WHITE PAPER

An Initial Investigation of State Agency Selection Approach and Experiences with Evidence Based Practices and Standardized Assessment Instruments For Adolescent and Young Adult Substance Abuse Treatment Services

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Prepared by:
The National Association of State Alcohol and Drug Abuse Directors

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An Initial Investigation of State Agency Selection Approach and Experiences
with Evidence-Based Practices and Standardized Assessment Instruments
For Adolescent and Young Adult Substance Abuse Treatment Services

EXECUTIVE SUMMARY AND INTRODUCTION

State Substance Abuse Agencies are making increasing use of and providing progressively more support for evidence-based practices (EBPs). This reflects their understanding of the importance of and intent to incorporate current research findings into the practices of their provider networks. State efforts in this direction are being undertaken under many different processes, including procurement requirements, program licensing standards, credentialing requirements for practitioners, as well as through direct funding and technical assistance providers and practitioners. SAMHSA has made important contributions to these State efforts through a variety of mechanisms, including grants to State and providers (such as the SAT-ED and SYT initiatives) and the support to NASADAD and the States to develop and disseminate the *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide*.

It has become apparent recently that when States approach the decision to select evidence-based practices (for whatever reason) that the selection process can be challenging. The stakes in selection of EBPs for treatment protocols and/or standardized assessment instruments are fairly high. There is evidence that excellent implementation generally yields discernable improvements in terms of outcomes of adolescents and transitional age youth. However, it is demanding to accomplish full implementation and also quite difficult to sustain it. A major part of the challenge appears to be that EBP protocols and standardized assessments require strong technical skills from practitioners and this in turn requires material levels of support--often this means that the costs to treat are substantially greater than for treatment as usual (TAU) or the established assessment approach.

This document represents one step in an effort to make State selection of EBP protocols and standardized assessment instruments more effective and efficient. It is envisioned that a guide to selection of EBPs could be helpful to States in these efforts. In this rapid-turn-around project NASADAD has explored the experiences of four States in selection, implementation and sustainment of evidence base treatment protocols and standardized assessment instruments. The goals were to learn about:

- how States went about selecting EBPs that they intended to implement with the support of a grant from SAMHSA (either the SAT-ED or the SYT); and
- the experiences they had in the implementation and operation of those treatment protocols and/or assessment instruments.

In this very concentrated effort structured discussions were held with officials responsible for management and oversight of youth treatment services with four States: Kentucky, New York, Oklahoma and South Carolina. NASADAD is extremely grateful to these professionals for their willingness to rapidly schedule and hold structured discussions.

The primary findings from discussions with the four States are:

States do find it very challenging to select EBP treatment protocols and assessment instruments:

- They primarily relied on their own experience and knowledge to select EBP tools;
- Other sources were contacted, including local providers, but also EBP developers;
- They would have liked more information about the EBPs, particularly the experience of other State agencies in implementation and operations;

The issues that States considered most important to have information about in making selection decisions were:

- The nature and demands of the implementation process, e.g.,
    - What training is required for staff and providers
    - Whether staff must acquire certification prior to delivering the EBP
    - Who is qualified/allowed to do staff trainings
    - How much staff time is required to deliver (and do quality control of) the EBP
    - How the EBP would interface with existing services (e.g., augment or supplant)
    - How flexible was the process of implementing and operating the EBP
- What are the costs of implementing and delivering the EBP
- If the EBP is expected to be more expensive than treatment/assessment as usual, how likely is it, and what it would take to get enhanced reimbursement from (public and/or private) payers for the EBP.

The four States that shared their adolescent treatment EBP experiences each wrestled with these issues either during their selection process or gained "meaningful insights" about these issues during the course of their SAMHSA-funded projects. Of course, each State had a different discernment process, both in terms of EBP selection as well as in the implementation and operational experiences.

The Report provides an overview of the methods used in this rapid-turn-around project, summarizes what was learned from each of the four States from the structured discussion, and summarizes the salient lessons learned that could inform the construction of an inquiry to create a guide for State selection of evidence based practices for adolescent treatment protocols and/or standardized assessment instruments.

METHODOLOGY

This project was envisioned and designed as a formative assessment of State experiences in selection and implementation of adolescent treatment evidence-based practices. It is intended to inform a potential future effort to design and collect information for a State guide to EBP selection. Such a guide might in part be based on examining and reporting on the actual experiences of State substance abuse agencies that have been already working with adolescent EBPs. This could assist other States that are either just getting into widespread use of EBPs, or States that want to consider new or different EBPs.

Accordingly, our approach was to have structured discussions with a small sample of States that had been funded by SAMHSA through the recent SAT-ED or SYT grants about how they made the decision(s) to select particular treatment protocols and assessment instruments, as well as their actual experiences during the implementation and operational phases for these EBPs.

The intent was to learn what type of information was weighed during the decision making process, what information they wanted but did not have during the process, how States went about attempting to gather the information, and "lessons learned" by States during implementation and operation that they wish they had known while selecting the EBPs.

A "Discussion Guide" was developed for use during the calls with States. The discussions covered both what States did during planning and conducting their projects as well as their decision processes. It was judged critical to the discussion to understand what the States did as well as why, and the decision making process. It was found that through description by a State of what they did in planning and conducting their project that important insights were gained about why they did them and how they might have done them better if not differently. The set of discussion topics benefitted from discussions with and input from Dr. Doreen Cavanaugh, Matthew Clune and John Roberts of JBS Intl., and Ms. Twyla Adams of SAMHSA/CSAT.

The discussions with each of the States addressed all of the topics, in the Discussion Guide below. However, due to limits of time and resources the summaries of each State discussion tended to highlight the more salient factors learned that might inform the development of an inquiry of States that would provide the input for a Guide to EBP Selection.

SAT-ED/SYT EBP Discussion Guide

EBP (treatment and/or assessment instrument) Selection Process

- What EBPs (treatment and/or assessment instrument) for youth and transitional age youth (young adults) is your State currently implementing as part of the SAT-ED/SYT grant?
- Please tell us about your State's EBP selection process for each of these.
- Who was part of the selection process?
- Did you talk/work with providers during the selection process?
- What resources did you use to help select an EBP?
- What resources and/or information would have helped while selecting an EBP?

EBP Implementation

- Please describe the implementation process for the EBP treatments and/or assessment instruments that were selected? (planning, setting, consultants, technical assistance, etc.)
- Who delivers the EBP?
- What training is required and/or provided for staff?
- Is any particular certification required for staff?
- What kind of evaluation(s) have been done so far?
- Do you have any process or outcome data available?
- What are the costs associated with implementing this EBP?
- What would help with EBP implementation?
- What lessons have been learned about the selection and implementation of this EBP in your State?

There was a four week window for this project. The project plan allowed for about one week to start and plan the project, one week to conduct the discussions with States and then two weeks compile findings and draft the report. To recruit States for this effort NASADAD put out a request to all of the

State Youth Coordinators. It was hoped that up to five States would we willing and able to engage in the structured discussions during the time available. Ultimately four States were able to participate.

SUMMARY OF STATE DISCUSSIONS

KENTUCKY

Introduction

SAMHSA/CSAT is preparing to develop a guide for future SAT-ED/SYT Grantees to use as they choose an evidence-based practice and assessment tool for adolescent SUD treatment services. NASADAD has been tasked with conducting case studies on current grantees that have been through the assessment tool and EBP selection and implementation processes. This summary highlights a discussion with Michelle Kilgore, Youth Coordinator for the State of Kentucky. Kentucky chose the Global Appraisal of Individual Needs (GAIN)-Q3 as the assessment tool and the Adolescent Community Reinforcement Approach (ACRA), an evidence-based practice that is designed to treat adolescents with drug and behavioral problems.

EBP (treatment and assessment instruments) Selection Process

The State had prior experience using the GAIN as part of the State Adolescent Substance Abuse Treatment Coordination (SAC) grant, as well as two Reclaiming Futures sites. State-level work with Reclaiming Futures led to the incorporation of the GAIN into the Department of Juvenile Justice, and the positive outcomes in that Department influenced the decision to choose the GAIN for the SAT-ED grant. As part of the SAC grant, Kentucky implemented Seven Challenges, with many providers throughout the state already having received training for it. However, when selecting an EBP for this grant, cost and sustainability were the most important factors, and they believed that the train-the-trainer model included in Seven Challenges would not be cost-effective. ACRA was also chosen because it built upon skills that providers developed while implementing Seven Challenges, such as motivational interviewing and addressing co-occurring disorders.

In addition to taking into account prior State experiences, SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) was used during the selection process to compare Seven Challenges to other EBPs. NREPP, as well as conversations with Chestnut Health Systems were resources that Michelle Kilgore used to learn about the costs, training requirements, and sustainability of ACRA, which she compared to Kentucky's experience with Seven Challenges. Selection of the ACRA was decided by Ms. Kilgore along with the agency's policy advisor, and SAC grant coordinator.

EBP Implementation

The agency selected two pilot sites to implement the GAIN-Q3 and ACRA. They focused on regions that had previous experience with implementing system-wide change and successfully adapting different interventions within varying populations. The agency made sure to include sites that differed in characteristics by choosing one program site in an urban region, while choosing another in a rural region.

A Request for Proposals (RFP) was sent to all providers in the two regions that were targeted, and the State selected program sites based on their proposed methods of conducting training, interviewing, and developing successful intervention strategies. A webinar was set up for interested providers to offer more information about the ACRA model, and selected criteria was used to assess the providers best suited to implement the ACRA model in the selected communities.

Orientation for the ACRA consisted of phone calls with the agency and clinical supervisors, where expectations and requirements for program implementation were explicitly discussed. Subsequently, local demonstration sites and trainers assisted in the 2 ½ to 3 day in-person training, which entailed training on the manual, core procedures, digital session recording, and also included role-playing. Coaching calls were scheduled periodically to assess the progress of trainees in completing their core procedures. Trainees were given specific timeframes to complete core procedures towards certification. Certification for administration of the GAIN-Q3 assessment tool began with initiation calls to talk with potential trainers, followed by a four-month distance learning training. In order to assure that all sites were compliant with training and certification requirements, the State asked all providers to sign an agency commitment form. The CEO or agency director had to sign the commitment form, confirming that there was buy-in from the top down. The form prevented sites from falling behind schedule or failing to complete training.

The only challenge that Ms. Kilgore mentioned is that for a short period during statewide implementation, the State had to use carryforward money to cover the training of providers and costs of expansion sites. The agency encountered no specific issues requiring technical assistance during the training and certification processes of the ACRA model and GAIN-Q3, as the costs, training, and implementation went as expected. The agency does not require all contracted providers to use ACRA and GAIN-Q3, but is considering it as an option in the future; the State does currently mandate that an evidence-based assessment is used by providers. While some States reported being unaware of the specific costs associated with implementation of the ACRA and GAIN-Q3, Kentucky was well-informed of the specific costs associated with planning and implementation ahead of time, and credits the developer for clearly outlining costs.

Lessons Learned

With regard to lessons learned, Michelle Kilgore stated that having a detailed RFP and an agency commitment form proved to be very helpful. The RFP might have been considered overly complicated by potential applicants, which could have been a deterrent that resulted in a relatively low RFP response rate. However, it's possible that by putting a high level of detail into the RFP, the applications received will be more competitive. The agency commitment form assured that sites knew what expectations were ahead of time.

Kentucky advises future SAT-ED grantee States to take the budget into account before actual implementation of the evidence-based program selected. The State also recommended that the RFP announcement sent to potential program sites be as clear and explicit as possible regarding requirements and expectations of the potential providers.

NEW YORK

Introduction

SAMHSA/CSAT is preparing to develop a guide for current and future SAT-ED/SYT Grantees who are experiencing difficulties choosing an evidence-based practice and assessment tool for adolescent SUD treatment services as mentioned in the grant. NASADAD been tasked to conduct case studies on current grantees that have chosen and implemented an EBP and assessment tool. This summary highlights a conversation with Maria Morris-Groves, WSN and Youth Coordinator for the State of New York, Shazia Hussain, and Danielle Olson. New York State chose The Seven Challenges, a SAMHSA-approved evidence based practice that is designed to treat adolescents with drug and behavioral problems, and the Gain-Q3 as the assessment tool.

EBP (treatment and/or assessment instruments) Selection Process

Several years ago, the New York Office of Alcoholism and Substance Abuse Services (OASAS) used State dollars to pilot a model that would implement Evidence-Based Practices (EPBs) in adolescent treatment services. As the State moved towards becoming a State Adolescent Treatment Enhancement and Dissemination (SAT-ED) Grantee, it had already trained to fidelity in Multi-Dimensional Family Therapy in one or two programs, trained to partial fidelity in Functional Family Therapy, and had received extensive training in Motivational Enhancement Cognitive Behavioral Therapy and Adolescent Community Reinforcement Approach (ACRA).

The State began to train providers and treatment staff in the ACRA model; however, the cost of re-training individual providers in ACRA every 18 months due to staff turnover was fairly expensive. Maria Morris-Groves (NY) began to research EBPs that might be more cost-effective in terms of training and sustainability. Eventually, the State chose The Seven Challenges. Ms. Morris Groves mentioned that if she had based her decision solely on the Seven Challenges website, she would have not chosen it to be piloted by the State because the website was not as marketable as those of other evidence-based practices. Besides the website, the only information regarding The Seven Challenges that was available was information on NREPP, the initial studies conducted on the model, and the ATTC's five-session training course for Seven Challenges. Maria mentioned that she would have chosen Multidimensional Family Therapy because of its strong Family Therapy component; however, the model was too expensive to sustain when it came to training and rolling out the model Statewide. Maria chose the Seven Challenges because of her experience and training with other EBPs and conversations with individuals such as Mark Godley and Randolph Muck to discuss cost effective tools.

The Seven Challenges was appealing because it certifies an entire program rather than an individual provider. For example, if an individual who has been designated as the leader of the program, individual staff can continue to be retrained, and the program will maintain fidelity. The Seven Challenges provided an opportunity for the State to try something that was less scripted, more flexible in regards to implementation, and that had more potential to sustain over the long run. The State also selected the Global Appraisal of Individual Needs (GAIN) –Q3 assessment tool, a shorter version of the original GAIN assessment tool, to be used with the implementation of The Seven Challenges. The GAIN-Q3 was chosen because it had positive reviews overall and featured a larger data set for scoring.

EBP Implementation

Once The Seven Challenges and the GAIN-Q3 had been chosen, the RFP entitled 70% of the funds would go towards piloting the EBP and assessment tool with two providers, while up to 30% of the funds could

be used for building up statewide services/infrastructure. The State set a goal to use additional contract dollars to train additional providers so that the EBP could be piloted in three residential programs and rolled out into urban, suburban, and rural environments. The Office of Children and Family Services has already developed their own contract with The Seven Challenges to spread the EBP into State juvenile justice facilities.

To choose two provider sites to pilot The Seven Challenges, a competitive bid process was conducted. An RFP was developed that asked for two sites located up north and downstate, and it detailed what the provider sites would do. The upstate provider which received the top score was located in Franklin County, and the downstate provider was located in the Bronx. Trainings were conducted in the Bronx, up north in Albany, and in a central location. Each provider receives $150,000 a year.

The training for the GAIN Q-3 is primarily done online to make training more efficient; however, the online training can seem cumbersome for many providers. Maria noted that implementing the GAIN-Q3 included some sustainability issues, mainly because one provider site chose not to use the GAIN while another site was already in the process of implementing the GAIN due to another grant; therefore, Ms. Morris-Groves was more likely to work with second provider site to sustain the assessment tool selected for the grant. Shazia Hussain (NY) mentioned that the Bronx location uses the GAIN-Q3 while the northern site in Franklin County already uses its own assessment tool besides the GAIN. The Franklin County site found using the gain redundant and cumbersome because their assessment tool produced similar assessment results compared to the GAIN.

With regard to evaluating the GAIN data, Ms. Hussain mentioned that the State has its own client data system, which providers use to input client information, which is linked to the GAIN data set. The providers also fill out a form ns developed for The Seven Challenges that is used to determine how the clients are responding to the EBP. Recently, Shazia Hussain has gathered all of the collected client data and is using the GAIN scaling system to see where the clients reported at a baseline, at three months, and at six months. She hopes by six months that there will be an obvious trend in the data.

Maria Morris-Groves mentioned that she has not attempted to implement the GAIN-Q3 Statewide because of the costs associated with implementing the GAIN. The State made a decision through the managed care redesign to develop its own levels of care assessment tool for adolescent treatment. The GAIN-Q3 is only being implemented in the pilot sites.

Lessons Learned

For New York, many of the lessons learned revolved around implementing the assessment tool for providers rather than the EBP. Maria Morris-Groves mentioned that it would be helpful for States to prepare a formal orientation on the assessment tool for the providers and with Chestnut before the tool is implemented. An orientation with the providers would have helped the providers and the State choose the best version of the GAIN tool that would have been helpful for all providers; furthermore, it would be helpful to have more options for assessment tools available for the providers rather than just one. Once the tool is implemented, in-person training should be required. Finally, Ms. Morris-Groves mentioned that it would have been helpful to more explicitly explain to providers that the assessment tool chosen for the grant would be the only assessment tool to use, rather than using it to supplement a previously implemented assessment tool. Many of these lessons learned emphasize more communication with providers on successful EBP and assessment tool implementation.

OKLAHOMA

Introduction

SAMHSA/CSAT is preparing to develop a guide for future SAT-ED/SYT Grantees to use as they choose an evidence-based practice and assessment tool for adolescent SUD treatment services. NASADAD has been tasked with conducting case studies on current grantees that have been through the assessment tool and EBP selection and implementation processes. This summary highlights a conversation with Jennifer Dell and Tiffany Harrison from the Oklahoma Department of Substance Abuse and Mental Health Services. The State chose the Adolescent Community Reinforcement Approach (ACRA) treatment model as the EBP and the Global Appraisal of Individual Needs - Initial (GAIN-I) as the assessment tool.

EBP (treatment and/or assessment instruments) Selection Process

The Oklahoma Department of Substance Abuse and Mental Health Services had prior successful experience with the Teen Addiction Severity Index (T-ASI), which was used along with a distinct but complementary biopsychosocial assessment component. Teresa Croom, Youth Coordinator for the State, was a writer for the SAT-ED grant and helped choose the GAIN-I as the assessment tool because it included the biopsychosocial component that was used concurrently with the T-ASI. Choosing the GAIN-I would allow the State to use one complete assessment tool rather than using two separate components during one assessment.

The ACRA had already been used in the State's outpatient facilities with positive outcomes. That prior experience, as well as conversations with Chestnut Health Systems, guided the decision to choose the ACRA for the SAT-ED grant. The State, which is currently trying to become more focused on providing full co-occurring disorder treatment services, has a smaller amount of SUD treatment providers compared to mental health treatment providers. The ACRA features a manual that can act as a guide for mental health treatment providers who may not have SUD treatment competency, which was an important factor during selection. Furthermore, the State wanted to utilize the continuing care component of ACRA because there was a need for better services for adolescents who were being discharged from residential treatment.

Ms. Dell mentioned that besides using Chestnut Health Systems and taking into account prior agency experiences, talking to other States that have implemented the GAIN-I and the ACRA would have been a helpful resource when the State was preparing the for SAT-ED grant.

EBP Implementation

The ACRA and GAIN-I were fully piloted at two community-based treatment provider sites. The costs associated to train two clinicians in the ACRA in one site was $26,000, and for the GAIN-I, it costs several thousand dollars. When the implementation initially started, the GAIN-I training was not web-based; the providers were sent to Chestnut Health Systems in Illinois to receive 2.5 days of training in the GAIN-I. In order to be certified in the GAIN-I, the providers were instructed to log into the Chestnut Health Systems data system and use a digital recorder to record sessions with clients. The recorded sessions were uploaded to the website and were evaluated by the Chestnut staff. Providers, on average, would make five or six attempts before passing and becoming certified.

The providers were previously trained in the ACRA with Assertive Continuing Care (ACC). For the SAT-Ed grant, providers were sent back to Chestnut Health Systems in Illinois and again engaged in 2.5 days of training. To become certified, the process was similar to becoming certified in the GAIN-I; however, the ACRA session recordings would be uploaded to a different database. It takes up to a year for providers to become certified in the ACRA, as it takes about six months to earn their basic certification, which involves becoming proficient in nine key strategies that are discussed in the ACRA manual. After that period, it takes another six months to become proficient in the other nine intervention strategies addressed in the manual. Unfortunately, the State had to drop the ACC certification piece because of statute that mandated that peer recovery support services in the State would not be administered to individuals under the age of 18. Chestnut Health Systems was accommodating towards this issue and allowed the providers to train in the ACC component, but they could not become certified in it. In September 2014, the State changed the age from 18 to 16.

In June 2013 the Tulsa Oklahoma Boys' Home and the CREOKS Behavioral Health Services, which includes nine community mental health center sites across the western and northeastern regions of the State, were trained for the GAIN-I. In September 2013, the State provided ACRA training to both sites. The State plans to train up to 15 more agencies in the ACRA to expand Statewide implementation efforts.

During the statewide implementation phase, the State ran into barriers while attempting to certify providers in ACRA and GAIN-I. Treatment staff were being trained and certified in both the ACRA and the GAIN-I while simultaneously working with clients and learning other treatment models. This overwhelming workload may have contributed to staff burnout and subsequent staff turnover. Another notable challenge was experienced at a site that primarily served Spanish-speaking clients. The site's clinical supervisor only spoke English, so when a clinician who served the Spanish-speaking families would record the sessions in Spanish, the supervisor was unable to understand the recording. The supervisor contacted Chestnut Health Systems and inquired if they could interpret the Spanish, but Chestnut did not have the resources to review the Spanish recordings. Ultimately, the agency had to find a supervisor who was bilingual.

Lessons Learned

One of the most important lessons learned for Oklahoma was to not pursue simultaneous certifications for treatment staff. The State already had a small number of SUD treatment providers, so they were easily overwhelmed with training and certifying in two different models while managing large caseloads at the same time. Additionally, States should try to focus on implementing their EBPs and assessment tools in agencies that have a stable treatment staff so that training may go smoothly. Staff turnover was a major barrier for training and certification, and in the future, States should research how much time it takes to implement different models and certify staff in case they encounter similar staff turnover.

SOUTH CAROLINA

Introduction

SAMHSA/CSAT is preparing to develop a guide for future SAT-ED/SYT Grantees to use as they choose an evidence-based practice and assessment tool for adolescent SUD treatment services. NASADAD has been tasked with conducting case studies on current grantees that have been through the assessment tool and EBP selection and implementation processes. This summary highlights a conversation with Susie Williams-Manning, Youth Coordinator, and Hannah Bonsu, Bridge Director for the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS). South Carolina chose the Gain-Q3 assessment tool and the Adolescent Community Reinforcement Approach (ACRA), an evidence-based practice that is designed to treat adolescents with drug and behavioral problems.

EBP (treatment and/or assessment instruments) Selection Process

South Carolina chose to implement the Adolescent Community Reinforcement Approach (ACRA), a manualized EBP that can be implemented in various settings. Its ability to be successfully implemented in different environments lent to its selection by the agency. Another important factor in the selection of an EBP was family engagement in youth treatment, and ACRA was chosen in part because of its family involvement component.

The agency's decision to implement ACRA was made prior to Ms. Williams-Manning and Ms. Bonsu's involvement in the SAT-ED grant. The agency had previous experience with ACRA in other departments and was deemed an effective evidence-based program within the State. The agency's continuous work with the Chestnut Institute also influenced the selection of ACRA. With regard to assessment tool selection, other State agencies had prior experience with the GAIN-I, but it was not well-received by clients; DAODAS instead chose to utilize GAIN-Q3 as the assessment tool because it was less time-consuming.

EBP Implementation

The delivery of the EBP began first with training and certification of health care professionals charged with assessment and implementation at the program sites. Trainees are required by Chestnut to be certified as an addiction counselor through the South Carolina Association of Alcoholism and Drug Abuse Counselors (SCAADAC) Board, and complete a 2 ½-3 day training on the ACRA model. Trainees receive training on the GAIN-Q3 assessment tool through online training and coaching.

A significant drawback the agency noted regarding implementation of the ACRA and GAIN-Q3 assessment tool stemmed from their associated costs. Training of staff in the ACRA model was found to be very expensive. The State is not allowed to certify staff through a train-the-trainer model, even though that would be more cost effective, because the certification process must be conducted within the agency and must involve the Chestnut Institute. Prior to implementation the agency had understanding of the general certification process, but was unaware of the costs and restrictions tied to the training component of the program. The agency is unable to confirm if a different program may have

been selected had these costs and restrictions been considered, as the agency is satisfied with the implementation and outcomes of the ACRA model.

South Carolina began implementation of GAIN-Q3 and ACRA with two providers, and has since added four more program sites in four different counties in an effort to expand implementation of the intervention. The agency experienced attrition of program trainers and has worked to replace them. With regard to reimbursement, the State has contracted with South Carolina's Health and Human Services (HHS) for reimbursement of youth and adult services. Substance abuse reimbursement is currently approved at a lower level than mental health for the comparable services, but the agency is currently engaged in discussion with HHS on an increased rate for evidence-based models. HHS has contracted with the Mercer Company to examine resources and financial mapping around substance abuse services, and the agency anticipates rates to be increased by next year for all EBPs implemented within the State. Providers have evaluated the costs to implementing the ACRA model in South Carolina in comparison to alternative models, and have concluded it in fact being more expensive than comparative models, though cost is heavily dependent upon the target population and characteristics of the region where implementation will take place.

The agency is uncertain of sustainability of the ACRA model within the State, because it utilizes individual counseling sessions, while the agency typically employs group sessions for its interventions, working with eight to twelve participants at a time. The group counseling approach is more cost effective for the agency, while individual sessions have proven less economical. South Carolina has also adopted the managed care organization (MCO) model in the State, and is working through the growing pains of educating the MCOs on behavioral health. The agency has successfully educated four of the six MCOs it is working with, and continues to provide clarification to the two in need of assistance. The agency hopes that the financial state of program sites will be strengthened once reimbursement standards are clarified with the MCOs.

With regard to sustainability, the agency anticipates being able to train more clinicians and physicians with carryover funds in order to properly train them as clinical supervisors. The agency plans to use the outcome data gathered to convince its director and Medicaid to adopt the ACRA model statewide, as the results have been superior and outcomes are commendable. The agency has seen high engagement in the program, no adolescent substance use in last 30-90 days, more consistent high school attendance, and lowered recidivism. The agency plans to use the data as support for statewide program adoption by the legislature, and at higher reimbursement rates.

Lessons Learned

South Carolina advises that future SAT-ED grantee States plan ahead before seeking to execute statewide implementation of an EBP. The agency also advises potential program sites to do extensive research on upfront and sustainability costs of program implementation, and know which financial resources are available. Agencies and program sites must be sure they are on the same page with their Medicaid and service reimbursement providers before beginning program, as this will greatly assist with sustainability.

POTENTIAL TOPICS FOR INQUIRY AND STATE GUIDE

Based on the discussions with officials of the four States it appears that there would be value to development of a Guide to assist selection of Adolescent evidence-based Treatment Protocols and Structured Assessment Instruments. Moreover, the discussions provided insight on a variety of issues and topics that States considered while making their selections of EBPs as well as "lessons learned" from implementation and operation that they wish they had known when making the selection. States appeared to particularly want to know the experiences and assessments of other States of the respective EBPs.

States gave very careful consideration to selection of EBPs for their SAT-ED and SYT grant applications and projects. In general the official spoken with had authority to select the EBPs for the State application/project. Perhaps understandably, they started by considering EBP protocols and structured assessment instruments that they had first-hand experience with. They checked with other State officials as well as key providers and practitioners that had prior EBP experience. Several of them had reviewed the NREPP documentation for various EBPs, however that material didn't seem to offer sufficient insights into the actual requirements and experience of implementation and operations. Most of the States directly contacted one or more developers of EBPs under consideration, as well as reviewing developers' websites and materials for training and implementation. Ultimately, developers had a direct role in the projects because they were an indispensable part of the implementation process, providing training and in some cases quality assurance and/or certification.

Keys to Decision-making

- Resources used during selection process:
  - Prior experience with treatment protocols and assessments
  - Discussions with developers
  - EBP developers' websites
  - NREPP
  - Training manuals
- Important factors during selection process:
  - Prior experience with a particular EBP informed decision
  - Cost
  - Training and certification requirements
  - Flexibility/versatility
  - Sustainability

The discussions identified a variety of implementation issues that States considered important in making their selections of EBP protocols and standardized assessment instruments. Initially, they were concerned that the EBP would interface rather than interfere with existing treatment and assessment practices. Accordingly, they attempted to learn about the stringency and flexibility of standards for using the protocols and instruments. Ultimately, several States learned during their implementation and operations phases that the various demands of the selected EBPs were materially greater than they had anticipated during the decision making phase. These unanticipatedly heightened demands particularly related to the initial training of staff that would use the EBPs and instruments and the need to train new/replacement staff due to turnover and expansion of staff.

Implementation Issues

- Be aware of State mandates that might interfere with EBP delivery
- How instrument/EBP interfaces with current service delivery methods
- Implementation costs should be considered; might veer from budget
- RFP announcement sent to potential community-based treatment provider sites must be clear and explicit
- States should plan orientation with developer for providers before implementation
  - Be aware of ease working with developer
- Developer played integral role in training and providing technical assistance during implementation
- Does Medicaid adequately reimburse for protocol
- Does the instrument diagnose disorder, screen for mental and physical health issues, and provide guidance on appropriate level of care

Financial aspects of EBP implementations and operations also were important to States. Again, this was carefully considered during the initial selection process. However, in light of their experiences in implementation, several States felt that the demands were even greater than they had anticipated. These financial considerations related to the costs of initial implementation, the costs for replacement or expansion of staff required to deliver the EBPs as well as the ongoing delivery of the EBP (protocols and assessments). States had budgeted for cost A to deliver the selected EBPs to a target number of adolescents, and the reality was that several States found that costs ran materially higher than anticipated.

The other side of the financial issue was equally as challenging to the projects: getting reimbursed for the actual cost to deliver the EBPs. States agencies with fixed budgets had little latitude to increase funding to defray costs that were higher than anticipated. Furthermore, where it was hoped or expected that insurance plans would provide reimbursement for the EBPs it was a protracted process to get approval (if approval is ever to be gained). Different insurance providers (e.g., Medicaid plans, exchange plans) generally have their own distinct process for approving reimbursement of novel services, increasing the difficulty as well as time required to get adequate reimbursement for services (protocols and assessments) that entail higher costs than "services as usual."

Based on these discussions with States and the issues that were identified, the general topics (in the following table) are recommended for a potential inquiry that would explore State experience with adolescent EBPs. It is recommended that an examination is made of which EBP protocols and assessments the respective States have experience with, as well as the degree of experience that they have. This will be useful in order to direct State only to questions about EBPs that they have a "meaningful" degree of experience and knowledge with. Another section of the inquiry could examine the process that States used in selection of EBPs, as this could help other States to learn what resources have been most useful.

Beyond questions about the selection process, it would be important to focus questions about respective EBPs on issues about the implementation experiences. Specifically, these should look at the processes required to train and retrain staff to deliver the EBPs and the certification of staff and/or providers to deliver the EBPs. As mentioned above, the financial aspects of costs and reimbursements would be important further considerations that build on the actual implementation experiences. Most

of the questions about the selection process and implementation should be framed as closed ended questions in order to minimize the burden on potential State respondents, but also to maximize the utility of the results of the inquiry. Finally, open ended questions should be asked about additional assistance that States would like to have as well as other strategies that could encourage implementation and use (and sustainability) of adolescent EBP protocols and assessments.

Inquiry Domains

- Degree of experience with selected EBPs and assessments
- Selection Process
  - Resources used
  - Decision-makers
- Implementation
  - Training process (and retraining)
  - Certification requirements
  - Costs of implementation and operation
  - Experience in getting enhanced reimbursement for EBP is more expensive than usual service
- What would have helped with EBP selection and implementation?
- What would you do differently to encourage statewide adaptation of the evidence-based assessment?

The experiences of the four States strongly suggest that conducting an inquiry of State experiences in implementing and operating EBP treatment protocols and standardized assessments would be of utility to States as they consider new or different EBPs. States have a unique set of roles. They are purchasers and payers of treatment for adolescents and young adults, they perform regulatory functions, they monitor quality and outcomes and they provide accountability for how public funds are spent.

The structured discussions with Kentucky, New York, Oklahoma and South Carolina illustrate that there is a need and demand for information about State experiences with adolescent EBPs. Just as important, States are willing and able to answer questions about/describe the nature and quality of their experiences in implementing and operating those EBPs.