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KNOWLEDGE TRANSFER, POLICYMAKING  
AND COMMUNITY EMPOWERMENT: A  
CONSENSUS MODEL APPROACH FOR  
PROVIDING PUBLIC MENTAL HEALTH AND  
SUBSTANCE ABUSE SERVICES

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An important problem in creating new programs and policies is how to encourage the transfer of knowledge in non-hierarchical ways so that new, relevant and specific knowledge is co-created by all interested parties. In this paper, we suggest that a consensus model of policymaking is one response and identify four key structural elements thought necessary for creating such a consensus infrastructure. These are a) a leadership and facilitating capacity for initiating and promoting such an endeavor, b) a network or consortium of key researchers, practitioners, consumers, and policymakers to empower community ownership of the endeavor, c) a process for consensus building and strategic problem-solving for such a consortium, and d) the continued creation of a multi-directional dialogue through information dissemination. We examine these elements in action by describing a particular problem solving and consensus building model for developing and implementing a program, resolving group differences, and evaluating the group's process and products.

**KEY WORDS:** knowledge transfer; policymaking; mental health; substance abuse; community empowerment; consensus model.

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A commonly posed problem in creating new service programs and public policies is how to transfer expert knowledge to practitioners and other end-users. In a public context, this transfer takes place in conjunct circumstances of policymaking (creating change) and power relations among relevant participants (oppositional forces). Beyond the mere mechanics of knowledge transfer, the problem can be posed more broadly as one of joining different kinds of knowledge and distinct ways of knowing, while negotiating power relationships among theorists and practitioners, in making public policy (1). Yet, the transfer of knowledge between practice and research can be understood as more than an epistemological exercise. Kurt Lewin's (2) model of organizational change suggests viewing the transfer of knowledge as a complex dynamic balance of new programs, for instance, can result as much from research-generated ideas and findings as from the more traditional sources of individual or organizational experience and the political interests of relevant actors (3). According to Lewin, "If the theorist does not look toward applied problems with highbrow aversion and if the applied psychologist realizes that there is nothing so practical as a good theory, . . . cooperation between theoretical and applied psychology can be accomplished" (p. 169)(4). However, explicit processes for incorporating research ideas and findings into policymaking, where they can be revised and adapted through input from practitioners and end-users, are required.

Further, in a policy making process, knowledge exchanges take place in a context of power relations. They are exchanges of claims to power as much as they are exchanges of knowledge, for example, the researcher's claims to expertise. Opposing forces often ground their differing positions in terms of knowledge claims. Yet, a policy is actually what is "learned" in implementation; it is not simply the agreed-upon conclusions of higher-level decision makers (5). One implication of this observation is that a more efficient, effective, and democratic policy making process should not rely solely on higher-level officials but incorporate those who actually implement policy decisions as well as those the policy ostensibly addresses. If the process includes more of the relevant implementer actors from the beginning, the learning process can begin earlier than the actual initiation of a policy.

These premises suggest a policy making process that promotes two fundamental constructs—the importance of ideas and research, and the co-creation of knowledge by all stakeholders. The particular emphasis on creating a "community of knowing" is more likely to

yield a new "product" that will be successfully implemented, and then sustained by participating organizations, communities, and individuals.

The research and theoretical literature on cooperation between research and practice and on ways to disseminate knowledge for sustaining implemented services is extensive and has been thoroughly reviewed by Backer (6) from a technology transfer perspective. During the last several years, there has been an increased national interest in utilizing empirical and theoretical work on cross-dissemination of knowledge for areas of soft, disembodied, and dynamic technology (terms used to describe non-laboratory information and distinguish the current technology transfer field's focus from its initial work on dissemination from the laboratory to the marketplace) (7). Due to the complex nature of public health intervention and prevention initiatives, work in this area has more consistently focused on the need for collaboration and on techniques useful in creating collaboration (e.g., perspective-taking, communication techniques, diversity training) (7,8). A number of government agencies, for instance, have sponsored workgroups, consortiums, and networks to conceptualize the priorities and infrastructure needs of a framework for collaboration (9-12). Further, as part of their grant-making research cycles, several agencies have awarded grants to develop local community models based on reviews of "best practices" and to adapt these models for community implementation (e.g., Substance Abuse Mental Health Services (SAMHSA) Community Action Grant (CAG) initiatives) (13).

This paper builds on this research in several ways. In the next section, we discuss a collaborative approach to policymaking and show how such an approach addresses the previously mentioned issues of co-transference of knowledge, power relations, and implementation and sustainability through community empowerment. A second concern of the paper is to conceptually identify key elements necessary for creating a consensus infrastructure that addresses the issues identified above. Lastly, the paper describes a particular nine-step consensus building model, adapted from government and non-profit worlds, that integrates these elements (14). Examples of this model-in-action will be drawn from two projects: one creating integrated treatment services for mentally ill substance using individuals in Arizona and the other developing a comprehensive court-based diversion program, in a predominately Hispanic/Latino New York City community, for individuals with mental health and substance abuse problems and criminal justice contact.

### MODELS OF KNOWLEDGE DEVELOPMENT: TRADITIONAL KNOWLEDGE TRANSFER VS. CONSENSUS BUILDING

Traditional knowledge utilization models envision knowledge being transferred from researcher or "expert" to community practitioners. Their premises are that: (a) only experts possess relevant knowledge, (b) only a single, typically empirical, basis for knowledge exists, (c) this knowledge is best transferred from the "top" down to the target audience, and (d) learning is simply a matter of instruction by establishing pipelines for communication. Williams and Gibson (15), for instance, describe the "knowledge utilization" model of change as one in which the learning needed for change results from the one-way, linear transference of knowledge from experts to end-users. Problems that arise in implementing or acting upon such knowledge are thought to stem from an implicit assumption that end-user groups lack understanding (or worse, lack the capacity for understanding), thereby reinforcing the importance of "experts" and the need for continued oversight and enforcement. Educational institutions (where teachers impart knowledge for students to learn) and military organizations (where those in charge distribute orders through a chain-of-command) are typically cited examples of this approach. These and other such structured systems allow for little feedback and simply pass on information but not responsibility.

A key weakness of the traditional knowledge utilization model lies in its failure to incorporate an "epistemologically active" end-user. It ignores the facts that individuals receiving ideas and information actively interpret what they receive and that learning is shaped both by what individuals already know and by how they know it. The values and personal experience of users, together with organizational and other constraints, play crucial roles in user learning and in replicating expert-identified "best practice". Knowledge is not simply possessed by experts but is created by the engagement of both experts and end-users. This suggests alternate conceptions of knowledge transfer, where users play a role in communicating and transferring, say, an exemplary practice, and in developing and shaping the practice to fit the particular environment in which it operates. In the process of molding and adapting, "new" knowledge is created that may be more likely to "work" for particular communities. One approach based on these latter premises is "consensus building". It eschews the idea of singular expert consultation and suggests a more complex model of multiple holders of different kinds of knowledge, all of whom

must be brought together to create the knowledge needed to develop and implement a program.

An initial basis for a consensus building model is Habermas's notion of communicative action (16-18). Social action is often understood as "purposive-rational", that is, people and other elements of a given situation are taken into account only insofar as they are needed to achieve a given goal. Habermas argues instead that action can be understood as an attempt to arrive at mutual understanding and agreement. Here he emphasizes the interpersonal interactive aspects that are necessary to action and, hence, the necessary role of language in such interactions. Because we interact through language, we are forced to negotiate some consensus about the claims each of us makes about ourselves and our understanding of the world. In these negotiations, we give reasons for particular claims and so engage each other in discourse. It is the very act of engaging in public discourse that gives rise to the consensus, in part because in such discourse it is often pragmatically impossible to argue that a given solution should be chosen just because it is good for oneself.

Habermas's argument provides a conceptual and philosophical basis for the role of processes that encourage consensus. A more specific and political basis that follows from this argument is the concept of "community empowerment", which joins the ideas of shared power and diverse knowledge to generate a "community of knowing". Empowerment is frequently defined by its absence: for example, unempowered communities are "alienated" or have "learned helplessness". Following from Habermas, however, empowerment may be more usefully understood as a social action process that promotes collaborative participation among people, organizations and communities to effect change (19). Freire (20), for example, sees empowerment as a learning and problem-solving process where people use group efforts to identify issues, critically assess barriers and issues, envision a healthier society or other optimal outcomes, and develop strategies to overcome obstacles and achieve goals. By creating a participatory community process that generates new knowledge, empowerment targets broad group and structural changes and rejects the simple expert-to-end-user knowledge transfer model (19).

In settings trying to adopt an exemplary practice, empowerment and collaborative processes, as envisioned by Freire and others (21), hold key advantages over traditional knowledge diffusion models. To begin with, the empowerment paradigm values the process of group learning over knowledge or the end product itself. Further, participants are the agents of change as well as the architects. Thus the

content of the product is more likely to be successfully implemented and the breadth of support needed for success flows naturally from the process itself. Concomitantly, participants take ownership of process outcomes, maintenance, and further development. An on-going network of actors and organizations is established that can be brought together for future endeavors. Finally, collaborative processes increase the benefits of diversity in different "communities of knowing". Such processes allow "providers and consumers to meet at the front-line . . . the front-line serves as the bottom line in technology transfer, for it is there that knowledge as technology is tested and either utilized or rejected" (p. 67) (19). We can extend Denzin's depiction to researchers and policy makers as well, bringing them to the front-line to allow for an informative shaping of each discipline's unique "knowing". Collaborative exchange is particularly important when the community's project involves multiple systems and constituencies where no one individual can have expertise in each professional and experiential domain that may be relevant to a program's development, implementation, evaluation, and sustainability.

In addition, establishing a practitioner-research-consumer-policy-maker interchange through a collaborative group provides a formal mechanism where one rarely exists. More common informal consensus building collaborations allow programs to improve and change direction, but they do not necessarily allow relevant stakeholders to jointly learn, train, share information, formally develop agreements, and implement research and program prevention and intervention models *de novo*.

### INFRASTRUCTURE ELEMENTS FOR A CONSORTIUM TASKED WITH DEVELOPING SERVICES

The following section describes four elements that are essential to building a community infrastructure that can "bridge the gap" (11) between research and practice: (1) utilization of "bridgers"; (2) development of a group of actors drawn as widely as possible from organizations, agencies and individuals with specific interests in the program, thus creating the potential for community ownership; (3) implementation of a consensus building process that includes a method for collaboration, a work plan identifying activities and products, and an evaluation of both the process and its results; and (4) maintenance of a conversation among participants and relevant others by disseminating and reintegrating ideas and information gener-

ated by the process. These elements create a theoretical and, perhaps, empirical tension between co-creation of knowledge, utilization of knowledge from "outside" the community and a hierarchical structure where the process is driven by those initiating and leading it.

#### *Bridgers*

"Bridgers" are those who bring together practitioners, government officials, consumers, researchers, and others to collaborate in implementing a network-consortium. By facilitating collaboration, they increase chances for the longevity and success of a network. Bridgers are akin to the "boundary spanners" introduced by Steadman (22) in discussing jail diversion initiatives. The boundary spanner is the product of, and is funded by, the collaboration between systems and so is charged with maintaining front-line collaboration to facilitate movement between systems.

In the tradition of boundary spanners, bridgers bring expertise in areas relevant to a particular project. Like the boundary spanner, the bridger is likely to be more effective if s/he is viewed by actors in one or more of the "powerful" systems as sharing their experience: the bridger is at least capable of understanding their experience, even if s/he does not share their view. The bridger, however, is distinct from the boundary spanner in that his or her position is often that of a "project director": the individual(s) who initially develops and leads the project, thus helping to create the collaborative, rather than being his "employee". Bridgers also act between meetings to encourage feedback, hear differences and concerns, and facilitate resolution of these issues to maintain momentum.

#### *Community Ownership*

As Altman notes (23), "Resolving issues surrounding the ownership and control of programs is often what most threatens the relationship between researchers and communities and, subsequently, the sustenance of interventions" (p. 528). Over thirty years ago, George Miller (24) admonished researchers (psychologists) to give their science away. Obviously, this has not been an easy task.

To address these issues, Altman (23) observes the importance of (a) recognizing and discussing what each participant or set of participants has to lose or gain from the project, (b) involving community constituencies early in the development of research, and (c) identifying the role of researchers once control and "ownership" has been

transferred from them. Altman also cautions that communities must be structurally, financially, and politically prepared to assume the responsibility for interventions if they are to effectively control and administer them.

A collaborative learning model creates the opportunity to address Altman's concerns. By creating both a structure and a process through which information is exchanged, new programs implemented, and research planned, ownership becomes shared. Lamb, Greenlick and McCarty (10) in their work on community-based treatment, emphasize such a structure: a broad based network or consortium of consumers, researchers, policymakers and experts. Essential to this network is a "bi-directional" information flow for research, treatment, and policy, where each set of actors informs the others and, in combination, creates and implements proposals for training, research, consumer involvement, and management information systems. It is vital that decision-making control be exercised collaboratively, otherwise the process becomes a mere exercise.

#### *Consensus Building, Product Development, and Implementation*

This element can be understood as comprised of three conceptual phases: the structure, the process, and the outcome. Structure consists of forming an initial vision of the project and mapping the scope of collaborative partners and the procedures for working as a group to reach consensus on a product and to implement it. Process focuses on the group interaction, importantly identifying personal and systemic barriers and ways of overcoming them. Outcome includes the decision to implement and the initial piloting of the proposed plan.

This construction is based on a model proposed by Donabedian (25-27), who categorizes care systems into the components of structures, processes, and outcomes. Structures include the facilities, staffing, equipment, and collaborative relationships. Processes include the activities, procedures, protocols, and methods used in the system of care. Outcomes represent the system and personal results to be achieved. Systems outcomes may include reduced cost, increased efficiency, or improved market share while personal outcomes are typically reduced symptomatology, improved vocational activity, reduced homelessness, and so forth. While it may not be necessary to address the items in any specific sequence, the group needs to systematically address each of the components described in Donabedian's model in order to develop a coherent vision of the "best practice" model.

This approach is incorporated in the consensus model developed by Franczak and Dye (28) that is elaborated below. It builds on the empowerment and collaborative philosophy described by Freire (20) and Denzin (19), and the strategic planning process outlined by Bryson (14), as well as the best practice program components described by Donabedian (25-27). This model is a formalized method of group decision-making that brings together the knowledge of experts, providers, policymakers, individual consumers, family members, advocacy groups, researchers, and other key stakeholders. Its premise is that all who are involved bring vested interests and unique experiences to the table. In practice, group members are guided by a facilitator to create communal knowledge by providing ideas and information from their own experience and interests. These include desired outcomes, structural, professional, and environmental barriers, and individual perceptions.

#### *Disseminating and Reintegrating Information*

Information dissemination, at one time thought to be the primary means of transferring technology, is viewed here as only one element of a structure needed for implementing and sustaining new public health programs. Lamb, Greenlick, and McCarty (10) recommend multiple strategies for information dissemination, including newsletters, fact sheets, professional publications and forums. The purpose of this type of dissemination is to build continued community ownership for the ideas and plans that are being implemented in order to impact policy and funding agency resource allocation, build an infrastructure, and continue participant investment. In creating a consensus process, a communication strategy for the consortium itself as well as for the larger community is necessary. It is this consensus process through which a consortium directs the adoption and adaptation of best practices to improve services, fills a community's service gaps, or shifts the systemic method by which a target population is being served.

For the consortium members, dissemination helps maintain a network of concerned "investors" who initially become involved in developing and implementing a project and then maintain a dialogue around it (allowing information to more easily be reintegrated as the program develops). These investors serve to protect projects against rifts between systems that may otherwise hinder development. Dissemination to the larger community also allows for continued invest-

ment and policy support through on-going community attention, for the opportunity to seek additional funds, and, most importantly, for feedback to the consortium. Such feedback, combined with a consortium's constructed knowledge, helps to direct the future areas of focus for public health initiatives and guard against one-way knowledge dissemination. Without this feedback, the consortium has no lasting purpose and is little more than an advisory board.

Another type of information dissemination and inherent reintegration mechanism has been highlighted in the substance abuse and mental health fields, though primarily as a programmatic tool: non-proprietary, computerized management information systems (MIS) (29-30). One such system, the University of Maryland's HATTS-HIDTA, is based on a cross-systems collaborative approach to both gathering information and revising the information system—each jurisdiction's additions and modification to the system are shared with other jurisdictions (30). The breadth of information that can be collected, with client consent, across organizations (e.g., mental health, substance abuse and criminal justice) allows each system to use the other's information and embark on a continuing conversation as different uses and interpretations of the information are received.

#### THE NINE-STEP PROBLEM SOLVING AND GROUP CONSENSUS MODEL

The "Nine-Step Problem Solving and Consensus Building Model" (28) process is a formalized method of group decision-making that facilitates access to and use of the knowledge of diverse representatives of the community's multiple cultures and systems. Specifically, the model includes identifying relevant issues, forming the group, articulating project scope, developing a shared vision of desired outcomes, analyzing current group consensus and the distance to desired outcomes, identifying barriers to implementation and methods to overcome those barriers, developing an actual plan and piloting proposed solutions, measuring progress, refining and implementing successful solutions, and maintaining or "holding the gains" made during planning and development while a project is being implemented.

The nine-step model was first developed to address a situation that occurred in Arizona in the late 1980s. The Arizona Department of Health had attempted several initiatives to improve services for individuals with co-occurring disorders; none had the desired impact of

changing the system of care. One of the main reasons the initial efforts failed was that they did not include a broad range of stakeholders in the decision-making and planning process, but rather focused exclusively on providers who, although vital, were already constrained by the numerous requirements of the existing fragmented system.

Practice and research recommendations for involving all stakeholders in decision-making have increasingly been emphasized during the last decade. The 1999 Surgeon General's Report on Mental Health (31) emphasized the vital role that advocates, consumers, family members, practitioners, providers, scientists, and government agencies have played in advancing mental health treatment during the past century and the roles that need to be filled for the future. Carr and Litman's (32) work on Total Quality Management describes how government organizations need to extend beyond their organizational boundaries to involve stakeholders and customers in order to implement quality initiatives. Osborne and Gaebler (33) outlined a process of customer-driven government that stimulates innovation and choice and brings both primary and secondary customers to the table to develop the system of care. Yukl (34) reported that when stakeholders are allowed to participate in making a decision, they gain more influence over the decision but are also likely to become more committed to carrying out the decision. Because it is premised on empowerment and collaboration, this model increases the chances that a program created by a relevant community will be implemented.

Yukl (34) detailed four process problems that reduce the utility of the group's product: (1) hasty decisions, (2) incomplete participation, (3) polarization, and (4) superficial action planning. These problems are more likely to emerge when the process is less formal or when the decision-making or implementation responsibility is not delegated to the group. Therefore, the Nine-Step Problem Solving and Consensus Building Model (28) was developed, adapting a formalized problem solving/decision-making model (14) along with Bradford's (35) group-centered leadership approach, implemented in a variety of settings. This model provides a process that ensures that a collaborative group thoroughly considers each issue before consensus is attempted, addresses group polarization, and optimizes participation by all members through using a trained, neutral facilitator. Arizona implemented this model to facilitate integrated mental health and substance abuse treatment, and New York followed suite developing court-based diversion services for mentally ill substance using defendants, because of similar systems fragmentation problems.

**TABLE 1**  
**Nine-Step Consensus Model, Steps 1-3: The Structure**

<i>Step Definition</i>	<i>Activities</i>	<i>Deliverables</i>
<p>Step 1: Identifying issues.  Specify the activity or process that requires improvement.  Identify potential support for an improvement activity.  Identify stakeholders.</p>	<ol style="list-style-type: none"> <li>1. The project has support of government agencies, providers, advocates, consumers and family members.</li> <li>2. The process targeted for improvement has direct impact on the target service's external customers, internal customers, and stakeholders.</li> <li>3. The process is related to: key issues, strategic plan goals and objectives, and mission.</li> <li>4. Infrastructure is in place to support the group's work.</li> <li>5. The scope of the project has identifiable start and end points.</li> <li>6. Project goals are achievable and measurable.</li> <li>7. Potential financial resources are identified.</li> </ol>	<ul style="list-style-type: none"> <li>• Identification of stakeholders and potential group members.</li> <li>• Preliminary problem statement, addressing: <ul style="list-style-type: none"> <li>• WHO is affected?</li> <li>• WHAT is involved?</li> <li>• WHEN is it happening?</li> <li>• WHERE is it happening?</li> <li>• HOW often is it happening?</li> </ul> </li> <li>• Identification of and contact with local and national experts.</li> </ul>
<p>Step 2: Forming the collaborative consortium.  Group members are selected or asked to volunteer based on their understanding of an involvement in the process. Select group leader and facilitator.</p>	<ol style="list-style-type: none"> <li>1. Appropriate members have volunteered for the group and are knowledgeable of the task.</li> <li>2. Define mission and scope.</li> <li>3. Develop communication plan to keep key stakeholders informed and work product flowing.</li> <li>4. Define process for issue resolution.</li> <li>5. Meeting evaluation tool is developed to assess the group's "health" following each meeting.</li> <li>6. Baseline evaluation measures of group composition and project focus are developed and administered.</li> </ol>	<ul style="list-style-type: none"> <li>• Full group established; group rules, roles, and responsibilities defined.</li> <li>• Work plan.</li> <li>• Communication plans including templates for announcing and recording group activities and events.</li> <li>• Issue resolution process.</li> <li>• Evaluation tools to gauge process and project activities and products.</li> </ul>
<p>Step 3: Developing a vision.  Select an improvement strategy/model to be adapted for the group to pursue; develop the "To Be" process.</p>	<ol style="list-style-type: none"> <li>1. Experts present detailed "best practice" model.</li> <li>2. A flowchart of the desired "To Be" process is completed.</li> <li>3. Project and process goals and objectives are revisited.</li> <li>4. Performance measures are established.</li> <li>5. Qualitative and quantitative benefits of the recommendations have been identified.</li> <li>6. Costs to implement recommendations have been estimated.</li> </ol>	<ul style="list-style-type: none"> <li>• "Best practice" model is developed.</li> <li>• Defined criteria for each component.</li> <li>• Flowchart of "To Be" process with benefits noted.</li> <li>• Performance measures.</li> <li>• Estimated cost of proposed recommendations.</li> </ul>

### *Role and Importance of Facilitator*

Because group members bring to a consortium diverse and specific interests and unique experiences, the model calls for the process to be guided by an independent facilitator who will refrain from providing information that presupposes desired outcomes. However, while viewed as impartial by the group, the facilitator needs to know group facilitation and consensus building techniques, to understand product aims and process structure, and to overcome barriers to understanding differing perspectives. The facilitator ensures movement through each step, helping the consortium focus on specific project activities, product completion and goals. The group may work at several steps of the model simultaneously, or it may return to a previously "completed" stage to address a concern that was held in abeyance due to lack of information or consensus. The facilitator maintains the overall momentum toward project completion and balances this momentum by reminding the group of more subtle barriers and compromises that need to be explored.

### **I. The Structure**

See Table 1.

#### *1st Step: Identifying Issues*

The idea of an interdisciplinary and inter-organizational collaboration about some inchoate issue is initially presented by a "bridger" and reviewed with service providing agencies, researchers, consumers, and government agencies—often within the context of seeking seed money through a grant application to a government agency or private foundation. A decision is made to develop such an on-going collaboration around a broad focus, but not all stakeholders will have been specified by this point. During the initial meetings, then, the group identifies perceived lapses in stakeholder representation, and new panel members are added based on group consensus.

#### *2nd Step: Forming the Collaborative Consortium*

Members are recruited from a variety of interest groups identified during Step 1 (above) to form the consortium. The scope of the project, the processes for project development, initial communication strategies, and support staff are identified. Evaluation concepts and instru-

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mentation concerning the consensus process itself are developed; baseline measures on attitudes, opinions, and interests likely to be affected by the consensus process are administered.

#### *3rd Step: Developing a Vision*

Members develop a vision of desired outcomes for this project, referred to as the "To Be" process. Local and national experts are recruited to identify possible best practice models. Choosing models or model components to be adapted is based upon a community needs assessment specific to the chosen project and the diverse expertise of group members.

*Establishing the Structure, Steps 1-3.* In Arizona and in New York City the first step involved grant applications to SAMHSA under its Community Action Grant program. This required an informal needs assessment, identification of stakeholders for support and an outline of the project and its proposed products. This work plan, along with the process steps, proposed evaluation strategies, and initial vision was disseminated prior to the first meeting for review and again shared during the initial meetings through discussion and overhead presentations. In New York, the second step included focusing on instrument development to measure the nine-step model and assess the group's baseline ideas about the proposed initiative. To that end, detailed surveys were developed to capture participant characteristics, beliefs and attitudes toward mentally ill substance using individuals with criminal justice contact, diversion models, and the nine-step process itself. End of meeting satisfaction surveys contained a core set of questions for all meetings and questions peculiar to the context of each planned meeting. Instrument development, while led by the evaluation team, was revised through written and verbal input from panel members including the consumer led cultural competency work-group.

As the infrastructure is created, during these first steps, both the facilitator and project bridgers are more active, as members are not yet ready to take on a leadership role. Communication among panel members, as well as among stakeholders not part of the group, is essential. Communication strategies used in the Arizona and New York projects included letters announcing meetings and events, materials, and agendas disseminated prior to meetings, address and phone lists of members and consultants, binders with duplicate materials for each meeting, court-reporter minutes of large group meetings, e-

**TABLE 2**  
**Nine-Step Consensus Model, Steps 4-7: The Process**

<i>Step Definition</i>	<i>Activities</i>	<i>Deliverables</i>
<p>Step 4: Analyzing the system of care. This step represents the group's analysis of the current process. Baseline performance measures are established as an indicator of "As Is" process performance.</p>	<ol style="list-style-type: none"> <li>1. Process "inputs" and "outputs" are identified.</li> <li>2. Identify current structures, processes, and outcomes.</li> <li>3. Add additional customers and stakeholders.</li> <li>4. A process map or flowchart is completed to identify all activities in the process.</li> <li>5. "Other" analysis tools are used to capture baseline measurements (number of individuals served, outcomes, per member/per month costs).</li> <li>6. The gap between what the group wants and what the group is getting is determined.</li> </ol>	<ul style="list-style-type: none"> <li>• Process map or flowchart of "As Is" process.</li> <li>• Inputs, outputs, and outcomes of the process.</li> <li>• Customer/stakeholder analysis.</li> <li>• Baseline measurements.</li> <li>• Gap analysis.</li> <li>• Workgroups are established.</li> </ul>
<p>Step 5: Identifying implementation barriers. Obstacles and barriers to implementing the "To Be" process are identified.</p>	<ol style="list-style-type: none"> <li>1. An analysis of the "To Be" process is conducted with specific barriers identified.</li> <li>2. Obstacles and barriers with the greatest impact are identified.</li> <li>3. Stakeholders associated with each barrier are identified.</li> </ol>	<ul style="list-style-type: none"> <li>• Flowchart indicating each barrier and source.</li> <li>• Type of barrier is identified (perception, financial, staff knowledge, etc.).</li> </ul>
<p>Step 6: Identifying solutions to barriers. Barriers to implementation are examined; methods to overcome each barrier are identified.</p>	<ol style="list-style-type: none"> <li>1. Methods to overcome each obstacle or barrier are identified.</li> <li>2. Accountable parties or sub-work groups are identified for each obstacle or barrier.</li> <li>3. Time lines are established for work on each barrier.</li> <li>4. A comprehensive work plan is developed.</li> </ol>	<ul style="list-style-type: none"> <li>• A work plan with accountable parties and timelines is developed.</li> <li>• Initial work plan is reviewed and adjusted.</li> <li>• Sub-workgroups may be established.</li> </ul>
<p>Step 7: Developing the implementation plan. A plan to implement the "To Be" process is developed. A pilot test of the new process proposal is conducted to test effectiveness.</p>	<ol style="list-style-type: none"> <li>1. Pilot implementation steps are outlined.</li> <li>2. Pilot area and population to test the program or service has been identified.</li> <li>3. Due dates and milestones have been targeted.</li> <li>4. Methods for monitoring pilot progress have been put in place.</li> <li>5. Training/guidelines have been afforded to everyone who will be involved in the pilot.</li> </ol>	<ul style="list-style-type: none"> <li>• Pilot plan (Who and What is involved? Where is it involved?).</li> <li>• Pilot milestones and due dates.</li> <li>• Performance measures.</li> <li>• Training guidelines are developed.</li> </ul>

mail lists and bulletin boards, a newsletter, and meetings with key stakeholders between large group meetings.

For the third step, both New York and Arizona recruited experts with research and implementation experience. During several knowledge exchange sessions, additional stakeholders were invited to the presentations for active exchange of the best practices models potentially relevant to the community at large. The expert presentations allowed the group to clarify which aspects of the national models presented were most relevant for community adaptation and so, in this interchange between experts and the group, began the process of co-creation of knowledge.

## II. The Process

See Table 2.

### *4th Step: Analyzing the System of Care*

In this step the current process is analyzed and progress toward goals and the project's vision are determined. This is referred to as the "As Is" process, whereby both the community system of care relevant to the chosen project and the current group process are analyzed.

### *5th Step: Identify Implementation Barriers*

Obstacles and barriers to implementing the process are identified to pave a pathway toward the desired solutions and results.

### *6th Step: Identifying Solutions to Barriers*

The obstacles and barriers to implementation identified in Step 5 are examined and methods to overcome each barrier are identified. During this step it is easy for group members to jump to the conclusion that all barriers can be overcome by increased funding and to become "stuck" on this as the primary solution.

### *7th Step: Developing the Implementation Plan*

A plan is developed to implement the results from a formal needs assessment. The plan includes time frames for implementation, validation of each result, identification of responsible parties and opera-

tional parameters. A development or modifications plan for a management information system can be introduced during this step to address information dissemination and continued collaboration between systems to enhance continuity of care within fragmented public service systems for populations with health, mental health, and substance abuse problems.

*The Process, Steps 4-7.* Both Arizona and New York began workgroups during Step 4. Arizona used the identification of the main barrier categories as the topics for separate workgroups (i.e., funding, competencies, continuum of care, and policies and procedures); groups identified specific action plans to overcome barriers. While workgroups in New York took on the task of developing strategies to overcome barriers, these groups were organized around the main products outlined for the project (i.e., developing the model of diversion, developing the model for community service linkages, and developing culturally competent assessments for clients and agencies, procedures, and staff training specific to our diverse Hispanic community). Additional barriers and ideas for overcoming them, along with initial implementation proposals, were then brought back to the larger panel for discussion, to resolve an impasse or arrive at consensus. During this phase, the group may realize that some of the barriers are perceived rather than actual and may reside in their own practices and attitudes. Evaluation tools continue to be developed. In New York, for instance, adaptation of a culturally competent measure of individual and organizational beliefs, attitudes, and practices was completed, administered to the panel for group process and training proposes, and then used by members to assess their agency. Finally, it is critical during the sixth and seventh steps to examine existing funding resources for the pilot (Step 8).

## III. The Outcome

See Table 3.

### *8th Step: Implement Plan*

The plan is piloted. The group evaluates the implementation status of its objectives and decides whether or not to modify or to pursue the existing plan. Recommendations are summarized in a full report.

**TABLE 3**  
**Nine-Step Consensus Model, Steps 8-9: The Outcome**

<i>Step Definition</i>	<i>Activities</i>	<i>Deliverables</i>
Step 8: Implementing the plan. Evaluate Pilot. Refine implementation plan.	<ol style="list-style-type: none"> <li>1. The implementation steps were followed (everyone did what they said they would do).</li> <li>2. Initial barriers were removed.</li> <li>3. Performance objectives were met or exceeded.</li> <li>4. No gap between "As Is" and "To Be" states exist.</li> <li>5. Modifications are or are not required prior to full-scale implementation.</li> </ol>	<ul style="list-style-type: none"> <li>• Pilot project.</li> <li>• Gap analysis.</li> <li>• Implementation action plan (once no further modifications are required).</li> <li>• Evaluation report.</li> </ul>
Step 9: Monitoring and holding progress. Institutionalize the proposed process. Plan has sufficient detail so that it can be replicated.	<ol style="list-style-type: none"> <li>1. Steps have been proposed to assure continued use of the process.</li> <li>2. Stakeholders have been identified to implement and monitor the process.</li> <li>3. Performance measures have been implemented.</li> <li>4. Methodology to communicate the efficiency and effectiveness of the process has been chosen.</li> <li>5. Actual project costs and results are recorded.</li> </ol>	<ul style="list-style-type: none"> <li>• Operations/procedure manual is developed.</li> <li>• Performance measurement system, goals and objectives.</li> <li>• Communication plan.</li> <li>• Executive summary.</li> </ul>

*9th Step: Monitoring and Holding Progress*

The focus of this step is the group's work plan to institutionalize the proposed process throughout their community. The plan is presented in sufficient detail so the time elements to complete implementation, major action areas, and individual responsibilities are understood. Funding is secured to support the plan. Evaluation results are made available to the group to aid in overcoming potential difficulties during the expansion of the pilot for broader implementation.

*The Outcome, Steps 8-9.* An implementation committee was established in Arizona. New York, only half way through its funded project year, has not yet reached these steps. The Arizona committee has been composed of individuals in positions to ensure that the issues identified by the group would be considered in agency and system development, funding, training, and policy. Consumer and advocacy representation in this group has been critical to continued development and dissemination of the project's goals and products to its constituents and the legislature.

**CONCLUSION**

To address the issue of knowledge transfer in policymaking that is democratic and effective, this paper has laid-out the conceptual basis for a consensus building process, described four key components of such a process, and described a specific model. The relevance of delineating a formalized structure and process derives from the particular complexity and scope of issues often faced by individuals with mental illness and substance use disorders and the number of public and private service systems whose involvement is necessary for solving such issues.

The next step is an empirical one: How does this particular model work? Concretely, what is the relationship between the steps described in the model and what actually happens? More conceptually, does the model help the development of knowledge co-creation? How is expertise incorporated and impacted by the process? How is the tension resolved (or not) between a leadership that initiates and helps sustain the process and the consortium's theoretical responsibility for the process and the product? And, finally, is consensus produced and if so, how does it happen and is it effective in producing a product that can be implemented and sustained? In both New York City and

Arizona, extensive data collection has been integral to the process, with measurement developed to examine the nine-step model in action and address these questions. Both projects are following the nine-step model, producing the promised products, with Arizona beginning implementation and New York City moving toward implementation. Results from baseline and follow-up data collection regarding group composition, attitudes and beliefs about cultural needs and public mental health and substance abuse services, and the efficiency of the process itself will be reported in the future.

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## ANNOUNCEMENT

We are pleased to announce the following changes to the Board of *Psychiatric Quarterly*.

Pedro Ruiz, M.D. joins as an Associate Editor. He is Professor and Vice Chairman of the Department of Psychiatry and Behavioral Sciences and Director of the Mental Sciences Institute at the University of Texas Medical School at Houston. His special interests are psychiatric education, cross-cultural psychiatry, administrative psychiatry and health services research. The recipient of many awards, he has also served in senior national leadership positions in several professional organizations. Dr. Ruiz brings to us a wealth of experience as an author of several hundred publications and as a member of other editorial boards.

Laurence B. Guttmacher, M.D., who has served as an Associate Editor for the past eight years, is relinquishing that position but has agreed to remain with the journal as a member of the Editorial Board. He is Associate Professor of Psychiatry and Medical Humanities and Director of Faculty Development, Curricular Affairs and Advisory Dean at the University of Rochester (NY) Medical Center.