



The relationship between consumer, clinician, and organizational characteristics and use of evidence-based and non-evidence-based therapy strategies in a public mental health system



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ARTICLE INFO

Article history:

Received 31 March 2017

Received in revised form

15 July 2017

Accepted 21 August 2017

Available online 25 August 2017

Keywords:

Evidence-based practice

Implementation

Cognitive-behavioral therapy

ABSTRACT

We investigated the relationship between consumer, clinician, and organizational factors and clinician use of therapy strategies within a system-wide effort to increase the use of cognitive-behavioral therapy. Data from 247 clinicians in 28 child-serving organizations were collected. Clinicians participating in evidence-based practice training initiatives were more likely to report using cognitive-behavioral therapy when they endorsed more clinical experience, being salaried clinicians, and more openness to evidence-based practice. Clinicians participating in evidence-based practice initiatives were more likely to use psychodynamic techniques when they had older clients, less knowledge about evidence-based practice, more divergent attitudes toward EBP, higher financial strain, and worked in larger organizations. In clinicians not participating in evidence-based training initiatives; depersonalization was associated with higher use of cognitive-behavioral; whereas clinicians with less knowledge of evidence-based practices were more likely to use psychodynamic techniques. This study suggests that clinician characteristics are important when implementing evidence-based practices; and that consumer, clinician, and organizational characteristics are important when de-implementing non evidence-based practices. This work posits potential characteristics at multiple levels to target with implementation and deimplementation strategies.

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1. Introduction

Most people do not have access to evidence-based mental health care (McHugh & Barlow, 2010; Bruns et al., 2016). While

there are many evidence-based practices (EBP; Butler, Chapman, Forman, & Beck, 2006; Chorpita et al., 2011), efforts to translate efficacious treatments from research to practice have been slow (Stewart & Chambless, 2007; Weissman et al., 2006). In the past decade, large behavioral health systems have invested substantial resources in support of implementation of EBP (Bruns et al., 2008, 2016; Ganju, 2003; Lau & Brookman-Frazee, 2016; Powell et al., 2016). These resources have primarily supported training the existing workforce in EBP. However, the field of implementation science – the scientific study of methods to promote the systematic uptake of research findings into routine practice (Eccles & Mittman, 2006) – suggests that training clinicians in EBP alone is unlikely to result in behavior change (Beidas & Kendall, 2010). Rather, multiple

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strategies targeting consumers, clinicians, and organizations are needed to routinize the use of EBP in usual care (Proctor et al., 2011). In order to successfully tailor strategies to increase the implementation and sustainment of EBP, it is necessary to understand the mutable characteristics that can be intervened upon at each of these levels (Powell, Beidas, et al., 2015).

Many factors beyond the clinician can affect clinician behavior within a clinical encounter. Implementation frameworks (Tabak, Khoong, Chambers, & Brownson, 2012) posit that consumer, clinician, and organizational factors all affect care (Aarons, Hurlburt, & Horwitz, 2011; Damschroder et al., 2009). Clinician knowledge, attitudes, and organizational factors such as organizational culture (i.e., expectations and norms of how things are done in an organization) are associated with successful implementation (Beidas et al., 2015; Wolk et al., 2016). Consumer diagnoses can also influence which practices clinicians deliver (Garland et al., 2010; Wolk et al., 2016). Previous research has largely examined singular relationships between characteristics of consumers, clinicians, or organizational factors and EBP use. For example, studies have focused on the relationship between clinician characteristics and EBP use without examining organizational and consumer characteristics (Nakamura, Higa-McMillan, Okamura, & Shimabukuro, 2011; Nelson & Steele, 2007). It is important to examine these constructs collectively in order to identify targets for comprehensive implementation strategies to support clinicians in the delivery of EBP.

In this study, we investigate the relationship between consumer, clinician, and organizational factors and clinicians' use of cognitive-behavioral (CBT; an EBP) and psychodynamic (non-EBP) therapy techniques with youth receiving behavioral health services in a large public system. We specifically investigated this questions in clinicians participating in EBP training initiatives and clinicians not participating in EBP training initiatives within a system-wide effort to increase the use of CBT in an urban public behavioral health system. CBT has amassed a large body of evidence supporting its effectiveness as a treatment for a wide range of youth psychiatric disorders (Dorsey et al., 2017; Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2016; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; McCart & Sheidow, 2016; Weisz et al., 2017; Zhou et al., 2015). To date, there is not yet adequate data from well controlled studies to support psychodynamic interventions for children (Abbass, Rabung, Leichsenring, Refseth, & Midgley, 2013; De Nadai & Storch, 2013), making these two groups of therapeutic strategies of particular interest. Based on prior work (Beidas et al., 2015), we anticipated that, when controlling for client and clinician variables, organizational factors would be the primary predictors of CBT use, whereas clinician variables would be the primary predictors of psychodynamic use after controlling for consumer and organizational variables. The purpose of this work is to understand empirical relationships between each of the constructs of interest and use of evidence-based practice in order to target implementation strategies to increase use of EBP and decrease use of non-EBP in future studies.

2. Methods

2.1. Setting

The Philadelphia Department of Behavioral Health and Intellectual disability Services (DBHIDS) has supported four EBP initiatives. The department began widespread implementation of CBT in 2007 (Creed et al., 2016; Stirman et al., 2010, 2012), prolonged exposure in 2011, trauma-focused CBT in 2011 (Beidas, Adams, et al., 2016), and dialectical behavior therapy in 2012. These four initiatives have supported and financed training, expert

consultation, and ongoing technical assistance in more than 60 organizations and in over 500 clinicians (Powell et al., 2016). Two of the initiatives, CBT and trauma-focused CBT, were implemented in child outpatient settings.

2.2. Agencies and participants

We used purposive sampling to identify the 29 child-serving organizations from the approximately 100 in Philadelphia that serve more than 80% of all youth in outpatient behavioral health programs. Of these 29 organizations, 22 (76%) agreed to participate. Several agencies had multiple locations, resulting in a sample of 28 sites and 247 clinicians. All clinicians employed by the organizations providing outpatient behavioral health services to youth were eligible to participate. Approximately 58% of clinicians employed by the 22 organizations participated in the study. They were predominantly female (77.7%) and self-identified as Asian (4.5%), African American/Black (30.0%), White (40.9%), Hispanic/Latino (16.2%), Multiracial (4.0%), and Other (2.0%); 2.4% did not provide data on race/ethnicity.

2.3. Procedure

This study was approved by the University of Pennsylvania and City of Philadelphia Institutional Review Boards. The leader of each organization was approached to solicit participation. A one-time meeting was scheduled with potential participants. During this meeting, the research team presented the study, obtained informed consent, and collected measures. Clinicians completed the measures in one location and were compensated \$50; measures were completed between January and June of 2015.

2.4. Measures

2.4.1. Client-level

Client demographics. Clinicians provided information about a representative client they were working with including his/her age, gender (male, female), and primary DSM-IV diagnosis (primary internalizing disorder, primary externalizing disorder, or primary other disorder). Clinicians were asked to think about this representative client when reporting on use of therapy strategies.

2.4.2. Clinician-level

Clinician demographics. Participants completed a brief demographics questionnaire that assessed age, gender, race/ethnicity, years of experience, years at current agency, weekly caseload, weekly supervision hours, worker status (independent contractor or salaried), and formal participation in DBHIDS EBP initiatives (Weisz, 1997).

Knowledge. The Knowledge of Evidence-Based Service Questionnaire (KEBSQ; Stumpf, Higa-McMillan, & Chorpita, 2009) is a 40-item self-report instrument that measures knowledge of EBP techniques. The 2013 KEBSQ scoring key was used in this investigation to correspond with the timing of data collection (the scoring key changes based on the knowledge base over time). Knowledge is measured on a continuum from 0 to 160. Higher scores are indicative of more knowledge of EBP. Psychometric data suggests temporal stability, discriminant validity, and sensitivity to training (Stumpf et al., 2009). As items are considered orthogonal (Stumpf et al., 2009), no internal consistency value was calculated.

Attitudes. The Evidence-Based Practice Attitude Scale (EBPAS; Aarons, 2004) is a 15-item self-report measure assessing attitudes toward adoption of EBP. Four subscales represent dimensions of attitudes toward EBP adoption: appeal (is EBP intuitively appealing), requirements (would EBP be used if required by

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