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Inter-Agency Strategies used by State Mental Health Agencies to Assist with Federal Behavioral Health Parity Implementation

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Abstract

State mental health agencies have potential to enhance implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA), particularly through collaborations with state insurance agencies. Little research, however, has examined state agencies' MHPAEA implementation strategies. The study purpose was to describe the trend in collaboration between state mental health agencies and other state agencies to assist with MHPAEA implementation between 2010–2015 and characterize implementation strategies used. A content analysis of information in the State Mental Health Profiling System was conducted. In 2010, 54.9% of state mental health agencies anticipated involvement with MHPAEA implementation through collaborations with other state agencies, but only 23.5% were involved in 2012 and 11.8% were in 2015. Ongoing consultation (58.5%) and local technical assistance (14.6%) were the implementation strategies most frequently used. State mental health agency involvement with MHPAEA implementation though inter-agency collaboration has been limited. Future research should examine factors that influence such collaborations.

Introduction

Health insurance plans in the United States (US) have historically imposed restrictions on the utilization of behavioral health services that are more restrictive than those for medical/surgical benefits (e.g., fewer covered behavioral health visits, higher deductibles and higher copays for behavioral health services).^{1–3} These disparities in insurance coverage have placed a disproportionate financial burden on people with behavioral health conditions and have been a barrier to accessing behavioral health services.⁴ The Paul Wellstone and Pete

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Conflict of Interest Statement

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Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA; Pub. Law: 110-343) was enacted to address this issue.

Recognized as one of the most important behavioral health laws in the US,^{1,2,5} MHPAEA prohibits health insurance plans that offer behavioral health benefits from imposing restrictions on the utilization of behavioral health services that are more restrictive than those for medical surgical/benefits.^{1,6} MHPAEA implementation began in 2010 when interim final regulations were published. As of October 2, 2017, all Medicaid Managed care organizations, Medicaid alternative benefit plans, and Children's Health Insurance Programs were required to be in compliance with MHPAEA.⁷ The Patient Protection and Affordable Care Act expanded the reach of MHPAEA by classifying behavioral health benefits as Essential Health Benefits—in effect requiring individual and small employer insurance plans to cover behavioral health services.^{8,9} Although evidence suggests that MHPAEA has been effective at improving financial protection for people with behavioral health conditions,¹⁰ increasing the utilization of behavioral health services,^{11,12} and reducing quantitative treatment limits (e.g., number of covered visits),^{6,13,14} many implementation challenges have been identified related to enforcement of the law.^{5,15–20}

MHPAEA is generally enforced by state insurance agencies,¹ which have the statutory authority to regulate insurance markets and the responsibility to ensure that insurance plans sold in the state are in compliance with federal and state laws.²¹ However, state insurance agencies typically lack specialized knowledge about behavioral health services and are often limited in their ability to make evidence-informed determinations about whether there is true parity between a plan's behavioral health and medical/surgical benefits—particularly in regard to non-quantitative treatment limits (e.g., medical management standards, step-therapy protocols).⁶ Furthermore, while state insurance agencies might work to increase awareness about MHPAEA among insurance companies, it is generally beyond their scope to promote awareness about the law among behavioral health patients and providers. It is important for patients and providers to be knowledgeable about the law because they are best positioned to identify and report potential MHPAEA violations to state insurance agencies.

To address these enforcement issues, inter-agency collaboration between state insurance agencies and state mental health agencies (SMHAs) has been identified as a potential strategy to enhance MHPAEA implementation.^{22–24} SMHAs have specialized knowledge about behavioral health services, regularly communicate with behavioral health patient and provider organizations, and are thus well-positioned to provide guidance to state insurance agencies about parity determinations and increase public awareness about MHPAEA.²² A 2012 report by the National Association of State Mental Health Program Directors stated that, “For parity to achieve its intended goals, it is important for [SMHAs] to work closely with their state insurance divisions [and] promote education of, and compliance, with parity requirements, monitor results, facilitate handling of consumer complaints, enhance transparency and accountability, and expand consumer protections”²² (p. 34).

In 2015, the US Substance Abuse and Mental Health Services Administration conducted qualitative case studies of effective MHPAEA implementation in seven states and interview respondents resounding expressed that communication and collaboration between state

agencies, such as SMHAs and state insurance agencies, enhanced enforcement.²³ In 2016, the White House Mental Health and Substance Use Disorder Parity Task Force emphasized the importance of inter-agency collaboration between state agencies, including SMHAs and insurance agencies, to MHPAEA implementation.²⁴ Most recently, inter-agency collaboration to improve MHPAEA implementation was a focus of US Congressional mandate through the 21st Century Cures Act (Pub. Law No: 114–255). Title XIII is focused on improving MHPAEA implementation and directs the US Department Health and Human Services to “identify specific strategic objectives regarding how the various Federal and State agencies charged with enforcement of mental health parity and addiction equity requirements will collaborate to improve enforcement” [§13002(c)(3)].

Despite broad consensus that the success of MHPAEA hinges upon its implementation,^{1,15–19,22–25} little empirical research has examined MHPAEA implementation strategies—neither related to inter-agency collaboration between SMHAs and insurance agencies nor otherwise. Scholarship has discussed potential challenges to MHPAEA implementation,^{15–19} surveys have documented low levels of awareness about MHPAEA among healthcare administrators²⁶ and the general public,²⁷ and numerous studies have evaluated MHPAEA’s impact on behavioral health insurance coverage and service utilization.^{6,10–14,28–31} Virtually no studies, however, have focused on state agencies’ MHPAEA implementation strategies. The dearth of evidence about MHPAEA implementation strategies reflects a larger gap in the field of behavioral health policy implementation research. Behavioral health implementation science has largely focused on interventions at the clinical- and organizational-level and public policy-focused implementation research is an underdeveloped area in the field.^{32–35}

This article presents the results of an exploratory study that sought to begin and address the knowledge about MHPAEA implementation strategies. The study purpose was to describe the trend in collaboration between state mental health agencies and other state agencies to assist with MHPAEA implementation between 2010 and 2015 and characterize the implementation strategies used.

Methods

Data

Information on SMHA involvement with MHPAEA implementation was obtained from the 2010, 2012, and 2015 State Mental Health and Substance Abuse Profiling System surveys.³⁶ First conducted in 1996, State Profiling System surveys collect information on the structure and activities of SMHAs via a web-based survey sent to the SMHA program director in all 50 US states and the District of Columbia. In 2010 the survey asked SMHA directors to indicate whether their SMHA anticipated being involved with MHPAEA implementation “along with other state partners, such as the state insurance department” (yes/no) and, if yes, to describe the SMHA’s role (open-ended). This question was also asked the 2012 and 2015 surveys, but was adapted to assess active, as opposed to anticipated, SMHA involvement in MHPAEA implementation through inter-agency collaborations.

Coding and analysis

A content analysis was conducted of SMHA responses to open-ended questions about their collaborations with other state agencies to assist with MHPAEA implementation. A “directed” approach to content analysis³⁷ (p. 1,281) was used in which *a priori* categories derived from an existing coding scheme (i.e., the Expert Recommendation for Implementing Change [ERIC] compilation) guided the development of coding categories. The ERIC compilation is a list of 73 discrete implementation strategies, each with a definition, that was developed through a three round Delphi processes with implementation science experts.^{38–40} The ERIC compilation was used because it offers an extensive and flexible compendium of implementation strategies and is often used in behavioral health services implementation research.

A codebook was created and responses were coded through a five step process. First, two authors (JP and BB) read SMHAs’ open-ended responses and selected 19 ERIC strategies that were potentially relevant to SMHAs and MHPAEA implementation. Next, the two authors reread the open-ended responses, re-assessed these 19 ERIC strategies, and took notes about which ERIC strategies were most relevant and how their definitions would need to be revised to accommodate the content of open-ended responses. Guided by recommendations for writing implementation strategy definitions,⁴¹ the two authors then revised the definitions for the five ERIC strategies that were most relevant to MHPAEA implementation so that the definitions aligned with the actors, actions, targets that were identified in the open-ended response text. The two authors then separately re-read and coded the open-ended responses using the five ERIC categories. Incongruent coding decisions (two) were resolved through discussion. Coding categories were not mutually exclusive and a single open-ended response could be coded at multiple ERIC strategies.

Univariate statistics were generated to describe the proportion of open-ended responses assigned to each coding category and determine the proportion SMHAs that anticipated being involved with MHPAEA implementation through inter-agency collaborations during each of the survey years (i.e., 2010, 2012, 2015). χ^2 tests were used to assess the statistical significance of differences in the proportion of SMHAs involved with MHPAEA implementation during each year. Analyses were conducted in SPSS 24.0.

Results

In 2010, the majority (28, 54.9%) of SMHAs in the US anticipated collaborating with other state agencies to assist with MHPAEA implementation (Figure 1). However, only eight of these SMHAs reported being involved in these activities in 2012 and only three of them were involved in 2015. In total, the proportion for SMHAs reporting inter-agency collaborations to assist with MHPAEA implementation decreased from 28 (54.9%) in 2010 to 12 (23.5%) in 2012 ($\chi^2 = 10.529$, $p = .001$) to six (11.8%) in 2015 ($\chi^2 = 2.428$, $p = .119$).

In 36 of the 46 instances in which the SMHA reported “yes” the question about using inter-agency MHPAEA implementation strategies, the SMHA also responded to the follow-up open-ended question and provided information about the specific implementation strategies they anticipated/actively were using. Forty-one implementation activities were identified in

these responses that fit within five ERIC implementation strategy categories: 1) providing ongoing consultation, 2) providing local technical assistance, 3) building a coalition, 4) developing educational materials, and 5) using advisory boards/workgroups. Table 1 shows the number of SMHAs that reported each of these implementation strategies, how each ERIC definition was revised, and examples of the responses that were provided.

Ongoing consultation was the inter-agency MHPAEA implementation strategy most frequently reported by SMHAs and identified in 24 (66.7%) of the open-ended responses. These consultation activities mainly consisted of informal partnerships through which the SMHA shared their specialized knowledge about behavioral health services with state insurance agencies. Local technical assistance activities were identified in six (16.6%) of the responses. These activities consisted of SMHAs providing state insurance agencies with assistance on specific MHPAEA implementation tasks, such as processing behavioral health patient and provider complaints about potential MHPAEA violations. Coalition building activities were identified in five (13.8%) of the responses, with SMHAs developing partnerships with other state agencies and stakeholders involved with MHPAEA implementation. In three (8.3%) of the responses, SMHAs reported developing and disseminating educational materials to increase awareness about MHPAEA. These materials targeted behavioral health providers, advocacy organizations, and the general public. Also in three (8.3%) of the responses, SMHAs reported involvement with advisory boards and workgroups related to MHPAEA implementation.

Discussion

SMHA involvement with MHPAEA implementation through collaborations with other state agencies appears to have been limited between 2010 and 2015. When MHPAEA was first implemented in 2010, most SMHAs anticipated that they would provide consultation or technical assistance to state insurance agencies to assist with implementation. However, few SMHAs reported that they were actively performing these activities in 2012 or 2015—despite persistent challenges to MHPAEA implementation and enforcement across the US.^{5,15–20}

The current study raises questions about why most SMHAs were not engaged in inter-agency collaborations to assist with MHPAEA implementation in 2012 or 2015, despite anticipating to do so in 2010. For example, it is possible that SMHAs ultimately decided not to engage in such activities because they did not have the resources to do so, or that their attempts to collaborate with state insurance agencies on MHPAEA issues were met with resistance. Prior studies have identified barriers to inter-agency collaboration within the context of the provision of social services to children (e.g., lack of time, lack of trust),^{42–46} but it is unclear whether the same barriers apply to inter-agency collaboration within the context of behavioral health policy implementation.^{32,33,35} Future research should examine factors that influence collaboration between state agencies in the implementation of federal and state behavioral health policies.

The low levels of inter-agency collaboration observed between SMHAs and state insurance agencies could be contributing to sub-optimal enforcement of MHPAEA's non-quantitative

treatment limit rules. A 2013 report issued by the US Department Health and Human Services estimated that approximately one-third of insurance plans imposed non-quantitative treatment limits that were not compliant with MHPAEA.⁶ As noted above, non-quantitative treatment limit rules are primarily enforced by state insurance agencies, but determining compliance with these rules requires specialized knowledge about behavioral health services—which SMHAs are capable of providing. Additionally, low levels of inter-agency collaboration could be a contributing factor to limited public awareness about MHPAEA. A 2014 survey of adults who had used behavioral health services found that only 14% had heard of “mental health parity” and 8% had heard of the “Mental Health Parity and Addiction Equity Act of 2008” (i.e., MHPAEA)—a proportion that only increased to 13% after respondents were provided with a definition of the law.²⁷ SMHAs are well-positioned to increase public awareness about MHPAEA, but in only three instances did SMHAs report developing and disseminating educational materials about the law in collaboration with other state agencies.

Five implementation strategies in the ERIC compilation (ongoing consultation, local technical assistance, coalition building, educational materials, advisory boards/ workgroups) were found to be relevant to the inter-agency strategies used by SMHAs to assist with MHPAEA implementation. A survey of implementation science experts found that these five strategies were rated as being among the most important and the most feasible implementation strategies of the 73 in the ERIC compilation,⁴⁰ suggesting that these strategies have potential to be more widely adopted and produce positive impacts. The original ERIC definitions only required modest revisions across the domains of greater specificity about the actor (i.e., SMHAs), the action (i.e., activities related to MHPAEA implementation), and the action target (i.e., assisting other state agencies).⁴¹ This indicates that the ERIC compilation, which is often used in clinical behavioral health implementation research, also has utility for behavioral health policy implementation research.

Limitations

This exploratory study has at least four main limitations. First, SMHA directors provided information about MHPAEA implementation strategies via textual responses to open-ended questions through a web-based survey. As a result, responses were concise and lacked the detail that would likely be obtained through a more extensive survey or interview. Second, textual responses did not provide information about the intensity or duration with which implementation strategies were used. Third, only SMHA directors, not state insurance agency directors, were surveyed about inter-agency MHPAEA implementation activities. Thus, the study offers a one-sided picture of inter-agency collaboration. Fourth, survey questions were specifically about SMHA implementation strategies that involved inter-agency collaboration with other state agencies and did not capture information about other strategies that SMHAs were independently using to promote MHPAEA implementation.

Implications for Behavioral Health

SMHAs have potential to enhance MHPAEA implementation through collaborations with state insurance agencies by providing consultation on non-quantitative treatment limit

determinations and increasing awareness about the law among behavioral health patients, providers, and the general public. The current study suggests, however, that such collaborations have been limited. Interventions are likely needed to promote inter-agency collaboration between SMHAs and other state insurance agencies on issues related to MHPAEA implementation. Future research should assess whether recent MHPAEA implementation initiatives, such as those promoted by the White House MHPAEA Taskforce and the 21st Century Cure Act, increase inter-agency collaboration between SMHAs and state insurance agencies. Future research should also examine collaborations between SMHAs and state Medicaid agencies as Medicaid Managed care organizations, Medicaid alternative benefit plans, and Children's Health Insurance Program were required to be in compliance with MHPAEA by October 2, 2017.⁷ Finally, inter-agency collaboration is only one of many strategies that have potential to improve MHPAEA implementation. For example, workbooks and templates that provide standard formats for state insurance agencies to assess parity compliance, market conduct examines and network adequacy assessments with an explicit focus on MHPAEA, and communication campaigns to increase awareness about MHPAEA rules among the public and providers are all promising strategies that warrant future study.^{23,24}

References

1. Health Policy Briefs. Enforcing Mental Health Parity. Health Affairs; Available online at <https://www.healthaffairs.org/doi/10.1377/hpb20151109.624272/full/> [Accessed on April 15, 2017]
2. Barry CL, Huskamp HA, Goldman HH. A Political History of Federal Mental Health and Addiction Insurance Parity. *Milbank Quarterly*. 2010; 88(3):404–433. [PubMed: 20860577]
3. Barry CL. The Political Evolution of Mental Health Parity. *Harvard Review of Psychiatry*. 2006; 14(4):185–194. [PubMed: 16912004]
4. Burns JK. Mental health and Inequity: A Human Rights Approach to Inequality, Discrimination, and Mental Disability. *Health and Human Rights*. 2013; 11(2):19–31.
5. Frank RG. Realizing the Promise of Parity Legislation for Mental Health. *JAMA Psychiatry*. 2016; 74(2):117–118.
6. Office of the Assistant Secretary for Planning and Evaluation. Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. U.S. Department of Health and Human Services; Available online at <https://aspe.hhs.gov/report/consistency-large-employer-and-group-health-plan-benefits-requirements-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act-2008> [Accessed on April 15, 2017]
7. Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; The Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans. Office of the Federal Register; Available online at <https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of> [Accessed on April 15, 2017]
8. Beronio K, Glied S, Frank R. How the Affordable Care Act and Mental Health Parity and Addiction Equity Act Greatly Expand Coverage of Behavioral Health Care. *Journal of Behavioral Health Services & Research*. 2014; 41(4):410–428. [PubMed: 24833486]
9. Frank RG, Beronio K, Glied SA. Behavioral Health Parity and the Affordable Care Act. *Journal of Social Work in Disability & Rehabilitation*. 2014; 13(1–2):31–43. [PubMed: 24483783]
10. Busch AB, Yoon F, Barry CL, et al. The Effects of Mental Health Parity on Spending and Utilization for Bipolar, Major Depression, and Adjustment Disorders. *American Journal of Psychiatry*. 2013; 170(2):180–187. [PubMed: 23377639]

11. Grazier KL, Eisenberg D, Jedeke JM, et al. Effects of Mental Health Parity on High Utilizers of Services: Pre-Post Evidence from a Large, Self-Insured Employer. *Psychiatric Services*. 2015; 67(4):448–451. [PubMed: 26620288]
12. Stuart EA, McGinty EE, Kalb L, et al. Increased Service Use Among Children with Autism Spectrum Disorder Associated with Mental Health Parity Law. *Health Affairs*. 2017; 36(2):337–345. [PubMed: 28167724]
13. Horgan CM, Hodgkin D, Stewart MT, et al. Health Plans' Early Response to Federal Parity Legislation for Mental Health and Addiction Services. *Psychiatric Services*. 2015; 67(2):162–168. [PubMed: 26369886]
14. Thalmayer AG, Friedman SA, Azocar F, et al. The Mental Health Parity and Addiction Equity Act (MHPAEA) Evaluation Study: Impact on Quantitative Treatment Limits. *Psychiatric Services*. 2017; 68(5):435–442. [PubMed: 27974003]
15. Dixon K. Implementing Mental Health Parity: The Challenge for Health Plans. *Health Affairs*. 2009; 28(3):663–665. [PubMed: 19414872]
16. Bendat M. In Name Only? Mental Health Parity or Illusory Reform. *Psychodynamic Psychiatry*. 2014; 42(3):353–375. [PubMed: 25211430]
17. Friedman RC. Introduction to the Special Issue on Psychotherapy, the Affordable Care Act, and Mental Health Parity: Obstacles to Implementation. *Psychodynamic Psychiatry*. 2014; 42(3):339–342. [PubMed: 25211426]
18. DeLoss G, Ashpole L, Whelan K. Mental Health Parity and Addiction Equity Act Final Rules: Limited Enforcement Options Don't Overcome Unequal Treatment. *Journal of Health & Life Sciences Law*. 2014; 7(3):73–105.
19. Heller BD. Revolutionizing the Mental Health Parity and Addiction Equity Act of 2008. *Seton Hall Law Review*. 2017; 47(2):569–602. [PubMed: 28351120]
20. Berry KN, Huskamp HA, Goldman HH, et al. Litigation Provides Clues to Ongoing Challenges in Implementing Insurance Parity. *Journal of Health Politics, Policy and Law*. 2017; 42(6):1065–1098.
21. State Insurance Regulation. History, Purpose, and Structure. National Association of Insurance Commissioners; Available online at http://www.naic.org/documents/consumer_state_reg_brief.pdf [Accessed on April 15, 2017]
22. NASMHPD Publications. Too Significant to Fail: The Importance of State Behavioral Health Agencies in the Daily Lives of Americans with Mental Illness, for their Families, and for their Communities. National Association of State Mental Health Program Directors; Available online at <https://www.nasmhpd.org/content/too-significant-fail-importance-state-behavioral-health-agencies-daily-lives-americans> [Accessed on April 15, 2017]
23. Substance Abuse and Mental Health Services Administration. Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States. Rockville, MD: Center for Substance Abuse Treatment; 2016. HHS Publication No. SMA 16-4983
24. Mental Health & Substance Use Disorder Parity Taskforce. Final Report. U.S. Department of Health and Human Services; Available online at <https://www.hhs.gov/about/agencies/advisory-committees/mental-health-parity/task-force/final-report/index.html> [Accessed on April 15, 2017]
25. Public Policy Reports. A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care. National Alliance on Mental Illness; Available online at <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/ALong-Road-Ahead/2015-ALongRoadAhead.pdf> [Accessed on April 15, 2017]
26. Edmond MB, Aletraris L, Roman PM, et al. The United States' Federal Parity Act and Treatment of Substance Use Disorders: Administrators' Familiarity and Perceptions of Impact. *International Journal of Drug Policy*. 2016; 34:80–87. [PubMed: 27450320]
27. Psychology Help Center. 2014 Mental Health Parity Survey. American Psychological Association; Available online at <https://www.apa.org/helpcenter/parity-survey-2014.pdf> [Accessed on April 15, 2017]
28. Harwood JM, Azocar F, Thalmayer A, et al. The Mental Health Parity and Addiction Equity Act Evaluation Study. *Medical Care*. 2017; 55(2):164–172. [PubMed: 27632769]

29. McGinty EE, Busch SH, Stuart EA, et al. Federal Parity Law Associated with Increased Probability of Using Out-Of-Network Substance Use Disorder Treatment Services. *Health Affairs*. 2015; 34(8):1331–1339. [PubMed: 26240247]
30. Ettner SL, Harwood JM, Thalmayer A, et al. The Mental Health Parity and Addiction Equity Act Evaluation Study: Impact on Specialty Behavioral Health Utilization and Expenditures Among “Carve-Out” Enrollees. *Journal of Health Economics*. 2016; 50:131–143. [PubMed: 27736705]
31. Friedman SA, Thalmayer AG, Azocar F, et al. The Mental Health Parity and Addiction Equity Act Evaluation Study: Impact on Mental Health Financial Requirements Among Commercial “Carve-In” Plans. *Health Services Research*. 2016
32. Raghavan R, Bright CL, Shadoin AL. Toward a Policy Ecology of Implementation of Evidence-Based Practices in Public Mental Health Settings. *Implementation Science*. 2008; 3(1):26. [PubMed: 18485219]
33. Purtle J, Brownson RC, Proctor EK. Infusing Science into Politics and Policy: The Importance of Legislators as an Audience in Mental Health Policy Dissemination Research. *Administration and Policy in Mental Health and Mental Health Services Research*. 2017; 44(2):160–163. [PubMed: 27418342]
34. Purtle J, Peters R, Brownson RC. A Review of Policy Dissemination and Implementation Research Funded by the National Institutes of Health, 2007–2014. *Implementation Science*. 2016; 11(1):1. [PubMed: 26727969]
35. Purtle, J., Dodson, E., Brownson, R. Policy dissemination research. In: Brownson, RC, Colditz, GA., Proctor, EK., editors. *Dissemination and Implementation Research in Health: Translating Science to Practice*, Second Edition. New York: Oxford University Press; 2018. p. 443–448.
36. State Mental Health Agency Data Search. The State Profile System. NRI, Inc; Available online at <http://www.nri-incdata.org/> [Accessed on April 15, 2017]
37. Hsieh HF, Shannon SE. Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*. 2005; 15(9):1277–1288. [PubMed: 16204405]
38. Powell BJ, Waltz TJ, Chinman MJ, et al. A Refined Compilation of Implementation Strategies: Results from the Expert Recommendations for Implementing Change (ERIC) Project. *Implementation Science*. 2015; 10(1):21. [PubMed: 25889199]
39. Waltz TJ, Powell BJ, Chinman MJ, et al. Expert Recommendations for Implementing Change (ERIC): Protocol for a Mixed Methods Study. *Implementation Science*. 2014; 9(1):39. [PubMed: 24669765]
40. Waltz TJ, Powell BJ, Matthieu MM, et al. Use of Concept Mapping to Characterize Relationships Among Implementation Strategies and Assess their Feasibility and Importance: Results from the Expert Recommendations for Implementing Change (ERIC) Study. *Implementation Science*. 2015; 10(1):109. [PubMed: 26249843]
41. Proctor EK, Powell BJ, McMillen JC. Implementation Strategies: Recommendations for Specifying and Reporting. *Implementation Science*. 2013; 8(1):139. [PubMed: 24289295]
42. Darlington Y, Feeney JA, Rixon K. Interagency Collaboration Between Child Protection and Mental Health Services: Practices, Attitudes and Barriers. *Child Abuse & Neglect*. 2005; 29(10):1085–1098. [PubMed: 16315352]
43. Weinberg LA, Zetlin A, Shea NM. Removing Barriers to Educating Children in Foster Care through Interagency Collaboration: A Seven County Multiple-Case Study. *Child Welfare*. 2009; 88(4):77. [PubMed: 20405778]
44. Sloper P. Facilitators and Barriers for Co-ordinated Multi-Agency Services. *Child: Care, Health and Development*. 2004; 30(6):571–580.
45. Cooper M, Evans Y, Pybis J. Interagency Collaboration in Children and Young People’s Mental Health: A Systematic Review of Outcomes, Facilitating Factors and Inhibiting Factors. *Child: Care, Health and Development*. 2016; 42(3):325–342.
46. Bryson JM, Crosby BC, Stone MM. The Design and Implementation of Cross-Sector Collaborations: Propositions from the Literature. *Public Administration Review*. 2006; 66(s1):44–55.

Figure 1.
Trend in State Mental Health Agency Involvement with Federal Mental Health Parity and Addiction Equity Act Implementation Through Inter-Agency Collaboration with other State Agencies, 2010–2015
MHPAEA = Mental Health Parity and Addiction Equity Act of 2008; SMHA = State mental health agency

Inter-Agency Strategies Used by State Mental Health Agencies to Assist with Federal Mental Health Parity and Addiction Equity Act Implementation, 2010–2015

Table 1

ERIC Category	Original ERIC Definition	Revised SMHA MHPAEA Definition	Revisions to ERIC Definition	Examples SMHA MHPAEA Implementation Activities	Number of Responses (%) ^a
Provide ongoing consultation	"Provide ongoing consultation with one or more experts in the strategies used to support implementing the innovation"	SMHA provides consultation to state insurance agency and/or other stakeholders by sharing content expertise on behavioral health issues and services related to MHPAEA through an informal relationship with other state agencies and stakeholders	Expertise broadly relates to behavioral health, not a specific innovation	"[SMHA] is offering guidance to the state insurance department in terms of the provisions of the interim [MHPAEA] rules. Our SMHA consults with our Division of Insurance and has met with health plans jointly to discuss implementation questions." "The State Mental Health Agency expects to be involved in planning discussions and as implementation of needed changes for mental health services occurs."	24 (66.7%)
Provide local technical assistance	"Develop and use a system to deliver technical assistance focused on implementation issues using local personnel"	SMHA provides support to state insurance agency and/or other stakeholders on specific, discrete tasks related MHPAEA implementation	Technical assistance is provided by the SMHA, but not necessarily through a system that the SMHA developed Technical assistance is provided by an entity at the state, as opposed to local, personnel	"[The SMHA] is also working with the state insurance department to process inquiries/complaints that they receive from consumers concerning the parity law and rules." "The SMHA will reach out to the state insurance department to offer TA about [behavioral health] service needs and best practices"	6 (16.6%)
Build a coalition	"Recruit and cultivate relationships with partners in the implementation effort"	SMHA partners with state agencies and/or other stakeholders involved with MHPAEA implementation	SMHA does not necessarily initiate the relationship with partners	"The SMHA will partner with Medicaid regarding implementation of the new statute." "[SMHA is a member of] parity coalition to identify and eliminate problems."	5 (13.8%)
Develop educational materials	"Develop and format manuals, toolkits, and other supporting materials in ways that make it easier for stakeholders to learn about the innovation and for clinicians to learn how to deliver the clinical innovation"	SMHA develops educational materials about MHPAEA and/or assists with the dissemination of information about MHPAEA to behavioral health patients and providers, advocacy organizations, the general public, and other stakeholders to increase awareness about the law.	Assisting with dissemination of materials in addition to developing materials Increasing public awareness added as a goal of the strategy Informational materials can target a wide range of audiences, not only clinicians	"Work with the Commission on Insurance, business/trade associations, public health, provider organizations and consumer/family advocate organizations to coordinate and formulate accurate accessible public information statewide." "We also work to communicate with the advocacy community and create opportunities for the public to learn more about the technical details of the law."	3 (8.3%)
Use advisory boards/workgroups	"Create and engage a formal group of multiple kinds of stakeholders to provide input and advice on implementation efforts and to elicit recommendations for improvements"	SMHA is a member of a formalized group of agencies and stakeholders focused on MHPAEA implementation	SMHA is a member of the formal group, but does not necessarily create it	"[SMHA] is represented on Mental Health and Substance Abuse Task Force, which monitors parity of health insurance coverage throughout the state and reports annually to the General Assembly"	3 (8.3%)

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n = 36.

ERIC = Expert Recommendation for Implementing Change complication; MHPAEA = Mental Health Parity and Addiction Equity Act of 2008; SMHA = State mental health agency