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The field of children's mental health services research has identified several evidence-based practices (EBPs) for intervention and treatment of children and adolescents with emotional and behavioral challenges and their families (see *Data Trends* #149), but research on state level implementation is scarce (p. 370). In these two brief articles, the authors discuss ways in which states are playing a role in the implementation of EBPs. The authors find that there is not a single, clear pathway to the successful adoption of these interventions at the state level. Rather, states are beginning to implement EBPs in ways consistent with their particular needs, goals and constraints.

The first column introduces the Child and Family Evidence-based Practices Consortium, a national collaboration of organizations (state government, universities and other research organizations, and technical assistance centers) committed to providing a forum for sharing ideas and strategies for implementing EBPs at the state level. Bruns and Hoagwood highlight activities among six state members of the Consortium (California, Colorado, Hawaii, Michigan, New York, and Ohio). Taken together, these states collaborate with universities and state and community agencies to: offer training and consultation; assist in the development and adoption of implementation plans, databases, and outcomes monitoring; address funding issues and provide enhanced clinic rate structures; support peer-to-peer networks, best practices conferences and practice guidelines; and collaborate with research partners, family advocates and advisors.

Although each state implements and monitors EBP plans differently, states are, overall, "clearly in a position to lead mental health service and system reform efforts, including the use of EBPs to improve outcomes" (p. 499). However, while the ways in which states contribute to implementation efforts are unique and diverse, there is little research on which approaches are likely to be most successful.

In the second article, Bruns and colleagues discuss six primary dimensions that they have observed which appear to characterize the state of large-scale implementation efforts today:

- **Impetus**—The impetus to adopt EBPs is often provided by leaders who advocate for their implementation. Other driving forces may be legal, regulatory or fiscal in nature. For instance, Oregon has mandated that 75% of public mental health services be evidence-based by 2008.
- **Fiscal drivers**—New funding approaches to deliver EBPs are being developed, such as a defined benefit plan in Texas to manage services and support multiple layers of services for children in the state mental health system. New York State also has instituted an enhanced clinic rate structure to incentivize quality practices, and New Mexico has an evaluation of an approach underway to integrate financing for all behavioral health services under one state umbrella.

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- **Locus of support**—The “home” of implementation efforts vary with each state. For some states, guidance, support, and policy development of EBPs are housed at the state level (Hawaii, New York), while other states operate at the county level (Ohio). A heavy reliance upon universities or public-university partnerships is also common (Michigan). Another locus of support can be found in complex collaborations between states and nongovernmental purveyor organizations (Hawaii).
- **Training infrastructure**—Some states have established local training programs (California), while others look to purveyors located outside of the state (New York, Colorado).
- **Evaluation model**—States have differing ideas about what data elements (e.g., cost, fidelity, outcomes) are to be collected and how such data will be used.
- **Conceptual models**—These models in some states include a theory of change, while other states focus specifically on implementation “as an end unto itself, relatively disconnected from a theory of change” (p. 501).

Because it takes time to build solid relationships with key stakeholders, states involved with the Consortium recommend that initial implementation efforts be phased in slowly. Also, it is best to restrict implementation to counties or providers that demonstrate readiness for the EBP and to test fidelity before moving on to additional sites. The support of “champions,” or individuals whose contributions are critical to the vision and support of EBP implementation (e.g., legislators, advocates, local community leaders, and others who may not be involved with day-to-day implementation efforts), should also be included in implementation plans and activities. Further, states should be cognizant of both the expense and time that it takes to implement a program successfully.

Although the federal government has supported state level implementation in a variety of ways, further policy and programmatic initiatives are needed to sustain implementation efforts. Federal policymakers also should be aware of the multiple issues and challenges related to restructuring clinical practice when EBPs are implemented at the state level so as not to “inadvertently inhibit innovation” (p. 503). Overall, there is a call for much more research to be done on how to implement EBPs at the state level, and how to align specific EBPs with real-world systems of care. To paraphrase one researcher, “we need the evidence on how to use the evidence” (p. 369).