Chapter Twelve

Bringing Science to Service

Transformation Facilitation: Developing and Evaluating a Model for Intensive Technical Assistance for States

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Introduction

In 2003, The President's New Freedom Commission on Mental Health (2003) called for the transformation of mental health care in America to support prevention, early detection, and effective treatment of mental illness so that anyone with a mental illness at any stage in life has access to effective treatments and supports essential for participating fully in the community. Many states and territories are now engaged in transforming their mental health care systems, following the recommendations of the New Freedom Commission. The Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Mental Health Services (CMHS) are supporting a number of initiatives to assist states in carrying out this transformation agenda and in fostering state leaders as agents of transformation.

The Georgetown University National Technical Assistance Center for Children's Mental Health, in partnership with the National Association of State Mental Health Program Directors and United Advocates for Children of California, has undertaken an exciting new initiative called Transformation Facilitation (TF) to support Children's Mental Health Directors (CDs) as leaders of transformation in their states and territories. Launched in March 2006, the TF effort is supported by the Child, Adolescent, and Family Branch of SAMHSA's CMHS and is an integral part of SAMHSA's overall strategy to promote the transformation of mental health care in America.

Overview of Transformation Facilitation

TF is a unique 18-month process that is strategic, accountable, intensive, and relationship-based. It is grounded in system of care values and principles.

A team of two Transformation Facilitators (TFers) partner with the CD in a state to:

- Build leadership competencies;
- Assess the current status of mental health systems development for children and families;
- Identify goals and outcomes for transformation;
- Leverage strategic opportunities;
- Facilitate collaborative alliances;
- Address risks and challenges;
- Develop and implement action plans; and
- Track accomplishments and outcomes.

"TFers" serve multiple roles. They are strategists, coaches, brokers, technical assistance (TA) providers, and conveners. TFers work with the CDs to understand the big picture and to define and realize goals by observing, listening, teaching, supporting, motivating, strategizing, bringing in appropriate resources when necessary, and engaging other partners when appropriate. The TF is a resource for both content and process expertise, serves as a link to a variety of technical assistance offerings, and is backed by a cadre of consultants and experts.

Because TF is an intensive model, the CDs are asked to make an 18 month commitment to 1-2 hour monthly conference calls, participation in baseline and annual follow-up evaluation activities, provision of information and material as part of an assessment process, tracking progress, and participation in two peer meetings.

Methods

The evaluation of TF documents the effectiveness of our strategies and provides valuable information for continuous quality improvement. Through a three-pronged approach, the evaluation: (1) tracks *outputs* to assess the implementation of TF; (2) examines the *utility* (usefulness and satisfaction) of our strategies; and (3) assesses the *impact* of our work by focusing on the outcomes achieved as a result of our strategies. The evaluation collects data on process/outputs, utility and satisfaction, and impact through self-report surveys and data management records.

Outcome objectives. The TF outcome objectives exist at the individual, system and TA Center levels. Table 1 highlights TF outcomes objectives at the three levels.

Table 1
Impact/Outcome Objectives

Individual level changes	*System level changes*	*TA Center level changes*
Short-term outcomes:		
Increase in knowledge, skills, and attitudes to move the system forward	States are aware of available resources	An increased ability to identify new resources
Increase in leadership development		An increased knowledge of what is going on in states
Increase in support for the CDs via peers and facilitators		Increased family involvement
Increase in knowledge of resources and consultants		
Increase in peer sharing		
Intermediate outcomes:		
With the new knowledge, skills, and attitudes, the CD identifies gaps/ opportunities and transforms system structure and processes	More services and supports are developed at the local level, cross-system linkages are made, training is occurring, states are utilizing strategic financing strategies, and there are links across federal grants and activities	There is an increase in the Center's ability to be more strategic in planning TA
Long-term outcomes:		
The individual's goals for system reform are realized	TF affects the states transformation agenda and ultimately the national transformation agenda for children's mental health	The national transformation agenda for children's mental health is affected
Children and families get the services they need		
Children and families live, work, and play in their communities (SAMHSA National Outcomes Measures – NOMS)		

Sample. The first cohort of states/territories involved in the TF initiative include: American Samoa, Arizona, Florida, Indiana, Maryland, Minnesota, Missouri, New Hampshire, North Carolina, Pennsylvania, and Vermont[1]. Data sources for all three levels of measurement include the CDs from each state/territory and the assigned TFers.

Instruments. Several data collection instruments created to house both process and impact information have been or will be developed: CD baseline survey; TFer baseline survey; Peer-to-Peer Retreat Evaluation form; TF contact logs and progress notes; CD priority area log; CD one year follow-up survey; TFer one year follow-up survey; and Yearly CD and TFer follow-up survey (4 years post-TF).

Results

Process implementation issues that emerged during TF developed around determining readiness, developing the relationship, doing the work, and handling transitions and continuity.

Some state issue areas that CDs chose to focus on include:

- Ensuring forward momentum and progress in transformation mental in a constantly changing political environment;
- Obtaining meaningful family and provider engagement in the implementation of an outcomes- and data-driven mental health system;
- Transforming public mental health services without new funding using cross-agency workforce development strategies;
- Determining role in developing a strong family network, identifying key activities, and engaging families in the work;
- Engaging and empowering child and family teams as the primary determinants of services; and
- Overcoming resistance and difficulty in moving the mental health field toward a public health model.

Monthly contacts between the CDs and TFers to work on priority areas ranged from a minimum of 3 contacts or 4 hours to a maximum of 12 contacts or 19.5 hours in an 11 month timeframe. Upon examination of the utility and satisfaction results from the peer-to-peer retreat evaluation form ($N = 9$), the mean for overall usefulness on a scale of 1 = *poor*, to 5 = *excellent*, was a 4.9. All of the CDs present at the retreat gave the highest satisfaction rating of 5 and strongly agreed that the retreat was helpful.

More specifically, CDs made the following comments:

> "The overall experience has been excellent. The combination of calls along with the retreat provided an unprecedented opportunity to not only focus in on your personal issues but hear what others are struggling with and learn from that…"

> "An excellent opportunity to work with colleagues"

> "Very satisfied and helpful"

Baseline responses on select individual level survey items are presented in the table below. While the baseline survey was rated on a scale of 1 to 4, the peer retreat evaluation was rated on a scale of 1 to 5.

As shown in Table 2, results from the baseline survey and peer-to-peer retreat suggest that the TF model is demonstrating effectiveness in a variety of domains. The data revealed that the CDs expected the TF relationship to increase their knowledge, further develop their leadership skills, and offer them support. More specifically, on a scale of 1 = *strongly disagree*, to 4 = *strongly agree*, the CDs ($N = 8$) had high expectations that the relationship would be confidential ($M = 3.6$) and include supportive guidance ($M = 3.4$). These strong expectations serve to confirm critical components of the TF model, that is, the TF process is relationship-based and strategic.

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[1] *Two states/territories discontinued participation in the TF process.*

Table 2
Results from Baseline Survey and Peer to Peer Retreat

Baseline Survey Item	Outcome Obj	N	*Percentage of Responses*				Mean	SD
			1	*2*	*3*	*4*		
Reflect back to the onset of the TF relationship to indicate your level of expectation for the following:								
Current Status of MH Systems	Incr. Knowledge	8		12.5	12.5	75.0	3.62	0.74
Content Expertise	Incr. Knowledge	8		12.5	25.0	62.5	3.50	0.76
Process Expertise	Incr. Knowledge	8		12.5	37.5	50.0	3.37	0.74
Leadership Development	Leadership Development	8		12.5	37.5	50.0	3.37	0.74
Collaborative Alliances	Peer sharing	8	12.5	12.5	62.5	12.5	2.75	0.89
Relationship Based Journey	Incr. support	8		12.5	62.5	25.0	3.12	0.64
Supportive Guidance	Incr. support	8		12.5	37.5	50.0	3.37	0.74
Rapport Building	Incr. support	8	12.5	62.5	25.0		2.12	0.64
Confidential	Incr. support	8			37.5	62.5	3.62	0.52

Peer Retreat Feedback	Outcome Obj	N	*Percentage of Responses*					Mean	SD
			1	*2*	*3*	*4*	*5*		
Overall Results									
Format		9				33.3	66.7	4.67	0.50
Balance		8				25.0	75.0	4.75	0.46
Quality		9				33.3	66.7	4.67	0.50
Usefulness		9			11.1	22.2	66.7	4.56	0.73
This peer to peer retreat provided…									
An Opportunity To Dialogue & Come To a Shared Understanding Around The Meaning of a Transformation Agenda	Incr peer sharing	9			11.1	55.6	33.3	4.11	0.93
Peer Support	Incr Support	9				33.3	66.7	4.67	0.50
Strategic Consultation For My Individual Challenge	Incr Support	8			12.5	12.5	75.0	4.63	0.74
Information & Strategies From My Peers That I Can Use In My Transformation Efforts	Incr peer sharing	8			12.5	25.0	62.5	4.50	0.76
I found the following parts of the peer to peer retreat to be helpful:									
Presenting an Issue Area, State Context & Background	Incr peer sharing	8				50.0	50.0	4.50	0.53
Receiving Strategic Consultation From My Peers	Incr peer sharing	8			12.5	25.0	62.5	4.50	0.73
Providing Strategic Consultation To My Peers	Incr peer sharing	8				50.0	50.0	4.50	0.53
Please give us feedback about the effect of the retreat experience:									
Gained New Skills or Knowledge	Incr knowledge	9			11.1	22.2	66.7	4.56	0.73
Have Ideas & Strategies That I will Incorporate Into My Work	Incr knowledge	9				33.3	66.7	4.67	0.50
Overall retreat experience:									
Overall Satisfied with the Retreat		8				12.5	87.5	4.88	0.35
Overall Found the Retreat Helpful		7					100.0	5.00	0.00
Valid *N* (listwise)		5							

After participating in the peer-to-peer retreat, the CDs indicated increased knowledge, increased peer sharing, and increased support via peers and TFers. In particular, on a scale of 1 = *strongly disagree*, to 5 = *strongly agree*, the CDs ($N = 9$) indicated that the retreat did indeed provide an opportunity for strategic consultation for their individual challenge area ($M = 4.6$) and gave them ideas and strategies that they will incorporate into their work ($M = 4.7$). On a scale of 1 = *poor*, to 5 = *excellent*, the CDs rated the format ($M = 4.7$), balance ($M = 4.8$), quality ($M = 4.7$), and usefulness ($M = 4.6$) of the retreat very highly. These ratings lend value to the peer sharing component of the TF model.

In general, preliminary data from this first iteration of TF indicates positive effects on several outcome objectives. TF strategies and outputs have begun to yield changes in the awareness, knowledge, skills, and abilities of the CDs who are working to improve outcomes for children and families in their states.

Conclusion

Challenges. Evaluation of outcomes for TA involve numerous challenges both methodological and those emanating from confounding contextual factors affecting results. Many of the basic principles of impact evaluation designs (comparable pretest-posttest design, control groups, random selection) often are difficult to apply to evaluating TA. Given that TF is not a standardized model but more of an individualized approach with multiple providers, outcomes were closely monitored. Due to the intense nature of TF and limited resources, the sample size was small. As a group, the CDs are very busy individuals and the evaluation team was respectful of their time and tried not to overburden them with evaluation activities.

Next steps. To further refine the TF model, the evaluation team will continue to cull through process and short-term outcome data to monitor changes on the individual, system and TA Center levels. Given that the TF model is new and emerging, all of the information gathered feeds back into the process to make it more relevant and effective. The data allow the TF team to adapt and make necessary shifts in work to optimize outcomes. Long-term impact will be tracked and lessons learned during program implementation will be carefully documented. Data obtained will test the assumption that the intensity of TA correlates with the depth and breadth of outcomes. The process of sharing data with stakeholders will continue through each phase of the evaluation.

The process and impact data will allow the TF team to determine the critical components of TF. As a hybrid model of coaching, TA, knowledge application, and strategic planning, TF is unique. Therefore, descriptive information and data from the TF pilot will contribute to the growing literature on coaching, which has sparse long-term impact data at this juncture, and will strengthen the field of TA.

References

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report.* DHHS Pub. No. SMA-03-3832. Rockville, MD.

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Impacting the Mental Health Workforce: The Graduate Curriculum in Children's Mental Health

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Introduction

The purpose of this topical discussion was to engage current and prospective students and faculty in a dialogue about the new Graduate Certificate in Children's Mental Health developed by the Louis de la Parte Florida Mental Health Institute, University of South Florida. The Graduate Certificate addresses basic principles of Systems of Care, cultural competence, and special topics critical for development and implementation of effective services (including financing, program development, leadership, and wraparound services).

In collaboration with our partners through the System of Care Professional Training Consortium, the first-ever distance learning Graduate Certificate in Children's Mental Health was offered at USF beginning fall, 2006. The overarching goal of this program is to begin to address the enormous shortage of qualified, appropriately trained professionals in the children's mental health field by offering educational opportunities to students and professionals interested in policy, systemic, and administrative issues related to children's mental health. The distance learning delivery system, including web-based knowledge sharing and interaction, extends the Certificate's reach beyond the boundaries/resources of any one campus, drawing on the strengths of many. Since its inception, more than 100 students have enrolled in 10 classes taught by faculty from USF and six from universities and organizations participating in the Consortium. The first cohort of students will complete the Certificate in spring, 2008.

The discussion included an overview of the certificate program courses and target audience, the focus of the curriculum, access to resources on application and registration requirements, and progress of the program to date. Specifically, the following topics were discussed:

Overview of program marketing materials
- Certificate brochure
- Certificate conference poster and marketing materials

Review of certificate program curriculum and procedures
- Core and elective courses
- New courses to be submitted for departmental approval
- Tuition and fee schedule for out-of-state students
- Website and application information

Program highlights and achievements
- Selected for 2007 Registry of Innovation Practices
- Collaboration with historically black and minority universities and institutions
- Outreach to rural areas
- Evaluation of certificate program impact on practice behaviors
- Planned expansion to a Master's Degree
- Planned expansion to continuing education in-service training

Certificate student and faculty experiences
- Comments and concerns
- Suggestions and recommendations

Currently enrolled certificate students from Florida, Georgia and Kentucky shared their academic experiences, identifying ways in which the Certificate coursework meets their professional needs with regard to their learning and practice behaviors. Faculty also provided feedback on the distance-learning teaching methodologies utilized in the delivery of certificate curriculum. Current and prospective students participated and provided their reactions and suggestions for refinements to the curriculum and its dissemination, thereby increasing the content's saliency for subsequent users.

Themes from Student and Faculty Discussion

Several topics were raised in the discussion of student and faculty experiences with the certificate program curriculum and distance-learning format, as follows.

Utility of the online discussion boards. Overall, current students agreed that the discussion boards on the Blackboard Academic Suite were a great medium for facilitating interaction among students and faculty. Many of the students commented that learning of other students' experiences and problem solving helped address barriers to delivering services in their own systems. This exchange fostered an intimate connection among students despite lack of face-to-face contact. Additionally, some students felt the online format for discussions provided a safe environment for raising challenging and controversial issues and believed their participation in the certificate courses exceeded that of traditional lecture-style classes.

Balance between school and work. Many students raised the issue of balancing their participation in the certificate program with their professional and personal lives. The flexibility of the distance-learning format and the accessibility of the courses and discussion boards at any hour of the day provided a learning environment in which students felt they were better able to meet the demands of their coursework in addition to their daily lives. Faculty also identified the distance format and accessibility of the program as a benefit, since many of them have full-time positions at universities across the country.

Applicability of curriculum to professional work. Following discussion of the balance of school and work, students expressed the desire for the ability to put more time and effort into many of the topics they were introduced to in the certificate courses. Students identified several ways in which course information and materials were both relevant to and utilized in their work environments. Some students specifically raised course-related discussions in their weekly staff meetings and were eager to find ways to apply their knowledge to their individual systems of care.

Anticipation of future program expansion. Current students, faculty, and prospective students alike expressed excitement over the progress of the certificate program to date and the planned expansion into a Master's Degree and in-service continuing education programming. Several prospective students requested materials and resources to learn more about the planned expansions.

Conclusion

Several common themes emerged throughout the topical discussion. Current students and faculty were enthusiastic about the material they were covering in courses and eager to share experiences they had in applying it to their professional work. The online discussion boards provide a safe and instructional learning environment for students and faculty across the country. While the challenge of the school-work-personal life balance still remains, faculty and students found the distance-learning format and the 24-hour accessibility of the certificate program benefits in optimizing their participation. Finally, all participants in the discussion expressed interest in the certificate program expansion projects and requested to be kept informed of progress made.

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An Evaluation of Collaboration and Communication among Centers in the National Child Traumatic Stress Network

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Introduction

The New Freedom Commission Report (2003) emphasizes the need for greater collaboration among child-serving agencies and reducing the gap between research and practice. The mission of the federally funded National Child Traumatic Stress Network (NCTSN) is to "improve access to care, treatment, and services for traumatized children and adolescents exposed to traumatic events." To accomplish this mission, the NCTSN has developed a network of trauma centers, which consists of academic institutions that develop evidence-based treatments and disseminate them to trauma centers that serve children and youth with traumatic stress. These two Network activities contribute extensively toward the expansion of the knowledge base for evidence-based interventions in trauma and in the widespread dissemination and implementation of evidence-based treatments and practices.

For any interorganizational network, collaboration is the most critical and essential component for exchanging knowledge and experience. Through collaborations, the NCTSN can accomplish its goals of improving service accessibility and quality for children and youth with traumatic stress. The purpose of this study is to examine the level of collaboration among NCTSN trauma centers at two points in time and to assess the influence of collaboration on NCTSN center development and outcomes. This report presents results of the first wave of the Network Survey.

Method

Network analysis methods are being used to assess collaboration within NCTSN at two points in time. A web-enabled survey was used; the Network Survey assesses collaboration by inquiring about the extent to which each NCTSN center interacted with every other center on selected key Network activities (governance/decision-making, information sharing, coordination of activities, product development, product dissemination and adoption, and training and technical assistance). This survey also contains items concerning factors that facilitate and inhibit collaboration. The Network Survey was administered to center directors and associate directors or project coordinators who had extensive knowledge of their centers' interorganizational relationships. All centers that have received funding through the NCTSN ($N = 44$) were included in the sample.

Respondents for this Web-based survey were recruited to participate through an e-mail invitation. The recruitment process occurred in four stages: (1) an advance invitation to participate; (2) a formal invitation, which included the Web site URL, unique username, and password; (3) a reminder to all respondents; and (4) a targeted reminder to nonresponders and those who had only partially completed the survey. The response rate was 72.6% with the four-stage approach to the administration of the Web survey. Results will be presented from the network analysis, descriptive information, qualitative responses on factors that facilitate or inhibit collaboration, and recommendations for improved collaboration.

Results

Network Analysis

The network data confirm intuitions about how the trauma network functions and also provides insights into the set of collaborative relationships that currently exist. The center personnel were asked to select from the list of all the network centers they have collaborated with in one or more of the areas highlighted in Table 1.

Table 1
Description of Network Activities

Network Activities	Description of the Activity
Governance	Worked with on activities related to network governance or decision-making (e.g., Steering Committee or other planning or direction-setting activity or body)
Developing Products	Worked with on activities related to network governance or decision-making (e.g., Steering Committee or other planning or direction-setting activity or body)
Adopted products from	Adopted products or innovations from
Delivered training to	Delivered training, technical assistance, or consultation to
Received training from	Received training, technical assistance, or consultation from
Hosting conferences	Worked with in hosting or sponsoring special meetings/conferences
Coordinated NCTSN activities	Coordinated with on NCTSN related activities
Communicated frequently	Communicated with most frequently

These eight questions constitute eight network measures of communication and coordination among the 44 NCTSN centers. Table 2 provides univariate data on the eight networks. These data indicate that *adopting products from network* measure elicited the most responses (*n* = 39) while *hosting conferences and coordinating on NCTSN related activities* elicited the fewest (*n* = 29). For the *governance and developing products* there were no isolates (i.e., every center chose or was chosen by at least one other center). In contrast, in the *hosting conferences and adopting products from* network measures there were 11 and 10 isolates, respectively. The average number of network linkages was greatest for *governance*, 5.03, indicating that on average centers reported links with five other centers they collaborated with on *governance* issues. In contrast, they reported less than half that many links, 2.35, for collaboration on conferences. These individual links translate directly into measures of network density and the number of links overall. In sum, the *governance* network is the largest (as indicated by the number of links) and the *hosting conferences* one the smallest. The *developing products and communicating frequently* with other centers indicators are the next largest, whereas the *hosting conferences* one is the smallest.

Table 2
Basic Metrics for the 8 Networks

Network	# w/ Data	# Missing	# Isolates	Avg. Center Links	Net. Density	# Links	Clustering	Centralization
Governance	35	36	0	5.03	7.18	357	7.53	33.87
Products	36	35	0	4.83	6.9	343	10.02	28.30
Adopt From	39	32	10	3.37	4.81	239	7.57	27.45
Training To	28	43	2	3.44	4.91	244	5.52	5.28
Training From	37	34	8	3.51	5.01	249	7.14	31.61
Conferences	29	42	11	2.35	3.36	167	4.05	20.10
Coordinate	29	42	9	3.73	5.33	265	5.89	26.92
Communicate	37	34	0	4.35	6.22	309	4.42	12.82

Clustering is a measure of the degree that the network consists of interconnected pockets of centers. These clustering values are small indicating that the network is not overly clustered into distinct subgroups. The most clustered network was for *adopting products from* indicating that there might be some subgroup interconnectivity among center staff/administrators who consult each other on products or interventions. Centralization is a measure of the degree to which links are concentrated toward one or a few centers. The most centralized network was *governance* followed by who they *received training from*. The least centralized network was *provided training to*. The centralization scores make sense as most centers would report collaborating on governance issues with the national coordinating centers. Since fewer centers provide training, the *training to* network would be the least centralized. The *training to* network measure also elicited the fewest number of responses ($n = 28$).

Several centers play prominent roles in the networks. As expected, the two national coordinating centers are the most frequently cited centers in most of the networks: governance, products, training from, conferences, coordination, and communication. Three others were frequently cited, which have a longer history in the network and which disseminate trauma-focused evidence-based practices.

Facilitators and Barriers to Collaboration

A major facilitator of collaboration was the shared interest and program focus of the NCTSN centers. Willingness of the network centers to learn and share expertise, as well as participate on workgroup committees and collaborative groups, also was reported to have greatly enhanced the potential for successful collaboration. Some of the major challenges to collaboration reported by the Network survey respondents included time and resource constraints, the long-distance communication between centers, and limited opportunities for face-to-face meetings with staff members from other centers.

Recommendations

Several recommendations were made to improve collaboration between NCTSN centers. Respondents suggested that resources should be set aside for collaboration and that collaborative activities should be evaluated to find network structures that increase and foster collaboration. Emphasis was placed on the need for more opportunities for face-to-face meetings and networking with staff members from other centers, especially those with a similar interest and program focus.

Conclusions

In sum these data indicate a well integrated network with some important characteristics. First, centers are more likely to report frequent communications with other centers and linkages with regard to *governance* but less likely to report linkages with regard to *adopting products* from or *hosting trainings*. These findings suggest that although significant efforts have been made to maintain the collaborative structure of the network, additional efforts are needed to facilitate each center's ability to actively participate and fully benefit from membership. Second, the coordination of NCTSN activities by the national coordinating centers is viewed by others as being very important to the network. Third, there are few centers that also play prominent roles but quite a few others that seem to be peripherally connected to the network and less active in NCTSN activities. The analysis presented here is a first picture of how the NCTSI network is functioning using a quantitative measure. The network survey will be administered again in the year 2008 and further analysis will be conducted to better understand the patterns of communication, influence, collaboration, and change in collaboration over time.

References

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report* (DHHS Pub. No. SMA-03-3832). Rockville, MD: U.S. Department of Health and Human Services.

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Monitoring the Development, Dissemination and Adoption of Evidence-Based Practices and Other Products Within and Beyond the National Child Traumatic Stress Network

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Introduction

The mission of the National Child Traumatic Stress Initiative (NCTSI) is to raise the standard of care and improve access to services for traumatized children and their families. To that end, the initiative supports training and other efforts to develop and disseminate trauma-related knowledge and products including clinical interventions viewed as integral to achieving this mission. This paper reviews the design, methods and findings of two separate, yet connected, evaluation studies devoted to assessing the nature and extent of development and dissemination efforts as well as the adoption and implementation of related resources by the specialized, trauma-focused centers funded by the initiative.

In the research literature related to the evidence-based practices, the terms *transporting*, *adopting*, *implementing*, and *disseminating* are often used interchangeably. As part of the cross-site evaluation design focused on the impact of the NCTSI, *development/dissemination* and *adoption/implementation* have been distinguished as two discrete measurable activities. The two cross-site evaluation studies that are the focus of related data collection efforts and the findings presented include:

- The Product/Innovation Development and Dissemination (PDD) study
- The Adoption of Methods and Practices study

Together these studies assess the development, dissemination and adoption of NCTSI's trauma-informed interventions, methods, innovations, and resources. This paper describes the methods and preliminary findings of both study components. Research questions include: (1) What products/innovations have been developed and disseminated within the Network and what factors influence the process?, and (2) What Network generated products/innovations have been adopted by Network centers and affiliated providers and what factors are associated with adoption?

NCTSN stakeholders, including NCTSN centers, researchers, trauma survivors, family members, and Federal Government officials interested in program monitoring will benefit from the data collected. In addition, data collection should contribute to the literature related to dissemination and adoption of interventions, methods, innovations, and resources.

Methods

Definition of "Product"

Within the cross-site evaluation, based on information-gathering activities such as interviews with Network centers and site visits, products have been grouped into four broad categories: (a) Assessment instruments supplying information service providers need to plan treatment for individual children and evaluate the outcomes of care, (b) clinical treatments designed to diminish effects of trauma in children, (c) training approaches or curricula for professionals and other stakeholders, and (d) information resources.

Data Collection and Measures

The PDD study is designed to identify and describe products developed and disseminated to NCTSI centers and their partners. To date the PDD study has drawn data about products from a number of sources:

- Quarterly Progress Reports (QPRs) (N = 87) submitted by Centers (N = 44) to SAMHSA
- Telephone interviews with leaders of NCTSN collaborative groups (N = 17)

- The Product/Innovations Development and Dissemination Survey (PDDS) completed by NCTSN project directors as part of centers' 2006 Annual Report (*N* = 44)
- Case studies of centers active in product development and dissemination (*N* = 10)

Quarterly Progress Reports and the PDDS provide general descriptive information regarding the development and dissemination process, and help update a growing list of Network products and innovations developed each year. Interviews with collaborative group leaders examine the role and impact of the Network's collaborative workgroups in the development and dissemination of products and innovations. Ongoing case studies are designed to provide detailed information about product development and dissemination challenges and accomplishments.

In the first phase of data collection for the Adoption of Methods and Practices Study, potential respondents including project directors (*N* = 44), evaluators (*N* = 37) and a variety of service providers affiliated with NCTSN centers (*N* = 248) were invited to participate in the Web-based General Adoption Assessment Survey (GAAS) in August 2006. The GAAS survey assesses the extent to which such professionals are involved in adopting Network-generated products, the extensiveness and timing of the adoption, and factors impacting adoption such as engagement processes, facilitators, barriers and characteristics of actors in the adoption process. Respondents were invited through a five-stage invitation mailing (Dillman, 2000). Of the 329 total possible respondents, to date, 118 (36%) have completed a survey.

Analysis of Data

Data analysis for the PDD data collection efforts as well as the GAAS is largely descriptive and consists of charts and tabular displays of information. Data collected as part of the GAAS will be used to formulate models of adoption penetration rates for certain population segments, centers, or specific innovations. Data collected for the PDD component will involve longitudinal analysis identifying products developed and disseminated, and the factors which facilitate or challenge the design and dissemination of these products.

Findings

Analysis of data collected through NCTSI centers' first and second quarterly progress reports show centers engaged in a broad range of development activities spanning over 130 products. Findings to date on product type, age of target population, target audience, and stage of development are summarized in Table 1.

Interviews with collaborative group leaders yielded descriptions of these groups' strategies for product development/dissemination, center participation in these strategies, and recommendations for how processes can be improved. Positive aspects of the collaborative structure include the opportunity for group members to share knowledge and experience. Some centers are seen as providing valuable substantive and technological resources in product development and dissemination efforts. A number of group leaders suggested that concentrating on one product and working in a focused manner with group members helped to counterbalance the potentially cumbersome nature of a collaborative group structure. Several collaborative group leaders and NCTSI staff commented that substantial collaboration, including work on product development and dissemination, occur through other Network activities such as training programs and NCTSI meetings at the national and regional level.

Building on the PDD data collection efforts, preliminary findings from the GAAS survey indicate that considerable variety exists in the range of Network-generated products currently being adopted. Overall, respondents indicated being personally involved in adopting 7 of 8 possible assessment instrument choices, 25 of 32 clinical treatments, 53 of 54 information resources, and 6 of 8 training

Table 1
Summary of Data on Product Development
from Quarterly Progress Reports
(1st and 2nd Quarter FY 2005-2006)

Product Type	N
Assessments	31
Clinical Treatment	50
Training or Technical Assistance	68
Information Resources	89
Publication	61
Other	50
Products by Age of Target Client Population	
0 – 3 yrs	61
4 – 12 yrs	93
13-17 yrs	89
18-21 yrs	52
Products by Target Audience	
Caregiver/Family Member	98
Other Consumer Groups	47
Clinicians	159
Social Services	95
Child Welfare	70
Teachers	67
Health Care/Public Health	78
First Responders (i.e., fire, EMS, police)	40
Other Professionals	72
Products by Stage of Development	
Conceptualization	53
Development and Standardization	77
Pilot Testing	56
Dissemination	97
Evaluation	25
Another Stage	14

resources. Trauma-focused cognitive behavioral therapy (TF-CBT), an evidence-based intervention for traumatized children, was by far the most frequently selected product (Table 2). Most frequently endorsed facilitators in the adoption process include accessibility of materials and consultation, as well as the support of management, and NCTSN meetings and other venues for communication. Based on GAAS data, NCTSN centers currently in the process of adopting the top clinical intervention will be invited to participate in a second phase of data collection designed to further investigate factors impacting adoption on multiple levels (e.g., the product, individuals, and organizations). A diffusion of innovation framework (Rogers, 2003; Silverman, Kurtines & Hoagwood, 2004) will be used to more fully understand the factors facilitating adoption.

Table 2
General Adoption Assessment Survey: Top Products Being Adopted

Category 1: Clinical Treatments
1. Trauma-focused Cognitive Behavioral Therapy (TF-CBT)
2. Parent Child Interaction Therapy
3. Culturally Modified Trauma Focused Treatment

Category 2: Assessment Instruments
1. UCLA PTSD Reaction Index
2. Child Behavior Checklist
3. Trauma Symptom Checklist for Children

Category 3: Information Resources
1. Child Trauma Information – For Caregivers
2. Complex Trauma in Children and Adolescents
3. Psychological First Aide Field Operations Guide

Category 4: Training Resources
1. TF-CBT Web: Medical University of South Carolina
2. Breakthrough Series Information Packet
3. Cops, Kids and Domestic Violence: A Training Video

Conclusion

Preliminary cross-site evaluation data indicate that the Network is engaged in developing, disseminating and adopting a broad range of types of products spanning the product categories described. Ongoing data collection efforts will continue to monitor the types of products most frequently disseminated and adopted within and beyond NCTSN centers in an effort to catalog the information for Network use, assess Network progress in meeting stated objectives, and meet accountability requirements for NCTSN stakeholders including the Federal government. The joint goal of these studies is to obtain a comprehensive and accurate description of products developed, disseminated and adopted by Network centers in an effort to improve understanding of Network impact as well as provide insights into how the process, product development, dissemination, and adoption can be continuously improved.

References

Dillman, D. A. (2000). *Mail and internet surveys: The tailored design method.* 2nd ed. New York: John Wiley and Sons.

Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York: Free Press.

Schoenwald, S. K., & Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of interventions: What matters when? *Psychiatric Services, 52*(9), 1190–1197.

Silverman, W. K., Kurtines, W. M., & Hoagwood, K. (2004). Research progress on effectiveness, transportability, and dissemination of empirically supported treatments: Integrating theory and research. *Clinical Psychology: Science and Practice*, *11*(3), 295-299.

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Implementation of Behavioral Health Overlay Services in a Pediatric Medical Home: From Science to Service

Joni Hollis
Kathleen Wilson

Introduction

The nation is facing a public health crisis in mental health care for children (US Public Health Service, 2000). Approximately 20% of children have a diagnosable mental health condition (Costillo, Mustillo, Keller, & Angold, 2004). The public health system, with an emphasis on early intervention and prevention, has not traditionally addressed mental health diagnoses within its focus, despite the likelihood that doing so may interrupt the negative trajectory associated with mental health problems. Furthermore, lack of coordination between the medical and mental health sectors is thought to restrict access to needed mental health services for all children (Stroul, Pires, Armstrong, & Meyers, 1998).

In the past decade, interest in the interface between primary health care and mental health has increased markedly among the many stakeholders working to increase positive outcomes for young children's mental health and wellbeing. The American Academy of Pediatrics (AAP) and Health Resources and Service Administration leadership have shaped the medical home concept with the goal of improving access to services for children with special health care needs and have provided national recommendations for these endeavors.

Children's Medical Services Big Bend Region (CMS-BBR), a Title V program within the Florida Department of Health, focuses on children with special health care needs in partnership with the primary health care system. These children may possess physical, developmental and/or behavioral health concerns that impede one or more of their domains including home, school and community.

Primary health care providers are a natural point of contact for children and their families (Rosman, Perry & Hepburn, 2005). The CMS-BBR medical home model focuses on the need for an early ongoing source of primary health care for children that is "accessible, continuous, comprehensive, coordinated, compassionate, and culturally effective" (AAP, 2002; p. 184). Central to the medial home model *all* aspects of the child's care (physical, developmental, and behavioral) should be managed and facilitated in a mutual, trusting partnership between the provider and the family. It is the family that is deemed the expert in identifying the child's needs.

CMS-BBR expanded their response by addressing children's mental health issues in the current managed system of care. Principles from the ecological model (Bronfenbrenner, 1979) were used to guide the integration of behavioral health overlay services within the medical home model. This initiative maximizes the potential of the child (microsystem) by building capacity within the medical home (mesosystem) and facilitating linkage of medical and mental health services utilizing existing community resources (exosystem). The ecological model is a child-centered approach, which acknowledges that humans do not develop in isolation, but in relation to their family, home, school, community and society. Each of these ever-changing and multilevel environments and their interactions are an integral part to a child's development(Bronfenbrenner, 1979).

Despite the prevalence of mental health disorders in children, clinical judgment (also known as "surveillance" or "eyeballing") identifies fewer than 50% of children who have serious emotional and behavioral disturbances (Glascoe, 2000). Therefore, CMS-BBR implemented a screening process for developmental, behavioral, and emotional concerns with consideration of current practice realities in the pediatric medical home. This prevention intervention utilized current evidenced-based practices and national recommendations for early identification and formalized screenings (AAP, 2006; New Freedom Commission on Mental Health, 2003).This summary describes administration and initial findings from integrating mental health screening protocols in CMS-BBR pediatric medical homes programs.

Method

Due to prior provider resistance related to the complexity of navigating the mental health system, a convenience cohort was expanded to include three regional pediatric primary care practices (medical homes) for this initiative. Stakeholder buy-in was crucial because local pediatricians relied on surveillance and were concerned with the time, cost, and risk of implementing structured screening tools. Specifically, they did not want to identify problems for which there were limited resources and follow up available.

Behavioral health screenings were initiated through use of the Pediatric Symptom Checklist (PSC; Jellinek, Murphy, & Burns, 1986). This one page, multi-lingual screening tool has demonstrated high psychometric properties of validity and reliability (Jelinek, Patel & Froehle, 2002). Due to the current lack of established services addressing the three- to six-year old population and the crisis orientation of the adolescent population, the project focused on well visits for children 6-12 years of age and *any* child or adolescent with physician or parental concern.

The PSC was administered with the caregiver at the time of sign-in for a check-up or upon expression of parental or physician concern. A licensed mental health provider was provided by CMS-BBR and was co-located in the medical home setting. The mental health provider scored the PSC and followed up on "positive" screenings or direct referrals from physicians. In follow up with the family, a further strength and needs based assessment was developed by the licensed mental health provider, and Bright Futures anticipatory guidance materials (Jellinek et. al., 2002) were provided. Referrals to appropriate providers also were facilitated based on the funding source and need.

An independent evaluator was secured during the follow-up phase in Year 2. This was done to elicit feedback and allowed for the evaluator to facilitate additional resources or referrals for the family, if indicated. A Likert-scale questionnaire with the rating scale of 1 = *False*, to 5 = *Very True*, was completed with the family by phone, and included components to measure the satisfaction with the mental health consultant, the screening process, the overall screening experience and the referral resources provided.

Phase 1 results and collective satisfaction supported inclusion of additional pediatric practices in Phase 2, as well as expanded use of formalized screening tools to include postnatal mothers, infants and toddlers. The Edinburgh Post-Natal Depression Scale (Cox, Holden, & Sagovsky, 1987) was chosen to screen post partum mothers for depression at babies' two-month check up. The Ages and Stages Developmental Questionnaire (Squires, Potter, & Brickler, 1999) and Ages and Stages Social Emotional (Squires, Brickler, & Twombly, 2002) tools were used to screen infants to preschool children on their developmental and social emotional progress. These adjunctive screening programs were based on state and national recommendations, including the American Academy of Pediatrics policy statement (July, 2006).
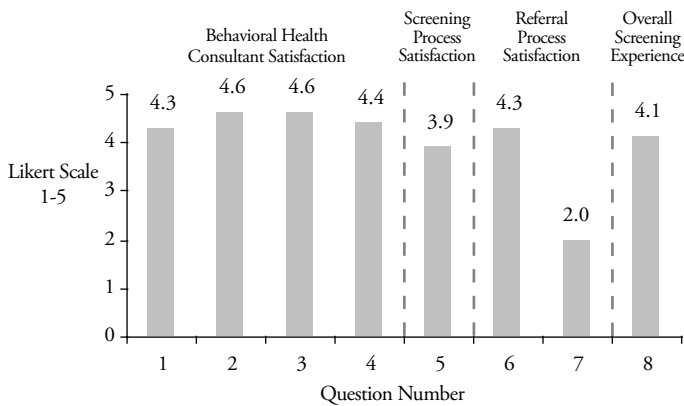
Results

Following two years of implementation, 1,141 children had participated in the screening program. Consistent with national statistics, 16% (N = 182) of participants were identified as having emotional, behavioral or learning concerns; the percentage fluctuated throughout the two years with a high of 21%. Most of the affected population were male (n = 116; 64%). Medicaid funding was used for 52% (n = 95) of the participants with identified concerns.

Satisfaction with the mental health consultant, the screening process, and the overall screening experience scored higher than the referral process itself (see Figure 1). Scores remained consistent until Question 7, which read: "Did the services you were referred to meet your expectations?" The main negative influence reported by the families was a lack of follow up and return response from the community mental health providers.

Qualitative evidence was also extracted from case studies including testimonials regarding the impact and positive changes experienced by the families who participated in the project. Common themes

Figure 1
DOTTS Program Satisfaction Survey

emerged, including the validation of parental concerns and status, increased feelings of support, and awareness of the next step in the process.

With regard to the second tier of this project, first year results included 580 participants with 18% ($N = 103$) identified with developmental or social-emotional concerns; longitudinal data are needed to continue to monitor the progress and functional outcomes of children identified.

Discussion

Formal screening in a pediatric primary care medical home setting resulted in identifying 16%-21% of children with developmental, emotional, behavioral or learning concerns. This finding matches the national average for mental health concerns (Costello et al., 2004). Participants agreed that a standardized screening tool was useful in identifying needs, and the process was beneficial in meeting the families' need. Providers expressed a high satisfaction and willingness to continue the program.

Ultimately, similar programmatic outcomes will likely impact state and national policy to support ongoing screenings for early identification and intervention. Future consideration should be given to state-level policy changes related to evidence based practices. To garner sustainability strategies that incorporate fiscal reimbursement for the use of formalized structured screening, identification of empirically grounded tools and procedures will be key.

The results of this initiative suggest that community collaboration efforts toward system of care change are needed in order to more fully meet the mental health needs of the identified population and their families. Future implications also include the need for more studies related to public health initiatives for mental health education, prevention and early identification; mental health collaboration efforts within the pediatric medical home; and programs that incorporate national recommendations into current practice realities.

References

American Academy of Pediatrics. (2002). Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The medical home. *Pediatrics.*;110, 184-86.

American Academy of Pediatrics, Council on Children with Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee, and Medical Home Initiatives for Children with Special Needs Project Advisory Committee. (2006). Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening. *Pediatrics. July; 118*: 405-420.

Bronfenbrenner, U. (1979). *The ecology of human development.* Cambridge, MA: Harvard University Press.

Costello, E. J., Mustillo, S., Keeler, G., & Angold, A. (2004). Prevalence of psychiatric disorders in childhood and adolescence. In B. L. Levin, J. Petrila & K. D. Hennessy. (Eds.), *Mental health services: A public health perspective* (2nd ed., pp. 111-128). New York: Oxford University Press.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry, 150,* 782-786.

Glacsoe, F. P. (2000). Early detection of developmental and behavioral problems. *Pediatrics in Review, 21*, 272-280.

Jellinek, M., Murphy, J. M., & Burns, B. (1986). Brief psychosocial screening in outpatient pediatric practice., *Journal of Pediatrics, 109*, 371-378.

Jellinek, M., Patel, B. P., & Froehle, M. C. (Eds). (2002). *Bright Futures in practice: Mental health-Volume II.* [Took kit]. Arlington, VA: National Center for Education in Maternal and Child Health.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report.* DHHS Pub. No.SMA-03-3832. Rockville, MD.

Roseman, E. A., Perry, D. F., & Hepburn, K. (2005). *The best beginnings: Partnerships between primary health care and mental health substance abuse services for young children and their families.* Georgetown University National Technical Assistance Center for Children's Mental Health.

Squires, J., Potter, L., & Brickler, D. (1999). *Ages & Stages Questionnaires* (Second Edition). Baltimore: Paul H. Brooks Publishing Co.

Squires, J., Brickler, D., & Twombly, E. (2002). *Ages & Stages Questionnaires: Social-Emotional.* Baltimore, MA: Paul H. Brooks Publishing Co.

Stroul, B. A., Pires, S. A., Armstrong, M. I., & Myers, J. C. (1998). The impact of managed care on mental health services for children and their families. *Future Child, 8*(2):119-33.

U.S. Public Health Service. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A national action agenda.* Washington, DC: Department of Health and Human Services.

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