



*Issues in Implementing EBPs for  
Children in New York State:  
Reverse Engineering*

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# *Similarities between children's and adult's implementation*

- Types of stakeholders
- Significance of buy-in process
- Significance of consumer/family participation
- Continuous Quality Improvement
- Fidelity and monitoring
- Leadership roles
- Cultural adaptations
- Training/consultation important but insufficient by themselves
- Meager implementation science to guide efforts

# *Differences in Status of Child and Adult EBP Implementation*

## CHILDREN

- No toolkits or resource guides
- Research fdn strong on risk factors, longitudinal course, developmental processes
- Weak on assessment, efficacy, effectiveness and implementation
- Multiple systems and significant fragmentation
- Significant context differences across the systems

## ADULTS

- Toolkits and resource guides exist
- Research fdn strong on effective treatments for SMI
- Diagnostic assessment measurement less ambiguous and contentious
- Fewer systems to coordinate

## *What are the scientific leading edges in EBP implementation for children?*

- Treatment development within the context of service systems (Weisz Deployment Focused Model)
- Assessment technologies (Chorpita, Bickman, Hodges)
- Training technologies (web-based vs in-person) (Cohen, Jaycox)
- Differential approaches to supervision (Mufson)
- Community participatory processes (Wells)
- Community development teams (Chamberlain)
- Organizational processes within work environments (Glisson, Schoenwald)

# *NYS: Evolution of EBP Implementation for Children*

- **2000-01: J. Lyons report identifies deficiencies in children's outpatient system; New funding expands community-based services**
- **2002: Commissioner mandate: OMH restructuring around EBPs**
- **2002: Selection of specific clinical services**
  - **FFT (with OCFS for JJ population)**
  - **CBT trauma (9/11) (CATS)**
  - **School mh treatments (CBT, IPT)**
  - **Medication management of atypical antipsychotics**
- **2003: NIMH/SAMHSA R24 to examine stakeholder attitudes towards EBPs (DOOR)**
- **2004-05: 2 NIMH R34s on engagement-empowerment of families (Parent Empowerment)**
- **2005: Evidence-based Treatment Dissemination Center (EBTDC) established as core OMH function**
- **2006: New funding for state-wide screening, enhanced clinic services, and expansion of EBTDC**
- **2006: NIMH Developing Center grant to experimentally examine implementation strategies**

# *Dimensions of Organizational Readiness (DOOR) (NIMH/SAMHSA R24)*



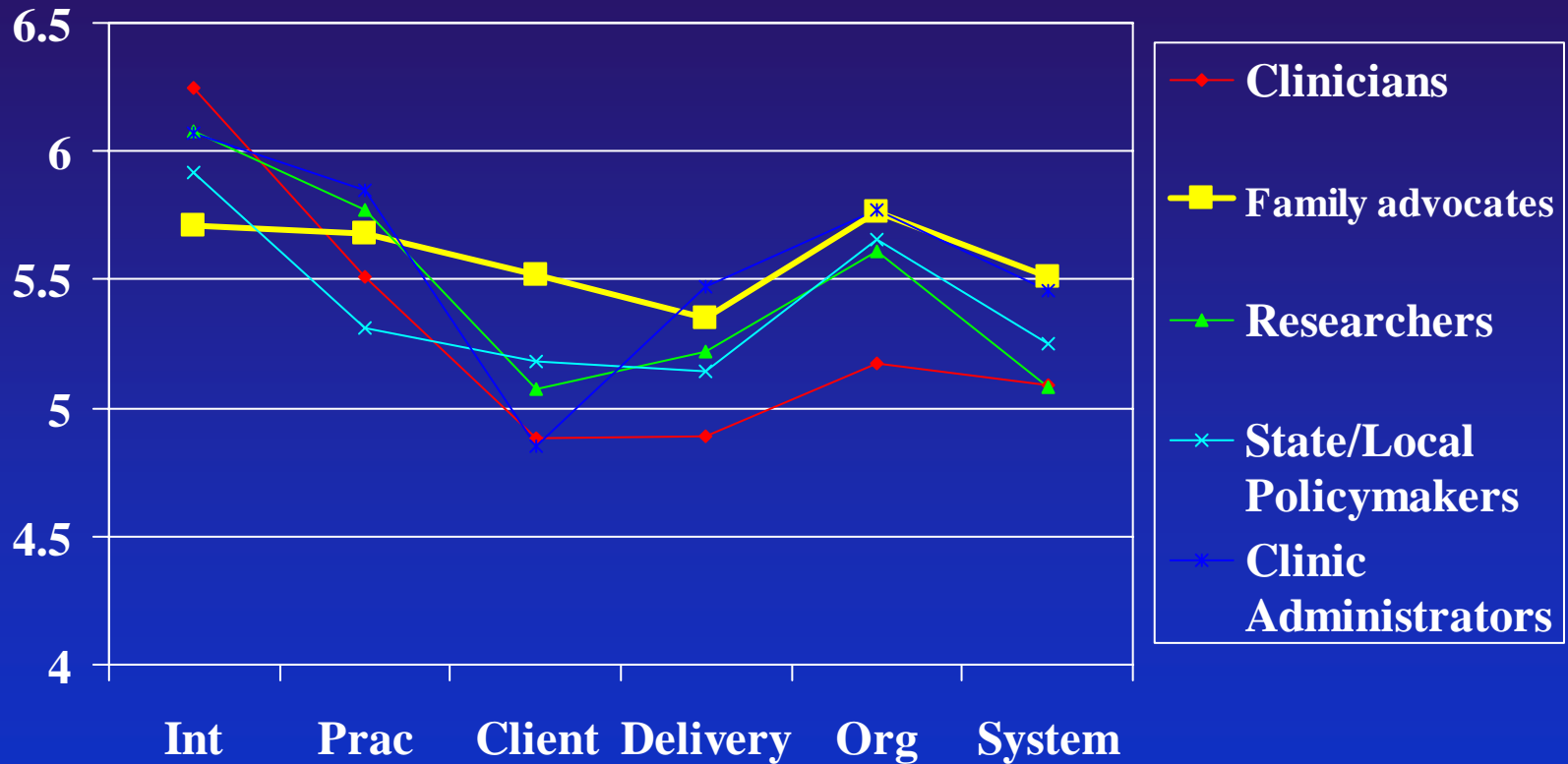
- ◆ What factors are considered important to the uptake of evidence-based practices?
- ◆ Do all stakeholders agree on the relative importance of specific factors?

<b>Intervention</b>	<b>Clinician</b>	<b>Client</b>	<b>Service Delivery</b>	<b>Organization</b>	<b>Service System</b>
Nature of intervention theory	Specialized training	Nature of referral problems	Frequency of sessions	Structure, hierarchy	Policies of referral source, pay
Focus of intervention	Adherence monitoring	Family context	Length of sessions	Personnel policies	Financing methods
Intervention specification Manual?	Supervisor/ Researcher	Source of referral	Physical location of sessions	Org culture	Legal mandate for referrals
Similarity of int to std practice	Training of practitioner	Age and developmental status	Source of payment	Org climate	Interagency working relationship
Complexity of intervention	Endorsement of intervention	Gender		Org mission	
Clarity of intervention	Salary level/ Criteria for increases	Ethnicity/ cultural iden		Organizational mandates	<i>Schoenwald &amp; Hoagwood, 2001</i>

# *DOOR Pilot*

- State-wide sample of clinics stratified by mental health service site type (i.e., school or community-based)
- Types of EBPs: Family Functional Therapy; Interpersonal Therapy; Psychopharmacological Management of ADHD
- Five stakeholder groups: clinicians, family advocates, administrators, treatment dev/researchers, policy-makers
- 200 survey packets (194 deliverable) yielded 135 returned surveys
- Response rate = 70%

## Comparison of Respondent Group Ratings



Scale

1	2	3	4	5	6	7
Very Unimportant	Unimportant	Somewhat Unimportant	Neutral	Somewhat Important	Important	Very Important

# *Analysis of Group Differences*

DOMAIN	RESPONDENT GROUP	RESPONDENT GROUP	MEAN DIFFERENCE
Intervention Characteristics	Clinician	Family Advocate	.54018(*)
Service Delivery	Clinic Administrator	Clinician	.57768(*)
Organization (Serv Agency)	Clinic Administrator	Clinician	.60119(*)

\* The mean difference is significant at the .05 level.

# *The Issue*

- Attitudinal gap on what matters for EBP implementation is widest between clinicians/families and clinician/administrators
- Initial Strategy: Improve clinician engagement with families

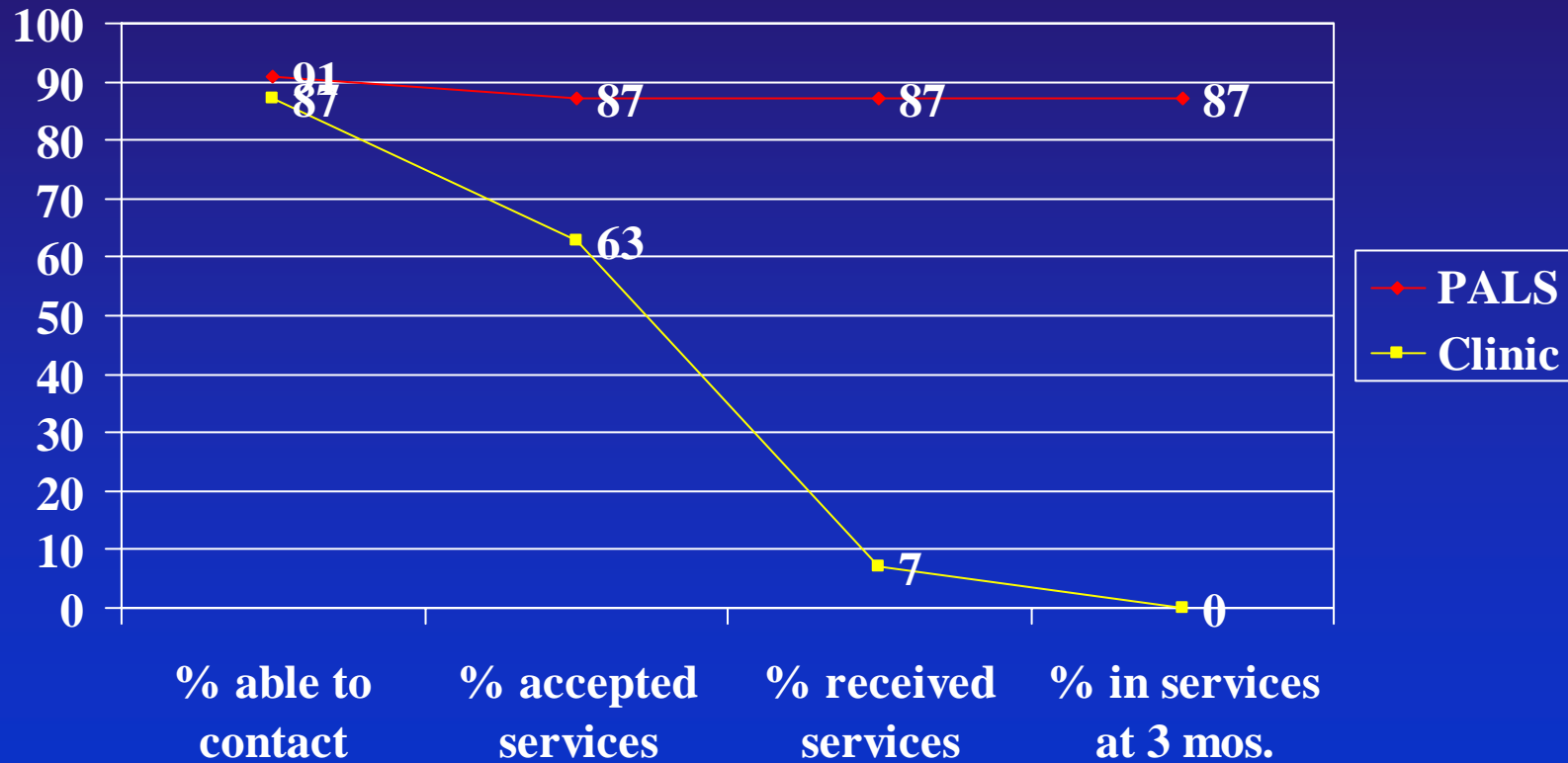
## *Example: Implementation of CBT for trauma after Sept. 11*

- Child and Adolescent Trauma Treatments and Services Consortium (CATS)
- For children and adolescents affected by the World Trade Center disaster

# *CATS Project*

- 173 routine practice therapists working in schools and clinics trained in 2 EBP trauma models
- Ongoing consultation/support provided by treatment developers
- 589 children and families offered trauma-focused CBT or treatment as usual
- Baseline, 3, 6, 12 month follow-up
- 3 day training + 2 booster sessions + bi-weekly consultation calls for 1 year
- Bi-weekly site visits + weekly steering committee calls with all sites + weekly site coordination meetings
- Regression discontinuity design, reliable change indices, propensity score matching to assess outcomes
- Evaluation assessed implementation processes and outcomes (e.g., PTSD anxiety, depression, behavior problems, strengths, school functioning)
- Key contextual factors (e.g., organizational culture, climate, fidelity, and alliance)

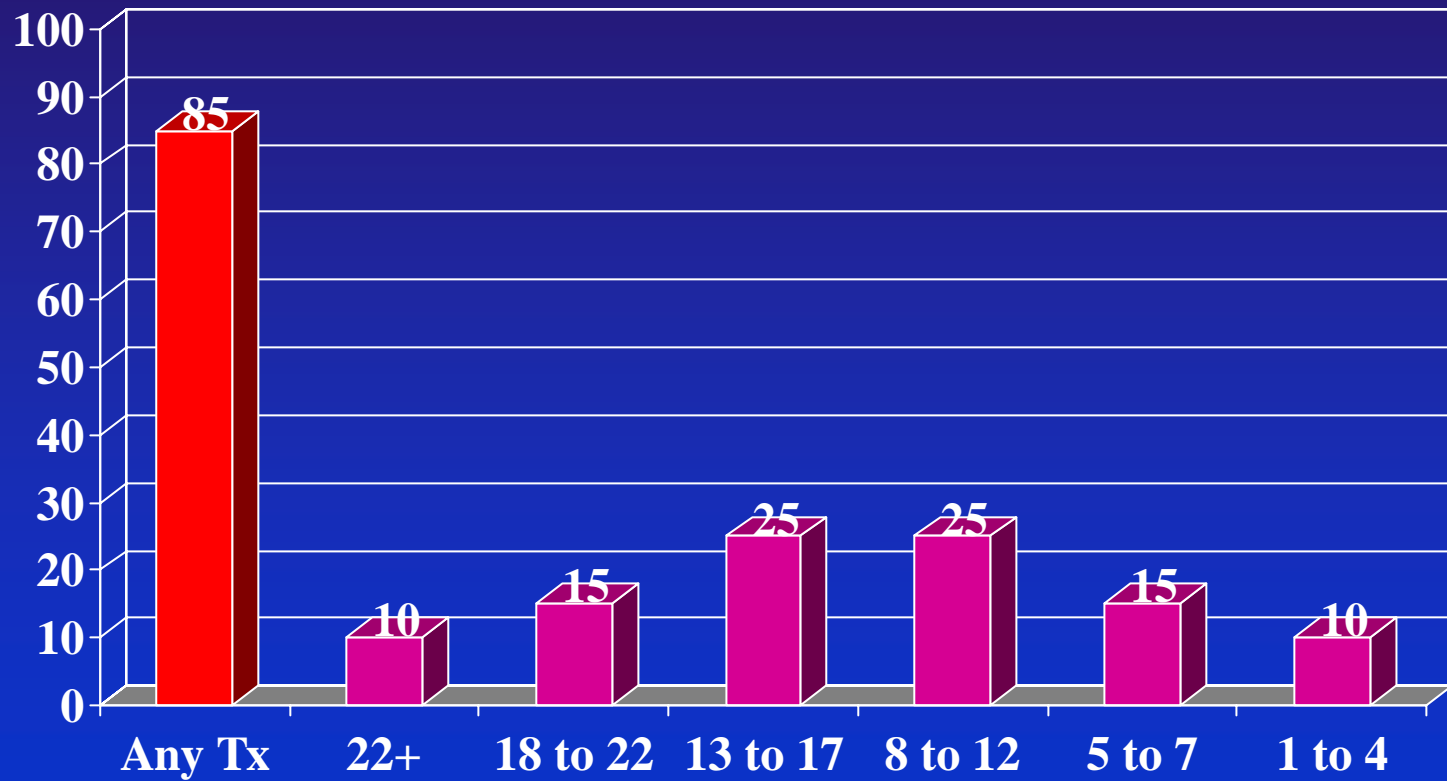
## *McKay et al., 2003: Family service involvement - PALS vs. Clinic*



# *Empirically supported engagement interventions*

- Reminders reduced missed appointments by 32%  
(Kourany et al., 1990; McLean et al., 1989; Shivack et al., 1989)
- Intensive family-focused telephone engagement associated with 50% decrease in initial show rates and a 24% decrease in premature terminations  
(Szapocznik, 1988; 1997)
- Combined telephone and first interview engagement interventions associated with attendance rates of 74%, representing a 16 to 25% increase above the clinic comparison families (McKay et al., 1998).

*Engagement rates (% of treatment sessions kept) in CATS (N=446)*



N=446

# *Lessons learned*

- Engagement strategies can improve access and retention in services
- Linking engagement to clinically effective services may improve outcomes for more children

# *The Issue*

- Engagement targeted clinician directed behaviors. Clinicians still faced burn-out and workload issues. Families wanted tools to support their engagement in services.
- Strategy: Develop a program to support families and family advocates

# *Empowerment: Theoretical Underpinnings*

- Jurgen Habermas' Theory of Communicative Action (1983; English translation, 1990)
- Bandura (1977; 1986) self-efficacy—consistent predictor of initiating and sustaining behavior change
  - Predictor of health-related behaviors (Strecher, DeFillis, Becker & Rosenstock, 1986)

## *Parent Empowerment (PEP) in NY: Towards a Science Base on Family Advocacy*

- 4 year process of collaborating with family advocates, researchers, policy-makers
- Scientific review of the literature
- Expansion of family advocacy services in NYS
- Identified one controlled trial of empowerment (Bickman et al, 1998)
- Co-taught by professional family advocate and mh professional
- Adapted for multi-ethnic families
- Added modules about EBPs for specific child mental health issues (e.g., ADHD, depression, trauma, conduct)
- Focus on collaborative skill building
- Added engagement strategies
- 4 program manuals developed for advocates and parents
- 2 NIMH-funded R34 effectiveness trials to examine impact of program on knowledge, skills, self-efficacy and use of services (behavior)

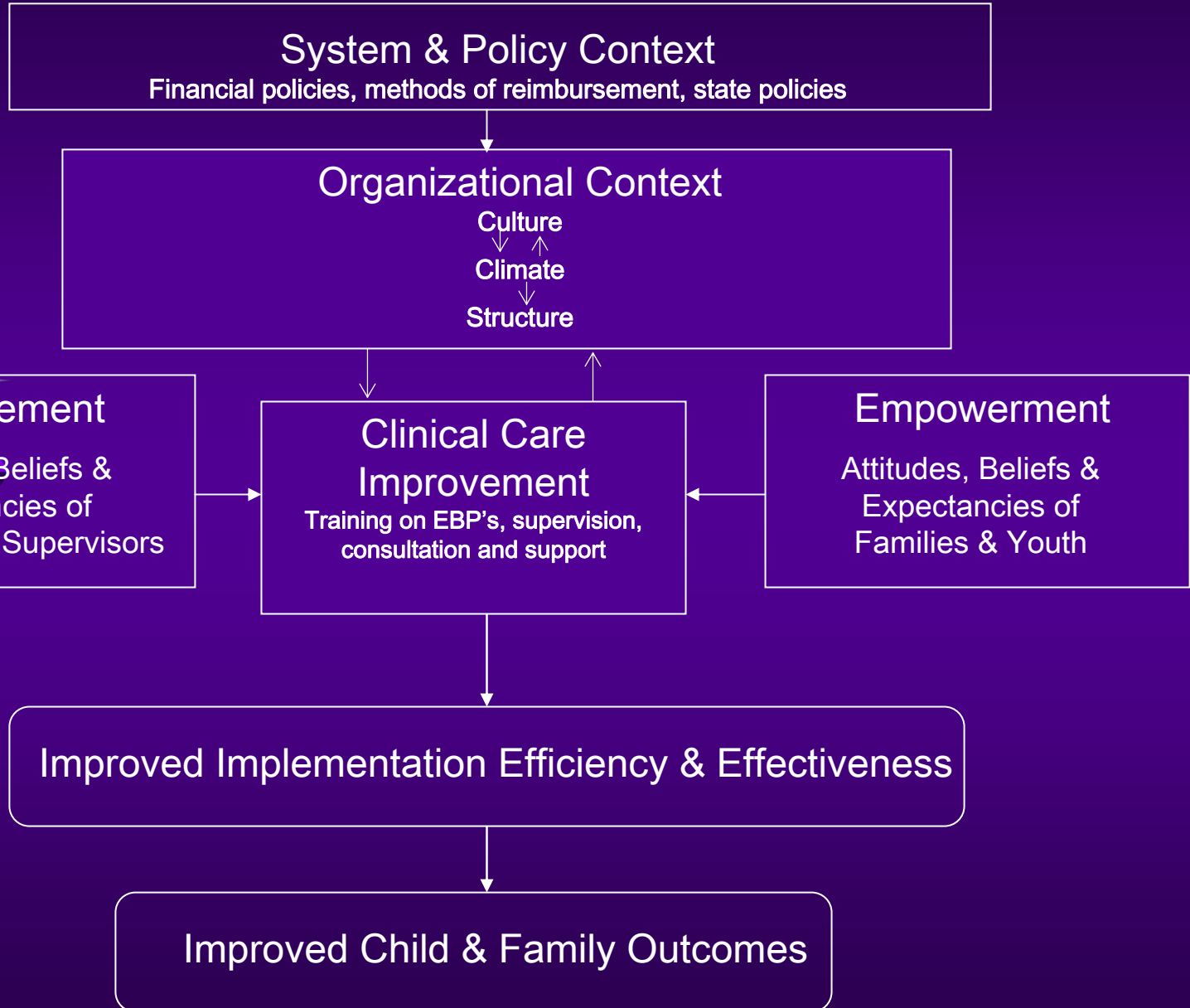
# *Mid-point lessons*

- 1<sup>st</sup> R34: 40 family advocates randomly assigned to PEP training or TAU.
- Preliminary results: Significant pre/post changes in knowledge about EBPs, collaborative skills/working alliance, and self efficacy
- Role definition for family advocates within their clinics varies enormously
- Structural and organizational supports for family advocates are limited
- 65% of caregivers being served by family advocates score in the severe range for depression (average CES-D score = 22.6)
- 2<sup>nd</sup> R34: 60 school-based family coordinators randomly assigned to PEP training or TAU. Identify core competencies. Track fidelity.

## *New York State's Evolving Model*

- **Train** clinicians using expert treatment developers and provide intensive consultation for 1 year
- **Engage** families in services by removing barriers to access: Target clinician outreach
- **Empower** families with tools, skills, and support: Target families and advocates
- **Assess and intervene** to improve core organizational processes
- Create system-wide **incentives** to sustain change

# New York State Implementation Model



## *NYS-EBP Training/Dissemination Center and NIMH Developing Center (P20)*

- EBTDC for Children: NYS-driven training for up to 500 clinician/supervisors
- Two-year cycles
- First effort: 500 clinician/supervisors trained on CBT for childhood trauma and depression
- Training + 1 year consultation (bi-weekly by telephone)

## *Major Aims of the NIMH Developing Center (P20)*

- To advance knowledge about effective implementation strategies for improving the uptake of evidence-based practices (EBPs) in state-funded public mental health systems, thereby improving child and adolescent mental health
- To advance service systems research by targeting development of innovative methods for improving the uptake of EBPs
- To examine experimentally a set of theory-based strategies to improve EBP implementation *efficiency* and *effectiveness*.

# *Specific Aims: Pilot Study 1*

- To examine the preliminary impact of 3 interventions on implementation *efficiency* (e.g. no-show rates, treatment completers, staff retention/turnover, working alliance) and *effectiveness* (e.g., family self-efficacy, youth symptom and functioning improvement); and 2) to estimate intervention parameters, including effect size, study population variance, attrition rates etc.
- To experimentally examine the impact of Engagement-Empowerment among a sample of 45 clinicians employed in 15 clinics. Clinicians will be randomly assigned to receive either: a) **CBT Trauma Training & Consultation (CBT Only)**; b) CBT Trauma Training & Consultation, enhanced with the E-E intervention (**E-E Enhanced**); or c) the **E-E Intervention only**.

# *Organizational Targets: Next Steps*

- Assess impact of an organizational intervention targeted at core organizational processes on sustainability of clinical services within clinics

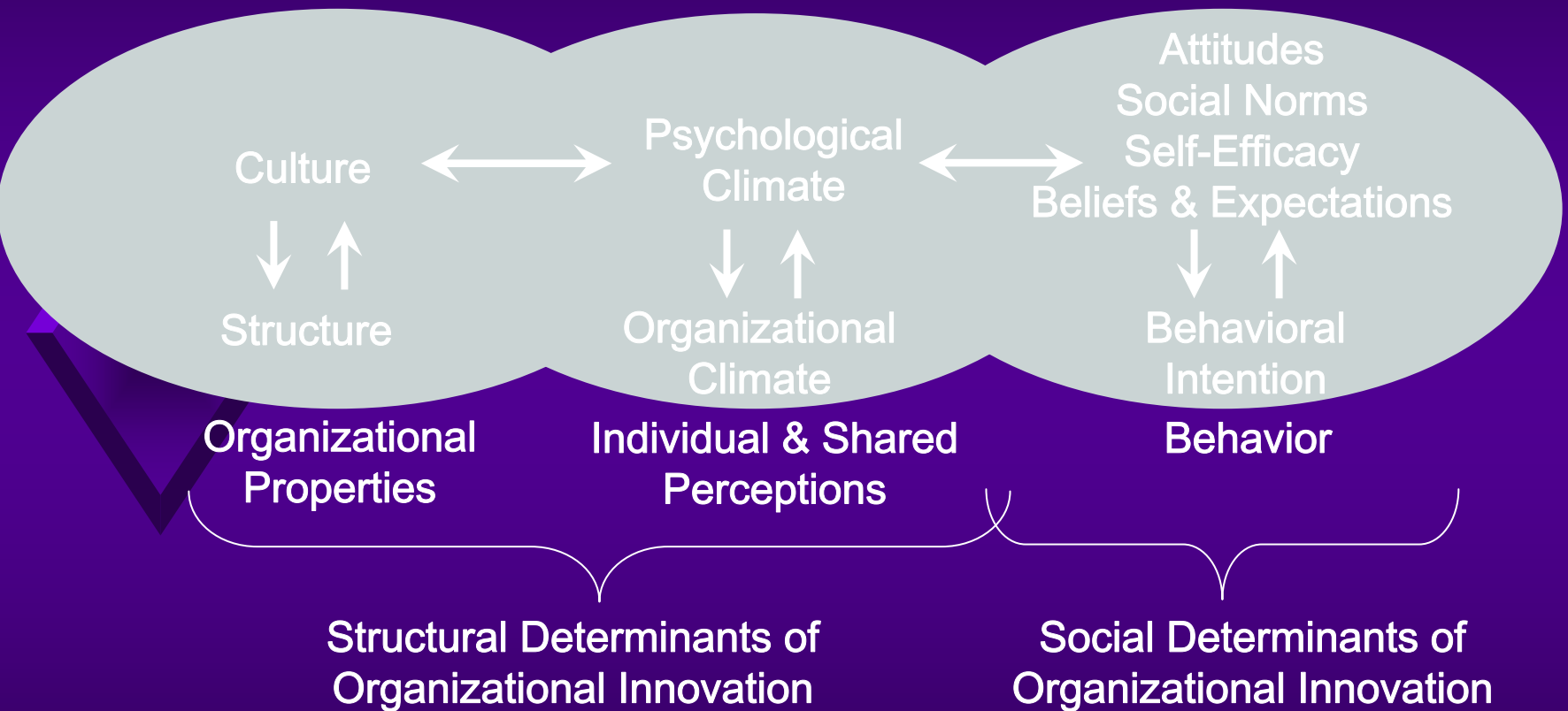
# *Organizational context affects uptake of EBPs and outcomes*

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- Three decades of studies by Glisson and colleagues
- Glisson & Himmelgarn's (1998) study of child welfare agencies found that the strongest predictor of child improvement was organizational climate
- Organizational *culture*, not climate, explains variations in service quality (Glisson & James, 2002)
- Organizational factors affect youth outcomes (Schoenwald et al., 2003)
- Organizational level interventions can improve climate and reduce staff turnover (Glisson, et al., 2006)

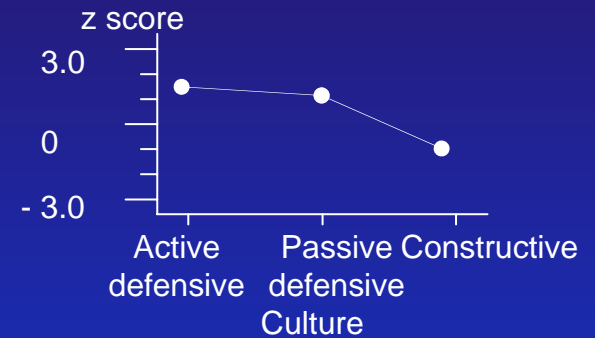
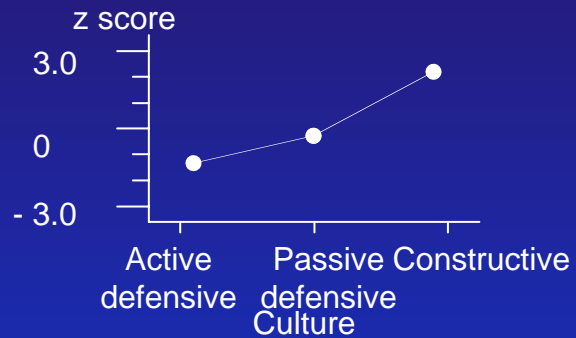
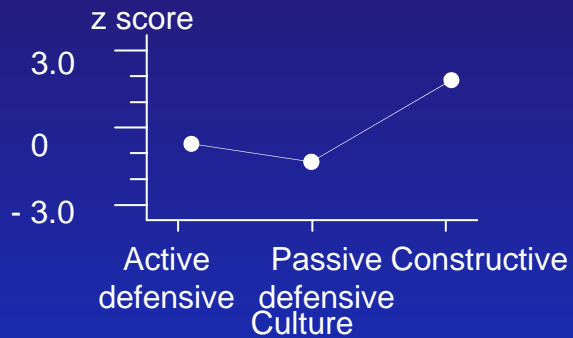
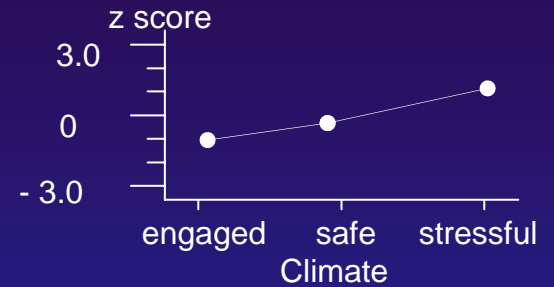
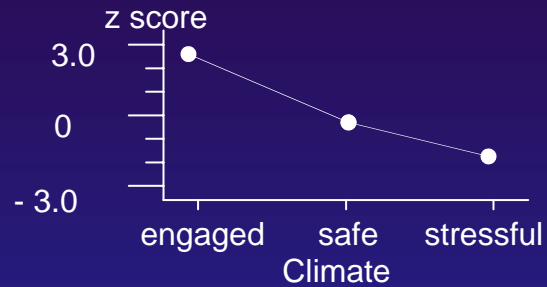
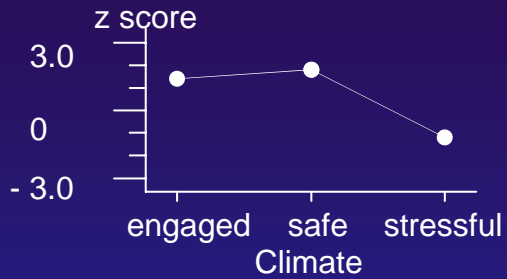
# Models of Diffusion, Organizational Implementation & Social Processes

## Systems Context



Adapted from Glisson 2002

## Examples of Clinic Profiles with z scores based on National Norms (C. Glisson)



# *The Big Issues*

- Basic science on implementation doesn't yet exist.
- Create scientific and state policy consortia
  - Sharing data across states, using common measures
  - Developing new measures to track basic implementation processes
  - Developing vertical fidelity measures across levels of the system
  - Expanding range of designs
- Develop state-level connections with NIRN
- Expand NIMH-SAMHSA state planning grants
- Examine front-end (access, engagement, recruitment) and back-end (retention, sustainability) strategies along with core mediational processes to examine why change happens. Look for interaction effects

# *Big issues*

- EBPs are not commodities to be exchanged but ways of learning. Building them into systems requires a fundamental shift in how systems handle the process of empirical inquiry. Inquiry and adaptation cannot be tangential to systems change; they must be integral to it.

# *Closing thought*

- “New technologies alter the structure of our interests: the things we think *about*. They alter the character of our symbols: the things we think *with*. And they alter the nature of community: the arena in which thoughts develop.”

Neil Postman, *Technopoly*

