

The Impact of Neuroscience on Nonprofit Behavioral Health Care:

Reactions from the Human Services Field

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Finally, we would like to thank Patrice A. Heinz, Project Director of *Exploring the Impact of Neuroscience Advancements on Nonprofit Behavioral Health Care*. Her guidance throughout this phase of the project and her invaluable perspective in the many discussions on our results provided a much needed context for positioning our analysis within the realities of this new frontier.

Introduction

With funding from the Robert Wood Johnson Foundation, the Alliance for Children and Families initiated efforts in 2005 to explore how advancements in neuroscience will impact the abilities of nonprofit human service providers to organize and deliver behavioral health services in ways that benefit children and families. The project focuses on identifying:

- diagnostic and treatment advancements that are likely to impact nonprofit human service providers
- potential organizational capacity changes in response to those advancements
- ethical considerations raised by advancements and their impact on nonprofits
- emerging public policy issues.

Primary research studies were conducted to assess nonprofit agency understanding of and preparedness for integration of neuroscience advancements with behavioral services. The first effort was an electronic survey with Alliance members that elicited both closed ended and qualitative responses to issues and opportunities prompted by neuroscience advances. The second effort included qualitative research conducted with selected nonprofit providers. Through focus groups and telephone interviews, researchers probed the implications of neuroscience advancements on those providers.

We begin with a synthetic interpretation of the overall findings of this project. Though atypical, this organization confronts the reader immediately with the essential lay of the land, places the two constituent studies in context, and obviates the need for a separate Executive Summary. Subsequent sections provide the essential supports for this interpretation, setting forth a narrative summary of the survey results (Part II), offering the survey data themselves in outline form (Part III), and interpreting the interviews and focus groups, with the raw data appended (Part IV).

Interpretation of Results: Assessment of the Prospects for Neuroscience Integration into Nonprofit Behavioral Health Care

Thomas E. Lengyel

Taken together, the survey results, telephone interviews, and focus groups offer us a window on how Alliance members currently apprehend the advent of new understandings and their technical embodiments in the field of neuroscience and how they will react in the near future. That in turn suggests what foundations need to be constructed in order to encourage integration of neuroscience into their operations, and from that assessment what constructive roles the Alliance and other intermediaries might play as this tide advances.

The Future For Adoption Of Neuroscience Advancements In Nonprofit Behavioral Health Care

Insofar as Alliance members constitute a microcosm of nonprofit human service agencies delivering behavioral health care this service universe is not engaged with neuroscience. The clearest finding of our studies is that human service managers almost to a person lack familiarity with the developments so carefully portrayed in *The New Frontier*. Nor are they about to engage with these technologies by making them part of normal service delivery, evidenced by the minute fraction of members who report considering adoption. These two results are indisputably connected, even though questions probing this linkage elicited a confused response.

At the simplest level whether and how nonprofit behavioral health providers adopt neuroscience advancements depends on what is meant by "adoption." If this means that the agency itself implements the technology in-house then adoption is extremely unlikely. Nonprofit human service providers are heavily invested in human capital, both in terms of their resources—the credentials, expertise, and experience of staff—and in terms of the modes of treatment they deliver, which these days center on capacitation. They have not been and are not currently deeply invested in the hardware and technology of testing and diagnosis. On the other hand, if adoption means integrating neuroscience technology into service delivery through targeted referrals of clients to the actual technology provider as an extension of capacitation strategies then there is a possibility or even the likelihood that it will be adopted over 10 to 20 years. After all, the primary investment of these human service organizations is in the education and training of their staffs, and that

primes them for the rapid uptake of knowledge, including new scientific developments.

A fundamental conflict is taking shape not at the level of hardware and technology but at the level of philosophy and theory of personal change. The rapid tide of neuroscience developments will meet a counter-current in the form of a strong trend in the design of services toward the prevention end of the service continuum. Neuroscience, as focus group participants were quick to note, arises from the "deep end" of the medical model of service delivery (i.e., diagnosis and remediation of disease). It is easy to anticipate increased specialization within the social work staff to acquire and maintain competence in these services. If this technology follows the pattern of drug therapy in mental health it will be controlled by specialists, such as psychiatrists, who will be the gatekeepers. Nonprofit human service providers will therefore face watershed decisions regarding prevention vs. medical models of treatment. They will have to decide where to invest scarce resources.

It seems possible that the attraction of neuroscience may pull some nonprofits back into the gravitational field of the medical model of service delivery. However, given the current distribution of resources and investments in nonprofit human service agencies and the reactivity to the medical model voiced by our respondents, other scenarios are more likely. Either behavioral health services at nonprofits will bifurcate into medical and non-medical divisions, or medical models of treatment encompassing neuroscience advancements and technology will be wholly housed in hospitals and medical clinics. In the latter case, human service agencies would merely function as a source of referrals.

Independent evolution of social work-derived behavioral health care and neuroscience would be reinforced if neuroscience interventions are in practice extended only to marginal cases and fail to establish themselves as conventional treatment modalities. Will neuroscience technologies be used only for extreme cases or those that fail to respond to known treatments in the behavioral health care armamentarium? The interviews and focus groups allude to this possibility. High capital costs and unit of service costs, coupled with the need for esoteric technical competence promote marginalization of neuroscience from a risk to a foreseeable outcome.

The partnerships that would under gird a true integration of

neuroscience into current behavioral health care practice would be between very different and unequal players. Heavily capitalized medical centers and hospitals will almost certainly control the hardware and interpretive competence (e.g., reading test results), paired with undercapitalized human service providers rich in human and social resources. Neuroscience technology, it must not be forgotten, has been developed entirely externally to these non-profit agencies and it answers to a paradigm distinct from that which prevails in human services. This division of labor and imbalance of power will threaten human service agencies, more than it will be a force for collaboration.

As *The New Frontier* predicts and focus group participants voice, neuroscience advancements will pose a new set of ethical issues, not all of which can be foreseen. Many, probably most, applications of neuroscience have not yet been invented or conceived. But enough parallels exist with other recent innovations in health and biology that some issues can be forecast with certainty.

Since neuroscience technology promises to be no less costly than other types of high tech diagnosis and testing we may reasonably expect unequal access based on demographic characteristics of users, including insurance status, economic class, and place of residence. To the extent that the technology has been demonstrated to be effective and therefore necessary, access will convert to an equity issue between citizens. As framed by focus group participants, there will be haves and have-nots. Neuroscience could easily lapse into the status of a “boutique” mental health service if access is not equitably apportioned up front. This bias will be aggravated if major insurers, including government funded programs, fail to rapidly resolve eligibility for coverage before the technology catches on.

In *The New Frontier*, author Laudan Aron raises the converse possibility that neuroscience might level the playing field that currently differentiates demographic groups by reducing or eliminating disparity of condition (e.g., health, well-being, poverty, homelessness). Few examples of this type of result from health care advances come to mind. Instead many scientific developments in health and health care appear to recapitulate or replicate existing disparities between racial, economic, and social classes, usually mediated by access and utilization differentials and the health practices of the demographic groups.

Neuroscience results could easily become highly controversial, particularly if they are accepted as bearing materially on personal responsibility for behavior, including criminal behavior. Since, to some degree, test results capture biology, and therefore destiny, neuroscience assumes a status parallel to genetic make-up. Findings would then be considered highly sensitive information, similar to the results of tests for fatal or debilitating genetic diseases. As one participant framed it: What are the implications of diagnosis? The issues presented by such developments include:

- Who would have access to the information?
- How will access to the information be regulated?
- How will oversight of access limitations be exercised?

Obviously, these issues will be addressed. The manner of doing so leads us naturally to the subject of institutional foundations for the integration of neuroscience into behavioral health care.

Prerequisites For Integration

Above all, behavioral health care providers must acquire the motive to deliver these neuroscience services. It must become somehow in their interest to pursue this, whether that comes through their reactive response to external pressure or from their internal drive for excellence, client outcomes, revenue, or the cachet of being viewed as progressive—all considerations mentioned by study participants. Given recent history in behavioral health care the motive, if it emerges, will likely come in the form of a push-pull: Competition from other providers coupled with the incentive of certain funding of the service by insurers.

The presence of competition as a motivating force for adoption presupposes the evolution of effective partnerships between medical centers and human service agencies for at least some players. These partnerships between referral sources and hard technology providers need to be seeded in enough contexts to learn what works and what doesn't and thereby provide confidence in the business model that smaller human service providers require in order to take the plunge.

Lack of familiarity or knowledge of neuroscience governs all potential responses by human service providers. Codified education and training are critical and must become available reliably and widely. This means more than just information such as might be acquired through a workshop or conference presentation. It requires codified curricula for service providers, perhaps offered by schools of social work, and perhaps even as part of the standard social work curriculum. Another option would be establishing neuroscience as a specialty within social work, beginning at several key graduate social work programs such as Columbia, and the University of Michigan.

In addition, the profession of social work probably needs some form of certification that recognizes competence in this area. This might have to be incorporated in new certification and licensing standards for social workers by the states. Such standards of course presuppose the availability of the professional training to meet these standards, mentioned above.

The risk of reinforcing existing disparities argues strongly for the early development of policy foundations for extending neuroscience services. Agencies will need guidelines on when it is appropriate to apply these technologies and whether payment, and thus insurance status, will determine access. These currently do not exist and that is probably responsible for some of the uncertainty manifested in the comments of focus group participants.

Appropriate Roles For Intermediaries

Can intermediaries such as the Alliance, other national human service associations, accrediting bodies, and the universities and medical centers with major capital investments in the knowledge and technology act in ways to mitigate some of the risks sketched above and to construct the institutional and policy foundations on which adoption of neuroscience will be based? The answer is almost certainly yes, for one or another of the factors.

The overwhelming need for basic information, and then for formal education and training is a void many of these intermediaries are well adapted to fill. The Alliance itself, in its well honed role as a compiler and disseminator, is positioned to select, organize, and evaluate information resources on neuroscience. The production of annotated bibliographies, summaries of research, vetted lists of experts and consultants, and directories of technology partners are easily within its ability. Medical centers and universities possess the capital in terms of research skill and technical competence to impart knowledge and capacity to potential human service partners. And universities are the logical home for incorporating neuroscience into the formal training of the social work curriculum.

If this analysis is correct, hospitals, medical centers and university-based neuroscience research centers will also exercise a fateful decision in how they manage incipient partnerships with human service agencies with respect to neuroscience. If they are able to mitigate the inherent imbalance of power deriving from the medical origins of the knowledge, technology, and service model, and reinforced by their own heavy capital investment, arriving instead at a collaborative equilibrium that honors the contributions of the human service partner, they will set the stage for integration of neuroscience into the standard service array. Such intentionally balanced partnerships carry the potential to establish the viability of the business model and foster the competition that will drive adoption.

Accrediting bodies, such as the Council on Accreditation and the Joint Commission on the Accreditation of Health Care Organizations, have an opportunity to enhance the speed and breadth of neuroscience adoption and the quality of services extended via the early development of standards. That would attenuate the risk that neuroscience services will replicate existing disparities of condition. It will also remove some of the uncertainties repeatedly unearthed in these investigations about when and how to apply the technology and thereby ease its integration into the standard set of services.

The federal government, or perhaps some other large, well-resourced institution, may even have an enabling role. The Dana Alliance for the Brain has been suggested as one organization that has been effective in disseminating knowledge and fomenting practice of neuroscience advancements and models of service. There is no reason that this national resource center should not become a worthwhile addition to the inventory of resources available to non-profit behavioral health care providers, and there are many reasons to believe it could play a significant role in stimulating dialogue about the integration of neuroscience advancements within traditional social service models of behavioral health care.

Finally, since neuroscience is so novel its ramifications in knowledge, practice, policy, and ethics are more latent than patent. Like an iceberg, the majority of implications for behavioral health care providers, the forces for change they will face, and the institutional and policy developments that will support adoption of neuroscience into the standard service array remain temporarily out of view. The emergent quality of the paradigm suggests an even more important role for service provider intermediaries, policy shops, and accrediting bodies: Namely, to monitor developments as they occur, promulgate them to behavioral health care providers, and attempt to forecast the impact on their operations. No more vital role can be imagined in the rapidly evolving landscape of human services.

Summary of Survey Results

Thomas E. Lengyel

The project's first research approach to broadly investigating the impact of neuroscience advancements on behavioral health care providers took the form of a primarily quantitative survey of organizational members of the Alliance for Children and Families. This network serves as a rich field in which to probe these issues since almost all of these human service organizations deliver behavioral health care services, and it is a major program area for many of them.

The Survey Instrument

The survey sought to tap the state of knowledge of Alliance members about neuroscience in general, and also their attitudes toward adopting some of the new technologies described in a recently written report, *The New Frontier: Neuroscience Advancements and Their Impact on Nonprofit Behavioral Health Care Providers*. The manner of operationalizing this intent was to query their actual practices around seven specific neuroscience techniques mentioned in the report and to engage them in an assessment of their prospects for adopting these techniques. In this regard the instrument also asked them to reflect on barriers to adoption of the techniques.

Survey Implementation

The Neuroscience/Behavioral Health Care survey was opened to all Alliance members through an e-mailed invitation from the Director of Research on January 17, 2006 and closed on February 6. Members had just over three weeks to respond. Since the survey overlapped fully with the Alliance's annual compensation survey, we did not send weekly reminders to non-respondents to avoid burdening the Inboxes of member CEOs. The survey drew the participation of 56 Alliance members, yielding a response rate of 17.6%. It's reasonable to assume that this survey drew that portion of Alliance members with the highest degree of interest or involvement in neuroscience. Two Alliance members wrote back declining to participate on principle,¹ and a third declined without specifying a reason.

Profile of Respondents

The 56 respondents represented primarily community-based agen-

cies (64.3%), and to a much lesser degree agencies that had a foot in both worlds of community services and residential treatment (23.2%). Only about one in eight of the organizations who replied (12.5%) was exclusively a residential treatment facility. This cohort was therefore roughly in line with the Alliance membership as a whole, about 35% of which offers residential services as part of the service array. However, in terms of the regional distribution the Midwest (48.2%) was strongly overrepresented relative to its presence in the membership (37.8%). The northeast (16.1% vs. 28.1%) was just as strongly *under*represented. This suggests that interest in neuroscience is strongest in the Midwest.

The survey was ultimately submitted by a variety of managers and officers, concentrated at the senior management level. The largest group of respondents was surprisingly not involved in the direct delivery of clinical services. 13 (23.2%) were the heads of their agencies—CEOs, Executive Directors, or Presidents. The other large contingents were professionals involved in the delivery of clinical services, such as Clinical Directors ($n = 10$, 17.6%), and vice presidents ($n = 10$, 17.6%). Various non-clinical director level managers rounded out the profile of respondents. The recruitment of a large group of CEOs and Vice Presidents to the survey, as opposed to clinically oriented managers, might have depressed the level of knowledge of neuroscience reflected in the survey answers.

Patterns of Knowledge and Practice

The seven neuroscience technologies described in the report and queried in the survey were:

1. Neuroimaging to diagnose mental health issues
2. Neuroimaging to establish medication levels
3. Neuroimaging to track patient progress in therapy
4. Genotyping (genetic testing to diagnose mental health issues)
5. Electrical stimulation to treat psychological disorders
6. The integration of cognitive enhancing drugs with talk-based therapies
7. Pharmacogenomics (genetic testing to determine effectiveness/side effects of medication)

Within each of the seven technologies the question set was identical. The most fundamental question concerned the agency's degree of familiarity with the development. Respondents were

¹ One CEO noted that they have withdrawn from involvement in behavioral health and focus instead on individual and community capacity building. A second CEO stated that his organization de-emphasized behavioral health out of a strengths-based orientation, and to avoid the imputation that children in the agency's care were sick or broken.

offered three options for rating their familiarity: Not at all familiar, somewhat, and very familiar. Survey takers were then asked how often they actually exploited the technology, by what means, and how they funded it when they did provide it. Those that *did not* use the technology faced a question about whether they were considering its use, and then what funding they would seek to pay for it. Most of the following answers in the set were governed directly by the first reply regarding familiarity.

We found remarkable consistency both in the patterns of response by all respondents within a technology area, and by a single agency across the technologies. Typical of the overall pattern was the distribution of replies to the second query on neuroimaging to establish medication levels. Here about half ($n = 26$, 46.4%) reported no knowledge of the technology, half ($n = 28$, 50.0%) reported some awareness, and only two respondents (3.5%) felt they were very familiar with it. The vast majority of agencies ($n = 55$, 98.2%) did not provide this as a service. The small fraction of Alliance members who manifested competence (“very familiar”) in the area carried through in the following linked queries regarding provision of the technology, manner, and funding: almost identical numbers expressed familiarity and then answered the queries regarding provision, manner, and funding. So, it would be reasonable to conclude from these results, if not from the logic of service delivery, that considerable familiarity with the technology is the foundation for its application in the mental health services of Alliance members. However, the affirmative responses that support this conclusion are few indeed.

The 98% who were not engaged in delivering this technology currently likewise reported that they were not considering implementing the technology in the future. There is little tendency for those not active with this sector in behavioral health care to shift toward its implementation. This rigidity in the pattern of responses suggests that Alliance members attach little value to these technologies: the technologies do not exercise a normative pull.

With slight variations this general pattern held true for all of the technologies except the integration of cognitive enhancing drugs with talk-based therapies. 73.2% ($n = 41$) of Alliance members expressed some degree of familiarity with this latter approach, and 38.2% offered this method in selected cases (27.3%) or as a routine service (10.9%). There was also somewhat more awareness of neuroimaging as a diagnostic procedure (#1, above) and electrical stimulation (#5) as a treatment, the second having a long and controversial history in the mental health arena. However, relatively greater familiarity with these two technologies did not translate into greater implementation, as the responding agencies almost unanimously reported no use of the technologies and no plans for their use.

Moreover, there was evidence of a “whole cloth” pattern in the approach of an agency to neuroscience advancements: An agency tended to manifest the same level of familiarity with all seven of

the technologies. In other words, an agency that reported it was “not at all” familiar with one of the technologies was very likely to report the same level of familiarity with all the technologies. If they reported some familiarity with one of the technologies they were very likely to report some familiarity with all or nearly all the technologies. This result is displayed in table 1 (below) which offers the numbers of agencies making identical responses.

TABLE 1: *Familiarity Profiles of Agencies*

<i>Degree of Familiarity</i>	NUMBER OF IDENTICAL CHOICES ACROSS TECHNOLOGIES				
	3	4	5	6	7
Not at all	5	2	9	3	7
Somewhat	6	4	9	8	8
Very	0	1	0	0	1
Total agencies	11	7	18	11	16
Percent of pool	19.6%	12.5%	32.1%	19.6%	28.6%

Just about half (48.2%) of the agencies that filed a reply answered in identical fashion to six or seven of the queried technologies, highlighted in the bolded portion of Table 1. If we add those agencies who filed an identical reply for five of the seven advancements we have captured the pattern for four out of every five answers (80.4%). Such responses suggest that neuroscience is a relatively unified field of knowledge and that knowledge of one aspect tends to entail or entrain knowledge of the other parts, and similarly for the converse (i.e., lack of knowledge).

Agency Capacity

Agency capacity questions sought to probe the putative necessary foundations for implementing neuroscience advancements, viz.

1. Knowledgeable staff
2. Possession of qualifications and certifications by clinical staff
3. Staff possession of necessary technical training
4. Employment or contractual relationships with specialists who could provide neuroscience technologies
5. Ethical and policy foundations for neuroscience
6. Awareness of local research programs in neuroscience
7. Agency participation in neuroscience research or evaluation
8. Awareness of potential partners in offering neuroscience advancements
9. Formation of partnerships to offer neuroscience
10. Acquisition of funding streams to support delivery of neuroscience.

Follow-ups to each question strove to determine whether the absence of the foundational element was a barrier to the adoption of neuroscience technology.

Generally, only about one in ten respondents (range: 5% to 15%) affirmed having any one of these foundations for neuroscience in place. Correspondingly, 85% to 95% either confirmed that the foundation was not in place or reported they didn't know which has the same operational effect in terms of preparedness. The lone exception was awareness of potential partners (#8) for which one in four answered "yes." Assuming that the set of ten conditions tested in the survey are the necessary prerequisites for delivering neuroscience advancements Alliance member agencies clearly lack the foundations for entering this new arena of behavioral health services.

The follow-up queries were presented only to respondents who answered "no" to the head question. Responses seemed to call into question the very premise of the head. So, for example, the very first capacity question asked whether staff was knowledgeable on neuroscience advances and their application in behavioral health care. Those who answered negatively were then asked to indicate whether absence of this (presumably prerequisite) capacity was preventing their agencies from adopting neuroscience technology. About four in ten ($n = 17$, 40.5%) gave the expected "yes", about one-fourth ($n = 11$, 26.2%) said "no", but fully one-third of respondents ($n = 14$, 33.3%) stated "I don't know".

For those who answered "no" to the follow-up we might interpret their answer as an indication that other more important factors or preconditions were preventing their adoption of neuroscience technology, though it's a bit hard to imagine what might be more important than lack of knowledge in a decision to deliver behavioral health care, particularly in the current litigious health care delivery climate. However, "I don't know" appears to raise the possibility that one could, in some circumstances, deliver these advanced neuroscience technologies without having knowledgeable staff. Similar patterns are found in the follow-up breakdowns of "no" responses for qualifications and certifications, necessary technical training, preparation for contracting, awareness of potential partners, and acquisition of funding streams.² In attempting to reconstruct the internal dynamics of these paradoxical responses it seems more likely that respondents were confused by a question frame that contained a sequence of negative assertions: i.e., was absence (a negation) preventing (a negation) adoption of the technology? A following "no" can be taken as a negation of any of the preceding assertions. The spontaneous written comments of the CEO of a non-using residential treatment agency offer testimony:

It wasn't possible because of the design of the survey to explain the "don't know" answers. We know nothing about these advancements (not having read the recent report yet) but I "don't

know" if that failure is what is holding us back. If we did know about them, we might still not think it to be the right way to go.

Evidence-based Practice

The final section of the survey examined the degree to which so-called evidence-based practice had taken root at the agencies. This term is currently widely used, with an equally wide range of meanings. The survey instrument did not offer a definition but instead left it to the respondents to define the concept according to their own lights. Their answers show that they did not shrink from the implied invitation.

Just over two-thirds ($n = 39$, 70.9%) of the managers who answered told us that their agencies were engaged in evidence-based practice, specifically within their behavioral health care programs. One in ten replied "I don't know," which is difficult to interpret given that they also had the option of expressing lack of knowledge of the term.

The answers to follow-up questions served to substantially qualify the claim of evidence-based practice. Nine (23.1%) of the evidence-based practice group acknowledged they were in the planning stages, four (10.2%) reported they were piloting the concept, and another six (15.4%) were at the initial stages. Taken together, just about half (48.5%) of the self-identified group who affirmed that they were engaged in evidence-based practice had not yet implemented the referenced practices. Balancing this contingent, ten agencies (25.6%) reported agency-wide implementation, and ten more reported evidence-based practice implemented in one or two program areas.

Those who claimed to provide evidence-based programming were asked for details about those practices. One-quarter ($n = 10$, 25.6%) declined to provide any description, so we are unable to judge what definition of the concept they were applying. Those that did displayed an enormous range of understandings of the term, some of which would not fit our definition or definitions that are in common use.

A small number of agencies in the evidence-based practice group provided details that are consistent with the intent of the question. This seems to be most common with the subfield of substance abuse treatment. Among these responses:

- We offer the Strengthening Families program, a SAMHSA-identified evidence-based practice. We are developing the Sanctuary Model for trauma treatment, a SAMHSA-identified evidence supported "promising practice." — *A large, residential treatment center for children who have serious mental and emotion disorders, located in the Northeast*
- We use evidence-based models in our substance abuse – we have had federal funding and training in motivational enhancement and stages of change. — *A medium sized family service agency in the upper Midwest*
- We are using research based curriculum in all of our substance

²At first blush it would seem obvious that staff qualifications and certifications, necessary technical training, and acquisition of funding streams would be regarded as absolute prerequisites for providing neuroscience services to behavioral health care clients.

abuse prevention programs and in our offender programs for substance abuse. These are mandated by our funders.— *A large family service agency in a major metro area in the upper Midwest*

- Evidence based, gender specific AODA Treatment. Use of evidence based practices to treat childhood trauma after review of SAMHSA approved programs.— *A large family service agency in the upper Midwest*
- Have used the Teaching-Family Model for years in our KEYS section of treatment, as well as other evidence based cognitive-behavioral therapies.— *A small residential treatment center for children in the central plains*
- [Agency name] received a Federal grant from the Federal Center for Substance Abuse Treatment to implement two evidence-based practices at an adolescent residential treatment program.— *A large health services organization from the Mid Atlantic*

A significant group of respondents equate evidence-based practice with evaluation, documentation of outcomes, use of validated assessment tools, or simply with the systematic collection of information.

- We use single case methodology N=1. We compare the dependent variable with the independent variable using time series analysis.— *A medium sized family service agency in the upper Midwest*
- We are building a CD [chemical dependency] Curriculum that will have some evidence based components. Specially looking at cognitive-behavioral components. Also pre, post test components. Using standardized assessments, part of which have a norm based [i.e., validated] component to them. Main thing is trying to put together a program that shows its effectiveness and that this effectiveness can be verified in various data driven ways.— *A medium sized family service agency in the Midwest*
- We have had in-service training on it and keep careful statistics on client outcomes. We've all read a recent article put out by the NASW [National Association of Social Workers] on e.b.p.'s.— *A small family service agency in the upper Midwest*
- We are beginning to use a variety of standardized measures pre and post treatment with our clients and compiling this data.—

A large residential treatment center for children in the Midwest

- We have instituted an agency wide data management system called Qualifacts.— *A large family service agency in the South*
- We are just starting to review the methodology to evaluate our practice in several different areas.— *A medium sized family service agency in the Midwest*

Many of the remaining responses are simply wide of the mark. But what emerges relatively clearly is that the responding agencies want to be identified with evidence based practice. It exerts a normative pull not found in their responses to neuroscience advancements. And the value assigned to evidence-based practice is especially strong in the Midwest.

Conclusions

The small cohort of Alliance members who responded to this survey were evenly split between those who manifest some knowledge of the cited neuroscience advancements and those who conceded they have no familiarity whatsoever. A tiny fraction of Alliance members—countable on the fingers of one hand—are actually engaged in providing these neuroscience technologies to their clients. And, despite the fact that about half of respondents profess some familiarity with the new technologies only about one in ten of the surveyed group attested to having in place conditions that we assume are prerequisites to adopting the technology such as knowledgeable staff, appropriate certifications, and funding sources. The overall picture therefore is of a group of human service providers who are generally unprepared for these neuroscience advancements and are not on the verge of adopting them. Nevertheless, they are deeply interested in evidence-based practices, however imperfectly they understand this term. And, they are overwhelmingly united in their desire for the Alliance to serve as a source of information to them on this developing field of knowledge. The tight association of new neuroscience technologies with evidence-based practice may therefore provide the best avenue for purveying these practices to Alliance members, and the Midwest may very well be the best place to begin.

Presentation of Survey Results

Ryan Ziebert

Organization Type

7 (12.5%) Residential treatment facility
 36 (64.3%) Community-based agency
 13 (23.2%) A combination of residential
 and community-based

56

Region

27 (48.2%) Midwest
 9 (16.1%) Northeast
 10 (17.9%) Southeast
 7 (12.5%) South
 3 (5.4%) West

56

Job titles of Survey Participants

Associate Executive Director
 for Programs
 CEO
 CEO
 CEO
 CEO
 Chief Operating Officer
 Clinical Director
 Clinical Director
 Clinical Program Supervisor
 Clinical Program Supervisor
 Clinical Therapist/Supervisor
 Counseling and Education Director
 Dir. of Individual & Family Counseling
 director of Behavioral Health
 Director of Behavioral Health
 and Community Services
 Director of Clinical Services
 Director of Clinical Services
 Director of Community Initiatives
 Director of EAP, Access and Trauma Services
 Director of Home Care Options
 Director of Professional Services
 Director of Professional Services
 Director of Special Projects
 Director of Treatment Services

Director, Family Support Programs
 Director, Health Promotion
 DPS
 ex director
 Ex. Director
 Executive Director
 Executive Director
 Executive Director
 Executive Director/CEO
 Licensed Professional Counselor
 Medical Director
 Medical Director
 Medical Director
 President / CEO
 President and CEO
 President/CEO
 Program Director
 Program Director
 Psychologist
 Senior Vice President
 Senior Vice President
 Senior Vice-President for Programs
 Service Manager
 Sr. Vice President
 State Medical Director
 Supv. Chemical Dependency Program
 V.P. Professional Services
 Vice President
 Vice President for Behavioral Health
 Vice President of Programs
 Vice President of Quality Assurance and Clinical Services
 VP of Program Development

Neuroimaging to diagnose mental health issues

How familiar are you with the neuroscience diagnostic and treatment advancement listed above?

14	(25.0%)	Not at all
39	(69.6%)	Somewhat
3	(5.4%)	Very

56

To what extent does your agency provide this advancement?

51	(91.1%)	We do not provide this
4	(7.1%)	In selected cases only
1	(1.8%)	As routine service
56		

If you provide this advancement...

How does your agency provide the neuroscience diagnostic and treatment advancement listed above?

3	We provide this "in house"
0	Through hospital-based service
0	Through a partnership/collaboration with a research university
2	Through partnership/collaboration with other BHC provider(s)
5	

What reimbursement stream does your agency use to underwrite its delivery?

1	Private insurance companies
3	Government-funded health insurance
0	Partnership with a university research project
1	Private contribution and/or foundation grants
5	

If you do NOT provide this advancement...

Is your agency considering the use of the neuroscience diagnostic and treatment advancement listed above?

4	(7.8%)	Yes
47	(83.9%)	No
51		

What reimbursement (funding) stream would your agency seek out to underwrite its delivery?

2	Private insurance companies
1	Government-funded health insurance
1	Partnership with a university research project
4	Private contributions and/or foundation grants
8	(Note: More responded than plan to use the technology)

Neuroimaging to establish medication levels

How familiar are you with the neuroscience diagnostic and treatment advancement listed above?

26	(46.4%)	Not at all
28	(50.0%)	Somewhat
2	(3.6%)	Very
56		

To what extent does your agency provide this advancement?

55	(98.2%)	We do not provide this
0	(0%)	In selected cases only
1	(1.8%)	As routine service
56		

If you provide this advancement...

How does your agency provide the neuroscience diagnostic and treatment advancement listed above?

0	We provide this "in house"
0	Through hospital-based service
0	Through a partnership/collaboration with a research university
1	Through partnership/collaboration with other BHC provider(s)
1	

What reimbursement stream does your agency use to underwrite its delivery?

0	Private insurance companies
1	Government-funded health insurance
0	Partnership with a university research project
0	Private contribution and/or foundation grants
1	

If you do NOT provide this advancement...

Is your agency considering the use of the neuroscience diagnostic and treatment advancement listed above?

3	(5.5%)	Yes
52	(94.5%)	No
55		

What reimbursement (funding) stream would your agency seek out to underwrite its delivery?

2	Private insurance companies
1	Government-funded health insurance
1	Partnership with a university research project
3	Private contributions and/or foundation grants
7	(Note: More responded than plan to use the technology)

Neuroimaging to track patient progress in therapy

How familiar are you with the neuroscience diagnostic and treatment advancement listed above?

26	(46.4%)	Not at all
28	(50.0%)	Somewhat
2	(3.6%)	Very
56		

To what extent does your agency provide this advancement?

54	(96.4%)	We do not provide this
2	(3.6%)	In selected cases only
0	(0%)	As routine service
56		

If you provide this advancement...

How does your agency provide the neuroscience diagnostic and treatment advancement listed above?

0	We provide this "in house"
0	Through hospital-based service
0	Through a partnership/collaboration with a research university
2	Through partnership/collaboration with other BHC provider(s)
2	

What reimbursement stream does your agency use to underwrite its delivery?

0	Private insurance companies
1	Government-funded health insurance
0	Partnership with a university research project
1	Private contribution and/or foundation grants
2	

If you do NOT provide this advancement...

Is your agency considering the use of the neuroscience diagnostic and treatment advancement listed above?

4	(7.4%)	Yes
50	(92.6%)	No
54		

What reimbursement (funding) stream would your agency seek out to underwrite its delivery?

3	Private insurance companies
0	Government-funded health insurance
1	Partnership with a university research project
4	Private contributions and/or foundation grants
8	(Note: More responded than plan to use the technology)

Genotyping - Genetic testing to diagnose mental health issues

How familiar are you with the neuroscience diagnostic and treatment advancement listed above?

24	(42.9%)	Not at all
29	(51.8%)	Somewhat
3	(5.4%)	Very
56		

To what extent does your agency provide this advancement?

54	(96.4%)	We do not provide this
2	(3.6%)	In selected cases only
0	(0%)	As routine service
56		

If you provide this advancement...

How does your agency provide the neuroscience diagnostic and treatment advancement listed above?

0	We provide this "in house"
1	Through hospital-based service
0	Through a partnership/collaboration with a research university
1	Through partnership/collaboration with other BHC provider(s)
2	

What reimbursement stream does your agency use to underwrite its delivery?

0	Private insurance companies
2	Government-funded health insurance
0	Partnership with a university research project
0	Private contribution and/or foundation grants
2	

If you do NOT provide this advancement...

Is your agency considering the use of the neuroscience diagnostic and treatment advancement listed above?

4	(7.4%)	Yes
50	(92.6%)	No
54		

What reimbursement (funding) stream would your agency seek out to underwrite its delivery?

2	Private insurance companies
1	Government-funded health insurance
0	Partnership with a university research project
2	Private contributions and/or foundation grants
5	(Note: More responded than plan to use the technology)

Electrical stimulation to treat psychological disorders

How familiar are you with the neuroscience diagnostic and treatment advancement listed above?

17	(30.4%)	Not at all
36	(64.3%)	Somewhat
3	(5.4%)	Very
56		

To what extent does your agency provide this advancement?

55	(98.2%)	We do not provide this
1	(1.8%)	In selected cases only
0	(0%)	As routine service
56		

If you provide this advancement...

How does your agency provide the neuroscience diagnostic and treatment advancement listed above?

0	We provide this "in house"
0	Through hospital-based service
0	Through a partnership/collaboration with a research university
1	Through partnership/collaboration with other BHC provider(s)
1	

What reimbursement stream does your agency use to underwrite its delivery?

0	Private insurance companies
1	Government-funded health insurance
0	Partnership with a university research project
0	Private contribution and/or foundation grants
1	

If you do NOT provide this advancement...

Is your agency considering the use of the neuroscience diagnostic and treatment advancement listed above?

1	(1.8%)	Yes
54	(98.2%)	No
55		

What reimbursement (funding) stream would your agency seek out to underwrite its delivery?

1	Private insurance companies
0	Government-funded health insurance
0	Partnership with a university research project
1	Private contributions and/or foundation grants
2	(Note: More responded than plan to use the technology)

The integration of cognitive enhancing drugs with talk-based therapies

How familiar are you with the neuroscience diagnostic and treatment advancement listed above?

15	(26.8%)	Not at all
28	(50.0%)	Somewhat
13	(23.2%)	Very
56		

To what extent does your agency provide this advancement?

34	(60.7%)	We do not provide this
15	(26.8%)	In selected cases only
6	(10.7%)	As routine service
55		

If you provide this advancement...

How does your agency provide the neuroscience diagnostic and treatment advancement listed above?

10	We provide this "in house"
0	Through hospital-based service
0	Through a partnership/collaboration with a research university
11	Through partnership/collaboration with other BHC provider(s)
21	

What reimbursement stream does your agency use to underwrite its delivery?

6	Private insurance companies
11	Government-funded health insurance
0	Partnership with a university research project
4	Private contribution and/or foundation grants
21	

If you do NOT provide this advancement...

Is your agency considering the use of the neuroscience diagnostic and treatment advancement listed above?

1	(2.9%)	Yes
34	(97.1%)	No
35		

What reimbursement (funding) stream would your agency seek out to underwrite its delivery?

1	Private insurance companies
0	Government-funded health insurance
0	Partnership with a university research project
1	Private contributions and/or foundation grants
2	(Note: More responded than plan to use the technology)

Pharmacogenomics - Genetic testing to determine effectiveness / side effects of medication

How familiar are you with the neuroscience diagnostic and treatment advancement listed above?

36	(64.3%)	Not at all
19	(33.9%)	Somewhat
1	(1.8%)	Very
56		

To what extent does your agency provide this advancement?

55	(98.2%)	We do not provide this
1	(1.8%)	In selected cases only
0	(0%)	As routine service
56		

If you provide this advancement...

How does your agency provide the neuroscience diagnostic and treatment advancement listed above?

0	We provide this “in house”
0	Through hospital-based service
0	Through a partnership/collaboration with a research university
1	Through partnership/collaboration with other BHC provider(s)
1	

What reimbursement stream does your agency use to underwrite its delivery?

0	Private insurance companies
1	Government-funded health insurance
0	Partnership with a university research project
0	Private contribution and/or foundation grants
1	

If you do not provide this advancement...

Is your agency considering the use of the neuroscience diagnostic and treatment advancement listed above?

4	(7.3%)	Yes
51	(92.7%)	No
55		

What reimbursement (funding) stream would your agency seek out to underwrite its delivery?

0	Private insurance companies
0	Government-funded health insurance
1	Partnership with a university research project
2	Private contributions and/or foundation grants
3	(Note: Less responded than plan to use the technology)

Agency Capacity Statements

Our staff is knowledgeable on neuroscience advances and their application in nonprofit behavioral health care

8	(14.3%)	Yes
42	(75.0%)	No
6	(10.7%)	I Don't know
56		

If NO to the previous statement...

The absence of this capacity is preventing our agency from adopting and delivering neuroscience technology

17	(40.5%)	Yes
11	(26.2%)	No
14	(33.3%)	I Don't know
42		

Our clinical staff possess the necessary qualifications and certifications to provide neuroscience diagnostic or treatment services

5	(8.9%)	Yes
38	(67.9%)	No
13	(23.2%)	I Don't know
56		

If NO to the previous statement...

The absence of this capacity is preventing our agency from adopting and delivering neuroscience technology

14	(36.8%)	Yes
13	(34.2%)	No
11	(28.9%)	I Don't know
38		

Our staff has received the necessary technical training to provide neuroscience diagnostic or treatment services

3	(5.4%)	Yes
51	(92.7%)	No
1	(1.8%)	I Don't know
55		

If NO to the previous statement...

The absence of this capacity is preventing our agency from adopting and delivering neuroscience technology

19	(37.2%)	Yes
18	(35.3%)	No
14	(27.4%)	I Don't know
51		

Our agency has hired or contracted with, or is prepared to hire or contract with, specialists to provide neuroscience diagnostic or treatment services

8	(14.5%)	Yes
41	(74.5%)	No
6	(10.9%)	I Don't know
55		

If NO to the previous statement...

The absence of this capacity is preventing our agency from adopting and delivering neuroscience technology

13	(31.7%)	Yes
16	(39.0%)	No
12	(29.3%)	I Don't know
41		

Our agency has considered ethical issues of providing neuroscience diagnostic or treatment services and developed policies/procedures around those ethical concerns

4	(7.3%)	Yes
41	(74.5%)	No
10	(18.2%)	I Don't know
55		

If NO to the previous statement...

The absence of this capacity is preventing our agency from adopting and delivering neuroscience technology

10	(24.4%)	Yes
25	(61.0%)	No
6	(14.6%)	I Don't know
41		

Our agency is aware of local research program(s) investigating or evaluating neuroscience diagnostic or treatment services for behavioral health care providers

9	(16.4%)	Yes
38	(69.1%)	No
8	(14.5%)	I Don't know
55		

If NO to the previous statement...

The absence of this capacity is preventing our agency from adopting and delivering neuroscience technology

11	(28.9%)	Yes
17	(44.7%)	No
10	(26.3%)	I Don't know
38		

Our agency is currently participating in research program(s) investigating or evaluating neuroscience diagnostic or treatment services for behavioral health care providers

5	(9.3%)	Yes
48	(88.9%)	No
1	(1.8%)	I Don't know
54		

If YES to the previous statement...

Briefly identify and describe the research program(s) you are currently participating in:

1. Effects of cortisol on depression in Hispanic women in collaboration with UW Milwaukee.
2. We have a child that is part of a research study at Texas Christian University that is evaluating the impact of our treatment and the use of CALM PRT and Adreco on this child's brain chemistry.
3. We have funded service projects that are classified as Community Strategy programs. Some of these projects feed their data into external research projects that are managed by the funding resource.
4. Use of evidenced based practices such as PCIT and MI with our target population. PCIT training and consultation are provided by our Children's Hospital. The use of imaging and gene work is not part of this. It is practice oriented ...
5. We are supporting an NIMH grant application to pilot a specific psychotherapy treatment for depressed mothers with a local university.

If NO to the previous statement...

The absence of this capacity is preventing our agency from adopting and delivering neuroscience technology

15	(31.9%)	Yes
24	(51.1%)	No
8	(17.0%)	I Don't know
47		

Our agency is aware of other behavioral health care provider(s) to partner with in order to offer neuroscience diagnostic or treatment services

14	(25.4%)	Yes
32	(58.2%)	No
9	(16.4%)	I Don't know
55		

If YES to the previous statement...

What type of provider(s) are they?

7	(46.7%)	Nonprofit
3	(20.0%)	For-profit
5	(33.3%)	Both
15		

If NO to the previous statement...

The absence of this capacity is preventing our agency from adopting and delivering neuroscience technology

13	(40.6%)	Yes
11	(34.4%)	No
8	(25.0%)	I Don't know
32		

Our agency has formed, or is planning to form, the necessary partnership with other behavioral health care provider(s) in order to offer services

9	(16.4%)	Yes
34	(61.8%)	No
12	(21.8%)	I Don't know
55		

If YES to the previous statement...

What type of provider(s) are they?

5	(55.6%)	Nonprofit
0	(0%)	For-profit
4	(44.4%)	Both
9		

If NO to the previous statement...

The absence of this capacity is preventing our agency from adopting and delivering neuroscience technology

12	(35.3%)	Yes
16	(47.1%)	No
6	(17.6%)	I Don't know
34		

Our agency has secured the necessary funding streams to underwrite delivery of neuroscience diagnostic or treatment services

3	(5.4%)	Yes
47	(85.4%)	No
5	(9.1%)	I Don't know
55		

If NO to the previous statement...

The absence of this capacity is preventing our agency from adopting and delivering neuroscience technology

20	(42.6%)	Yes
16	(34.0%)	No
11	(23.4%)	I Don't know
47		

Evidence-based practice

Is your agency engaged in evidence-based practice within its behavioral health care program?

39	(70.9%)	Yes
8	(14.5%)	No
6	(10.9%)	I don't know
2	(3.6%)	I am not familiar with the term "evidence-based practice"
55		

If YES...

How far along are you in implementing evidence-based practice?

9	(23.1%)	In planning stages
4	(10.2%)	Piloting it now
6	(15.4%)	Starting full implementation but still at initial stages
10	(25.6%)	Fully implemented, but only in one or two program areas
10	(25.6%)	Fully implemented across our agency
39		

What served as the impetus for your agency's involvement in evidence-based practice?

3	(7.7%)	State-mandated
4	(10.2%)	Private insurance reimbursement requires it
29	(74.4%)	Agency leadership directed it
3	(7.7%)	Participating in a foundation-funded EB practice effort
0	(0%)	Participating in a university-funded EB practice effort
39		

Briefly describe your evidence-based efforts

1. Service plans are written in a manner that concretely identifies the evidence of behavioral changes targeted in therapy. They are written so that the client understands exactly what daily life events will occur to evidence that the behavior is changing.
2. We use a single case methodology N=1. We compare the dependent variable with the independent variable using time series analysis.
3. We are building a CD Curriculum that will have some evidence based components. Specially looking at cognitive-behavioral components. Also pre, post test components. Using standardized assessments, part of which have a norm based component to them.
4. The efforts are limited to a case-by-case application of practices that we are competent to provide and which are appropriate to a particular client's diagnosis.
5. We offer the Strengthening Families program, a SAMHSA-identified evidence-based practice. We are developing the Sanctuary Model for trauma treatment, a SAMHSA-identified evidence supported "promising practice."
6. Selection of core curricula as available and relevant and specific treatments for key treatment areas.
7. We use evidenced based models in our substance abuse—we have had federal funding and training in motivational enhancement and stages of change.
8. We have had in-service training on it and keep careful statistics on client outcomes. We've all read a recent article put out by the NASW on e.b.p's.

9. We are using research based curriculum in all of our substance abuse prevention programs and in our offender programs for substance abuse. These are mandated by our funders.
10. The Incredible Years Esperanza Para Los ninos
11. We provide treatment strategies that are appropriate for the diagnosis.
12. We are beginning to use a variety of standardized measures pre and post treatment with our clients and compliing this data.
13. We have instituted an agency wide data management system called Qualifacts.
14. Implementing PCIT and MI therapies into practice and exploring other evidenced based models. All therapists have been trained in the above models. We have encountered some resistance from some of our staff and are dealing with it.
15. Medication/cognitive behavioral therapy Home Visitor Model- Parents as Teachers Evidence Based Parenting Program Curriculum- Incredible Years and Triple P
16. Evidence based, gender specific AODA Treatment Use of evidence based practices to treat childhood trauma after review of SAMHSA approved programs
17. We employ EBT practices in a host of settings. We recruit scholars and trainers to assist in implementation of same. We have some services which are purely EBT in scope, including Multi Systemic Therapy, Early Intervention Foster care, and others.
18. Have used the Teaching-Family Model for years in our KEYS section of treatment, as well as other evidenced based cognitive-behavioral therapies.
19. All programs at daniel have a research part to it for evaluation and gov. funders have required we show evidence base impact.
20. Cognitive Behavioral Therapy, DBT, EMDR training highlighted for clinical staff and various treatments and modalities available for a variety of problems based on evidence-based best practices.
21. Select LSI leadership have been trained and are implementing pilot projects that are grant funded as evidenced based practice efforts. Some examples include wrap around projects, family team meeting, and work with serious emotional disturbances.
22. Beginning to develop a data base from which to develop an evidenced based practice.
23. All programs are expected to use evidence-based practice pursuant to COA accreditation standards and expectations of multiple funding sources. Some programs are more advanced than others but the goal is to continually improve our efforts.
24. [Agency Name] received a Federal grant from the Federal Center for Substance Abuse Treatment to implement two evidence-based practices at an adolescent residential treatment program.
25. We are just starting to review the methodology to evaluate our practice in several different areas.
26. The state has not mandated it yet, but may be moving toward it. We are aware of the few evidenced based practices for treating children for ADHD, adults and children for trauma and depression. We are trying to implement CBT evidenced-based efforts for it.
27. Use of proven interventions and protocols in counseling.
28. FAST, solution focused counseling, Ways to Work programs.
29. Formal programs/tools include: Functional Family Therapy, Equip Program, Thinking for a Change, Youth Level of Service/Case Management Inventory.

Alliance Role

Would it serve a useful function for your agency if the Alliance for Children and Families served as a resource of information on neuroscience diagnostics and treatment advances and their implications for nonprofit behavioral health care providers?

46	(82.1%)	Yes
1	(1.8%)	No
9	(16.1%)	No opinion

The Qualitative Study

*Donna Pinsoneault
Laura Pinsoneault*

Methodology

The initial plan for gathering data was to conduct four regional focus groups with survey participants. Both survey results and the initial round of invitations to participate in the focus groups indicated that an integration of personal telephone interviews and two targeted focus groups would be a more successful tactic for data collection. These two methods provided multiple mediums for Alliance members to provide their insight, experiences and thoughts about incorporating neuroscience advancements within their organizations. Invitations to participate in phone interviews and/or the focus group were extended to 60 Alliance organizations. (see Appendix A for a list of agencies who participated in focus groups and/or telephone interviews).

Phone Interviews

Prior to conducting phone interviews, survey results were used to identify group members based on the following criteria: (1) members who are currently using one of the identified neuroscience advancements, (2) members considering applying one of the identified neuroscience advancements; and (3) members not currently considering neuroscience advancements.³ The interviewers contacted the 13 Alliance members in the first two groups and 29 of the 40 members in the non-considering group.⁴ Initial contact was made through the CEO of the organization. Phone interviews were conducted with either the CEO or the referred staff. The interview protocol was modified as necessary during the phone interviews but focused on awareness, implementation, leadership, decision-making, and resource gathering (see Appendix B for the general interview protocol). Interviews were recorded when technology was available; detailed notes were also taken.⁵

Focus Groups

Focus groups were designed to stimulate member's thinking about current and future applications of neuroscience advancements within their organization and to encourage conversation about

³ The interviews uncovered that the "using" category included some members who had not yet implemented neuroscience advancements reported on the survey.

⁴ Actual participation was much lower due to inability to schedule an interview or the agency declined to participate.

⁵ Global Crossing did not serve useful for recording phone interviews. Because interviews were conducted at the convenience of the member organizations it was not always practical to access Global Crossing. In a few instances, we felt that interrupting the conversation to begin taping would interfere with the quality of the interview.

awareness, implementation, resource gathering and decision-making. Twenty-four members were invited to attend the focus groups; 20 survey respondents and four additional members. Participants were compensated \$200 for their time and travel.

The facilitator used different techniques to inspire participants to come at the topic from a variety of angles rather than representing a particular point of view or promoting a particular agenda. We used several approaches to help participants come at the topic from different views.

- The opening exercise helped participants put themselves into the future. It also identified some of the current priorities that, to accomplish in the next 10 years, might either compete with or complement the use of neuroscience advancements at their agency.
- The components of change discussion explored the issue of how prepared agencies might be for incorporating neuroscience advancements, i.e. how many of those components were already in place.
- The agree/disagree exercise gave participants a view of their agency in the context of the articles that stimulated this research in the first place.
- Interview questions tried to capture additional thoughts that may not have surfaced in earlier conversations.

One of the focus groups was conducted in a traditional, face-to-face format. Although the Midwest focus group was initially scheduled using the traditional format, transportation and other organization priorities made travel difficult and expensive. Several days before the group, the decision was made to shift to a conference call format to increase participation and accommodate various schedules. Face-to-face interaction and the absence of work distractions afforded by the traditional focus group format in New York produced a livelier and more in-depth conversation than the conference call format held in the Midwest. The New York focus group was digitally recorded and the conference call was recorded with Global Crossing technology.

Findings

Focus Group: New York

The New York focus group included five participants representing four member agencies. Topics of discussion were based on content

from two sections in the New Frontier report - “Advancements in Neuroscience” by Carl Zimmer and “The Implications for Nonprofit Behavioral Health Care” by Laudan Y. Aron.⁶ Participants were asked to read those sections in advance of the gathering.

The focus group format included an opening exercise and an agree/disagree exercise along with conversations about relevant components of change, the five “promising” aspects of neuroscience applications noted in the report, challenges to implementing, dealing with the challenges, the role of the alliance and responses to selected interview questions.

Participants were eager to respond to questions and engage in conversation about neuroscience advancements. All were either in the beginning stage of learning about advancements or just beginning to consider learning more about neuroscience. One agency represented had already made the commitment to engage in exploration in order to make an informed decision about whether to take next steps.

Common themes included (1) the need for considerable education about neuroscience advancements including access to experts throughout the learning and strategy development processes, (2) solid enthusiasm for moving forward tempered with skepticism based on experiences with organizational change, influences outside the profession and the priorities of funders, (3) gratitude to the Alliance for bringing the issue to the table coupled with hunger for more information, guidance and support from the Alliance.

The following factors were identified as influencers likely to promote the implementation of neuroscience advancements in their agencies:

- desire to deliver the best available service to clients
- intention to be proactive
- commitment to thoroughly explore the potential
- commitment to advocacy
- some potential for effective medical partnerships within current relationships
- widespread interest in brain imaging developments
- willingness of agency leadership to invest resources.

The following factors were identified as potentially hindering the implementation of neuroscience advancements in their agencies:

- low level of knowledge about neuroscience advancements
- low level of understanding of how the advancements might benefit their agencies
- time constraints
- work overloads
- skepticism
- considerable uncertainty about how to develop truly effective partnerships

- concern that other influencers will have great impact on how agencies apply neuroscience advancements
- need to develop credibility to work effectively with medical partners
- uncertainty about what to trust
- long lag time for implementing change
- cost constraints
- likelihood that professionals will wait for the change “to come to us.”

Participants agreed that the Alliance has a significant role to play in neuroscience applications in nonprofit agencies. Activities mentioned as possibilities include:

- lobbying and advocacy
- education
- pushing the agenda
- improving the flow of money
- helping agencies get grounded
- walking with agencies through the exploration process
- systematically facilitating the exploration process
- helping agencies embrace the findings together
- tell the stories
- multi-disciplinary dialogues not just with member organizations.

Focus Group: Midwest Conference Call

Three agencies from the Midwest area were represented on the Chicago conference call-focus group. These members advanced largely positive expectations with respect to the application of neuroscience advancements in the behavioral health field. It is commonly understood that this “new wave” trend is inevitable, not simply an alternative practice. Ultimately, they anticipate substantial integration of “talk-therapy” with neuroscience technology.

Each of the three agencies was engaged at different levels with respect to implementation or integration of neuroscience advancements. None of the agencies had incorporated technological advancements in the field into their daily practice. However, like some of the participants in the New York group, the use of evidence-based research with respect to brain functioning was being incorporated informally in designing treatment plans and some application in programming curriculum. The broadest knowledge base came from Cognitive Behavioral Therapy and trauma and attachment literature. One participant has also been able to utilize a partnership with a provider for treatment of one clinical case.

The discussion in this focus group centered on several themes: (1) education and awareness of neuroscience evidence and technology, (2) capacity to investigate and implement neuroscience advancements within their organizations, and (3) anticipated outcomes for clients, family and child serving and residential treatment organizations and the behavioral health field.

⁶ Aron, Laudan, and Carl Zimmer. *The New Frontier – Neuroscience Advancements and Their Impact on Nonprofit Behavioral Health Care Providers*. Copyright 2005, The Alliance for Children and Families

Education and Awareness. Participants expressed a tension about “not knowing enough,” to contribute to the conversation, but also mentioned having been involved in a lot of information gathering and informal learning and awareness about brain development and its implication for practice. Most of their education is occurring through conference attendance and participation in on-line list-servs. The Alliance Directors of Professional Services (DPS) list-serv was named as a good source of information. Individuals spearheading the effort are also engaged in a lot of on-line reading of journals. Another source of information was knowledge gained from perspectives of younger interns at the agency.

Although participants expressed access to a breadth of information, they countered that with concerns about asking “the right questions,” and determining objectivity and quality of information. They identified a need to bridge a gap in the literature between research and implications for families. Overall, they communicated a need for more direction and on-going communication about the integration of neuroscience and practice and more formal training and education. In addition, organizational sharing of information and experiences with integration appeared to be important. Participants were interested in gathering resource referrals and conference notices from other participants. In fact, individual “networking” was highlighted as one of the most beneficial assists. They were also very conscious of the need to keep this issue in the “fore-front” and saw the Alliance as a leader in meeting this objective.

Capacity. Each of the focus group components addressed organizational capacity to implement neuroscience technology. The representatives of these organizations characterized themselves as “learning organizations” with a lot of interest in keeping up-to-date and being ahead of the trends. At the organizational level, the participant was responsible for leading the effort along with CEO involvement and encouragement. The agencies had not yet engaged their Board; the represented governance model was one in which executive management sets the vision with relatively little involvement from the Board programmatically. Participants expected some “natural anxiety” among Board and staff as they approach implementation, highlighting the importance of being fully informed before involving more organizational staff and leadership in the process.

As to be expected, capacity presents one of the biggest challenges to implementation. Funding is a concern for both planning and implementation. Participants expect substantial internal education needs as well as retraining or hiring of specialized staff. An expressed concern was that “if we try to do this cheap, the outcome will be lower quality service.” There is a preference towards having a strong strategic plan and adequate funding before embarking on this project.

It is recognized that tracking outcome data will be an important component of implementation. There was mixed response about

current organization capacity to collect outcome data. All of the agencies are involved at some level in documenting outcomes and applying evidence-based models. Although in the early stages, all three agencies were prioritizing quality assurance and improvement.

Externally, building collaborative partnerships and access to and availability of “experts” were concerns. Informal networking is the primary mechanism by which these agencies are building awareness of neuroscience advancements and opportunities. For right now, partnership opportunities are limited and their creation is circumstantial. There is some apprehension about how to form these partnerships that stems from historically weak collaborations. Local access to large medical facilities and universities also presented a challenge to the agencies not near a major metropolitan area.

Anticipated Outcomes. The participants anticipate that integration of neuroscience advancements would reflect positively on the organization and better serve children and families. Providing “cutting-edge” services “showcases” the progressiveness of the organization and offers an edge in getting funding and building credibility. They see this as an opportunity to better serve clients but also to build organization reputation as consultants and model programs. They see a direct link between the usefulness of neuroscience advancements and client outcomes.

Expressed concerns centered on two main issues: (1) the misuse of technology and (2) access and affordability of services. The participants discussed the complexities of “studying the brain” and understanding neuroscience. Their concern is that there are a lot of unanswered questions. “How far do we take it?” “What don’t we know?” “What are the implications of diagnosis?” More practically, there is a concern of how this all will play out with managed care.

Telephone Interviews

Nine members who returned the electronic survey also agreed to participate in telephone interviews.⁷ Phone interviews explored neuroscience integration in the immediate and future plans of the organization. Agencies were engaged at various stages from “not considering at all” to “on the verge of integration.”

A small number of agencies are beginning to integrate research knowledge but not necessarily technology into their practice. These opportunities emerged as a result of informal dialogues with colleges or small agreements between community psychologists and psychiatric consultants. For some agencies, psychiatric consultants work with the agency for staff training and consultation on psychotropic medications. The larger number of agencies is considering applying neuroscience advancements in the following areas:

⁷ Three others were interested in being interviewed but were not available before May. Four organizations returned calls but did not feel they could contribute at this time.

- behavioral health diagnoses
- cognitive enhancing drugs
- incorporating testing with medical technology
- integrating evidence-based program models, but not in ways identified in “New Frontier” report.

At the moment, most of the participants didn’t feel anyone was formally leading the effort since they were primarily at the early stages of information gathering. The effort would likely be led by one or more of the following:

- “Probably me”
- CEO
- clinical directors
- management responsible for quality assurance/improvement.

Being in the “early stages” of information gathering was reflected in the decision-making models being employed. Decision models were almost always informal and guided primarily by one or two individuals. The following were characterizations of decision-making models:

- informal
- staff driven—getting staff educated using agency time and money
- CEO early in process in consultation with administrative team
- just realized we were missing something and sought to correct it.

Participants were asked a lot about resources being used to guide their decision-making. Most of the organizations are not making structured or formal efforts to seek out resources at this time. Several participants mentioned “finding what they can handle” and others alluded to the overwhelming amount of information. Several mentioned the Alliance as both a source of current information as well as an organization with the capacity to provide on-going and future support. Collectively, participants reported the following sources of information:

- the Alliance
- journal articles
- National Institute of Health
- books
- brain and behavior training classes
- conferences
- Journal of the American Medical Association (JAMA)
- National Institute of Drug Abuse (NIDA)
- on-line resources
- networking.

Agencies participating in the phone interviews identified several benefits to integrating neuroscience advancements at the organization and client levels. At the same time some agencies were unsure what the gains would be. Participants noted they found neuroscience promising in:

- aiding in diagnoses

- providing treatment that would have an impact over time
- promoting the agency and an opportunity to lead
- increasing effectiveness of practice
- demonstrating tangible improvements in client outcomes and quick, easily measured outcomes
- more opportunities for other services
- stronger, tighter partnerships.

Participants see neuroscience as an alternative to things that aren’t working now or as a whole “new wave” for behavioral health care. One participant suggested that mentoring would be a key component of success because “once children were diagnosed, you would want to mentor the entire family on how to interact with that child.” Another participant characterized their current integration as neuroscience on a level that is, “doable: working with families and teaching them how to do it through support, education and consultation.”

Alongside the benefits and opportunities provided through neuroscience technology, agencies expressed the following concerns:

- affordability
- risk management
- ethics
- loss of agency autonomy to bigger medical centers
- technology going ahead of our ability to make a good decision
- accountability
- mind sets
- viewing behavior through a medical model
- getting past old-school thinking, particularly with electrical stimulation.

Participants were asked about several issues related to implementation including their time lines, the anticipated challenges, and what is needed to make this transition a reality for their organization.

For the majority of agencies there was no planned window for neuroscience implementation. Although one agency intended to have implemented some of the neuroscience technology by year end; none of the others were thinking of seeing anything before 5-10 years.

When asked about their time line, they reported the following:

- “two weeks” [tongue-n-cheek]—anticipating that within three to six months they would have secured funding and/or a medical partner and be implementing by year-end
- not even on the radar—a small community doesn’t have the resources so we will probably wait for someone else to do it.
- no window or strategic plan
- quite a ways out, we need to lay a foundation and get current services up to speed
- there is “band-wagon” mentality. If others are going to do it, we will get on board
- struggling to meet the day-to-day services, not ready to embark on this yet.

Participants expected to face these challenges as they embark on this process:

- accessing experts to get answers that are relevant to their agency
- assessing and managing risks
- changing mind sets and helping others to look at things differently
- moving the community forward in their thinking
- dealing with resistance to medical model of viewing behavior
- involving individuals below administration in the process
- not just prescribing medications but changing how we view intervention
- integrating technology
- developing the capacity to incorporate change and meet current service goals
- finding time
- not having the right degrees or training
- accessing medical partners/facilities.

Participants were also asked about resources they need to take the next steps and in particular the “one assist” that would be most helpful. In general they mentioned the following things need to occur before implementation:

- credibility to talk with medical centers
- need to embrace a medical model of delivery in the organization
- community investment
- someone else to do it first.

The “one assist” suggested by participants to be most helpful in meeting these challenges were:

- cost-benefit analysis
- focused data collection with results
- demonstration that it works
- selected start-out measures
- check list that shows us what to do, when
- on-going leadership from the Alliance
- guidelines on creating effective partnerships
- links to experts with knowledge
- professional training on implementation
- practical ideas for implementation

Participants specifically identified the following as needs that could be potentially met by the Alliance:

- checklists that address needs specific to the size and locations of agencies (i.e. small agencies, mid-level agencies, etc)
- concrete references
- on-line articles
- Alliance sponsored research groups
- dissemination of information in a reader friendly way
- specific research on populations we serve

- basic research to “whet the palate”
- workshops, seminars
- video conferences with experts
- keeping people looped in
- training
- on-going leadership activities
- helping us support each other so there aren't 50 incubators doing the same thing from scratch
- cost benefit analysis
- lists of why we should take this on as initiative
- Q&A resources
- how to develop in phases
- be the “Mecca” of information.

Closing Remarks

Qualitative research revealed considerable interest in and enthusiasm for exploring the potential benefits of applying neuroscience advancements to behavioral health services. Many participants in the research expressed gratitude to the Alliance for bringing the issue to their attention and sparking a desire to learn more and/or stay ahead of the curve on the topic. At this time, agencies interviewed appear to be approaching the topic in one of two modes:

- proactive – committed to learning much more about whether and how best to deliver neuroscience advancements to benefit the children and families they serve
- wait and see – highly interested in learning more about neuroscience advancements but not convinced they should move forward until such advancements are more easily accessed and integrated and/or become standard practice.

Within agencies, CEOs and quality assurance, clinical directors or strategic program planning officers are the individuals most likely to pursue knowledge related to neuroscience advancements and advocate for implementation within their agencies. Some see success linked to agencies that are better connected geographically, able to make decisions quickly, and oriented towards learning leadership. Interviewees from agencies located near progressive medical centers were most optimistic about their ability to implement neuroscience advancements within the next five to ten years. Those who already have working partnerships and funding anticipate earlier implementation, in some cases within two years.

Though some voiced skepticism about whether nonprofit agencies will embrace neuroscience advancements within the next 10 years, everyone interviewed expressed a need to first deepen their understanding of neuroscience and its potential to benefit nonprofit behavioral health service providers and clients. To accomplish that level of understanding, they seek:

- background information
- ongoing access to experts in a range of related fields
- models and/or pilot cases from which to build their own strategies

- connection to, information sharing with and support from other agencies that are exploring and/or applying neuroscience advancements.

Agencies are looking to the Alliance to facilitate next steps. Ideally, they would like the Alliance to:

- routinely suggest resources – Web sites, white papers, journal articles and other literature to “whet the palate”
- keep the topic in the forefront at the CEO level and beyond
- create opportunities for multi-disciplinary dialogue with experts
- identify benefits that specifically apply to agencies that serve children and families
- develop a cost/benefit analysis
- explore risk management strategies
- facilitate inter-agency data sharing and support

- establish a pilot project to determine effective exploration strategies, implementation processes and evidence
- develop “how-to” resources that may include getting started techniques, comprehensive “road maps,” question and answer guides
- assist in generating funding
- advocate for appropriate policies.

The Alliance is uniquely positioned to assist its member agencies in exploring the benefits and challenges involved with the application of neuroscience advancements but the majority of agencies will require clear guidance, user-friendly tools and demonstrated results before investing time and financial resources in the process. Next steps for the Alliance may include brainstorming ways in which some or all of the above assists can be delivered.

Appendix A

Participating Organizations

Eastern Focus Group March 23, 2006

Children and Families First, Wilmington, DE
 Hillside Family of Agencies, Rochester, NY
 Jewish Board of Family and Children's Services
 Julia Dyckman Andrus Memorial, Yonkers, NY (2 participants)

Conference Call: Midwest Focus Group - March 30, 2006

Chaddock, Quincy, IL
 Presbyterian Children's Services, St. Louis, MO
 The Family Conservancy, Kansas City, KS

Phone Interviews

Alliance for Families and Children of Central Virginia, Lynchburg, VA
 Catholic Social Services of Wayne County, Detroit, MI
 Family and Children's Association, Mineola, NY
 Family and Youth, Lake Charles, LA
 Family Service of Piedmont, Jamestown, NC
 Idaho Youth Ranch, Boise, ID
 Lutheran Services, IA
 Personal and Family Counseling Services of Tuscarawas Valley, Inc.,
 New Philadelphia, OH
 Presbyterian Children's Services, St. Louis, MO
 (different participant than in focus group)

Appendix B

Phone Interview Protocol

Script:

Hello, this is [Donna, Laura Pinsoneault] calling on behalf of the Alliance for Children and Families. Thank you for participating in our online survey and agreeing to this telephone interview. Is this still a good time for us to talk?

I've prepared a set of questions but welcome you to add your comments and insights even if they don't seem related to the question at the moment. We're hoping to make the most of the next few minutes to learn as much as possible about how your [agency, organization, clinic, facility] may apply advancements in neuroscience to behavioral health care.

Do you have any opening comments or questions?

- In what areas is your agency considering applying neuroscience advancements?
- Who is leading the effort?
- What decision-making model are you using?
- What resources are you consulting to learn more about it?
- Are you finding the information you need?
- What benefits are you anticipating?
- What concerns do you have?
- What is your window for implementation?
- What opportunities are you anticipating?
- What opportunities have you experienced so far?
- What one assist has been most helpful in making the most of those opportunities?
- What challenges have you experienced so far?
- What challenges are likely to arise?
- What one assist would be most helpful in meeting those challenges?

- Do you see your agency making additional applications of neuroscience advancements within the next 2 years? 5 years? 10 years?
- Why? Why not?
- What resources would you need to take the next steps?
- Where would you look for resources?
- How can the Alliance be most helpful to your agency?
- Now that we've talked, what comments or questions do you have?

Applying evidence-based practice? Tell us more about what you are doing.

Appendix C

New York Focus Group Data

OPENING EXERCISE: 10 Year-Reunion

Responses

Goals cited:

- Leading an agency myself
- Assisting in creating a community of excellence
- Having our greatest impact in primary prevention and tertiary care
- Advocating daily and increasing my sense of awareness with the world
- Involved in advocacy
- Our agency will be the premier agency in our state and doing enormously positive things
- We'll be addressing ways in which changing understandings of neuroscience and neuropsychology are impacting our clients and community, e.g. would love to help our school system keep up with what's happening
- Straightening my office
- Establishing ourselves as a leader in early prevention work; we don't know enough about children under five.

Potential changes mentioned:

- New energy sources
- Less dependence on fossil fuels
- Better health care system, maybe some sort of national health care
- Gradual shifting of emphasis in toward; geriatric/elderly population; agencies have to change with the population
- Our organization will be larger
- More taxes

Experience with the exercise itself

- It is difficult to start with my age
- The truth hurts
- I don't know how much things will change in 10 years.

Not that much has really changed in the last 10 years so I don't know how much will change dramatically except for the things we've been talking about and hopefully will start to implement.

Implications [according to facilitation team]

Interests that may influence agencies to pursue advanced neuroscience applications:

- Desire for excellence
- Orientation toward prevention and early impact
- Commitment to advocacy

Interests expressed that may hinder application of neuroscience advancements:

- Time constraints
- Skepticism about the potential for dramatic change

CONVERSATION 1: *Shift to Medical Model*

One participant mentioned the possibility of their agency moving from a service model to more of a medical model. The facilitator suggested exploring that topic further.

Responses

- It's likely to be more of a split because the agency may decide that maybe there are things we shouldn't try to do and move those things into a medical center.
- Can the agency really bring in brain imaging equipment? Or focus more on what has been the traditional focus of the agency?
- Where we are going now is to train our therapists with a social work background in psychiatric
- If we follow the trajectory we have been on, there will be more of a medical aspect to our understanding of medications, and the biological and physical basis.
- At a minimum, a whole new range of knowledge and training may be essential for staff.
- Ultimately what's going to emerge is a different kind of partnership. The knowledge base will enable us to be more effective in a more specific way, e.g. what if we can stop drug addiction by medically interrupting the cycle?
- Must consider the impact in terms their environment and family system
- There is likely to be a closer relationship between the two professions in terms of being able to discriminate how to be effective.
- Partnerships and making decisions about how we will apply the advances in medicine to what we do.
- Our role is pivotal in partnering with consumers and using the partnership with the medical field to advocate for them.
- These are decisions that the agencies have to make.
- I don't see it going to completely medical; that would be going against what we have.
- What I liked about [the opening exercise] is that it is a reminder to be proactive.
- We will have to be collaborative but we will have to move fast before it's defined for us by bean counters and insurance companies.
- If we don't get in the forefront of saying this is how we can afford it, this is how the match can go, then we will be stuck with what others decide.
- There is a great risk in the medical model looking so much more cost effective on the surface so they can pick and choose what they are going to pay for.

Implications

- Some potential for partnerships exists within current relationships.
- Considerable uncertainty about how those relationships may need to shift.
- Desire to be proactive.
- Concern that other influencers will have greater influence on how agencies apply neuroscience advancements.

CONVERSATION 2: *Components of Change*

As another way to uncover attitudes toward applying neuroscience advancements, the facilitator named several components of change as noted in *The Second Half of Change* and asked participants to discuss how that component might come into play as their agency worked toward applying neuroscience advancements.

Responses

Intellectual component

- Just begun.
- Not us.
- Trying to get people to read the journals, understand the gravity of it
- Just trying to get through the day.
- We tend to delegate that. One person will present so not everyone has to come through that part of it.
- Helps if people become aware that their own little private world is not the only way.
- Getting people educated internally is the place to start.

Values Component

- Being considered by a relatively small group in our agency
- Some will do special projects but day to day line workers and managers are putting out fires.
- Outcomes are driving things; the outcomes are driving the research orientation.
- Vast numbers of people are just trying to get through the day.
- Not sure research is taking us to the medical piece because we don't traditionally go there.
- Related to the importance of the whole idea of stem cells, the ethical and moral underpinnings. Just beginning to think about it in terms of foster care.
- Considering a whole combination of things like moral dilemmas that grow from technical advancements.

Breaking with the Old Model Component (laughter)

- Both a challenge to and natural outgrowth of.
- Done a lot of talk at the leadership level because of extensive interest in innovation
- Trying to find out what's going on before taking next steps
- Approach everything as a learning organization
- Obstacles are at the line staff.
- If they don't have the education, they will give numbers but are they quality numbers?
- Getting people to jump on it.
- Enormous lag time before change takes effect.
- Have to anticipate there will be cultural resistance.
- Difficulty understanding the implications.
- Concern that things will just keep changing.
- Brain research is interesting.
- People are curious but they don't know what to do with it.

It's hard to push people who have been at the agency 20 years if it's not how we have always done things.

By the time they do it, science will find a different wrinkle and say 'it really doesn't mean this, it means this.

A little science goes a long way.

You don't know what's real and what to trust.

Right now, they'll say "this" means you have depression. If you don't have "this" on your scan, you don't get covered. Four years later, they say [something other thing] means you have depression.

Dealing with Contradiction Component

- No contradiction in and of itself; it will strengthen what we do
- Will allow us to measure in ways the public won't even appreciate
- It's not the science itself but what is done with that information
- Concern about unsophisticated interpretation – "it's scary."

Credibility Component

- Needed to speak intelligently with medical partners
- Communication needs to happen on many levels

CONVERSATION 3: Agree/Disagree Statements**Neuroscience advancement is the "new wave" for nonprofit behavioral health care.**

All disagree.

Leaders in our agency understand the implications of neuroscience advancements for behavioral health care.

All disagree

We have identified areas in which we might apply neuroscience advancements.

All disagree

We can name the benefits of applying neuroscience advancements.

Some said they could, especially after reading the articles.

We can name the barriers to applying neuroscience advancements.

All agreed.

- Access issues:
Have and have not.
Accessing expensive diagnostic tools.
Who will get access if it is a proven treatment?
Goal is to get everyone access that needs it.
- Education
Unsophisticated knee-jerk response
For collateral or financing agencies
It won't pay for kids on welfare.
- Present vs. future orientation.

We are preparing to integrate neuroscience advancements in two years.

All - No

In five years? Maybe

In ten years? Sure.

We don't have a plan or time.

Work loads of people are overwhelming

If we talk quickly and the make the technology available and affordable...

As soon as I figure out what an ipod is...

You can't go with every single technology advancement – I went from records to dvds.

The following advancements are promising for your agency:

More accurate diagnoses Yes.

- Based on where I've seen neuron-imaging going in the last 20 years, I doubt that it will be that precise in the next ten years.
- There's a certain point when you come to the nature/nurture debate; there will be real physical indicators but an overlap of learned behaviors; one informs the other.
- Will still require a skilled clinician to decipher
- I think that's the risk here; may be as commonly disseminated as a blood test so we'll check it off because that's what we can get
- Will not generally affect our treatment; may be used in extreme treatment.

Use of electrical stimulation devices Somewhat.

- Has to become precedent.
- Will be perceived more along the lines of a pacemaker, in terms of vagal nerve stimulation.
- magnetic stimulation is more like ECT.
- Those technologies will be applied to the very worst cases; our agencies may not see those cases.
- We see those cases – really entrenched trauma cases.
- Whenever I talk of ECT, people talk of the 50s, the Snake Pit.
- I worry a bit about Tuskegee experimentation; worry about access and need for controlled studies, traumatized but desperately poor and struggling, it's a messy group
- Right now, for example, I see a lot of mothers of my patients lining up for gastric bypass surgery. It's quite bizarre. I can't believe it's medically necessary. Somewhere along the line they decided it's economically better.

Improved drugs Yes.

- We're already seeing that.

Use of brain imaging to establish treatment strategies Not now.

- Falls further in the future
- Not precise enough,
- Kind of Captain Kirk, Mr. Spock

Integration of talk-based therapy Yes.

- Medications don't fix the problem but make the person a little more available.

Of these last two, one seems so far out and one seems today.

I wonder what they are defining as cognitive-enhancing – will I remember where I've parked my car?

We will choose to go forward with neurological advancements.

- Not easy to answer.
- Requires leadership decision to invest resources.
- Not a sure thing.
- Agency inertia may hold us back.
- Driven by what happens outside the agency.
- Requires money on the table.
- May require a "bandwagon."
- Not a quick decision.
- Timing
- Challenge of getting people to work together.

Initially my reaction was no no, no; we're going to go forward. But it depends on how available, how convoluted it gets whether it takes a broad swipe at things and tries to be more than it is. It's a little like shooting ants with a machine gun.

Because it's science, of the medical model, it's going to seem to be more than it is. Now, if you give people a diagnosis they want to know where you come up with it. You look at the list of symptoms and say, it's our best diagnosis. If you give them a blood test or MRI, they are going to want to go with it.

I was going to say "oh sure," but when it comes down to it, the decisions of leadership where they are going to put their resources, there may not be resources to put in that.

We will explore potential partnerships and implications, and then enter a stage of planning to make some informed decisions, maybe take two years, maybe 18 months to really understand the implications of these discoveries, [and] plan a mindful approach of what we are going to do.

New concepts won't be enacted unless there is a necessity. If Medicaid stops reimbursing us unless we have a scan, we get a scanner.

This is the future, would be stupid not to give consideration but it's an issue of timing, the other major barrier is it's not easy to get people to work together, in any system. If we are not able to bridge that, we're not going anywhere with this.

Put money on the table. Someone from the outside with the expertise will be brought in and there will be small pilot projects. If they are successful then [the agency] will do it.

People will jump on a bandwagon. Traditionally, someone from state government will go to a workshop and suddenly the state is financing it and it's a model program. Everyone jumps on it; it's the new in thing. That works.

If it's a mutual benefit situation, e.g. we work with a local college. It's in their best interest to have interns come to our site and our best interest to have them bring best practices.

CONVERSATION 5: Challenges to Implementing

All in the group agreed that each item listed below was a challenge to implementing:

- Delivery mechanisms
- Staffing requirements
- Client profiling
- Operating funds
- Privacy issues
- Policy issues

CONVERSATION 6: Dealing with Challenges

- With some techniques described in the article, first inclination is we have to find a partner
- Can't fathom having very expensive medical equipment
- Scope the nation for who might be the best partners in this field; who? And how would that partnership look?

Have you had effective partnerships in other areas?

- I feel like we already do it but in an informal, nonsystematic way
- Know which hospital units to send our kids to but making it systemic, more formal, that's in the infancy
- Enormously complex institutional structures in medical centers
- Do it well when tying into a service

We attempted about a year and a half ago to join forces to get a grant. We had great ideas but as soon as we started putting the paperwork together, it was a no-win situation financially.

- Physicians are trained to take charge.
- Medical facilities tend to see other organizations as subsidiary to them and do not engage on an equal plain.
- Hierarchical structure of medical partner internally makes it difficult unless it's a priority of the hospital to engage in any collaborative arrangement
- Hospitals won't engage in anything unless they see some economic advantage to the institution
- Are more likely to develop their own system or services rather than partner

CONVERSATION 7: The Alliance's Role

- Find organizations that have chosen to be on the front end of innovation curve, what have they learned, what method did they use, was their process done right?
- Who seem to be some of the best partners identified nationally as partners, where is the best research going on? How have those organizations partnered with organizations like ours to do the pilots, test the waters.
- Organizational psychology would be useful in terms of just academic resources, transfer of knowledge, lit I read on innovation and change, biases that staff have, the obstacles etc. I often am on the phone with my friends in organizational psychology
- Organize some opportunities for dialogue with physicians, psychologist, psychiatrists in a room around these topics – real learning comes because they come from different perspectives; can't get the same people with similar orientation in the room We ought to come out of that room with a different understanding.
- Different set of questions
- Who would develop the questions? It goes back to the different disciplines, policy questions, ethic questions, technology get the diverse group so here is everything we can bring to the table
- Consultant not embedded in the system or not under the same threats
- The new person often looks at things differently and asks how come if they are allowed to ask the naive questions, helps get out of the rut of inertia
- Enormous positive potential here you frame it not only in terms of resistances but in terms of the opportunities and the dialogue will enable you to get to the resistance, down the line is incredible, have to be able to see what that is; feel comfortable moving in that direction.

Best way to access the group, conference? Videotape? How would you access their thinking?

- Small groups
- An ongoing presence
- One-shot conferences don't make that much of a long-term impact
- Part of the agency, consultant, for implement the initiative
- Multi-dimensional thinking through how would one enable a transformation of this nature
- You started to move in the direction when you started out with it has to be relevant to the agency, dvd of a presentation – when are they going to get around to it,
- This is how we are going to address your shortfall of numbers, you start getting to the ongoing presence, but it has to be relevant to the agency
- Demonstrate how it's going to benefit, how's it going to make things easier
- Have a conference in Hawaii

*CONVERSATION 8: Interview Questions***How did you get interested in neuroscience advancement?**

- CEO went to conference in October and heard Pat and Laude speak at preliminary study
- Our CEO took part in online survey who is part of the Alliance; I became interested when she asked me to
- More poetic and personal slant; it's always been a balance of the structured and knowable with the more qualitative; it's always been a fascination for me
- We do a lot of psychological testing and you have to find out; when we can get a better clue as to what that's about
- Like being a detective; part of it is knowable, part is very ambiguous; a very enjoyable place for me

Who would lead it in your agency?

- Not me!
- Hope there would be a few of us would lead different aspects of it; my big thing is testing; how do you disseminate it; it has to be a collaborative team
- Director of policy and planning person would bring the academic piece; finance person would bring the bean counting; health center person would bring the medical aspects of it
- I would be managing it but it would be psychiatry, psychology, everyone would have a role
- In this agency, it would require a psychiatrist unless a psychologist with a neuroscience bent would join the agency; psychiatrist would have to get one of the administrators excited about it OK create a task force and get it going

What decision-making models do you foresee would be used?

- Team conversation is as far as we could go
- Another aspect financial piece of all this; in this agency, new initiatives get off the ground when there is someone out there who wants to spend money on it; money on the table
- Staff person goes to a conference; get really excited about it; something happens doesn't happen as often as it should
- High level of responsibility it is that strategically, if you are not aware of what is going on in your environment in terms of the future of the agency, you're dead
- Should be part of your environmental scan
- Could be some dialogue and talk at all levels of org. put this clearly on the strategic agenda

What resources are you going to right now to learn more about it?

- Alliance
- Laude came up met with our executive team, medical director
- Next step is scan of other organizations; either exploring or actually using
- Further connections with the Alliance; possibly Carl Zimmer
- We have instituted a theoretical model called sanctuary model treatment; Sandy Bloom is one of our faculty; she has brought a lot of info about how trauma affects cortisone level, that has really got us going as seeing our clients as traumatized
- I hate to say it but, when it comes to the hard technology, we are waiting for it to come to us; like something that is baking and is not cooked yet.

Are you finding the information?

- Is anyone looking for it?
- I don't know that any of us are looking

- We are waiting for it to finish baking, let someone else buy it first
- Extreme examples, those that don't respond to treatment, then you are doing a hunt; it's helpful but even if we were looking for it, there's no clear cut path
- No way of evaluating it, how valuable things are
- I don't think I understand half of it, just a little of it

Can you foresee your profession leading the way in this?

- We could play an important role in popularizing it, but it's going to start in the medical centers and may remain in the medical centers unless its disseminated more generally and that might be done through out agencies if there is some way for it to become more acceptable, more attractive
- It's unfortunate to wait because it gives the insurance companies the upper hand if they decide when it will come to us; it may never come to that, the technology may not be that precise, may not offer that hope of diagnostic purism.
- It gets more under my skin when it's personally relevant. A family member we are still trying to get technically diagnosed; there is a need and I ran for whomever I could find to help but not everyone has the background and resources to do that and I'm thinking of the people we serve; we are essentially advocates for the consumers for whom it may never cross their minds to look at it
- It's only when it becomes the tests they are ordering for things I couldn't even fathom, things I never realized existed; you just don't find – the bizarre things you only read about in books; this is an incredible luxury. Until it becomes cheaper than to sit down and talk to a person, we are not going to see it unless we are part of some great study.
- Yet if we are not abreast of it, it's going to overrun us

Have you done anything so far other than exploration?

- No.
- Sometimes you wish you could.... Not only do we not have access to the resource, we don't have access to the person who could tell us what the resource would be.
- We have a variety of kids on campus that go to incredibly wealthy.
- It's only when there is the need and the money, that you go find it

Example?

- We have a couple of children in special ed who are required to have tri-annual psychological evaluations along with their psychiatric evals. We will get them back and we can't figure out why their IQ is down here, or the young lady who seemed to be regressing; it's a child that is deteriorating; it's child who is deteriorating or like the five-year old who has seizures, but when she got on the right medication, she suddenly began to talk; she hadn't talked for four years; it's the real extreme cases when we don't know what's causing it, we don't know what to do and if money is available.
- Some sort of cross between need and means.
- Typically, we depend on medical centers to tackle the difficult cases; if the child is not responding to a course of treatment, we hospitalize them; sometimes the child comes back and sometimes they don't.
- Kids get sent to the diagnostic center; sometimes we can figure it out and sometimes we can't. Sometimes they have to go to another facility that can assist them because there is nothing we are doing that can actually impact them; there are a lot of gaps in services.
- Recent fad of spectrum disorders, when you hear pervasive development disorder; class that involves significant deficits, all the things we used to call autism, they may not all be autism.

- Psychiatric diagnoses say these things kind of look alike so we'll put them here. And we'll put those there.
- That's how the spectrum is not being evaluated; The history has often been because a treatment comes along that works with some people in the group and not others, or a diagnostic tool comes along; very different sets of strengths and weaknesses.
- A lot of what is not discussed in this article, a lot of advances has come along because some damage has been done or someone is injured. I'm thinking of the guy with the pole in his brain. Oftentimes it's back door.
- There has been a really large increase that can't be accounted for by diagnostic precision alone. That's what is driving the fad and driving the search for solutions.
- Remains largely academic until it impacts treatment in a significant way; this won't be driven towards that unless changing the label changes.
- We are only using 10% of reserves are available to us now; unless there is something to make it possible to use the resources available.

What role should the Alliance be playing?

- Lobbying, legislative, educative, things like this where we are getting together and talking about what will work and what won't
- It's getting out pieces like this article, that helps get to people who are in a position to make a decision
- Lobbying, legislative, there aren't enough resources allocated to developing/using new tools
- Push the agenda, allying with NIH like when pushing to make mental health reimbursable
- What will make the difference; if the Alliance can create or improve the flow of money toward this area, that's where it will count. Even if you raise the consciousness, until you get the funding..."
- That's how the funding happens when you raise the consciousness.
- If the surgeon general say it's important, OK that's where we are going to throw our money; they look for credibility. Does the surgeon general say it's important?
- We need a surgeon general with an autistic child and a bipolar brother.
- When there is someone with money who says I want to fund this.
- You have to put the people together. You have to put Christopher Reeve with another organization with the governmental stamp of approval. You get the organizations that need that type of rubber stamp.
- It's going to come back unfortunately to the governmental piece, the kids who are going to get funded by Medicaid. It's our kids that don't have the money.
- There are hundreds of tangents that we can take, depending on individual interests or where money flows, that's the pragmatic piece; in a more idealistic way, what if though through the implications, the nature of interaction between the players, knowledge of practice, get a sense of grounding, e.g. in the 60s, psychotropics were a revelation. We weren't prepared for people coming out of hospitals, we weren't working together, the power of all this is that its interactive, not just one aspect, it's the gestalt of all the aspects, I understand this is not pragmatic in the sense of let's do something, but it is pragmatic in terms of getting grounded
- Have some think tanks do some serious thinking;
- Walk with you through the exploration and start to tell your story;
- Are there other agencies who have an interest in exploration, and how can we partner as a discipline how can Alliance facilitate that and make the contacts, embrace some of the findings together

- Facilitate something multidisciplinary and a little bit more systematized; get networking and determining their level of interest, generating dialoguo

It's a good model, the National Child Traumatic Stress Institute or Network found places that want to look at trauma in kids, they pushed the agenda, organized the discipline and contact between organizations who found things. They have a good model, look at the web site.

I'm a New York cynic; to be forward thinking and proactive and Andrus wants to be in the forefront, so they think ahead, but then you have the obstacles and you have to get pragmatic.

I'm thanking you for bringing this to us.

The opportunity to get thinking about it in terms of breaking all kinds of barriers and stereotypes, ideological revolution, expertise that can be accessed anywhere in the world.

Have we thought outside the boundaries of our agencies in terms of the abilities to access expertise and be able to draw that together? I say this because if we get too pragmatic, then you can't explore.

Not that we can't think outside the box but by the time we finish putting out the fires, it arrives at our door and we're told when and why.

Evidence based practice

- Use the phrase quite a lot, almost sure that people using the phrase are not saying the same thing
- I'm not sure two people using that phrase mean the same thing.
- I'm sure they are not.
- It's tough, to do clinical research, if someone gets better, how do you know it's the therapy, as much as you control for it. Especially with children, how do you know it's not just development?
- Few of us have resources to do anything real scientific and nobody will fund it besides, unless you have a sugar-daddy, we speak the language but don't walk the walk; it's sort of a game and we rely on other people to define what evidence-based is and then we find out it's not really evidence-based, e.g. the FAST program.
- Term has been used so loosely, it's a joke now.
- We are using some modalities – trauma-focused CBT, but we are also trying to do this model of Sanctuary Treatment, we are also trying to build an outcomes protocol the evidence for it through an outcome based on before we used the model and now pre/post; we are moving in that direction.
- It takes resources to figure out what are the outcome measures, which measures have you used. you can poke holes in any research, it's like Swiss cheese, not because people are sloppy but because there are too many ways to slice it
- Alliance could use the agencies as the experimentation field; add the expertise to design the opportunity, generating the evidence-based, providing the resources
- We are trying the clinical models like trauma focused CBT and dialectical behavior therapy, so you are paying attention to fidelity of model and outcome measures but tying it together and getting all the clinicians together to inform practice, it would be a nice opportunity to coordinate that and have just a wealth of information and data.

What were you expecting to accomplish this afternoon?

- Wanted to get a sense of what other agencies are doing, are we behind or with the curve? Wanted to be part of the pack.
- I was thinking we would hear a little bit more about the Alliance's role and partnering with organizations.
- I was hoping for the same, but if we could have a sense of. develop-

ment of how the Alliance is going to be moving forward even getting us together to act proactively.

- I sort of lit up; I said this is the future. This needs to be given attention.
- I'm glad the Alliance is paying attention. I want to indicate how strongly I feel that this needs to progress and be part of what we all do to provide better treatment.
- Would they ever have a future-watch community of practice, thinking this is one of many things affecting our future? A futuristic think-tank, research on the forefront that impacts our organizations.
- Alliance strategic plan as it is now, is member services; members look at what's pragmatic and have a present orientation and not future orientation, if their orientation is giving the membership what they want, it won't happen
- Get people to stop thinking just locally.
- Think global, act local.
- Although methodology may be overrated, now we can really zero in on diagnoses, and that probably isn't true, it does highlight differentiations between certain groups, the knowledge that you can pinpoint certain things diagnostically changes the way you look at treatment, just disseminating the knowledge even without the technology is very important.
- May result in more of a gap.
- From an advocacy point of view, the Alliance should be paying attention to that gap between agencies and who receives opportunities.
- It's happening but it's more a matter of being swallowed up more by medical organizations.

Appendix D

Midwest Conference Call Data

OPENING EXERCISE: 10 Year-Reunion

Responses

Goals cited:

Work internationally with children who suffer from severe and chronic neglect

Potential changes mentioned:

- Growing technological familiarity and generation differences in acquisition of knowledge
- Less need for residential care—expectation that it will be obsolete
- Services at the community level

Implications

Interests that may influence agencies to pursue advanced neuroscience applications:

- Commitment to advocacy
- Orientation to community practice
- Technological advancements

Interests expressed that may hinder application of neuroscience advancements:

- Apprehension about the potential for dramatic change

CONVERSATION 1: Guiding Neuroscience Exploration

- One participant mentioned a specific trauma-case partnership looking at brain chemistry, hormone levels and medication that evolved from informal networking with local medical facility.
- Current emphasis is on applying existing research, not actual technology, into existing program framework. Integration is more about applying what we know to traditional talk-therapy models since this is more feasible for agencies located outside of major metropolitan areas.
- Family service agencies have traditional utilized a less medical model. There is some confusion on how integration of a more medical-based practice will work.

Implications

- Some potential for partnerships exists within current relationships.
- Feasibility for different size agencies and regional locations

CONVERSATION 2: Agree/Disagree Statements

These five advancements hold promise for our agency:

1. Identification of more accurate diagnoses using genotyping and brain imaging.

All agree

2. Use of electrical stimulation as treatments.

Mostly agreed but expressed some concerns.

3. Improved drugs.

All agree

4. Use of brain imaging to establish treatment strategies.

All agree

5. Integration of talk-based therapy with cognitive enhancing drugs.

All agree; is talk-therapy overused?

Neuroscience advancement is the "new wave" for nonprofit behavioral health care.

All agree this is probably true.

Leaders in our agency understand the implications of neuroscience advancements for behavioral health care.

Mostly agree, but that they still have a lot to learn. The knowledge may be there but there is not a lot of discussion.

We have identified areas in which we might apply neuroscience advancements.

All disagree

We can name the benefits of applying neuroscience advancements.

Mixed agreement. (discussion did not identify benefits)

Prior paradigm shifts show similar level of anxiety. The question is providing money for new training and addresses a new model of parenting. The expectation is that behavior changes need to occur in parents and staff.

Another participant also commented on

starting from scratch with staff and needing to address anxiety associated with change by providing information and recognizing the process is slow.

Using Alliance information to keep staff as up-to-speed as possible.

We can name the barriers to applying neuroscience advancements.

Agree:

Cost is huge. Developing connections and relationships with universities and hospitals is difficult because of geographical challenges.

Hurdles to overcome with counties, not always a cooperative population

Changing to private pay rather than child welfare practice is advancing quicker than the bureaucracy of child welfare.

We are preparing to integrate neuroscience advancements

In two years Yes [one agency]

In five years "Sure" [sounds reasonable]

In ten years No response

Partnership in place for one case

Not up to speed

We will be doing something, just don't know what

The biggest challenge to implementing neuroscience advancements is:

Delivery mechanisms All agree

Staffing Requirements All agree

Client Profiles Yes, perhaps

Operating Funds Resounding, yes

Privacy Issues No, consumer protocols already in place

Policy Issues Possibly

- Not relevant
- Don't know about insurance
- Don't foresee it as a problem

We are choosing to implement neuroscience advancements.

All agree at some point.

We know what is holding us back.

All agree

We do know cost is a factor and the ability to establish relationships and get the board "on board."

Cost is the major issue; we already have partnerships and board backing.

Who is going to pay for it?

There are "winners" and "losers" in applying neuroscience advancements.

All agree

Support needs to come top-down with a willingness to invest resources—tendency is to try and do it cheaply but then we end up with a lower quality product.

Agencies who are better connected will be able to move quicker—better geography and younger boards.

Decision-makers at our agency are informed and knowledgeable about neuroscience advancements.

CEO is well informed and the rest are getting there.

We are ready to collect high quality treatment and outcome data.

Mostly disagree

Continuous quality and improvement data we are okay, not capturing neuroscience—needs to catch up.

Not there.

Not there but recently developed with creation of quality and assurance. Moving in the right direction.

We are prepared to educate clients and consumers about neuroscience advancements.

Sort of.

We need to be able to call others in for technical aspects if someone is interested in what to do. Understand at the basic level.

We need to get everyone internally educated.

Have always talked about brain development and have ability to have conversation, but this is a new conversation.

We are seeking restricted funding to underwrite advanced neuroscience treatments.

Sort of.

We are talking about it.

Seeking and have dumped some of agency money into it.

We have found partners with whom to work.

Mostly disagree. One existing partnership is being used.

Student interns take conversation to a different level

Existing university partnerships linked to outcome measurement can be utilized

Having conversations

CONVERSATION 3: Board Leadership

- Board is progressive and is always thinking for the next thing
- Organization began shift applying research in attachment and trauma in order to prove it can be done
- Cautious: Any new shift is going to take awhile but eventually they will be interested and accept as something that needs to be pursued.

CONVERSATION 4: Interview Questions

Who is leading the effort?

- Clinician—needs support of CEO
- CEO—"pumped up" at Alliance conference
- VP of Quality Assurance and Clinical Services

What decision-making model are you using?

- Carver Board Model: Board is involved in governance, not operations. Executive leadership sets vision—board not really programmatically involved.

- Senior managers on board. Shift to middle management and then to Board. Need to address cost factor.

What resources are you consulting to learn more about it?

- Organization is a “learning organization”
- Conferences
- Academic literature—references are somewhat different than references in Alliance report
- Allen Shore conference coming up in St. Louis
- Alliance has been a big help—CEO pursuing through current agency connections
- DPS Alliance List-Serve

Are you finding the information you need?

- Overwhelming amount of information

What benefits are you anticipating?

- Better outcomes for family and children
- Increased respect for what has normally been a “soft science”

What concerns do you have?

- Human brain is complicated
- Managed care limits what they pay for
- “Bastardizing”
- Ethical concerns need to be addressed: How far do you take it? What are the implications of diagnoses?
- We don’t know all the questions

What opportunities are you anticipating?

- Organization displays facility
- Consultation
- Publications
- Reflect positively on agency
- Shores progressive aspects of organization
- Being at the forefront provides a greater edge on funding and credibility

What one assist has been most helpful in making the most of those opportunities?

- Networking and education
- Conferences
- Directors of Professional Services (DPS) network: conversations on list-serv about what other agencies are doing
- Senior leadership conferences

What challenges have you experienced so far?

- Discussion—asking the right questions
- Doubts about objective information

What challenges are likely to arise?

- Funding
- Bridging relationships with universities and larger hospitals

What one assist would be most helpful in meeting those challenges?

- Identify and addressing gaps in research discussing implications for families (This is also an opportunity for family serving agencies)
- Alliance could facilitate opportunities for discussion and partnerships
- Keep conversation in the forefront at the CEO level and beyond
- Conferences—can’t let the issue go away

CONVERSATION 5: Evidence-Based Practice

Not currently doing

Collecting data

Adaptation of various evidence-based practice models—SAMHSA, training in trauma focused on cognitive behavioral therapy, collaboration with SPARKS program, Latino home-based program

CONVERSATION 6: Closing Comments

Phone dialogs are very useful.

