

PRACTICAL IMPLEMENTATION RESEARCH WITHIN A STATE POLICY ENVIRONMENT



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State Initiatives to Implement EBPs for Children and Families

- Child and Family Evidence-based Practice Consortium (CF-EBP) (Bruns et al, 2008):
 - Originated with NASMHPD + Nat'1 Implementation Research Network (NIRN)
 - D. Bernstein (CO), Chair
- 12+ States and Canada: CA, CO, CT, HI, MD, MI, MN, NM, NY, OH, OK, PA, WA
- Interventions being implemented:
 - Multi-systemic therapies (MST)
 - Functional family therapy (FFT)
 - Multi-dimensional treatment foster care (MTFC)
 - Cognitive behavior therapies (CBT) for trauma
 - Cognitive behavior therapies (CBT) for depression
 - Parent management therapies (PMT)

Variation in State-level Strategies for EBP Implementation

- Outcome monitoring (MI)
- Single fiscal entities (NM)
- Centers of Excellence (OH)
- Community Development Teams (CA)
- Clinical decision-making supports (HI, MN)
- State mandates for EBP (OR)
- State-supported/academically linked EBP Dissemination Center with certification standards (NY)
- Learning collaboratives and enhanced fiscal rates (NY)

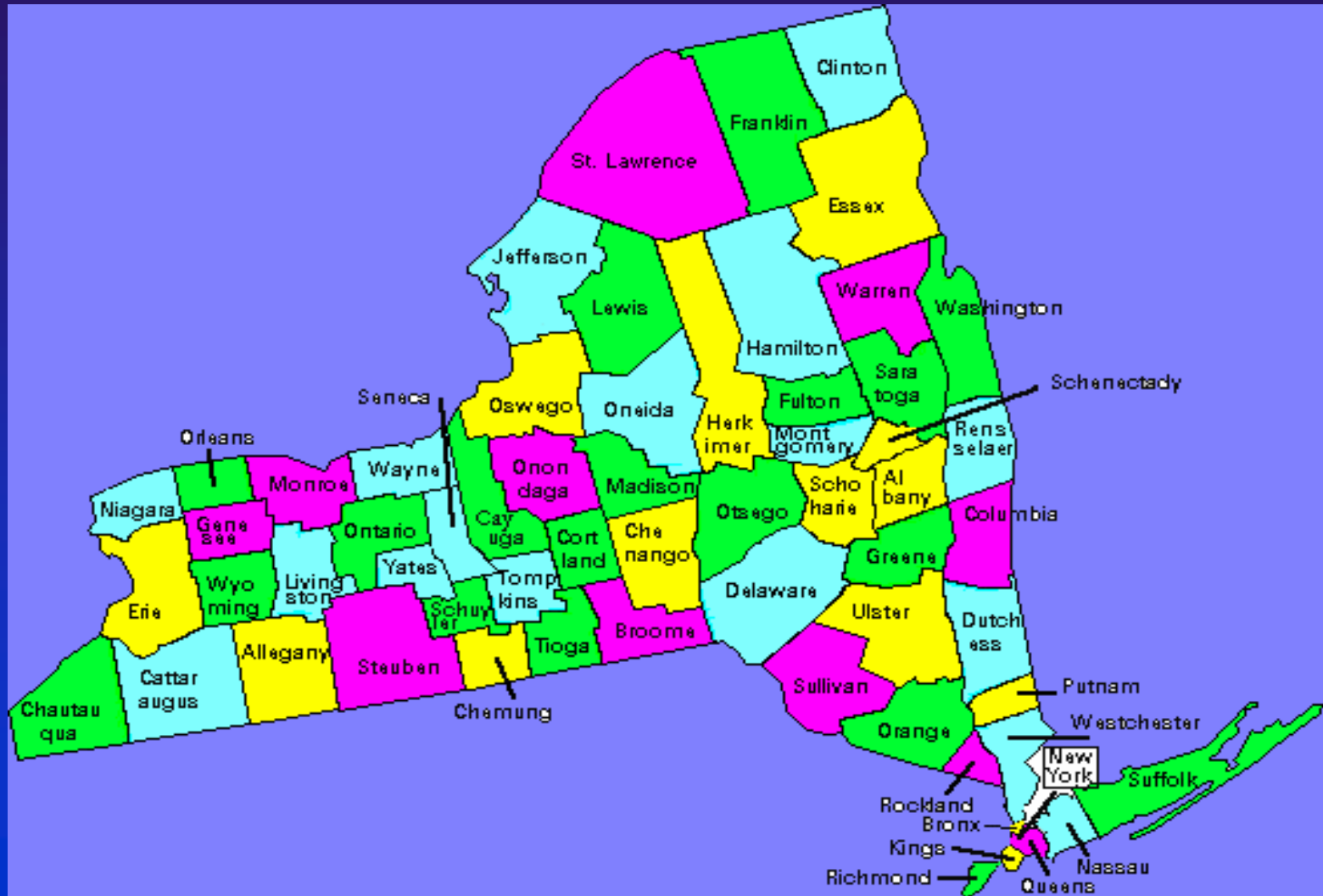
Unique D-I Challenges in State Contexts

- Policies to promote uptake of EBPs move faster than science: Creates jagged interface
- Pressures for inclusiveness may preclude systematic experimental designs
- Licensing or accreditation standards (e.g., what is billable, # of billable hrs, supervision) conflict with training/consultation models
- Outcomes of interest may be functional, pragmatic, and brief; research-derived measurement tools generally diagnostic, impractical and long
- Workforce: Retraining is labor intensive. Who pays?
- Data management systems for clinical decision-making in state systems often inadequate or regressive
- Fundamental difference in epistemologies between science and policy

Different epistemologies

- Science
 - Cumulative, builds on past knowledge
 - Generates more questions than answers
 - Proceeds slowly, incrementally
 - Self-correcting, gen. low impact
- State Policies
 - Driven by immediate political needs/crises
 - Can move quickly or erratically
 - Pragmatic, action-oriented
 - Large impact

New York State County Map



*Overarching Goals of Developing Center on
Implementation of EBPs for Children in a State System
(NIMH P20)*

- To advance knowledge about effective and efficient implementation strategies to improve the adoption of EBPs for children in State outpatient clinics and schools
- To provide guidance to other States on EBP implementation strategies for children and families
- To promote a participatory research agenda that reflects perspectives of EBP treatment developers, families and family advocates, clinicians, supervisors, clinic administrators, county directors, and state executive cabinet
- Each core co-led by OMH senior staff and academic researcher

Specific aims

- To examine experimentally a set of contextual strategies (engagement, empowerment, clinical consultation) to improve implementation efficiency and effectiveness of CBT for youth disorders (trauma, depression and DBD) within outpatient clinics and schools.
- To develop measurement tools for assessing multi-level change processes
- Efficiency refers to the extent to which state and local resources to improve clinical practices produce maximal effects.
 - Efficiency includes no-show and treatment completion rates, staff retention and turnover, working alliance between clinicians and families.
- Effectiveness refers to the extent to which changes in clinical practices improve child and family outcomes.
 - Effectiveness includes self-efficacy, collaborative skills, and symptom and functioning improvement.

Conceptual Scaffold: Three theoretical pillars

- Unified Theory of Behavior Change (Jaccard et al, 2002) drawn from basic behavioral sciences to understand the triggers for behavior change within individuals. Incorporates principles from the Theory of Reasoned Action (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1981) and Theory of Planned Behavior (Ajzen & Madden, 1986; Ajzen, 1991), and Self-Efficacy (Bandura)
- Organizational social context theory (Glisson 2002) to understand the organizational and team processes (culture, climate, structure) that affect agency adoption of new practices.
- Participatory action research based on Habermas' (1990) theory of communicative action, to ration and share decision-making among diverse constituents.
- Our model integrates these theories with the goal of improving the practical utility of the findings.

New York State Implementation Model for Children & Families

System & Policy Context of the State

methods of reimbursement, fiscal incentives, linkages to other healthcare systems,
certification, accreditation, licensing standards

Organizational Social Context of Agencies

Culture, Climate, Structure
(OSC—Glisson)

Family Engagement

Attitudes, Beliefs &
Expectancies of
Clinicians and Supervisors
(UTB, Jaccard)

Clinical Care Improvement

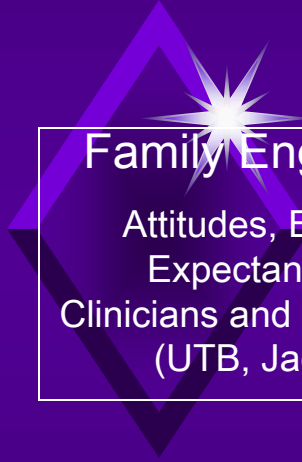
Training on EBP's, supervision,
consultation and support, outcome
monitoring (CFIT, Bickman)

Family Empowerment

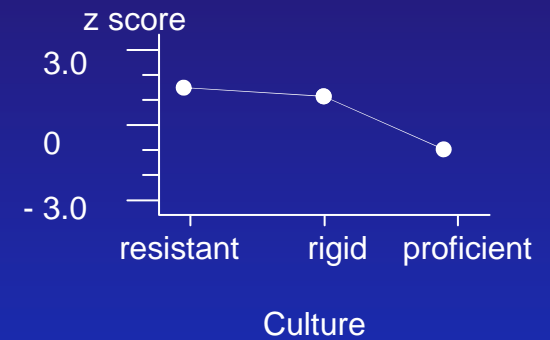
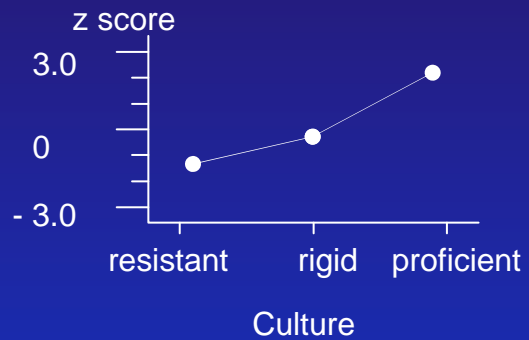
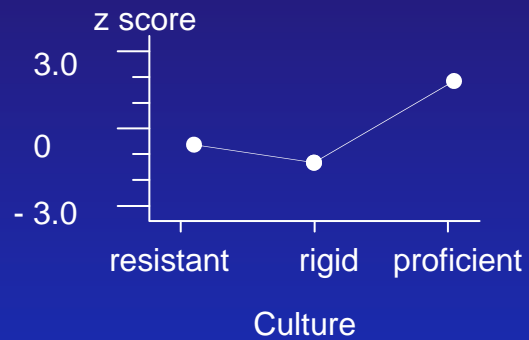
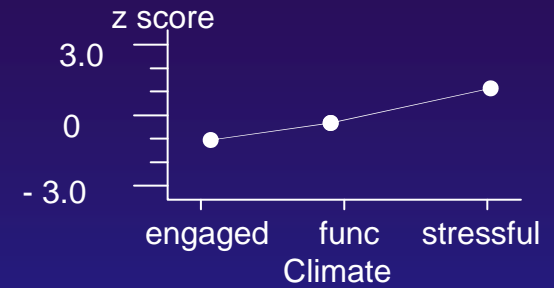
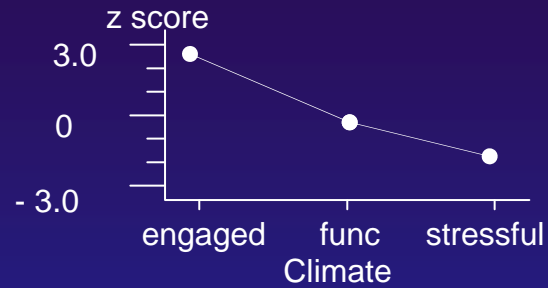
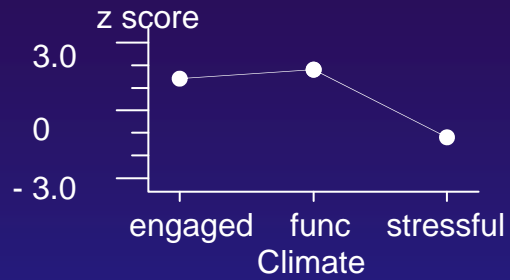
Attitudes, Beliefs &
Expectancies of
Families & Youth (UTB,
Jaccard)

Improved Implementation Efficiency & Effectiveness

Improved Child & Family Outcomes

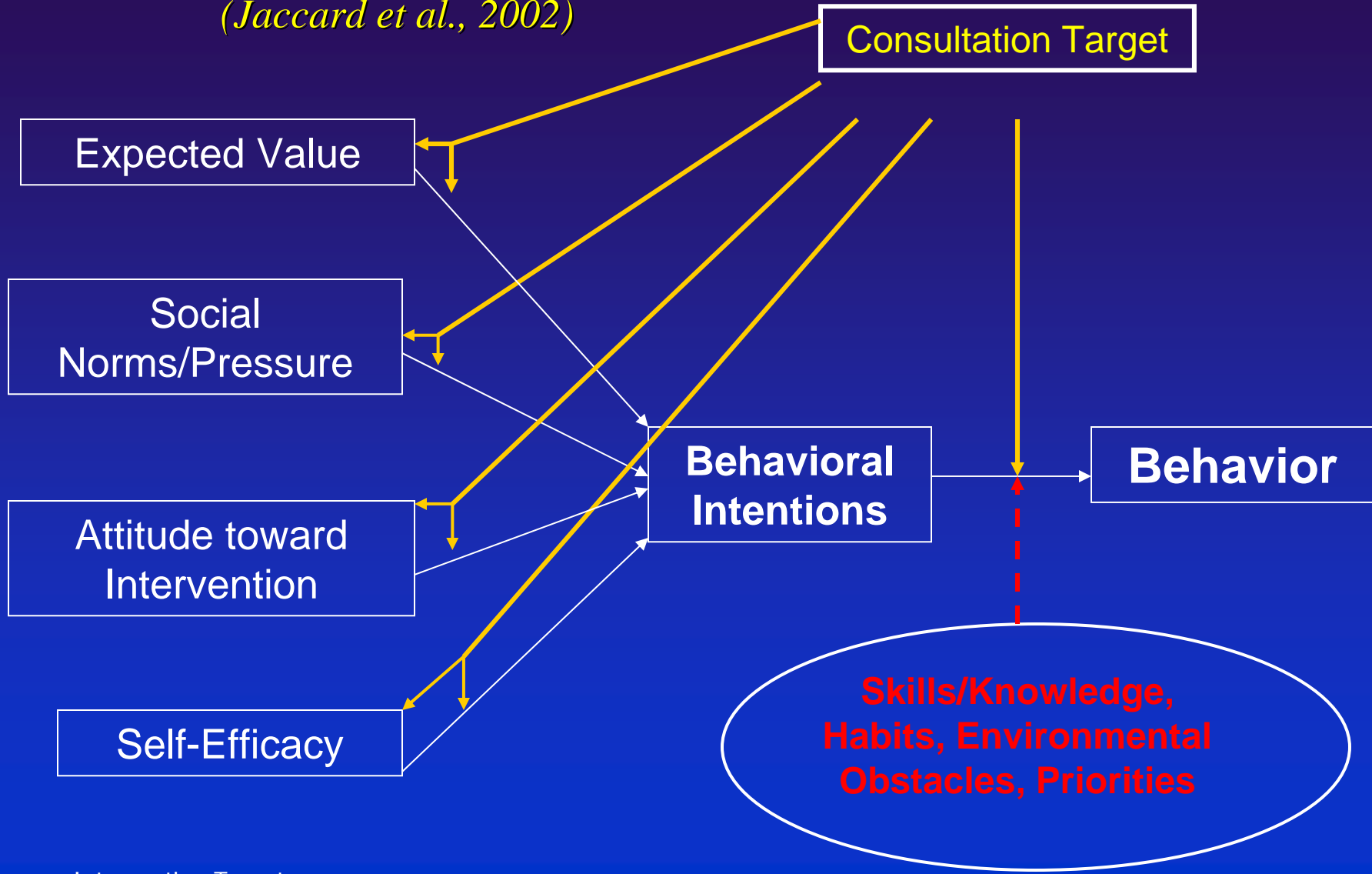


Examples of Organizational Social Context Profiles with z scores based on National Norms (Glisson et al., 2008)



Unified Theory of Behavior Change

(Jaccard et al., 2002)



Intervention Target →
Possible Barriers - - ->

Habermas' Theory of Communicative Action (1990)

- Discourse model of communicative action requires that perspective-taking among individuals be reciprocal, pervasive, and integral to the process by which persons reach rational agreement
- Moral foundation of communicative action is justified by the creation of consensually-validated norms: principled actions can be taken when there is uncoerced, rational agreement among those who consent to them
- Selection of research strategies, design of the intervention, and construction of measures depend upon sustained collaborative partnerships among those whose work or life will be affected by the products of the study.
- *Buy-in* requires participation and not merely observation.
- Collaborative processes for engaging and empowering individuals create a rationally motivated but not preemptory consensus

Example: The Evidence Based Treatment Dissemination Center (EBTDC) (North et al., 2008)



- **NYSOMH-funded (approx \$650K/yr)**
- **Provide in person training and year-long bi-weekly tel consultation in selected EBPs**
- **CBT for trauma and depression (Cohen, Mannarino, Deblinger; Curry and Stark); PMT (Wells and Lochman)**
- **Collaboration with treatment developers; with Columbia U for clinical consultation; creation of database tracking**
- **789 clinicians and supervisors first 2 yrs**
- **1738 consultation calls have been held with clinicians; 80 calls with supervisors**
- **Completion rates: 84.6% yr 1; 83.2% yr 2**
- **Significant consultant differences in completion rates (92.6% to 78.4%)**

Pilot Studies in Developing Center

- Random assignment to EBP consultation only or EBP+ linked engagement and empowerment intervention delivered by peer family advisors to improve adherence to EBP protocol among clinicians and improve retention, treatment completion, and working alliance among families (J. Rodriguez, A. Gleacher)
- Micro-analysis of consultation calls to typologize content and identify correlates of adherence and completion (S. Pimentel)
- Random assignment to consultation vs mental contrasting implementation intention to strengthen behavioral intentions to use EB treatments among school MH clinicians, and influence expected values, normative beliefs, and self-efficacy (J. Levitt, A. Gleacher)
- Analysis of organizational change processes in clinics to identify predictors of successful EB screening and assessments (M. Cavaleri, S. Olin)

What makes it work: Flexibility, Practicality, Responsiveness, Organizational Translation

- OF INTEREST TO STATE:
- Social marketing for new initiatives: Increasing acceptability, buy-in
- Supporting **clinics** not just clinicians: Reducing burden to clinics, improving operational efficiency (reducing staff turnover)
- Reducing no show rates, improving retention and treatment completion rates, reducing hospitalizations
- Expanding and retooling the workforce: Increasing # of peer family advisors in the workforce
- OF LESS INTEREST:
- **Fidelity**. Acceptance, use, ease of incorporation are important
- **Sustainability**
- **Clinical (symptom reduction) outcomes**

Closing Thought

- We need to move beyond viewing EBP implementation as a set of commodities to be purchased, trained to use, or routinized into practice. Instead we need to ask how we can instill curiosity into our systems. This will require a fundamental shift in how systems handle the process of inquiry. Inquiry, curiosity, constant questioning—these cannot be tangential to systems change; they must be drivers of it.

