Regular Article

Implementation of Evidence-Based Practices for Treatment of Alcohol and Drug Disorders: The Role of the State Authority

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Abstract

The current climate of increasing performance expectations and diminishing resources, along with innovations in evidence-based practices (EBPs), creates new dilemmas for substance abuse treatment providers, policymakers, funders, and the service delivery system. This paper describes findings from baseline interviews with representatives from 49 state substance abuse authorities (SSAs). Interviews assessed efforts aimed at facilitating EBP adoption in each state and the District of Columbia. Results suggested that SSAs are concentrating more effort on EBP implementation strategies such as education, training, and infrastructure development, and less effort on financial mechanisms, regulations, and accreditation. The majority of SSAs use EBPs as a criterion in their contracts with providers, and just over half reported that EBP use is tied to state funding. To date, Oregon remains the only state with legislation that mandates treatment expenditures for EBPs; North Carolina follows suit with legislation that requires EBP promotion within current resources.

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Introduction

The implementation of evidence-based practices (EBPs) in substance abuse treatment services is driven by efforts to integrate best research evidence, clinical expertise, and patient values.[1–6] Although definitions of evidence-based practices continue to evolve,[7–10] the National Quality Forum (NQF) endorses five categories of evidence-based treatment practices for substance use disorders: (1) screening and brief intervention, (2) proven psychosocial interventions, (3) access to medications, (4) use of wraparound services, and (5) aftercare and recovery management.[11,12]

Federal and state governments have focused varying amounts of resources, including fiscal support, on the development and diffusion of substance use disorder EBPs. Although support exists for adopting EBPs, challenges limit implementation.[13,14] Nevertheless, with appropriate resources and leadership, state substance abuse authorities (SSAs) can have a powerful effect on the implementation and diffusion of EBPs through the system.[15,16]

Historically, the substance abuse and mental health treatment systems evolved distinctly, including separate funding streams, state agencies, and provider requirements.[17] This contributed to a highly decentralized substance abuse health system, which lacks well-defined federal-level policy and points of accountability. Lack of broad federal policies governing system activities resulted in each state designing individual public substance abuse health care systems with substantial variation in organizational and financing factors.[18] Although decentralization provides states with a relative degree of control, that control is tempered by confounding challenges and priorities including budget constrictions and ever-changing political climates.[19]

Approximately one half of states have integrated the SSA and the state mental health authority (SMHA) under the same umbrella agency.[20] However, implementation of substance abuse EBPs has received less attention than mental health EBPs.[2,4,13,15,21] Barriers include disparities in insurance coverage, such that clients may have Medicaid or private insurance coverage that provides mental health services but excludes substance abuse services.[22,23] Additionally, providers may not share a common philosophical ground to support integrated treatment.[21] This fragmentation reflects conflicting treatment approaches and perspectives; one result is that mental health is often treated as a chronic disorder and substance abuse as an acute disorder.[24,25] It is important to recognize that both can be chronic disorders that may benefit from evidence-based treatment. In particular, integrated dual diagnosis treatment (IDDT) is an important link between mental health and substance abuse services needs.[26,27] Several states have addressed integrated treatment and services, although policy, programmatic, clinical, consumer, and family barriers remain.[22,27–31]

Recently, federal and local initiatives have advanced the adoption of substance abuse treatment EBPs. At the federal level, substance abuse EBPs have been prioritized through partnerships between the Substance Abuse and Mental Health Services Administration (SAMHSA) and non-profit organizations, such as the Robert Wood Johnson Foundation and the MacArthur Foundation.[28,32] Federal dissemination efforts also have included SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP), an online resource for independently reviewed and rated evidence-based interventions for the prevention and treatment of mental health and substance use disorders.[13,33]

Less is known about individual state initiatives in substance abuse treatment EBP implementation. Perhaps the most prominent initiative is Oregon's Senate Bill 267 (now Oregon Revised Statutes ORS 182.515 and 182.525), a state mandate requiring the SSA to incrementally increase its expenditures on EBPs to 75% of the budget for direct care services during the 2009–2011 biennium. Other state initiatives may be less prominent but just as influential in substance abuse treatment EBP implementation.

Although there have been few studies to date on implementation of EBPs in substance abuse treatment and almost none on dissemination,[18] research on mental health EBP implementation may provide a useful guide. For example, in a study examining SMHA methods for increased adoption

of EBPs in eight states, Rapp et al.[15] identified two broad state-level implementation support strategies aimed at treatment agencies. The first is a "marketing approach" whereby interested providers can apply to be an EBP site, often through a formal "request for proposal" mechanism. The second broad strategy employs a regulatory approach whereby the state mandates the adoption of EBPs. Oregon's legislation is an example of a broad regulatory approach. Additionally, an examination of effective strategies for implementation of mental health EBPs, including IDDT, from the Evidence-Based Practice Project identified 106 specific implementation strategies in eight states and classified them into five categories: (1) state infrastructure building and commitment, (2) stakeholder relationship building and communications, (3) financing, (4) continuous quality management, and (5) service delivery practices and training.[21,32,34] In Magnabosco's analysis,[21] states' emphasis on particular groups of strategies shifted for differing phases of the overall implementation process. For example, during the pre-implementation phase, states emphasized stakeholder relationship building and communication activities, whereas during initial implementation and sustainability planning phases, states emphasized financing.[21] Accordingly, organizational research suggests that evidence-based innovation requires the support of administration and management, sufficient financial and human resources, and an organizational culture that values scientifically based practice, problem-solving and creativity, and systems change.[16,35–37]

This trend toward national support and state-level requirements for adopting EBPs invites investigation of what constitutes effective methods for supporting and ensuring the implementation of EBPs in substance abuse treatment facilities. The National Institute on Drug Abuse (NIDA) Blue Ribbon Task Force recently released a report calling for an increase in funded studies examining substance abuse EBPs and their dissemination and sustainability in real-world settings.[38] A climate of instability and closure among substance abuse treatment centers further supports investigating ways states can facilitate the adoption and continued use of these practices.[39] For example, the NQF identified particular strategies for facilitating adoption of substance use EBPs including: (1) financial incentives and mechanisms, (2) use of regulations and accreditation, (3) education and training, and (4) infrastructure development.[12] These strategies provide broad categories, leaving room for individual state flexibility in implementation. Examining changes in state contracting, policies, and procedures, organizational change efforts, and state-wide collaboratives can help identify successful strategies that encourage the use of EBPs.

However, capturing these systemwide quality improvement and technology transfer endeavors is further complicated by each state's unique delivery system and policy environment. Thus, the first step in beginning to address these issues is an assessment of state substance abuse authority activities, efforts, strategies, financing, and contracting related to the implementation of substance abuse treatment EBPs. This paper presents findings from a systematic inventory assessing state substance abuse authority activities used to promote evidence-based practices for substance abuse treatment.

Method

The current project involved collecting and analyzing preliminary data from an initial screening assessment of participating state substance abuse authorities (SSAs) to capture state efforts to promote adoption of evidence-based substance abuse treatment practices. The assessment included questions regarding the National Quality Forum's categories of EBPs and strategies for facilitating adoption of these practices. When replicated, the interview can be used as a baseline assessment to document increases in adoption of EBPs.

For this initial phase of the larger two-phase State Authority project, investigators at Oregon Health and Science University developed a structured interview for telephone administration by representatives from Addiction Technology Transfer Centers (ATTCs) across the USA. The ATTC network operates in regional centers to translate and communicate substance abuse treatment research to practitioners and SSAs. For the current study, each participating ATTC identified a

program coordinator, trainer, or evaluator who was familiar with their region's state officials and EBPs overall to assist with this project. This initial ATTC-facilitated contact allowed project staff to contact SSA representatives directly for the follow-up project (not reported here).

Recruitment and participant involvement

For phase 1 of the State Authority project, a two-step strategy identified key informants in each state and facilitated a maximum response rate. The first step involved contacting and obtaining agreement from the regional ATTCs to assist with the initial contact and data collection from the SSAs within their respective territories. In compensation for their time, ATTCs were given $150 for each state for which they provided information. For example, the Northwest Frontier ATTC (NFATTC) provided information for five states (Oregon, Washington, Hawaii, Idaho, and Alaska), resulting in $750 total compensation. Twelve of the 13 ATTCs agreed to support this initial screening of the 51 SSAs (inclusive of the District of Columbia). The second step involved the study investigators and evaluators contacting the SSAs directly. This step was used when ATTC staff members were unable to reach the appropriate SSA representative (described below) or when an ATTC elected not to participate in the interviews. This two-step method maximized the sample size and ensured successful contact and data collection for all states.

The study investigators and evaluators held two group calls with the ATTC interviewers to discuss the project and explain the procedures for data collection. To train data collection staff and ensure consistency, interviewers also reviewed the survey and discussed potential answers, issues, and concerns. Identification of the appropriate SSA representative started with the SSA director in each state, and in most cases, the director or assistant director (55%) completed the interview or asked a program manager knowledgeable about EBPs (45%) to join the discussion. ATTC and project staff followed the guidance of the SSA director in each state, and if additional data could be provided by a specific EBP leader, project lead, or program manager, then efforts were made to reach that individual as well. For all states, recruitment included concerted effort to obtain participation from the most knowledgeable representatives available.

SSA representatives were then contacted by email and phone, and were asked to schedule 15- to 20-min interviews to answer questions about strategies to encourage the use of EBPs. Before each telephone interview, information sheets were provided to all participants regarding the purpose of the study and that data collected from their state may be included in summary reports. At the end of the initial assessment, they were asked to participate in the phase 2 follow-up, in-depth interview several months later. Informed consent was not required. This project was approved by the Oregon Health and Science University Institutional Review Board.

In total, ATTC interviewers obtained data from 39 SSA representatives, and project staff obtained data from an additional ten for a total sample of 49 SSAs, inclusive of the District of Columbia. Several SSAs representatives required multiple contacts by email and phone before responding to interview requests. Two SSAs were unable to share information within the timeframe of the project.

Procedures and instrumentation

Interviews were conducted between November 2006 and January 2007. Interviewers used a three-page structured interview to obtain quantitative and qualitative responses from representatives of each SSA. First, contact and job description data were gathered from each respondent. The main interview questions corresponded to the National Quality Forum's five categories of substance abuse EBPs (screening and brief intervention, psychosocial interventions, use of medications, use of wraparound services, and aftercare and recovery management). Each question consisted of four parts that corresponded with four of the NQF's EBP implementation strategies (financial incentives and mechanisms, regulations and accreditation, education and training, and

infrastructure development). The structured interview consisted of ten questions. The first five questions asked the SSA representative, "To what extent is your SSA using the following [four] strategies to promote [each of the five EBP categories, respectively]?" Respondents ranked the extent each NQF strategy is used to promote each EBP category using a Likert-type scale (scale of 1–5, with anchors at 1 = not at all, 3 = some, 5 = very much).

The other five questions (listed in Table 2) inquired about specific EBP implementation approaches through dichotomous (yes/no) response options. Interviewers encouraged representatives to elaborate on each response to generate detailed qualitative data on each state's activities in support of EBP adoption. When appropriate, actual documentation was requested regarding EBP-related legislation, contract language, and administrative rule and regulatory changes.

To maintain consistency, interviewers followed procedures, which included instructions for contacting SSA representatives and a list of NQF EBP definitions including (1) screening and brief intervention: Patients in primary care, emergency care, and mental health care settings are screened for possible alcohol and drug problems. All patients with a positive screen should receive a brief intervention by a healthcare practitioner trained in this technique. (2) Adoption of proven psychosocial interventions: Evidence-based psychosocial treatment interventions should be initiated for all patients referred to specialty care treatment of substance use disorders (examples include motivational interviewing, motivational enhancement therapy, and cognitive behavioral therapy). (3) Access to medication: Addiction-focused pharmacotherapy should be considered for all patients diagnosed with alcohol and/or opioid dependence (e.g., buprenorphine for opioid dependence). (4) Use of wraparound services: Ancillary services including housing, parental treating, and employment counseling should be offered to all residents in care. (5) Aftercare and recovery management: Patients treated for substance use disorders should be engaged in long-term, ongoing management of their care.[12]

Analysis

Quantitative and qualitative data were analyzed in this preliminary examination of SSA efforts toward adopting EBPs for substance abuse treatment. Mixed methods studies are relevant for this type of policy research because the findings provide a detailed view of or narrative about the adoption and implementation of evidence-based practices for substance abuse treatment. For the current study, qualitative research methods in particular were used to capture findings that compliment and provide depth and additional meaning to those findings available through the quantitative scales.[40] The mixed methods approach to analysis provided critical information necessary to move the process-oriented topic of policy implementation forward.[40–42]

Quantitative data were analyzed using SPSS version 15.0 to generate frequencies, including mode, mean, and standard deviation. For qualitative data, thematic categories were determined through an iterative process of systematic data review and (re)classification.[43,44] The research team minimized threats to validity by using a modified version of a five-step qualitative analysis training model developed by Luborsky,[45] which includes iterative thematic analysis to identify and refine re-occurring themes in the qualitative responses. While qualitative research does not lend itself to measures of statistical significance, it is possible to score qualitative results to provide an index of importance. Researchers employed two standards for evaluating and organizing themes and content within the transcriptions of SSA interviews: frequency of statements and direct statements of salience or meaning.[46] In the first step, the most frequently coded categories were deemed important, leading to additional in-depth analysis and interpretation for those themes. The second level of interpretation included judging the importance of a theme by examining direct statements indicative of a belief, practice, or experience related to adopting and implementing evidence-based practices for substance abuse treatment. These analytic procedures were employed to assess themes regarding the NQF

strategies, legislative policy, contracting, accreditation, and licensure, and to help us understand their effects on organizational systems and structures.

Results

Strategies to promote the NQF's EBP categories

Table 1 presents statistical means, standard deviations, and modes for responses to Likert-type items assessing states' use of NQF strategies for implementing specific types of substance abuse treatment EBPs. Overall, SSA representatives reported support for investment in education and training strategies to promote EBP implementation. In contrast, they reported less support for the use of regulatory strategies, and very little support for financial incentives and mechanisms to promote EBP adoption.

Legislative policy

Currently, Oregon is the only state with legislative policy (ORS 182.515 and 182.525, previously referred to as SB267) that financially mandates EBP implementation in substance abuse treatment. North Carolina has passed Mental Health System Reform legislation (Session Law 2001-437), which mandates development and implementation of substance abuse protocols based on EBPs and/or national standards of service delivery "within available resources." Finally, Alaska law (Chapter 59 SLA 07) attempts to mandate EBP use, but no state funds are allocated to support the mandate. Of the remaining states, 15 (30.0%) reported support for EBP implementation either through state-level encouragement, strategic plans, governor's commissions, or active movement toward legislation.

Table 2 presents the percentage of SSA representatives that responded to dichotomous (yes/no) questions about strategies to encourage the use of EBPs, including contracting criteria, funding linkages, regulations, and other activities aimed at increasing the use of empirically supported practices for substance abuse treatment. In addition to dichotomous response options to these questions, SSA representatives were asked to elaborate. What follows further describes findings available in Table 2 and incorporates frequencies and percentages of qualitative response themes.

Contracting

In terms of contracting, 31 SSA representatives (63.3%) reported use of substance abuse treatment EBPs as a criterion in contract agreements with treatment providers. Of those, seven (22.6%) SSAs require specific EBPs as part of their contract criterion, ten (32.3%) require EBP use (but no specific EBPs) in their contract language, three (9.7%) encourage EBP use through contractual or departmental policies, and five (16.1%) require EBP use in some special program contracts including prevention but not in treatment. The remaining six SSA representatives (19.4%) did not elaborate on their EBP contracting criteria.

Of the 18 SSA representatives (36.7%) that reported that EBPs were not a contracting criterion, ten (55.6%) SSAs encourage EBPs in substance abuse treatment and are moving toward requiring them, three (16.7%) encourage but do not require EBP use, two (11.1%) require EBPs in substance abuse prevention but not treatment, and one SSA representative reported that contractual requirements are not determined at the state level. The remaining two SSA representatives (19.4%) did not elaborate on the lack of EBP contracting criteria.

State funding requirements

Approximately half of the SSA representatives (n=25; 51.0%) reported that EBP use is tied to state funding. Although, upon elaboration, two SSA representatives (8.0%) reported that the SSA

Table 1
State strategies for encouraging implementation of evidence-based practices

	Evidence-based practices (*n*=49)									
	Screening and brief interventions		**Proven psychosocial interventions**		**Access to medications**		**Wraparound services**		**Aftercare and recovery management**	
Strategy	**Mode**	**Mean (SD)**	**Mode**	**Mean (SD)**	**Mode**	**Mean (SD)**	**Mode**	**Mean (SD)**	**Mode**	**Mean (SD)**
Financial incentives and mechanisms	1	2.08 (1.10)	1[a]	2.57 (1.40)	1	2.41 (1.37)	1	2.53 (1.53)	1	2.65 (1.30)
Regulations and accreditation	1	1.98 (1.27)	1	2.41 (1.37)	1	3.92 (1.02)	3	3.18 (1.20)	3	3.27 (1.04)
Education and training	4	3.18 (1.24)	4	3.92 (1.02)	3[a]	3.14 (1.19)	3	2.78 (1.31)	4	3.14 (1.23)
Infrastructure development	3	2.78 (1.34)	3	3.14 (1.19)	3	2.37 (1.47)	3	2.98 (1.49)	4	2.86 (1.50)

[a]Multiple modes exist. The smallest value is shown.
Measured with a five-point Likert-type scale (scale of 1–5, with anchors at 1 = not at all, 3 = some, 5 = very much)

Table 2
State approaches to evidence-based practice adoption

	% Response (n=49)	
	Yes	**No**
Are there any policy mandates in your state related to EBP implementation?	3 (6.1%)	46 (93.9%)
Is the use of EBPs a criterion in contracting with providers?	31 (63.3%)	18 (36.7%)
Is state funding tied to the use of EBPs?	25 (51.0%)	24 (49.0%)
Are there regulations or accreditation strategies in place that support the use of EBPs?	27 (55.1%)	22 (44.9%)
Are there any other activities or events occurring within the state that are aimed at accelerating the adoption of EBPs?	46 (93.9%)	3 (6.1%)

plans to tie EBP use to state funding in future fiscal years, and nine SSA representatives (36.0%) reported requiring EBP use only in some special subcategories of state funding (e.g., substance abuse prevention, criminal justice, drug courts, and co-occurring disorders).

Of the 24 SSA representatives (49.0%) that reported that EBP use is not tied to state funding; four (16.7%) SSAs do require EBP use in some special subcategories of state funding, and seven (29.2%) plan to have state funding linkages in the future.

Regulations and accreditation

The majority of SSA representatives (n=27; 55.1%) reported the use of regulations and accreditation as mechanisms for advancing EBP use in substance abuse treatment. Of the 22 SSA representatives (44.9%) that reported no regulations or accreditation regarding EBPs, approximately half (45.5%) noted that new plans, policies, changes in contracting language, and other key regulation shifts currently are underway.

Other activities or events aimed at facilitating adoption

Only three SSA representatives (6.1%) reported no other activities or events aimed at facilitating the adoption of EBPs. Qualitative responses noted that almost all SSAs are in the process of

considering different strategies and/or attempting systemic changes in infrastructure, financing, and regulation. Strategies included workgroups and committees, workforce surveys, regulation development, data systems, grant applications, Medicaid billing changes, financial incentives, and complete system transformation.

Discussion

This assessment of 49 states' implementation of evidence-based practices for substance abuse treatment reveals widespread articulation of support for EBPs among state substance abuse authorities (SSAs) but considerable variation in actual adoption of individual strategies. Each state has a unique approach to service delivery and funding of substance abuse treatment services. Therefore, to provide a framework for discussions with each of the SSAs, this comprehensive semi-structured interview protocol was based primarily on the NQF's practices and strategies.[12]

Of four EBP adoption strategies endorsed by the NQF, SSAs reported the highest emphasis on employing infrastructure and development, as well as education and training to promote all EBPs for substance abuse treatment. Regulations and accreditation strategies were reportedly used more for encouraging wraparound services and aftercare and recovery management than screening and brief intervention, proven psychosocial interventions, or access to medications. Importantly, SSAs also reported relatively low strategic emphasis on financial incentives and mechanisms, as well as regulations and accreditations. Problems with financial support options and accreditation could play a role in variation in actual adoption of EBPs.

The finding that financial incentives and mechanisms were used least of the five NQF strategies mirrors a study by Finnerty and colleagues ranking health-related barriers and strategies as (in descending order) money, engagement, training/consult, attitude, mandate, policies, credential, understanding, plan enacting, plan sustaining.[47] More recently, Koch and colleagues examined a partnership formed in Virginia to stimulate dissemination of EBPs for adolescents with co-occurring disorders.[31] They also found barriers to implementation that included financing concerns (e.g., unavailable or expensive training, individual clinicians disinterest in new treatment models, and treatment models being too expensive or too restrictive).[31]

In terms of legislative action, Oregon remains the only state with a statute that financially requires treatment expenditures on substance abuse EBPs. North Carolina's mental health system reform law incorporates EBP promotion within available resources. Alaska's EBP legislation was passed without funds appropriated. Other SSA representatives reported active movement toward legislation or other higher authority support, such as strategic plans or governor's commissions. Interestingly, some SSA representatives reported that EBP legislation was unlikely, either due to the SSA's relative autonomy in substance abuse treatment matters or political issues within the legislature. Thus, it appears that support for legislative mandates is highly variable.

In contrast to the lack of legislation, the majority of SSA representatives reported use of treatment EBPs as a criterion in contract agreements with or grants to treatment providers. Of those, some require specific EBPs as part of their contracting criteria (e.g., motivational interviewing, cognitive behavioral therapy, Matrix model). Additionally, even states without EBP contracting criteria indicated concrete efforts toward, at minimum, encouraging EBP use. However, one overall theme included defining what constitutes an evidence-based practice for such contracts. In some states, there is no specific definition of EBPs or list of practices to use in provider contracts because they are still debating what qualifies as an EBP. It should be noted that some SSAs contract indirectly with providers, through county (or other local) contracts or managed care entities, and may not control contracting language.

In addition to state contracts or grants awarded through requests for proposals (RFPs), state funding can be tied to EBP use through federal block grant requirements. For example, SAMHSA's Center for Mental Health Services promotes IDDT as an EBP for individuals with co-occurring mental health and substance abuse disorders.[28] Moreover, there is a combined effort from several

federal programs including the NIDA Clinical Trials Network and the Center for Substance Abuse Treatment (CSAT) Blending initiatives, SAMSHA's NREPP work, and CSAT's Treatment Improvement Protocols to establish substance abuse treatment EBPs. This conjoint effort links to the federal block grant funding, but the range of EBPs varies depending on the level of care. Additionally, a few SSA representatives noted that Medicaid funding does not allow billing of substance abuse treatment services. Other states have undertaken broad Medicaid reform to address financing issues.[20,21,30]

Several SSA representatives noted that there is a need for a greater number of best practices for specific populations such as pregnant women, women with children, and diverse populations. Generally, issues related to the lack of evidence for diverse populations are concerning, and some SSA representatives noted conflicting ideas about how to address the lack of EBPs for specific populations.

A majority of SSA representatives reported use of regulations and accreditation to promote implementation of EBPs. However the interview question, "Are there regulations or accreditation strategies in place that support the use of EBPs?," did not specify agency-level regulations (licensure standards, rules of practice) versus provider-level regulations (counselor credentialing). Additionally, some SSA representatives interpreted the question as a duplicate of the contracting question, "Is the use of EBPs a criterion in contracting with providers?" Mixed interpretations of these two interview items complicated attempts to compare qualitative responses to related state activities. In interview protocol design, the regulations question was intended to capture both agency- and provider-level data. Phase 2 will address regulations and accreditations in more detailed interviews.

Promisingly, almost all of the SSA representatives reported additional activities designed to facilitate EBP adoption. The most commonly reported activites were provider training, workshops, federal and private grants, and data system updates. Some SSAs are actively pursuing EBP implementation despite not having sufficient resources (funding or staff). This advocacy for EBPs in substance abuse treatment is key to successful adoption and fidelity.[48,49]

Indeed, a particularly important barrier to the implementation of EBPs are unsupportive state, local, and federal mental health authority administrative practices and policies.[15] The most prevalent examples are lack of a long-term vision, lack of agreement on desired outcomes, lack of penalties for non-evidenced-based practices, short-term horizons for policy planning, political mandates on competing public-sector priorities, resource limitations, and uncertainty associated with change and untoward events.[50] Phase 2 of this project will identify SSA-specific barriers to EBP implementation.

Overall, the current findings indicate that leadership plays a crucial role in effective implementation of EBPs at the SSA level. Leaders have multiple means to communicate the commitment to EBPs, including a commitment of resources, mission statements, and internal and external collaborations.[19,51,52] Various methods SSA policymakers can use to promulgate their expectations include state-provider contracts, design of RFPs and grant funding decisions, licensing regulations, quality improvement plans, and media dissemination (e.g., newsletters, reports, press releases, and presentations).[15,52] Of course, these efforts are dependent on appropriate financial support. Therefore, state effort and strategies to increase adoption of EBPs are encouraging, but without attention to key issues such as financing, implementation possibilities may be minimized.

The current project's preliminary data collection format, which primarily inquired about the five EBP adoption strategies endorsed by the National Quality forum, provided a useful structure for discussion of this topic. However, it is possible that additional information on related but separate implementation efforts was not obtained. Phase 2 of this study will compliment this report with a broad spectrum of in-depth qualitative data, including additional description of multiple activities employed in states representative of more intensive efforts aimed at adopting and implementing EBPs. Documentation of actual state efforts and review of legislative mandates, contract language, and SSA websites will provide additional material to augment the reports of those interviewed for the project. Additionally, it should be noted that each response in this study is one person's report and the job title/description of respondents did vary. However, each respondent's role included the

professional capability to represent the state substance abuse authority regarding the state's promotion of EBPs. Due to different job descriptions and titles, as well as varied hierarchical arrangements for each state office, in some cases, the SSA director or deputy director was best suited to address these issues; in other states, a program manager for treatment services was most knowledgeable about EBPs. Therefore, responses reflected the current organizational leadership's approach to EBPs within the confines of available resources. Finally, while this initial project phase provides a snapshot of SSA approaches to adopting EBPs for substance abuse treatment, commentary on the perceived value or effectiveness of a given EBP for substance abuse treatment or respective approaches to adoption are addressed in phase 2.

Implications for Behavioral Health

While specific strategies differ, reports from representatives of state substance abuse authorities (SSAs) offer an entry point into state efforts toward implementing EBPs for substance abuse treatment. Data and qualitative comments indicated that every state in the study is either (a) implementing steps toward policy (e.g., through workgroups, incorporating licensure standards, and planning system change), (b) requiring EBP use in some special program contracts including prevention but not in treatment, (c) utilizing contracts or department policies to encourage EBP use in treatment, or (d) requiring EBP use in contract language. These results offer the opportunity to track the number of states engaged in NQF-supported practices and changes in state contracting and EBP acceleration efforts over time. State agencies, substance abuse treatment providers, and policymakers can benefit from knowing how other states nationwide have responded to the call for increased substance abuse treatment EBP adoption and fidelity. Knowledge of SSA implementation strategies should facilitate opportunities for states seeking to increase their EBP adoption efforts. Such assistance supports prioritization of research-based, client-focused practices for substance abuse treatment.

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