
 **Multiple Stakeholder Perspectives on Evidence-Based Practice Implementation**

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 **Agenda**


- The need for effective implementation
- Barriers and Facilitators to Implementing EBP
- Study methods
- Results
- What does it all mean?

 **EBP Implementation is Happening**

- Effective implementation of EBPs into real-world service settings is important for improving service quality and outcomes for youth (Hoagwood & Olin, 2002; Jensen, 2003)
- Some (but not many) implementation improvement methods are being tried (Haynes & Haines, 1998)
  - Abstracting services
  - Evidence-based clinical guidelines
  - Incentives for better care systems
  - Increasing effectiveness of quality improvement programs
- Research is testing some factors associated with implementation but multiple stakeholder perspectives are not well defined (NIMH R01, R03, PI: Aarons; R01 Webster Stratton, R01 Chaffin, R34 Shipp. )

 **We are Learning about Implementation**

- Some barriers to implementation have been identified
  - e.g., lack of funds for continuing education (Simpson, 2002).
- We know little about the most effective manner in which to implement EBPs
  - (Henggeler, Lee, & Burns, 2002; Morgenstern, 2000)
- New models of implementation have been developed
  - (Aarons, 2005; Frambach & Schillewaert, 2002; Klein, Conn, & Sorra, 2002).

 **Implementation is Complex**

- Implementation should be evidence-based
- Implementation is a multilevel issue (Dixon et al., 2001).
  - Policies
  - Agencies
  - Programs
  - Administrative staff
  - Clinicians
  - Consumers
- Clear, comprehensive, measurable, and testable implementation models are needed to guide research on organizational change
- There are few empirical studies addressing these issues in youth mental health services

**Goals of the Study**

- To identify barriers and facilitators of adoption of EBPs for organizations serving youth with Mental Health disorders
- Examine what various stakeholder groups identify as most important and most changeable.

**Methods I**

■ Programs within agencies selected based on:

- Types of Services Provided
  - Outpatient
  - Day Treatment
  - Case Management
  - Residential/Inpatient
- Size of Agency
  - Large and Small
- Size of Program
  - Large and Small
- Location
  - Urban vs. Rural

**Participant Selection**

- Selected programs were either operated by the County or provided contract services to the county.
- Organizational structures varied by level of bureaucracy and fiscal constraints on services (Aarons, 2004)
- Individual participants selected by snowball sampling

**Sample Selection**

■ Participants drawn from 6 organizational levels:


- Policy: County Mental Health Officials (n = 6)
- Agency: Organization/Agency directors (n = 5)
- Program: Program managers (n = 6)
- Clinical: Clinicians (n = 7)
- Administrative: Administrative staff (n = 3)
- Consumers: Consumers of MH services (n = 5)

**Demographics (N=31)**


|                  | N  | %    | Mean | SD   | Range |
|------------------|----|------|------|------|-------|
| <b>Gender</b>    |    |      |      |      |       |
| Male             | 12 | 38.7 |      |      |       |
| Female           | 19 | 61.3 |      |      |       |
| <b>Age</b>       |    |      |      |      |       |
|                  |    |      | 44.4 | 10.9 | 27-60 |
| <b>Race</b>      |    |      |      |      |       |
| Caucasian        | 23 | 74.2 |      |      |       |
| Hispanic         | 3  | 9.7  |      |      |       |
| African American | 1  | 3.2  |      |      |       |
| Asian American   | 1  | 3.2  |      |      |       |
| Other            | 3  | 9.7  |      |      |       |

**Demographics Mental Health**


|                                     | N | %    | Mean | SD | Range |
|-------------------------------------|---|------|------|----|-------|
| <b>Experience Implementing EBPs</b> |   |      |      |    |       |
| Not at all                          | 8 | 30.8 |      |    |       |
| To a slight extent                  | 8 | 30.8 |      |    |       |
| To a moderate extent                | 8 | 30.8 |      |    |       |
| To a great extent                   | 2 | 7.7  |      |    |       |

 Procedure


- **Concept Mapping** (Trochim, Cook, & Setze, 1994)
  - Mixed qualitative-quantitative method
  - Qualitative methods used to generate data
  - Data analyzed using quantitative methods
- **Begin with structured brainstorming**
  - Participants **generate** and then **use** a focus statement to guide identifying barriers and facilitators to implementation

 Procedure


- **Focus statement**
  - “What are the factors that influence the acceptance and use of evidence-based practices in publicly funded mental health programs for families and children?”
- **Independent stakeholder group brainstorming**
- **Statements combined across all groups**

 Procedure


- **“Unstructured” Card Sort**
  - 105 Statements
  - All participants sort the same statements
  - Sorted based on similarity
  - >1 pile
- **Statement Ratings**
  - “Importance”
  - “Changeability”
  - 0 to 4 point scale
    - (Not at all → A very great extent)















 Analysis

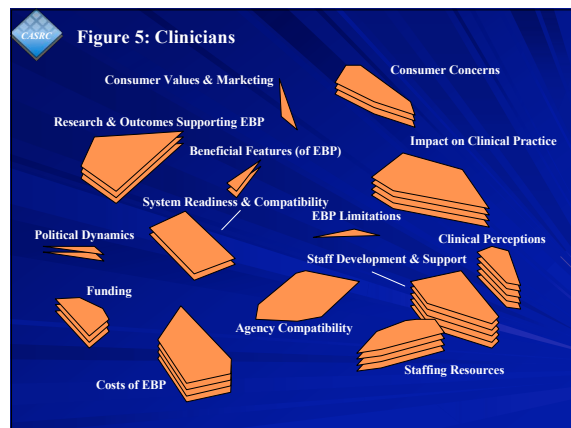
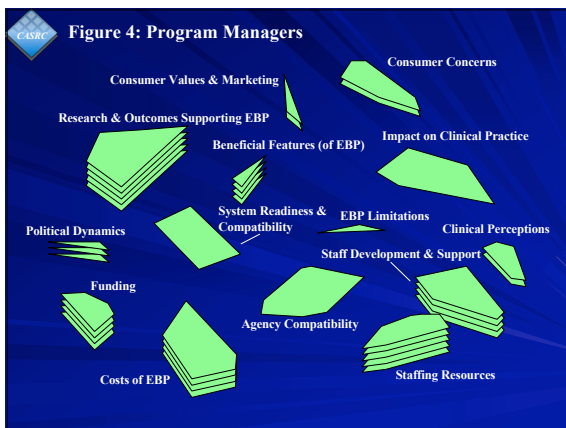
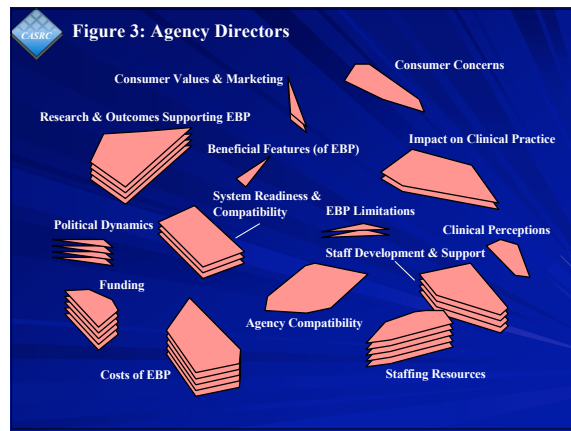
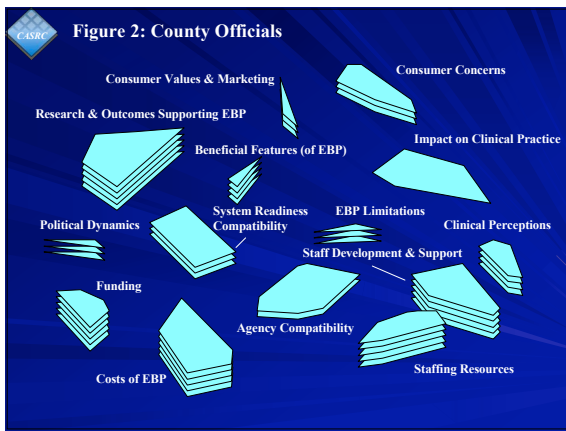
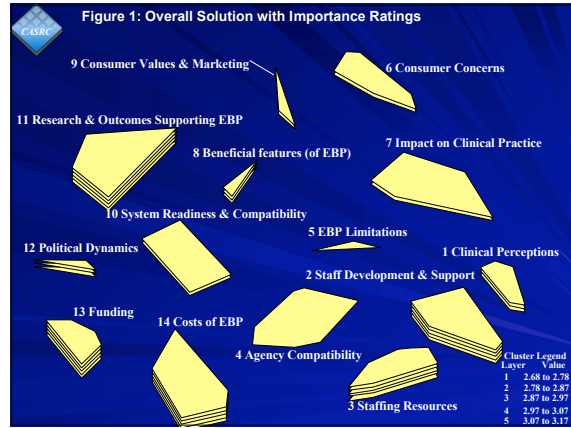
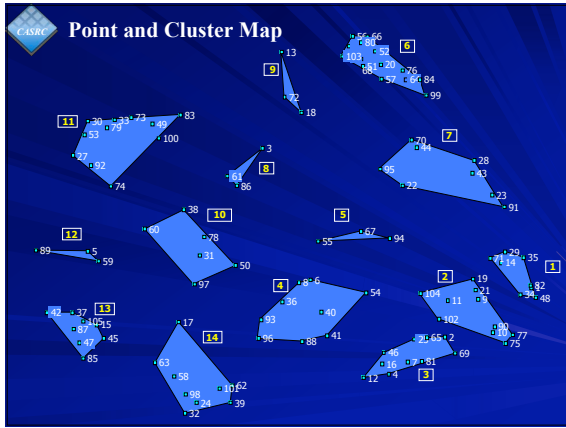
- **Multidimensional scaling (MDS) and cluster analysis**
- **MDS analysis results in a “map” of the conceptual space with similar issues closer together**
- **Solution represents psychological “distance” or similarity between concepts**
- **Statements more similar in meaning are closer together**
- **Statements grouped into non-overlapping categories called clusters**
- **Clusters closer together are more conceptually related**

 Results

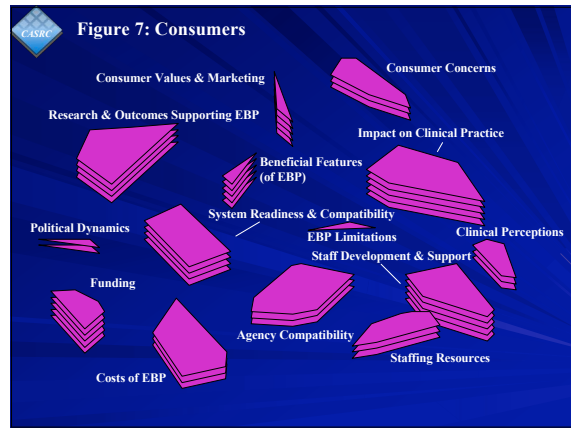
- **Fourteen overall clusters best fit data**
- **One overall solution for all participants**
  - Participants reconvene to “make sense” of solution
  - Cluster naming
- **Importance ratings overlaid on solution**

 14 Clusters

-  Clinical Perceptions
-  Staff Development & Support
-  Staffing Resources
-  Agency Compatibility
-  EBP Limitations
-  Consumer Concerns
-  Impact on Clinical Practice
-  Beneficial Features (of EBP)
-  Consumer Values & Marketing
-  System Readiness & Compatibility
-  Research & Outcomes
-  Political Dynamics
-  Funding
-  Costs of EBP







Importance Rating Scale

|                                    | All  | Cnty<br>Offcls | Agncy<br>Dir | Prgrm<br>Mgr | Clincn | Admin | Cnsmr |
|------------------------------------|------|----------------|--------------|--------------|--------|-------|-------|
| Agency Compatibility               | 2.68 | 2.36           | 2.64         | 2.54         | 2.72   | 3.11  | 2.91  |
| Beneficial features (of EBP)       | 2.94 | 2.80           | 2.53         | 3.05         | 2.78   | 3.11  | 3.40  |
| Clinical Perceptions               | 2.88 | 2.70           | 2.53         | 2.82         | 3.08   | 3.33  | 2.95  |
| Consumer Concerns                  | 2.85 | 2.59           | 2.67         | 2.84         | 2.87   | 3.26  | 3.03  |
| Consumer Values & Marketing        | 2.87 | 2.60           | 2.73         | 2.81         | 2.67   | 3.11  | 3.47  |
| Costs of EBP                       | 3.13 | 2.91           | 3.42         | 3.08         | 2.96   | 3.56  | 3.09  |
| EBP Limitations                    | 2.70 | 2.53           | 2.80         | 2.67         | 2.72   | 3.11  | 2.53  |
| Funding                            | 3.17 | 3.13           | 3.25         | 3.00         | 2.94   | 3.71  | 3.33  |
| Impact on Clinical Practice        | 2.81 | 2.00           | 2.80         | 2.59         | 3.02   | 3.33  | 3.38  |
| Political Dynamics                 | 2.90 | 2.67           | 3.13         | 2.95         | 2.78   | 3.22  | 2.80  |
| Research & Outcomes Supporting EBP | 3.09 | 2.91           | 3.11         | 3.21         | 2.95   | 3.15  | 3.22  |
| Staff Development & Support        | 3.16 | 2.96           | 3.12         | 3.09         | 3.15   | 3.47  | 3.32  |
| Staffing Resources                 | 3.16 | 3.06           | 3.26         | 3.29         | 3.05   | 3.27  | 3.08  |
| System Readiness & Compatibility   | 2.81 | 2.50           | 3.00         | 2.60         | 2.81   | 3.06  | 3.10  |

- ### Results
- For the overall group, Funding was rated the most important factor and rated the least changeable.
  - Staffing Resources and Staff Development and Support were rated most important after funding.
  - Clinical Perceptions and Consumer Values and Marketing were rated most changeable
  - Staff Development and Support ranked third in importance and fourth in changeability

- ### Conclusion
- Found a common solution that represents multiple stakeholder perspectives
  - There are a number of multiple stakeholder concerns that may impact implementation of EBPs in real world service settings.
  - Groups varied on Importance and Changeability ratings.
  - It is important to consider the concerns of multiple stakeholders in EBP implementation.

- ### Conclusions
- Processes for egalitarian multiple stakeholders input can facilitate cultural exchange
  - Stakeholder perspectives can inform implementation process
  - Examples:
    - Optimizing message content may promote more positive attitudes toward implementation of change in service models
    - Staff issues need to be addressed up front to promote implementation effectiveness
  - Further research is needed to better understand how factors identified in the present study impact actual EBP implementation efforts.

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