



## Evidence-Based Practices and Systems of Care: Implementation Matters

Over the past ten years there has been increasing professional and academic attention to the use of Evidence-Based Practices (EBPs) for children and youth with, or at risk for, mental health challenges.

Driven in part by studies that demonstrated that usual care is not effective for children and youth, there is a continuing push to see EBPs implemented in children's service systems. This is observed in increased or preferential funding for EBPs and in regulatory and contract clauses requiring the use of EBPs.

All EBPs exist within administrative systems that provide sets of values, norms, training experiences, and personnel that monitor and carry out treatment practices. The goal of this issue brief is to discuss findings regarding the role of EBPs in systems of care, which are particular interagency, collaborative administrative systems with specific values and principles guiding service delivery (Child Adolescent and Family Branch, 2006; Stroul & Friedman, 1994).

This issue brief presents key findings on the relationship between EBPs and systems of care from *Case Studies of System Implementation*. Strategies critical to implementing EBPs within systems of care are also presented. Sites participating in *Case Studies of System Implementation* include the following systems of care: Region 3 Behavioral Health Services, NE; the State of Hawaii; Placer County, CA; and Santa Cruz County, CA.

### Lessons Learned

#### 1. A Practice is Not a System

This observation was often made by systems participating in *Case Studies of System Implementation*. Evidence-based practices are practices – most often focused on treatments, services, and supports at the individual child and family level; they are not mental health service systems. Community-based systems of care refer to the local infrastructure, policies, routines and relationships that allow EBPs to be selected, implemented, paid for, and linked to other practices and systems and are, therefore, critical to effective EBP implementation. Specifically, systems of care assume a values framework that prioritizes treatments that are culturally competent, provide services in the least restrictive setting, and empower youth and families to direct their treatment. Additionally, to the extent that systems of care are data-based, they may provide the necessary evaluation infrastructure to assess which populations may have an especially pressing need for the use of EBPs, and the effectiveness of efforts to implement and adapt EBPs to specified populations.

#### 2. New Practices Compete with Existing Practices

Participating systems indicated that existing practices command nearly all of the resources of their systems. New practices must compete for scarce resources, including workers' time, effort, and material resources. Communities have a large investment in their current practices and routines. EBPs often require more resources to implement than initially estimated, in part because successful implementation of EBPs requires people to stop acting in ways in which they are accustomed, to learn new practices and encounter new problems, and to apply new practices frequently enough that they become routine practice.

Site-based data indicate that the introduction of an EBP is complicated by disagreement about which practices constitute an EBP. Several very prominent academic and trade organizations have created guidelines for EBPs and lists of EBPs that meet their guidelines (Center for the Study and Prevention of Violence, 2004; Substance Abuse and Mental Health Services Administration, 2005; Yannacci & Rivard, 2006), but these lists often have only partial overlap with each other, creating confusion in the field.

Decisions about which practices to support are further complicated in systems with a strong history of practice-based evidence. In systems in which personnel are successful in adapting routine practices to meet desired outcomes, EBPs may be looked upon with mistrust because they have not yet been adapted to the local context. EBPs often require substantive adaptation to the local context, a point that some purveyors of EBPs are beginning to note (Hemmelgarn, Glisson, & James, 2006; Schoenwald & Hoagwood, 2001).

### Study

#### Case Studies of System Implementation

is a five-year national study of strategies that local communities undertake to implement community-based systems of care. The purpose of the study is to understand how factors affecting system implementation contribute to the development of local systems of care for children with serious emotional disturbance and their families.

#### Methods

This study uses a multi-site embedded case study design. Participating systems were identified through a national nomination process and were selected on the basis of having: (1) an identified local population(s) of youth with serious emotional disturbance; (2) clearly identified goals for this population that are consistent with system-of-care values and principles; (3) active implementation of strategies to achieve these goals; (4) outcome information demonstrating progress toward these goals; and (5) demonstrated sustainability over time.

Data collection includes semi-structured key informant interviews, document review, site-based observation, and documented aggregate outcome data related to system implementation in communities with established service systems. Analysis uses an intensive and iterative team-based approach. The study will include a total of eight cases.

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For instance, many screening tools, manuals, and training curriculum are provided only in English, yet the population served may only speak Spanish. Other adaptations observed by the team involved the length of treatment, the age-range of the population being served, and the sequencing of particular practices within a treatment protocol.

### 3. People are Powerful

The implementation of EBPs is a social process involving communication and engagement with multiple stakeholders over an extended period of time (Hemmelgarn, Glisson, & James, 2006; Rogers, 1995; Tenkasi & Chesmore, 2003). As with any social process, conflicts may arise. Two of note are described here. First, evidence from this study suggests that the selection of certain persons to receive new training, and their adoption of new routine ways of interacting may cause conflict. There is a danger that perceived in-groups and out-groups will develop as a result of such selection. Additionally, because EBPs are increasingly preferentially funded, the perception of social in-groups and out-groups may be powerfully reinforced by real material benefits given to people trained in an EBP.

Second, conflict may arise between the EBP purveyor and system of care administrators and staff. Systems of care personnel attend to system and community contexts; EBP purveyors attend to clinical practice. The differing priorities and sometimes competing interests that this creates must be addressed through ongoing communication and negotiation. Examples of potential conflicts include questions about: Supplementary services that children and youth can receive while receiving an EBP; follow-up services that can be provided; the definition of fidelity and the resources needed to achieve an acceptable level of fidelity; and how well a program generalizes to persons and conditions under which it has not been tested. All of these can be seen as questions of how a program fits within the context of a local system of care. Good working relationships between EBP purveyors and systems of care representatives are critical in negotiating these difficult issues.

### Strategies for Successful Integration

So how do we take these lessons and apply them to our own efforts to implement and develop EBPs in systems of care? Our work suggests that sites should address several key issues as they consider implementing EBPs in their system.

#### 1. Be explicit about the role of the system in EBP implementation

This means identifying how EBPs and the system align (or fail to align) in terms of values, population in need of care, hiring and training practices, links to other practices and systems, and problem-solving methods. Problems of alignment at any of these (or other) points may be sufficient to prevent successful implementation and adaptation of EBPs.

#### 2. Address context

Balanced with the EBP purveyors' need for fidelity to implementation, there must be acknowledgement that each community and its populations are unique. Many times, this creates situations unanticipated by EBP developers. For example, EBPs may not have been tested and

validated with populations that are culturally and linguistically representative of the implementing community's populations of concern. Thus, there is no guarantee that an EBP is culturally or linguistically appropriate in a given community. Meanings of actions differ across contexts and cultures, as powerfully illustrated by authors in the mental health field and other fields (Hernandez & Isaacs, 1998; Rogers, 1995; Sue, 2006). Actions that communicate different meanings across contexts and cultures cannot be expected to have the same effects. The degree of adaptation necessary for a specific context is a key issue faced by EBP purveyors and system of care personnel.

#### 3. Anticipate competition and conflict

System leaders need to anticipate how a prolonged and substantive shift of resources will affect staff at all levels of the system and affect interactions between staff, family members, and youth. As potential conflicts surface, there must be a clear method to discuss and resolve conflict in a manner that instills trust in all stakeholders.

#### 4. Use social processes to the system's advantage

The adoption of innovative practices is affected by social processes including communication, conflict resolution, group dynamics, modeling and coaching. System administrators can create increased buy-in and commitment to the adoption of EBPs by publicizing aggregate and case data regarding the effectiveness of these practices. Practices can be reinforced by creating learning communities that receive intensive training and support. System administrators should also promote open communication among staff receiving such training and other staff, in order to prevent feelings of resentment among persons not receiving EBP training, or feelings of superiority among persons who do receive such training.

### Conclusion

Implementing an evidence-based practice in a system of care is not a simple or linear process. Systems of care exist in diverse community contexts often marked by broad needs and challenges. Evidence-based practices are designed to address specific time-limited needs of well-defined populations. Implementation of an EBP is an ongoing process that requires learning and adaptation on the part of EBP purveyors and system of care stakeholders. This process is facilitated by careful consideration and dialogue regarding how an EBP fits within the existing values, regulations, population, and practice contexts of a specific community's system of care. No practice in a system of care exists in isolation; evidence-based practices and typical system practices must be linked across systems and contexts to provide families with the continuum of effective services appropriate to their changing needs. Finally, all of these actions and processes are human processes, and it is critical to attend to the human dimensions of implementation. The experiences of families,

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Tenkasi, R. V., & Chesmore, M. C. (2003). Social networks and planned organizational change: The impact of strong network ties on effective change implementation and use. *The Journal of Applied Behavioral Science, 39*(3), 281-300.

Substance Abuse and Mental Health Services Administration. (2005). *SAMHSA model programs: Effective substance abuse and mental health programs for every community*. Washington, DC: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved January 25, 2007, from [http://www.modelprograms.samhsa.gov/template\\_cf.cfm?page=model\\_list](http://www.modelprograms.samhsa.gov/template_cf.cfm?page=model_list)

staff, and administrators must be solicited and used to inform the ongoing implementation and adaptation of evidence-based practices to meet the needs of each community's children and families. The promise of effective community care can only be attained when we understand how new practices fit with the needs and strengths of local communities and their existing care systems, and we adapt clinical and administrative practices to provide care that changes in response to community context.