Implementing Evidence-Based Psychosocial Practices: Lessons Learned from Statewide Implementation of Two Practices

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FOCUS POINTS
• Implementation of evidence-based practices is greatly affected by funding, credentialing, history of the practice within the local service system, and the availability of technical support, as well as by the structure of the practice itself.
• Strong leadership and mastery of practice-related skills were the two most prominent factors that impacted implementation efforts.
• Program planners often underestimate the amount of time it will take to achieve full implementation of a new practice.

ABSTRACT
Objective: As part of this national project, we examined barriers and strategies to implementation of two evidence-based practices (EBPs) in Indiana.
Background: Despite many advances in the knowledge base regarding mental health treatment, the implementation of EBPs in real-world setting remains poorly understood. The National EBP Project is a multi-state study of factors influencing implementation of EBPs.
Methods: Over a 15-month period we observed eight assertive community treatment (ACT) programs and six integrated dual disorders treatment (IDDT) programs and noted pertinent actions taken by the state mental health agency influencing implementation. We created a database containing summaries of monthly visits to each program and interviews with key leaders. Using this database and clinical impressions, we rated barriers and strategies at each site on seven factors: Attitudes, Mastery, Leadership, Staffing, Policies, Workflow, and Program Monitoring.
Results: At the site level, the most frequently observed barriers were in the areas of leadership, staffing and policies for ACT, and mastery and leadership for IDDT. Overall, barriers were more evident for IDDT than for ACT. Strategies were less frequently noted but generally paralleled the areas noted for barriers. However, our central finding was that ACT was generally more successfully implemented than IDDT throughout the state, and that this difference could be traced in large part to state-level factors relating to historical preparation for the practice, establishment of standards, formation of a technical assistance center, and funding.
Conclusion: In this case study, both state-level and site-specific factors influenced success of implementation of EBPs. To address these factors, the field needs systematic strategies to anticipate and overcome these barriers if full implementation is to be realized.

INTRODUCTION
In the last two decades, the mental health field has witnessed remarkable progress in identifying practices that lead to greater community integration and higher quality of life for clients with severe mental illness.
However, despite accumulating evidence about which services are effective for people with severe mental illness, usual community mental health center (CMHC) practices depart drastically from practice guidelines, and most clients do not have access to effective treatments. To bridge the gap between research and practice, the reasons for limited implementation of effective practices must be investigated.

In disseminating new practices, state planners have often assumed that CMHCs would be equipped to implement a new practice if they were given a written description of a program model, the funding to hire staff, some initial training, and perhaps an opportunity to visit a model site. However, the experiences with demonstration projects funded by the National Institute of Mental Health’s Community Support Program (CSP) during the 1980s showed the need for more systematic attention toward barriers to successful implementation. During that time, many programs were poorly implemented or never implemented for lack of an adequate implementation plan, inadequate leadership, and/or lack of model specification. Unfortunately, many of the common strategies used to promote model dissemination, such as workshops and didactic training, have little impact on practice. Formal presentations of research findings seldom alter practitioner behavior. The role of organizational readiness to adopt a practice also must be addressed for implementation to be successful. One further barrier facing state mental health agencies seeking to ensure that clients with severe mental illness receive the best treatment possible has been the lack of consensus about which of the many popular program models should be given priority. Over the last decade, mental health experts have asserted with increasing confidence that there does exist a set of practices that can be implemented or never implemented for lack of an adequate implementation plan, inadequate leadership, and/or lack of model specification. Unfortunately, many of the common strategies used to promote model dissemination, such as workshops and didactic training, have little impact on practice. Formal presentations of research findings seldom alter practitioner behavior. The role of organizational readiness to adopt a practice also must be addressed for implementation to be successful.

One further barrier facing state mental health agencies seeking to ensure that clients with severe mental illness receive the best treatment possible has been the lack of consensus about which of the many popular program models should be given priority. Over the last decade, mental health experts have asserted with increasing confidence that there does exist a set of practices that can be identified “evidence-based practices” (EBPs), described as well-defined services that have demonstrated positive client outcomes through rigorous research studies.

In 1998, the Robert Wood Johnson Foundation convened a national panel of experts who identified six EBPs for people with severe mental illness: assertive community treatment (ACT); integrated dual disorders treatment (IDDT); family psychoeducation; illness management and recovery; supported employment; and medication management approaches in psychiatry. These experts also concluded that simply identifying EBPs is not sufficient in order to assure their adoption, as suggested by the weak influence of practice guidelines in psychiatry. A more systematic approach to dissemination was needed.

In 1999, the National EBP Project was launched to address these deficiencies. Drake and colleagues lead this project and hypothesized that dissemination of EBPs was hampered by the lack of comprehensive, easily accessible information on their implementation. Consequently, in the first phase of this project, teams of researchers, practitioners, and clients created “implementation resource kits” (or “toolkits”) for each EBP. These toolkits include a variety of materials to facilitate practice implementation, such as workbooks, key research articles, fidelity scales, and introductory and instructional videotapes. Torrey and colleagues hypothesized that systematic training and consultation would be another critical component, in addition to the toolkits. They developed a training-consultation model that included the following elements: an implementation steering committee comprised of key stakeholders (eg, agency administrators, program leaders, family members, and clients) who would guide the process; introductory presentations (“kickoffs”) intended to build enthusiasm; skills training for practitioners; systematic assessment of model fidelity; ongoing consultation; and measurement of key client outcomes.

Based on these ideas, the second phase of the National EBP Project was launched in 2002. One goal of this 3-year phase is to assess the utility of the toolkits and the prescribed strategy for implementing an EBP. A second goal is to examine the barriers and strategies associated with successful EBP implementation. States participating in this phase agreed to implement two of the five psychosocial EBPs, in at least two sites for each EBP. Altogether, 53 sites from eight states are participating in the project.

Case Study of Implementation Efforts in Indiana

While the mental health field has made progress in identifying evidence-based practices, it is in its infancy in defining the principles of evidence-based implementation. Surprisingly, it has not been established empirically whether the major factors in successful implementation reside in policies and leadership at the state level, agency-level actions, or other sources (such as in practice itself, the training materials, the trainers, or the training plan). The current report uses a case study methodology, following examples found in the literature, augmenting our
observations with an observer checklist. Our focus is limited to agency-level and state-level actions. Our goal is to generate hypotheses that may aid in future hypothesis-testing studies.

The current paper is a preliminary report on the experiences in Indiana in implementing ACT and IDDT as a participating state in the second phase of the National EBP Project. This report summarizes the strategies and barriers related to implementation of these two practices, examining trends distilled from site-specific observations as well as state-level factors contributing to the success or failure of these projects over the first 15 months of the project. Although the National EBP Project uses a formal qualitative methodology, our report is an impressionistic and anecdotal account of the Indiana implementation efforts.

METHODS

Program Sites

In Spring 2002, Indiana’s Division of Mental Health and Addiction (DMHA) invited the state’s 30 CMHCs to apply for inclusion in the National EBP Project. Separate letters for the ACT and IDDT projects were sent out to CMHC directors, explaining the responsibilities of participating in the project (eg, a 2-year commitment of staff and resources to receive training and to implement the EBP, participation in interviews, assessments of program fidelity, completion of project evaluation forms, and agreement to be observed by project staff) as well as benefits of participation (eg, financial incentives, the addition of an EBP to their array of services, staff training and consultation, and the prestige associated with participation in a national project). CMHCs responded enthusiastically, and DMHA officials chose eight CMHCs to implement ACT and six CMHCs to implement IDDT. In accord with the timetable for the National EBP Project, the official “start date” to begin implementation was July 2002, although the actual rollout of the practices varied widely across sites.

The Evidence-Based Practices

The two practices were defined according to the toolkit materials developed during the first phase of the National EBP Project. ACT is a comprehensive treatment for clients with severe mental illness who do not readily benefit from clinic-based services. In the ACT model, multidisciplinary team members meet daily to plan interventions and share responsibility for providing a wide array of time-unlimited services in community settings (eg, medication management, symptom monitoring, housing services, hands-on help with daily living skills, and vocational and substance abuse services). ACT teams have low client:staff ratios and provide services directly rather than referring clients to other agencies.

The IDDT model is based on the philosophy that substance abuse and mental health treatment must be concurrently offered by one multidisciplinary team trained to provide both types of services. Comprehensive assessments of clients integrate mental illness and substance abuse issues. Treatment plans are individualized and client-driven. Recovery is viewed as a stagewise process, and treatment strategies reflect the client’s readiness to change maladaptive behaviors. Motivational counseling is provided to clients who are in earlier stages of change, while substance abuse counseling is provided to those in later stages of change.

Procedures

This preliminary report is based on the initial 15-month observational period (July 2002—October 2003) of the second phase of the National EBP Project. Each program site was assigned one of five trainer-consultants (four part-time ACT trainers and one full-time IDDT trainer) and one of three implementation monitors (IMs). A senior researcher coordinated the evaluation for state of Indiana.

The IMs were trained in qualitative data collection and analysis methods by project staff for the National EBP Project from Dartmouth. To enhance the quality and reliability of coding of the qualitative data, the National EBP Project held bimonthly conference calls and semiannual meetings of the IMs and senior researchers from the eight states. The IMs maintained approximately monthly contact with the sites, in addition to more frequent contact with the trainer-consultants, who informed IMs of pertinent developments at the sites. Following a protocol, IMs used multiple sources of information (eg, site visits, phone calls, E-mails) to create documents, which were then systematically coded in a database. Data sources included semi-structured, audiorecorded interviews with program leaders and trainer-consultants, informal conversations with various stakeholders (eg, practitioners, family members, clients), chart reviews, communications with the trainer-consultant, team meeting observations, fidelity assessments, and job shadowing.
Measures

Site-Level Stage of Implementation

As one crude indicator of progress in implementation, each site was classified as either “Pre” or “Post” skills training, based on whether the practitioner skills training curriculum prescribed by the National EBP Project had been completed by October 2003. For both practices, the formal skills training curriculum was designed to be ~16 hours in duration, covering six to eight topic areas. The training ranged from two consecutive daylong sessions at some sites, to multiple training modules lasting 2–3 hours each spread over a several month timeframe. The training intensity was largely dependent on each site’s preference and availability. Program fidelity as of July 2004 was also examined as a second indicator. For both practices, pairs of fidelity assessors consisting of a trainer-consultant and an IM made semiannual ratings at each site using a systematic protocol. For ACT, the assessors used an established fidelity scale, whereas the IDDT fidelity scale has not yet been validated.

Site-Level Assessment of Implementation Barriers and Strategies

Data gathered in the National EBP Project is coded and entered into a database using a conceptual framework that consists of 26 dimensions of implementation (ie, categories of barriers and strategies) developed by Torrey and McHugo. The database for Indiana sites was used as the primary source of information for site-level ratings.

The authors then summarized initial impressions from the 15 months of observation using a checklist developed for this paper. The checklist consisted of global ratings of barriers and strategies, defined by 7 factors derived from the 26-dimension conceptual framework employed by the parent project. To create the checklist, the authors first eliminated 6 of the 26 dimensions because they were either more pertinent to later stages of implementation (eg, rewarding success) or because they were being captured by one of the state-level factors (eg, money). The remaining 20 dimensions were collapsed into 7 global factors shown in Table 1. We further assumed that the IMs, by reason of their ongoing observations at each site, would be qualified to make summary assessments of the barriers and strategies related to EBP implementation. For each site, IMs identified up to 3 factors hindering implementation (barriers) and up to 3 factors promoting implementation (strategies). IMs then rated each of the top-rated factors on a 3-point scale indicating whether the factor had a small, moderate, or large impact on the implementation effort. After making these ratings, the IMs assessed the credibility of the ratings by “telling the story” of implementation at 3 sites, citing relevant actions and experiences of the key stakeholders; IMs compared the narrative version of their observations with the consolidated ratings. Group discussions helped clarify each IM’s ratings.

Overall Index of Importance of Barriers and Strategies

To obtain an indicator of salience for each factor within each EBP, the factor ratings were summed and divided by the number of EBP sites. Impact

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<th>TABLE 1. DEFINITIONS OF SPECIFIC FACTORS DIFFERENTIALLY IMPACTING INDIVIDUAL AGENCIES</th>
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<td><strong>Program Monitoring</strong></td>
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EBP = evidence-based practice.

scores <1.0 were considered small, those between 1 and 2 were considered moderate, and >2 were considered large. The overall means of the barrier ratings and of the strategy ratings were calculated for each EBP across the 7 impact indices.

State-Level Factors Influencing Implementation

During the observational period, the authors compiled an “event history” recording major events pertinent to EBP implementation, drawing on government announcements, E-mails, minutes of meetings, and other sources.

RESULTS

Overall Rate of Implementation of the Two Practices

The rollout of ACT within the state happened more quickly than for IDDT, as indicated by the number of sites completing skills training within the study period. All 8 (100%) of the ACT teams completed skills training by October 2003, compared to just 2 of 6 (33%) IDDT teams by that same date. By July 2004 (2 years after the official start date), seven (88%) of the ACT teams had achieved high fidelity. The fidelity rating for the remaining ACT site was close to the established norm for high fidelity. By contrast, three (50%) of the original IDDT programs had discontinued altogether their attempts to implement IDDT. The three remaining teams continued to struggle with staff turnover, limited understanding of motivational interviewing, and poor fidelity to the IDDT model.

Site-Level Barriers and Strategies

As shown in Table 2, the most frequently observed barriers were in the areas of leadership, staffing and policies for ACT, and mastery and leadership for IDDT. Based on the mean overall barrier rating, barriers were more evident for IDDT (0.98) than for ACT (0.64). Strategies were less frequently noted but generally paralleled the areas observed for barriers. The mean overall strategy rating was similar for ACT and IDDT (0.65 versus 0.43).

Attitudes

Attitudinal barriers were apparent at sites where agency administrators directed staff to implement the EBP, without first engaging practitioners or middle manager in the decision-making. One program leader, who was not consulted in the decision to implement IDDT and was not on board with the implementation, reported having to remind his staff to “keep an open mind,” as well as “remind myself, too.”

Another source of staff resistance was observed in sites where practitioners felt that they were already providing many elements of the practice, when in fact they were not. At these sites, practitioners were unresponsive to trainer efforts to teach them a “new” model. For instance, one IDDT program leader insisted that he and his team had been adhering to the principles of IDDT for quite some time, as it was simply “good old-fashioned social work.”

A major conflict stemmed from the difference between IDDT’s emphasis on acceptance of each client’s level of readiness to change, versus traditional “abstinence-only” philosophy. Several sites aligned with a 12-step treatment philosophy had difficulty accepting the use of stepwise interventions. Some practitioners felt their clients were “too sick for this model.” Thus, the philosophy that they were being asked to adopt contradicted how they thought about and worked with clients.

By contrast, ACT posed few attitudinal barriers. CMHC personnel across all organizational levels appeared receptive to the idea of implementing ACT. Practitioners typically expressed familiarity with the ACT model and viewed it as consistent with the agency’s cultural climate. Prior to the project start, many sites already had been operating in a multidisciplinary fashion, as well as doing some form of outreach work. At several sites, center directors enthusiastically expressed their intention to have the “best ACT team in the state.”

Mastery

From the beginning, IDDT implementation went poorly throughout the state, with sites reporting that they lacked a concrete description of IDDT to help staff visualize the model. The staff frequently complained that they did not know what “it” was when they were asked to implement IDDT. One CSP director noted, “…IDDT staffing requirements are not sufficiently spelled-out, for example, how many full-time equivalents per team?” Belatedly, several program leaders had the opportunity to shadow established IDDT teams in a neighboring state, nearly 1 year after the onset of implementation efforts. Feedback suggested that the experience finally led to a better understanding of the model.

All of the IDDT teams also had difficulty mastering the practical skills of IDDT, which is a clinically sophisticated treatment model, requiring the complex skills of assessing readiness for change and providing motivational counseling and other stage-wise interventions. Many practitioners, however, lacked even basic training in counseling skills and instead gravitated toward directive interventions.
Thus, the trainer-consultant was faced with the challenge of not only imparting a new philosophy and related skill set, but also teaching basic clinical skills (e.g., reflective listening), while helping practitioners unlearn maladaptive habits. For instance, at one IDDT site, practitioners shared the belief that most of the clients had severe cognitive impairments and therefore lacked the capacity to make good choices on their own. Accordingly, this site often used coercive interventions and frequently questioned during team meetings whether clients were “committable.” Another factor inhibiting mastery was that the trainer-consultant had relatively little experience with motivational interviewing and had difficulty effectively teaching this skill to trainees.

Mastery barriers were present for ACT as well, but ACT teams were better equipped to deal with the barriers via training, consulting, and their pre-implementation understanding of the ACT model. However, some teams erroneously assumed that merely by meeting the state’s ACT staffing standards they had fulfilled the functional roles associated with shared responsibilities across a multidisciplinary team. Many ACT teams had major difficulty mastering the

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<th>TABLE 2. RELATIVE IMPACT OF TOP BARRIERS AND STRATEGIES AT EACH SITE</th>
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<td>Stage of implementation‡</td>
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* Index score represents the overall salience of the factor and is calculated by sum of ratings/number of sites.
† Mean index score represents the overall impact of barriers and strategies for ACT and IDDT and is calculated by sum of index scores/number of factors.
‡ Stage of implementation refers to whether the site has completed the necessary skills training (Post) or has not (Pre) as of October, 2003.

ACT=assertive community treatment; IDDT=integrated dual disorders treatment; ●=small impact on implementation; ●●=moderate impact on implementation; ●●●=large impact on implementation; Post=post skills training; Pre=pre skills training.

nuances of the substance abuse treatment components of ACT model. Some ACT teams continued to broker out services, such as referring clients to day treatment, contrary to the ACT program philosophy.

**Leadership**

Because many senior clinicians were already familiar with ACT, the selection of ACT program leaders happened rather easily. At most ACT sites, the person who emerged as program leader had already been leading an ACT-like team. However, the shift to an ACT program leader position was not always by choice: at one site, a staff member was ordered to assume the position of ACT program leader or else be fired. Additionally, some ACT program leaders were not adequately supported by the agency administration. As one leader put it:

“Administration is all for the idea of implementing ACT, but they fail to understand the logistics of what that means, such as money to support staff, separating us out from the rest of the agency, and providing us with simple things like cell phones.”

In contrast, the general lack of familiarity with IDDT hindered identification of appropriate program leaders, except for one IDDT site, which was headed by an effective leader and made excellent progress toward model fidelity within the first 6 months. No clear champion emerged in the majority of the other sites implementing IDDT. Instead, the IMs observed several agencies appoint unempowered individuals who were a poor job match to the program leader position often accompanied by ineffective diffusion of responsibility among team members. For instance, an upper-level manager at one site submitted the EBP application to DMHA, but then drafted a lower-level manager to spearhead the implementation. This program leader was not highly invested in the implementation, but rather fulfilled the project obligations to “please the boss,” and repeatedly asked EBP Project staff when the project would be over.

Several IDDT sites underwent multiple changes in the identified program leader during the first 15 months of implementation. At one site, administration hurriedly identified a leader with moderate interest to head up implementation. The program leader resigned shortly thereafter and the administration then scrambled to find a replacement, eventually appointing someone with no experience with the severe mental illness population, no power within the agency, and no knowledge of IDDT.

**Staffing**

Both ACT and IDDT use a multidisciplinary team approach to treatment. Thus, staffing teams with the appropriate disciplines was necessary. However, identifying practitioners who were both qualified and genuinely interested in the model was a difficult task for several of the sites, especially in rural areas. In both practices, some sites appeared to coerce agency staff to join the EBP team, and in turn, many of these same sites also experienced higher turnover rates.

Psychiatrists play an essential role in both practices. Unfortunately, many programs have had difficulty securing adequate time commitments from psychiatrists. In IDDT sites, a perceived lack of targeted funding prevented several agencies from committing psychiatrist time commensurate with the model. In ACT teams, all teams were staffed with at least the minimum required psychiatrist time (as prescribed by state certification standards) but often had difficulty determining how the psychiatrists time with the team could be best used.

Finally, intra-team conflicts were observed to impact some ACT teams, which rely heavily on team cooperation, sharing of duties, and cross-training among disciplines. Team dynamics either served to greatly facilitate or impede the provision of quality services. To overcome this barrier, a few program leaders arranged retreats for staff to help work on building positive relationships within the team.

**Policy**

Inhibiting the development of ACT programs were site-specific policies relating to program admission criteria, assessment and treatment planning protocols, and unreasonable productivity standards. Regarding admission criteria, some ACT sites, seeking an expedient solution to their goals of rapid enrollment and low dropout rates, enrolled clients who were already well integrated into existing mental health services, contrary to the intent of the ACT model. CMHC documentation practices also were a significant barrier to planning the dynamic, individualized services that are hallmarks of well-implemented ACT and IDDT teams. At many sites, assessments and treatment plans were viewed as pro forma; sites commonly used generic, “macro-level” forms that were not used as treatment tools, but rather viewed as an inconvenience and “more paperwork.” Finally, productivity standards (ie, requirements that clinicians compile a minimum number of billable service hours) served as a significant barrier at most ACT sites. Start-up of a new program generally necessitates a loss of productivity, at least as defined by individual case manager billable hours, owing both to training time and to the learning curve required to master the procedures for a new practice. In addition, the daily ACT team meeting
often is viewed as reducing productivity, although some evidence suggests that it increases the team's efficiency over time.\textsuperscript{33} Despite these realities, some sites actually increased productivity expectations of practitioners during the start-up period when they encountered financial trouble.

**Workflow**

A lack of appropriate agency resources, such as adequate space and support staff, was not viewed as a major barrier in any of the sites. However, several ACT teams struggled to overcome the initial hurdle of having blended teams, where both ACT and traditional case management services were being provided by the same staff. At one site, a blended team eventually transformed into a discrete ACT team, which was functionally and structurally independent from the traditional case management services. However, 1 year into the project, staff in the traditional services continued to make numerous requests for consultation from the specialists on the ACT team.

**Program Monitoring**

As part of the National EBP Project, the IMs and trainer-consultants conducted semi-annual fidelity assessments. It was each team's responsibility, however, to use fidelity reports to guide needed changes. Two ACT program leaders used fidelity reports to help persuade their agency's administration for further supports to enable greater adherence to the model. Some teams chose not to address low-fidelity aspects of their program, in which case the program monitoring was less useful.

An important element of program monitoring is tracking client outcomes. Few sites collected outcome data during the early stage of team development, although a statewide outcome monitoring system was established in the second year of the project. Thus, program monitoring may prove to be one of the global factors in this study that contributes more prominently during the sustaining stage of implementation.

**State-Level Activities**

Prior to and during the implementation period, DMHA actions strongly influenced the quality and pace of implementation of both EBPs, although differentially. When the National EBP Project was launched, Indiana was far better prepared to implement ACT than it was IDDT. Five factors seemed most influential at the state level: choice of practice, state's prior experience in implementing model, establishment of standards, provision of technical assistance, and funding (Table 3). This section discusses each in turn.

**Choice of Practice**

DMHA officials were responsible for the selection of both EBPs for statewide dissemination. However, the differences were palpable between the two practices in the state's preparation and readiness to adopt the practices, owing both to the planning activities within the state and to the nature of these two practices.

Regarding ACT, DMHA's decision to launch a statewide ACT dissemination preceded the invitation to participate in the National EBP Project. The timing of the latter was serendipitous. Although the state's plan to disseminate ACT did not enjoy universal endorsement of center directors throughout the state, even prior to 2002, DMHA had a systematic timetable in place for elevating ACT to a Medicaid-billable service.

By contrast, the decision to implement IDDT was prompted by the design of the National EBP Project

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<th>TABLE 3. FACTORS DIFFERENTIALLY INFLUENCING IMPLEMENTATION OF TWO EBPS IN INDIANA</th>
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<td><strong>State-Level Factor</strong></td>
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EBPs=evidence-based practices; ACT=assertive community treatment; IDDT=integrated dual disorders treatment.

Establishment of Standards

In preparation for the establishment of ACT as a Medicaid-reimbursable service, DMHA contracted with a group of three university-based ACT researchers to develop a set of standards to be used for certifying CMHC programs as ACT programs in 2001. After consulting standards developed by the Madison Program for Assertive Community Treatment model and existing ACT standards in other states, reviewing the literature, studying the contents of ACT fidelity scales, and soliciting opinions of practitioners, clients, and family members, the group produced a set of draft standards in Spring 2002 (just before the launch of the second phase of National EBP Project). After a revision period, the standards were adopted as a state administrative directive. The standards were formally adopted as a Medicaid rule in June 2004. The Indiana ACT standards are very prescriptive, including details on staffing patterns, organization of services, hours of operation, and intensity and types of services. They give a clear picture of how an ACT team is organized and what kinds of services are expected. CMHCs have explicit rules about what is needed to be a certified ACT team.

IDDT, on the other hand, has no state-sanctioned guidelines, nor are there any written standards available from other sources that come close to the level of specificity of the state ACT standards.

Technical Assistance

The development of a technical assistance center for ACT within the state positively impacted implementation efforts. Established in 2001, the ACT Center of Indiana provides training and technical assistance, disseminates written materials and videotapes, answers questions posed by practitioners, advises DMHA on ACT policies, produces a newsletter, and facilitates a listserv. Within the state, the ACT Center trainers are regarded as credible leaders based on their extensive ACT-related work and educational experiences. The ACT Center was in operation for a full year prior to the inception of the second phase of the National EBP Project and provided numerous trainings throughout the state during that time.

The IDDT initiative was staffed by only one full-time trainer, with supporting administrative support from ACT Center staff. Its launch coincided with the second phase of the National EBP Project. Recruitment of a qualified IDDT trainer was hampered by the lack of expertise in IDDT within the state. Eventually a clinician from another state was hired to fill the trainer position. However, unlike the ACT trainers, the IDDT trainer had no prior experience with this specific model. Although he did have clinical experience working with the dual-diagnosed population, he did not have sufficient mastery of the IDDT model closely itself.
Funding

Another clear difference between ACT and IDDT implementation concerned funding. For three years starting in 2001, DMHA set aside funds of $333,000 annually per CMHC available to ACT certified teams enrolling at least 37 clients. Once selected for this initiative, CMHCs were required to meet the standards for certification before they received the funding. The incentive fund had its expected impact on CMHCs: all eligible CMHCs applied for and received certification.

Unlike ACT, no incentive funding was earmarked for IDDT. Although DMHA did set aside a source of funding for clients with dual disorders that they intended to be used for the new IDDT projects, the funding was confounded with one of DMHA’s usual funding streams and this set-aside was not perceived (or used) by CMHCs in the fashion intended by DMHA planners. Consequently, it is not surprising that the timetables for implementing IDDT met with many delays, staff changes, and postponement of meetings. Sites did not make implementation of IDDT a priority because there was no perceived financial incentive to do so. In fact, two sites ultimately abandoned their IDDT implementation in order to concentrate on developing ACT teams that could qualify for the ACT funding.

DISCUSSION

The sharp contrasts found in this case study of one state’s efforts to implement two EBPs cannot be denied. The reasons for these differences are of course open to many interpretations, as is always the case in a descriptive report. According to observations over the past 2 years, the actions taken by the state mental health authority have been the single most influential factor in determining the extent of successful implementation. We offer this case study in the spirit of hypothesis generation and remain uncertain whether other states and other practices might suggest very different conclusions, as the National EBP Project hopes to determine. While we are humble regarding the generalizability of the findings, we nonetheless believe that the lessons learned are not unique and should not be summarily dismissed.41

Our findings suggest that the implementation struggles observed at the individual site level were made more intelligible by examining state-level factors, such as the historical context for each practice and actions taken by the state mental health authority. In many cases, state-level factors overlapped considerably with site-level factors. Because sites were often already familiar with ACT because of statewide dissemination activities, center administrators typically were able to quickly identify a champion of the practice within their center. This was not true for IDDT. Also critical to successful implementation were the strong financial incentives to CMHCs to gain state certification as an ACT team so that they could then receive state funding. Clear incentives were not present for IDDT. In addition, the clearly prescribed standards of ACT promoted rapid assimilation of the model, whereas the clinical complexity of the IDDT model inhibited staff mastery of the necessary skills. Also, the structure of the IDDT model was perceived as ambiguous, leaving agency leaders unable to effectively plan implementation and contributing to inappropriate selection of program leaders, implementation sites, staff, and clients.

Some IDDT teams suffered from a lack of administrative commitment to the model. Fifteen months after start-up, most practitioners seeking to implement IDDT had insufficient understanding and skills supporting implementation. Relatively weak strategies were enacted in IDDT programs to overcome these barriers. ACT teams also experienced a variety of problems that hindered implementation related to leadership, understanding and mastery of skills, staffing issues, and conflicting policies. Overall, though, these barriers were not of the magnitude as seen with IDDT. Moreover, ACT teams appeared to be better equipped to deal with these problems.

The thrust of this report has been to focus on the barriers to implementation, which has given short shrift to the many dedicated and hard-working center directors, program leaders, practitioners, trainers, and state officials who have devoted long hours to the work of program design and implementation. Implementing EBPs is difficult. Even with a well-designed plan for implementation, the process is often slow, typically requiring 1 year or more to move from a start-up stage to a point that their staffing, procedures, and daily flow of work qualifies them as “sustaining the practice.” Our findings are also consistent with those of Becker and colleagues,42 who found that most agencies take at least 1 year to fully implement supported employment. Consequently, program planners need to set realistic expectations, make informed decisions about the preparation for implementing a model, and be willing to persevere.

Study Limitations

Many methodological limitations suggest caution in interpreting the study findings. First, due to its case-study methodology, causal inferences are not appropriate. Second, this study was conducted in a single state with an idiosyncratic his-
tory of mental health services. Other states, for example those with more decentralized mental health services, may have very different experiences with implementation. Next, the 15-month observational period is relatively short. Lastly, the rating methods used have not been validated.

Future Research

This study has reinforced our belief that it is critical to understand the forces that contribute to effective practice implementation. Some plausible hypotheses that have been advanced in the literature resonate with our observations over the last 15 months, whereas others do not. As yet, the mental health field has neither a coherent theory articulating the best strategies to implement an EBP nor a systematic body of evidence regarding implementation. The current study is offered in the spirit of hypothesis generation, recognizing the need for a broader theory under which to study these phenomena. Although we have learned a great deal about the barriers to implementation, our site-level information regarding strategies for success is fairly limited. To best identify effective strategies, future studies should purposively sample programs that have successfully implemented models rather than depending on newly formed programs. Although the data collected would require a historical review of events, this sampling strategy would be more likely to illuminate success stories.

CONCLUSION

In this statewide project, we conclude that the state-level preparation for the EBP, adequacy of funding, and the clinical complexity and degree of specification of the EBP were the three most important influences on successful implementation. Barriers relating to policies, staffing patterns for the practice, leadership (at both the center and program level), and practitioner mastery of clinical skills necessary to implement the practice were all evident during the early stages of implementation. To address these factors, the field needs systematic strategies to anticipate and overcome these barriers, if full implementation is to be realized.

REFERENCES