Objectives

- Examine process of innovation diffusion of an evidence-based practice in two publicly-funded mental healthcare settings

Methods

- Collective case-based methodology
- Participants
  - 2 urban, publicly-funded mental health clinics
  - 35 outpatient and school-based clinicians randomized to one of two arms
  - 10 social workers; 6 counselors; 1 psychologist

Methods (continued)

- Quantitative Data
  - Children's Services Organizational Climate Survey
  - Provider Attitude Survey
  - Children's Depression Inventory (eligibility screen)
- Qualitative Data
  - Medical record review
  - Therapy audiotapes
  - Supervision records
  - Field notes
  - 16 key informant interviews

Stages of the Innovation-Decision Process

Stage/Variable	Appraisal	Acceptance	Adoption	Assimilation
Adolescent/ Family			X	
Intervention	X			
Provider		X	X	X
Organization	X			X
Environment				X

Stages

- Appraisal
  - Stakeholders have sufficient knowledge of and evaluate feasibility, acceptability, compatibility of CBT
- Acceptance
  - Stakeholders commit to adoption of and preparation for CBT
- Adoption
  - Stakeholders implement CBT with high degree of fidelity
- Assimilation
  - Stakeholders continue to implement CBT with moderate to high levels of fidelity

Inhibiting/ Activating Factors

- Adolescent/Family
- Intervention
- Clinician
- Organization
- External Environment

Results

- Appraisal
  - Buy-in from management (2 clinical directors and 2 quality improvement managers per site)
  - IRB protocol and individual site authorizations
  - Clinician selection, education and recruitment
  - Intervention options
  - Procedures for adolescent screening, enrollment, and treatment
  - Considerations for research and EBP implementation

Results (cont.)

- Acceptance
  - Of 35 eligible clinicians, 25 agreed to participate and were randomized (11 intervention; 14 usual care)
  - 9 completed training; 10 remained in usual care arm; 6 dropped out)
  - 74%, 63% and 84% had no experience with a CBT treatment manual, formal training or supervision, respectively
  - 25% said they plan to ***never or rarely*** use an EBT for youth depression in the next 6 months

Results (cont.)

- Adoption
  - 87 adolescents screen positive for depression
  - 70 agree to be contacted; 44 were eligible; 34 agree to participate
  - 16 and 18 adolescents assigned to intervention and usual care clinicians, respectively
  - In 63% of intervention cases, clinicians adhere closely or very closely to CBT protocol

Results (cont.)

- Assimilation
  - 8/9 clinicians participate in at least 3 monthly supervision sessions
  - One clinician attends all supervision sessions
  - 5/9 clinicians report using CBT at follow-up (3 use manual; 2 use “CBT skills”)
  - 4/9 clinicians report no longer using CBT (2 use other interventions for depressed adolescents; 2 no longer provide direct service to depressed adolescents)

Appraisal Checklist

Adolescent/ Family	❑ General expectations of treatment consistent with EBP ❑ Concordance on EBP target condition ❑ Minimal co-morbid conditions interfering with treatment ❑ Initial satisfaction with clinic/provider
Clinician	❑ Level of prior exposure to EBP ❑ Positive expectations about EBP ❑ Able and willing to participate in training ❑ Proportion of clinicians devoted to full-time status ❑ Core of innovative, risk-taking clinicians ❑ Clinician meeting productivity requirements
Intervention	❑ Strong evidence base ❑ Applicable to population ❑ Compatible with other treatment components ❑ Broad inclusion criteria ❑ Acceptable training requirements ❑ Feasible to implement in setting

Stages of CBT Implementation: Appraisal through Assimilation

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Appraisal Checklist (cont.)

Organization	❑ Leadership advocates for EBP ❑ Organization supports new learning ❑ Leadership identifies, resources champions ❑ Milieu supports quality care ❑ Infrastructure working effectively to assist clinicians with productivity requirements ❑ Organization offers services compatible with EBP ❑ Resources available for EBP application ❑ Supervisory structure in place
Environment	❑ Extent to which EBP is favored by external stakeholders (e.g., payers) ❑ Financial support provided for EBP initiation ❑ Incentives offered for EBP initiation ❑ Performance appraisals tied to EBP provision

Acceptance Checklist

Adolescent/ Family	❑ Commitment to treatment ❑ Resources to initiate treatment ❑ Knowledge and acceptance of EBP ❑ Able to cognitively understand EBP approach to treatment ❑ Agree to treatment plan
Clinician	❑ Attends training ❑ Competent to detect depression ❑ Willing to learn manual, workbook ❑ Confident about skills ❑ Willingness to take risks with new learning ❑ Not overwhelmed with productivity, paperwork ❑ Competent at completing authorization to treat ❑ Positive attitude toward EBP implementation

Acceptance Checklist (cont.)

Intervention	❑ Adaptable for population ❑ Manual easy to master ❑ Training and materials available at minimal cost ❑ Addresses co-morbid conditions, crises, family concerns
Organization	❑ Screening mechanisms in place ❑ Referrals provided for clinicians trained in EBP ❑ Monitoring system available to track EBP provision ❑ Specialty clinic, treatment algorithms in place ❑ Leaders enthusiastic, supportive ❑ Champions receive incentives for EBP "coaching" ❑ Positive staff morale
Environment	❑ Reimbursements for care setting ❑ Authorizations streamlined for care ❑ Care setting amenable to EBP components

Adoption Checklist

Adolescent/ Family	❑ Adheres to weekly/bi-weekly treatment regimen ❑ Minimal crises or ability to work with crises within the context of EBP ❑ High engagement in treatment ❑ Resources continue to be available for treatment ❑ Adolescent not diverted to other service agency ❑ Completes homework, in-session activities
Clinician	❑ Participates in role plays in training, rehearses EBP components ❑ Able to engage adolescent/family in EBP process ❑ Willing to initiate EBP with 1-2 adolescents/families ❑ Maintains regular contact with agency, champion and EBP facilitator ❑ Maintains productivity requirements ❑ Accountable, accepts responsibility for learning ❑Able to deal well with crises

Adoption Checklist (cont.)

Intervention	❑ Incorporates strategies for engagement, motivation ❑ Supervision provided consistently in a feasible manner (e.g., transportation, continuing education, scheduling, location, modality) ❑ Instructions provided for "diversions" ❑ Parent(s) concerns addressed in an ongoing basis
Organization	❑ Organization provides incentives to intervention therapists ❑ Champion remains engaged in EBP implementation ❑ Minimal paperwork requirements ❑ Leadership remains committed ❑ No major changes in organizational operations

Adoption Checklist (cont.)

Environment	❑ No major changes in authorization procedures, paperwork requirements ❑ Incentives to organization for EBP implementation ❑ Continuing education framework

Assimilation Checklist

Adolescent/ Family	❑ Completes treatment regimen ❑ Continues to use EBP skills ❑ Receives "booster" sessions as needed
Clinician	❑ Remains in current treatment setting ❑ Treats targeted population ❑ Retains interest, enthusiasm for EBP ❑ Receives ongoing supervision or "booster" sessions as needed ❑ Receptive to feedback to improve skills ❑ EBT becomes part of clinical repertoire
Intervention	❑ Training and training materials easily replicated ❑ Ongoing supervision feasible ❑ Manuals can be reproduced, distributed widely

Assimilation Checklist

Organization	❑ High retention of staff ❑ Infrastructure in place to continue screening ❑Consistent service delivery model ❑ Referrals to trained clinicians sustained ❑ Incentives for trained clinicians to practice EBP ❑ Long-term financial sustainability for organization ❑ Milieu supports short-term treatment interventions ❑ Champion support, resources continue
Environment	❑ Reimbursement for targeted condition(s)/EBP ❑ Sustained external funding ❑ Minimal leadership, policy changes ❑ Recognition by others external to organization of EBP implementation efforts

Conclusions

- Implementation is a complex, dynamic process determined by multiple, interacting variables
- Successful implementation requires long-term strategies that address activating and inhibiting variables at different stages
- Of the clinicians who adopted CBT, none stated that organizational and environmental variables ***facilitated*** their work. However, non-adopters stated organizational and environmental variables ***inhibited*** their work.

Clinical Implications

- Training and training manuals must provide explicit instructions on how and when to deviate from and return to the protocol
- Protocols should address co-morbid symptoms, particularly aggressive behaviors, ADHD and trauma-related problems
- Training and supervision must include strategies to confront adolescent and family non-adherence, e.g., greater focus on motivation interviewing techniques

Clinical Implications

- Individually-oriented EBP may be most effective when augmented by case management in highly volatile families
- Thorough assessment of activating and inhibiting variables relevant to the settings and development of counter-strategies are critical to successful implementation