a strategy to broaden collaborative efforts throughout the agency.

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Another proactive activity is to **develop and implement an outreach strategy** with key policymakers and other stakeholders, and a collaborative / outreach strategy with criminal justice, law enforcement, child welfare, and Medicaid stakeholders.

The third action found in this analysis to be associated with implementation of EBPs is to **reach out to the closest CTN Node, ATTC** and other experts for ongoing collaborative initiatives, training, focused research endeavors. This includes ensuring that the CTN and ATTC become members of key SSA boards and committees.

Another action undertaken by some States was to develop a strategy to reach out to key State **policymakers**. In Florida, the "drug czar" has played a significant role in the coordination of substance abuse policy and actively supports adoption of EBPs but not every State has a drug czar and not every drug czar is effective in supporting EBP's. Other linkage and visibility strategies can also be pursued.

Another action that has been successfully utilized in some States has been to actively **use and disseminate existing and new data** and information to support the mission and performance of State substance abuse agency. Along with this action some States have developed a **strategy to improve data and information** collection and management use to ensure continued relevance and to support system improvements.

Finally, State agencies can reach out and closely **partner with counties and provider associations** to support initiatives that promote EBPs, innovation, continuous improvements, and inter-organizational initiatives.