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Talking About Translating Research into Practice

by H. Stephen Leff, Ph.D., the Evaluation Center@HSRI and Vera Hollen, M.A., NASMHPD Research Institute, Inc. (NRI)

How do we stop having the same conversations? Put differently, after decades of mental health research, why do we feel that all we have learned has not been translated into practice? The three brief reports presented here, all delivered at the Annual Conference of the National Association of State Mental Health Program Directors Research Institute, entitled, "How Do We Stop Having the Same Conversations?" point to different but related missing links in developing, testing, and implementing evidence-based practices.

The report by Drs. Dumont and Jones describes an innovative consumer/survivor-defined crisis hostel, shown promising in a single quasi-experimental study. However, the innovation may not be tested further, even in New York state where it was implemented: one reason being inconsistent standards for what constitutes effectiveness for services.

The report by Dr. Hogan, Ms. Roth and colleagues describes Ohio's efforts to require that providers offer certain new evidence-based practices. This effort encountered resistance from providers who asserted, among other things, that they should not be required to implement the new practices since their usual practices are already "best practices."

Finally, in a talk reported here, Dr. Rosenheck described the organizational barriers that must be overcome to implement evidence-based practices.

All of these reports point to the need for an orderly process, credible to consumers, providers, funders and regulators, for developing the evidence for promising psychosocial practices and

deciding what practices work best for whom, under what circumstances. In another paper presented at the 2001 conference, Leff and colleagues (Leff et al., under review) considered how a process like the one followed by the Food and Drug Administration (FDA) for approving drugs and medical devices might work when applied to public sector psychosocial services.

The FDA process is an example of a process for identifying promising practices, testing them to determine their safety and effectiveness both in comparison to harmless placebos and competing practices, and bringing practices to market in a responsible manner (Food and Drug Association, 1998). The FDA process is far from perfect; however, it is one that most stakeholders accept as better than nothing (Healy, 1999).

Two important attributes of the FDA process are: (1) there is an agency with a public mandate to operate the process of identifying promising practices, developing the evidence for them and bringing them to market and (2) private sector drug companies fund a substantial part of this process (Healy, 1999). How these aspects of the FDA process can be addressed with respect to public sector psychosocial mental health services is a challenge that will have to be addressed in the future. Intergovernmental collaboration at Federal, State, and County levels would seem to be a necessity.

The active collaboration of scientists and clinicians to develop rules of evidence for moving interventions from research to practice also will be necessary (Leff et al., under review). Last, but not least, consumers and advocates must be involved to insure that the evidence collected includes evidence relevant to their concerns.

In the absence of an FDA-like process, the development, testing, and implementation of psychosocial practices will continue to be characterized by missing links and conflicts about what works best

for whom, with no rules for resolving these issues, and we will continue to have the same conversations. On the other hand, the existence of such a process for psychosocial practices could provide guidelines and further resources for the testing necessary to establish services like consumer/survivor defined crisis hostels as evidence-based practices, resolve debates in systems like Ohio's about the relative effectiveness of new and existing practices, and help to rationalize change in treatment organizations like the Veteran's Administration. ▲

All of these reports point to the need for an orderly process, credible to consumers, providers, funders and regulators, for developing the evidence for promising psychosocial practices and deciding what practices work best for whom, under what circumstances.

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Findings from a Consumer/Survivor Defined Alternative to Psychiatric Hospitalization

Adapted from the NASMHPD Research Institute Conference Presentation by
Jeanne Dumont, Ph.D. and Kristine Jones, Ph.D. February 13, 2001

Introduction

Having a place in Tompkins County New York where people could retreat to if they viewed themselves in need and at risk of psychiatric hospitalization was the primary purpose of the Crisis Hostel Project. This place, which would consist of staff who had “been there,” a simple set of rules, meditation/massage space, raging space, was many years in the planning. During its evolution we applied for and were awarded a National Research Demonstration Grant to operate and evaluate the Crisis Hostel. In the session myself, Jeanne Dumont, who served as principal investigator, and Kris Jones, the cost analyst investigator, present the outcomes findings of the project.

We’d like to begin by telling you up-front about our findings. We found that access to and actual use of the Hostel significantly contributed to healing, empowerment and satisfaction with services. In addition, we found that people with access to and who actually used the Hostel spent less time in the hospital. This shift in acute care services use, coupled with the lower per diem costs of the Hostel as compared with the general hospital, accounted for modest cost savings. Thus we conclude that the Crisis Hostel was an effective innovation. How is it then that an effective innovation is not currently in operation?

You are all probably familiar with the story of the three little pigs and the wolf that blows down their houses. When

we consider the gap between research and services there may often be various versions of what happens in translating particular findings into practice. Even with the three little pigs there’s the story according to the wolf you might not be aware of. Mr. T. Wolf as he refers to himself claims circumstances are what brought the houses down. A bad cold, big sneezes. He was just looking to borrow a cup of sugar to make a cake for his sick grandma. Although there was no big bad wolf that blew the Hostel away, the research itself was both friend and foe — Foe in that vying for continuing funds before all the results were in, the service was held to a higher effectiveness standard than pre-existing services.

We would now like to describe the service and research components of the project in further detail and providing the evidence, we would like to take some time to talk with you about the existence of a hostel as a viable service option.

The Crisis Hostel, involving a small five bed residence, operated for two years in Tompkins County, NY, as an alterna-

tive to psychiatric hospitalization. Throughout the project’s planning and development, ex-patients and other consumers provided the initiative, expertise, concepts and staffing. A National Research Demonstration Grant funded by The Center for Mental Health Services was awarded to operate and evaluate the project. The type of evaluation that was conducted should provide insight for consumers and payers who are searching to improve the existing delivery system of specialty mental health services.

The Crisis Hostel Project distinguished itself from other crisis centers in its consumer/survivor involvement, voluntary non-medical model, self-definition of need, and basis in peer support. This alternative was designed to avoid the involuntary treatment system and the negative ramifications associated with inpatient hospitalization, e.g., disruption, loss of control, traumatizing treatment, avoidance of help, exaggeration of conditions to get in.

Consumers also felt that retreating to a healing supportive environment sur-

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rounded by others who have experienced similar problems or who show an implicit understanding of the effect of the experience could help them learn from and work through a crisis.

Organizers believed that this alternative would result in less frequent and shorter durations of crisis service use, either of the Crisis Hostel or traditional hospital-based services. They predicted that persons with access to the Crisis Hostel would experience a movement toward healing/recovery, a greater sense of empowerment and satisfaction with services than would person without access to the Hostel. They predicted that the reduction in use of crises services would lower crises service and total mental health treatment costs, when compared to the usual treatment system.

Methods

Using a random design, the presenters investigated these outcomes for 265 participants having or not having access to the Crisis Hostel (CH). All study participants had been labeled with a DSM-III R diagnoses. They had experienced substantial hospital stays with a majority having had four or more admissions and a median 'longest stay' or over one month. The median annual income of the group was \$8,400.

Persons in the test group had access to all CH services. CH services included preparatory Hostel training, crisis services, on-going workshops, peer counseling, advocacy and entry to a rage or meditation/massage room. Use of CH services was voluntary. Test group members also had access to usual services as did the study's control group. The control group was not able to avail themselves to CH services. Both groups were evenly distributed on all baseline variables.

Participants were assessed upon admission to the study, and both at six and 12 months with measures of empowerment, healing, symptoms, hospital admissions and length of stay, job maintenance and satisfaction with services. They were also asked about stays in the Crisis Hostel, the local community hospital and state hospitals as well about use of community-based specialty mental health services. Providers were contacted with the consent of participants to provide information concerning volume of service use. Each service category was assigned a unit-cost based on accounting data.

Results

The test group had better healing outcomes at the six month interval ($p=0.04$) and when a repeated analysis was conducted from baseline to 12 months ($p=0.05$). With respect to empowerment, the test group had greater levels of empowerment than the comparison group at the 12-month ($p=0.02$) and when repeated analysis was conducted from baseline to 12 months ($p=0.01$). Both groups reported the same number of hours spent in paid or volunteer employment over the entire study period.

Not surprising, the test group reported that the CH offered crises services that were more timely and useful by more competent staff who respected the consumer's rights than persons receiving usual crises services only. Greater levels of promotion of healing and self-care had been experienced by the test group than experienced by the control group. All in all, the test group had greater levels of service satisfaction than the control group ($p=0.00$). In the six months prior to entry into the study, a greater proportion of per-

sons in the study group experienced hospital admissions (24.7% vs.17.5%). Despite this, during the first six months the proportion of the test group with any hospital admissions was a similar 11.9% as compared to the control group's admission rate of 12.6%. While not significantly different in the second six-month period,

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the proportion for the test group was reduced to 7.7% as compared to a virtual no change in proportion of 13.2% for the control.

When the length of stays associated with those who had hospital admissions were taken into account, those in the test group did stay in the hospital for shorter periods than the control group. Over the year, the average stay was 10.7 days for the test group and 15.15 days for the control group. Hospital stays for those with hospital admissions in the control group were nearly fifty percent greater than the test group. This difference did not reach a level of significant difference. However, a repeated measure approach that took into account the entire sample did find a significant difference in mean hospital stay ($p=0.02$).

Turning to whether or not a service system that includes a CH would

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result in lower costs, a comparison of the two groups' psychiatric hospital costs (measure as inpatient stay-cost and emergency room service-cost) found that persons with access to the CH experienced significantly lower psychiatric hospital cost over the study period ($p=0.05$). Their average cost were \$1,057 while the control group's cost averaged \$3,187. The control group's crisis services costs were over 200 percent greater than those of the test group's. Even when the CH costs are combined with the other crisis service costs the test group average costs trended lower than the control groups. Their total crises service average costs were just \$2,018. Or, the test group's costs are slightly greater than a third of the average cost for the control group.

When all specialty mental health services are included - the crisis services cost as well as the expenditures on community mental health service and supportive housing programs, the test group was still associated with lower treatment costs. The test group's average cost for this expanded set

In nearly all areas, persons who had been assigned access to the CH were associated with both better outcomes and lower costs.

of services was \$9,088 and these costs averaged \$13,919 for the comparison group. This represents a cost difference of \$4,831 per person over just a year's time!

Conclusions

In nearly all areas, persons who had been assigned access to the CH were associated with both better outcomes and lower costs. Persons in the test group were associated with greater levels of healing, empowerment and satisfaction. They experienced no less disruption in their work life. Hospital

stays were relatively less frequent and shorter. Crisis service costs and total mental health service costs were lower for the test group than for the control group.

So what do the findings suggest about the existence of a hostel as a viable service option? And can savings be realized even as persons are given the choice whether and when to use an overnight night hostel?

We found that people's self assessments of their need to use the hostel ran the gamut from taking a time-out, to early prevention of crisis, to actually being in a crisis that in the past resulted in a hospitalization. People added the hostel to their service use or substituted the hostel for other service options such as the hospital.

During the study period, the Hostel was used as an early prevention option for the majority of users. They made use of the Hostel instead of doing whatever they would have done if the Hostel didn't exist, which in some cases included nothing, or included either riding the crisis out or finding that it was exacerbated with time, and more drastic measures such as going into the hospital were realized either on their own volition or through involuntary means.

In some cases, the Hostel was used in addition to the hospital. Usually persons went into the hospital and then subsequently used the Hostel. On average hospital stays were comparatively shorter for persons with access to the hostel than for those without access. If a hostel were to become a

service option and not merely a temporary innovation during a grant period, we think that a hostel might continue to be used in a step-down fashion; however, people would also more frequently turn to the hostel instead of hospitalization. This would be facilitated by people working at the hospital referring people to the hostel. In this project, attempts were made to facilitate hospital personnel seeing the hostel as a choice instead of a hospital admission, but we think it would be more likely to be realized if a hostel was in operation longer and positive findings from testing its effectiveness were distributed.

Finally, we think that with a hostel operating for a longer duration and persons learning how best to use it to fit their individual needs, for example, having period short term overnight stays, or making use of ongoing trainings and drop-in support, we would find that a hostel would be substituted for other service options, including high-end residential support. Although it's primarily through the substitution or use instead of hospitalization that cost savings would be realized, the findings from the Crisis Hostel Project suggest that the comparatively low cost of a hostel to a hospital would render modest cost savings even when a significant number of people add such an option to their support system or service utilization pattern.

The Hostel stemmed from the expertise of consumer/survivors and their desire for an entirely voluntary choice based on their self-defined needs. Since the findings point to effectiveness and modest cost savings, we hope the findings will translate to the implementation of voluntary self-defined alternatives to hospitalization in practice. ▲

Transforming Research Into Practice in a State Mental Health System

Michael F. Hogan, Ph.D., Dee Roth, M.A., Dale P. Svendsen, M.D., Bill Rubin, M.A.

Introduction

Ohio's public mental health system, like that of many states, has recently emerged from a period of structural reform, initiated by the 1963 national mental health centers legislation and enhanced by the Ohio Mental Health Act of 1988, which set the stage for the downsizing of state hospitals and the transfer of funds and responsibility for care to local communities. While regulation and leadership remain state-level functions, managing mental health services and funding are primarily under local control. Now that systems reform is largely completed, we focused on the fact that the quality of services consumers receive is variable. While some receive highly effective treatment, the majority get services which are mediocre and which fail to meet reasonable consumer or family expectations for life outcomes. The Schizophrenia Patient Outcomes Research Team (PORT) study in Ohio confirmed that, for the most part, services did not meet criteria established through research. We are also concerned, based on results from Ohio's Longitudinal Consumer Outcomes Study, that services are keeping people stable but are not helping consumers achieve personal role successes.

To improve mental health services, the Ohio Department of Mental Health

(ODMH) has implemented a strategic plan focusing on quality and recovery. The plan could be characterized as a "carrot-and-stick" approach, wherein we are using both our state regulatory authority and our discretionary funding ability to guide local systems into a path toward improved quality of services. The basic model is that of a triangle, the three sides being: measurement of consumer outcomes; the installation of quality improvement processes; and the use of evidence-based practices.

The "stick" part of the approach has been considered for all three sides of the triangle. ODMH has regulatory authority to set standards for provider operations, and has currently in place a large set of standards that cover various aspects of service provision and documentation. Our plan has been to greatly reduce this set of regulations and to substitute standards that would require mental health agencies to measure outcomes, perform quality improvement studies of clinical process, and utilize at least one evidence-based-practice from a list of several practices which have been validated by research.

Providers have asserted that they are already employing best practices in accordance with professional guidelines, and that mandating evidence-based practices would be an unwarranted state regulatory intrusion into their clinical arena.

While regulation and leadership remain state-level functions, managing mental health services and funding are primarily under local control. Now that systems reform is largely completed, we focused on the fact that the quality of services consumers receive is variable. While some receive highly effective treatment, the majority get services which are mediocre and which fail to meet reasonable consumer or family expectations for life outcomes.

It has been a difficult process to work with our constituencies regarding this change in state rules, and the dialogue about the inclusion of evidence-based practices in the rules has been particularly contentious. Providers have asserted that they are already employing best practices in accordance with professional guidelines, and that mandating evidence-based practices would be an unwarranted state regulatory intrusion into their clinical arena. Hence, we will probably remove this requirement from our draft standards and concentrate our efforts more in the "carrot" arena, with regard to the installation of evidence-based practices.

Although outcomes measurement and quality improvement will remain in state rules, we are also dedicating substantial resource to helping providers adopt these processes. After a

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four-year period of development, testing and product development, the Ohio Mental Health Consumer Outcomes Systems was launched in the Fall of 2000, with incentive grants to local systems for start-up costs. Plans are now underway for substantial training for providers in quality improvement methodologies, which should enhance their transition into this endeavor.

The area of translating research into practice — of getting providers to

Does the information come from a trusted source? Is the innovation “timely” as regards the needs of the organization? Is there a “fit” between the innovation and the culture of the organization?

We are attempting to use this information in crafting our “carrot” strategy to increase the use of evidence-based practices in Ohio’s mental health system. Our primary mechanism has been to work with universities and others in our state to create networks and centers focused on implementing best practices in local community health systems. These special centers are funded by ODMH, and are called Coordinating Centers of Excellence (CCOEs). Center tasks include sharing information, training, assessing fidelity to research-validated models, and evaluation.

In choosing those practices around which to focus CCOEs, we have considered both the level of research evidence that a particular practice has achieved and the level of salience of topical areas or

special populations for the mental health system. Examples of high-evidence practices are Multi Systematic Therapy and the dual-model of treatment for SA/MI consumers developed at the New Hampshire/Dartmouth Center. Examples of high-salience issues are school mental health and jail diversion.

Our current portfolio of CCOEs includes six which have been funded: MST, the NH/Dartmouth SA/MI model, the Ohio medication Algorithm Project, learning excellence

in alternative schools, advance directives and cluster-based clinical quality improvement. CCOEs on jail diversion, family psychoeducation and supported employment are in the planning stage.

One example of a recently funded CCOE is the Cluster-Based Planning Alliance, a collaborative endeavor between the Ohio Council of Behavioral Healthcare Providers, Inc., and Synthesis, Inc., an independent research organization. This CCOE is providing training and technical assistance to agencies to enable them to use methodology developed with ODMH research funds to subset their client population into clinically meaningful subgroups, or clusters. Identifying clinically relevant subgroups of consumers allows an agency to understand differential service use, cost and outcomes, and to use this information for quality improvement endeavors. To assist in that activity, this CCOE will be providing comprehensive data analysis and benchmarking information to providers who are members of the alliance

In summary, by utilizing state regulatory authority and discretionary spending ability, ODMH is embarking on a new and substantial agenda for improving the quality-of-care in Ohio’s mental health system. We intend to triangulate on the problem of quality via simultaneous efforts to: 1) implement evidence-based practices through Coordinating Centers of Excellence, 2) increase the use of quality improvement methods, and 3) systematically assess consumer outcomes. ▲

Dr. Hogan is Director of the Ohio Department of Mental Health.

Ms. Roth is Chief of the Office of Program Evaluation and Research at ODMH.

Dr. Svendsen is Medical Director of ODMH.

Mr. Rubin is President of Synthesis, Inc.

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employ evidence-based practices — has been the most daunting side of our triangle model to implement. We are aware from the NIMH “Bridging Science and Service: A Report by the National Advisory Mental Health Council’s Clinical Treatment and Services Research Workgroup” report and other studies that the translation of research into practice occurs at a disappointingly low level. The adoption of new knowledge in an organization tends to be rest on the following factors: Does the innovation conform to the decision-makers beliefs and values?



Dr. Robert Rosenheck Describes Key Factors For Research Dissemination

Reported by Vera Hollen, M.A. and H. Stephen Leff, Ph.D.

On Sunday February 11, 2001, Dr. Robert Rosenheck opened the Conference with a presentation titled “Muddling Through Science, Politics, Bureaucracy and Practice: A Life in Government.” He encouraged researchers to think about how what they do every day moves things forward, even if it seems like it is inch by inch. Dr. Rosenheck used two major examples from his own work, describing how critical windows of opportunity come along for researchers to use their findings to impact policy. He pointed out that research, as science is very different from research in the life of many organizations. Research systematically seeks to isolate a single factor. In much of real organizational life, one is always dealing with a multiplicity of factors and the goals are intensely ambiguous and contested. Decision-makers rarely have enough time to pay attention to any one thing, let alone follow it through. Dr. Rosenheck commented that decision-makers, in public mental health in particular, come and go with a fair amount of rapidity, and the focus of public mental health organization is constantly shifting, depending on the crisis of the moment.

Dr. Rosenheck described a type of research that has been relatively rare

in mental health, but that is worthy of focus: dissemination research. He pointed out that there are four types of research: the traditional efficacy research, which is small, sample-size, includes short time frames, under quite artificial conditions to maximize internal validity. Second is effectiveness research, which begins to relax the controls to more closely approximate real world practice, but is still formal research with random assignment. Translational research, purports to look at what Factors need to be in place to implement a new practice in the real world. Last, he said, we need dissemination research, which evaluates and tracks the process of importing new technologies in unbuffered organizational settings. He described that in dissemination research, there is a crucial process in which you develop a learning community of people that is no longer engaged in implementing something from the top down, but rather establishes a community and a dialog.

Dr. Rosenheck pointed out that the sustained translation of the research to practice requires ongoing participation in organizational processes. He used the analogy that one can't launch a ship just by pushing it. There has to be a motor, and somebody steering it

all along the way. Likewise, he suggested, processes need to be developed, and one of the tools for this is developing “numeracy”. He defined “numeracy” as the quantitative parallel to literacy. Researchers typically put out reports that demonstrate outcomes site- by-site. People need to be taught how to look at these reports, how to understand numbers, and how to use them locally to advocate for their programs.

Over his many years of service, Dr. Rosenheck has observed that organizational life is composed of routines and beliefs to support those routines. Researchers may find results that infuriate people because they contradict this status quo. Researchers need to be sympathetic toward those whose routines and beliefs are challenged.

Dr. Rosenheck stated that in some instances, one could make the case that changes brought about were a rational response to studies conducted. He points out that this is sometimes true, although often it's just that the changes were already present in the system. Researchers will move things forward at times of crisis, when there are windows of opportunity. If one has innovations that are moving with the grain, then things are likely to happen much more smoothly.

As a final point, Dr. Rosenheck suggested that the key elements for data or research dissemination are training, personal interaction, and sharing experiences and data to monitor implementation and move toward acceptance of innovation. ▲

Researchers typically put out reports that demonstrate outcomes site- by-site. People need to be taught how to look at these reports, how to understand numbers, and how to use them locally to advocate for their programs.

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For more information about the NASMHPD Research Institute, Inc. and our Research Projects, visit our web site: www.nasmhpd.org/nri or call us at 703-739-9333.

Center for Evidence-Based Practices, Performance Measurement and Quality Improvement

Mission

The mission of the Center is to promote quality and accountability in state mental health systems by providing support in the development and implementation of evidence-based practices, performance measurement, and quality improvement processes.

State mental health directors have identified evidence-based practices, performance measurement and quality improvement as the pillars on which to build and enhance mental health systems. They have created the Center to help produce better outcomes for consumers and their families through these initiatives.

A major goal for the Center is to develop a coordinated, coherent strategy related to research, implementation and knowledge management. Several research projects are currently under way related to evidence-based practices. Many states are implementing such practices and performance measurement systems. The disjointed nature of knowledge application, the lack of knowledge transfer across states, and the need for a systematic approach both at the national and state levels are the basis for the creation of the Center.

Center Operations and Activities

The Center is a major component of the NASMHPD Research Institute, Inc. and is accountable to the NRI Board. The Center will initially be funded by the Center for Mental Health Services. NRI staff will constitute Center personnel.

The Center will coordinate activities across various stakeholder groups and organizations. In the first year of operations, the plan is to create a web-site, build on the experiences and lessons learned for states implementing evidence-based practices and performance measurement systems, support a consortium of states interested in implementing EBPs, and sponsor an EBP Implementation Network Conference in August 2002.

For more information on the Center, please contact Vijay Ganju, Ph.D. at 703-739-9333 ext. 132 or vijay.ganju@nasmhpd.org.

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the Evaluation Center@HSRI

The Evaluation Center@HSRI is funded by the Center for Mental Health Services. The Center:

- Provides evaluation technical assistance to States, other public entities, and nonprofit organizations to improve the planning, development, quality, and cost-effectiveness of adult mental health services.
- Supports the evaluation of promising changes in adult mental health systems, encourages the dissemination and application of evaluation results, and advances useful evaluation methods and tools.
- Addresses topics such as cultural competency, evidenced based services, and performance measurement.

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The Knowledge Assessment and Application Program, based in the Evaluation Center, develops criteria and methods for assessing the evidence base for psychosocial intervention. The program draws upon meta-analysis, equivalence analysis, and related methods. The program is intended to provide technical assistance to investigators implementing research synthesis and to mental health stakeholders who want to know the evidence base for specific services or program models. Towards these ends the program will produce working papers on technical methods and knowledge assessment profiles for specific services and models.

If you would like more information about this program please contact the Program Manager, Clifton Chow, Ed.M. at chow@hsri.org.

If you would like more information about other Center programs please contact the Program Manager, listed below:

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Selected Evaluation Center@HSRI Resources for Knowledge Assessment and Application

Practical Meta Analysis Toolkit, 1996 (PN-6). Mark W. Lipsey and David B. Wilson (How to synthesize the evidence for a practice).

Toolkit on Manuals and Workbooks for Psychosocial Interventions, 2001 (PN-47). Terry Camacho-Gonsalves, H. Stephen Leff, and William C. Torrey. (How to manualize a practice).

Psychiatric Rehabilitation Fidelity Toolkit, 2000 (PN-44). Gary Bond, Jane Williams, Lisa Evans, Michelle Salyers, Hea-Won Kim, Heather Sharpe, and H. Stephen Leff. (How to measure whether a practice is implemented as intended).

Implementing Outcomes Management Systems in Mental Health Settings, August 1997 (PN-28). G. Richard Smith, Carol Nordquist, Ellen P. Fischer, Cindy Mosley, and Nancy S. Ledbetter. (How to measure and improve the outcomes of a practice).

Visit the Evaluation Center@HSRI website (www.tecathsri.org) for materials.