

Fostering Evidence-Based Practice Cultures in Public Sector Service Systems

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Agenda For The Presentation

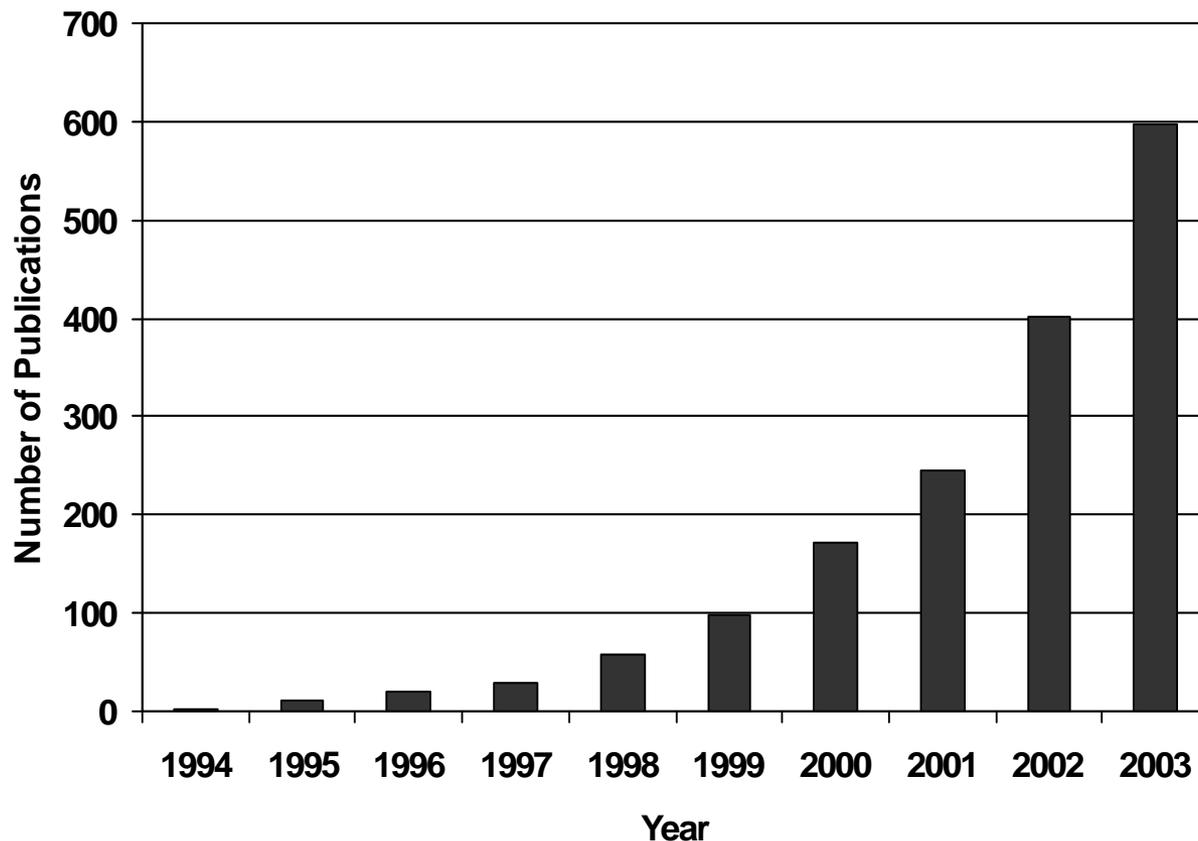
- How is an EBP service culture different from traditional practice models?
- What are the obstacles and issues for implementing EBP service culture in public sector service systems?
- Issues and lessons learned
- An example

Some Current EBP Projects in Oklahoma Involving Collaboration Between Researchers and State Service Agencies

- **SafeCare Study**
 - Cluster randomized trial, statewide. Comparing two in-home family preservation (SafeCare vs. Standard). Also comparing two implementation approaches (coached vs. uncoached). (OUHSC/OKDHS-DFACS/CDC/NIMH)
- **PCIT child welfare study**
 - Randomized trial. Field trial of Parent-Child Interaction Therapy (OUHSC/OKDHS-DFACS/CDC)
- **PCIT/FAS dissemination study**
 - Tribal and community based agencies
 - Comparing two implementation approaches, phone consultation vs. life telemedicine based co-therapy mentoring. (OUHSC/CDC/IHS/Tribes)
- **High-risk prevention trial**
 - Randomized trial. Initial testing of a home-based secondary prevention model (OUHSC/State Legislature/CDC)
- **Organization Readiness for Innovation study.**
 - Quantitative/qualitative study of provider and organizational factors related to EBP uptake (CASRC/OUHSC/NIMH)
- **Research-practitioner Partnership Study**
 - Contrasting two randomized trial implementations of Brief Strategic Family Therapy, one involving providers in tracking outcomes and allowing researcher-practitioner adaptation of the model, and one standard implementation (OKDMHSAS/OUHSC/CASRC/NIMH/SAMHSA)
- **MST aftercare trial**
 - Randomized trial testing field effectiveness of MultiSystemic Therapy following release from juvenile justice facilities (OUHSC/OJA/DOJ)
- **National Child Traumatic Stress Initiative**
 - Implementing Trauma-Focused CBT, PCIT and Sanctuary at various sites (OUHSC/TU/OKDMHSAS/F&CS/SAMHSA)

The Movement Toward Evidence-Based Treatments

Use of the term "evidence-based" in professional and scientific literature over the past decade

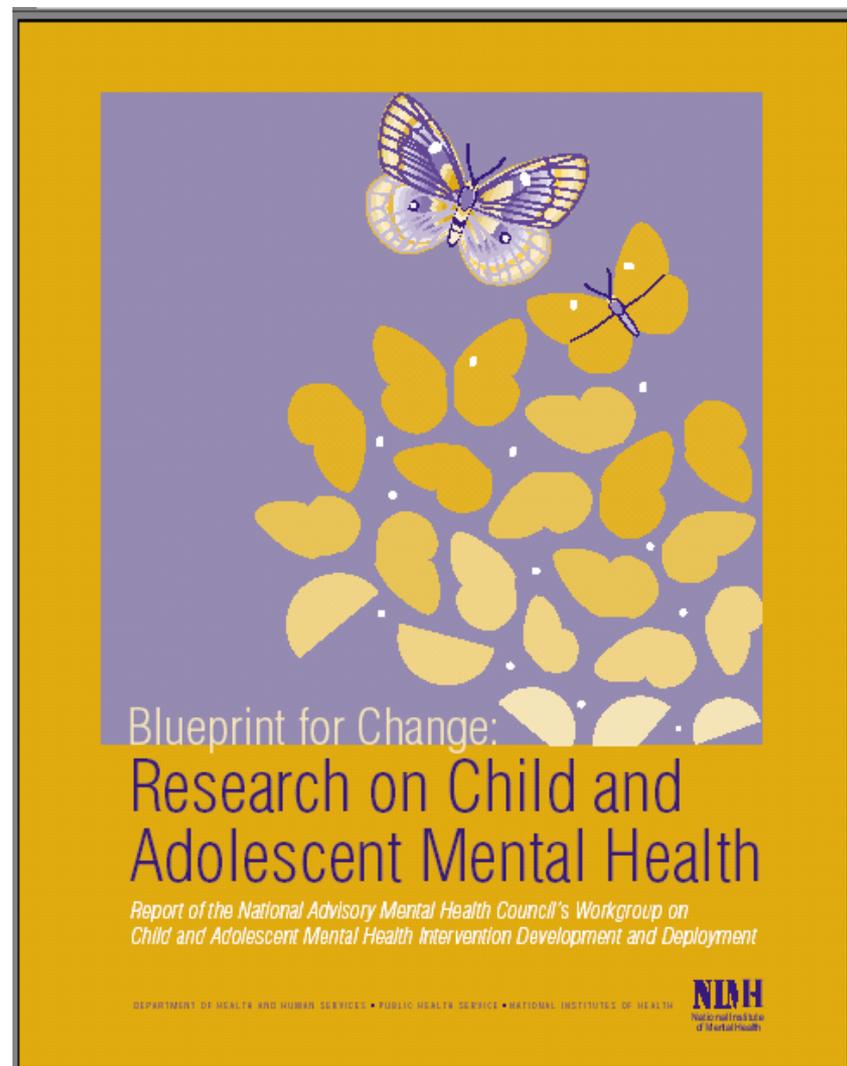


EBP Implementation Movement

- Documents or guidelines promoting implementation of EBP have been disseminated from key funding agencies and opinion leaders including:
 - NIH/NIMH
 - CDC
 - Surgeon General
 - SAMHSA (CSAT, CMHS, NCTSN, etc.)
 - Justice Dept: OJJDP, OVC
 - Kauffman Best Practices Project

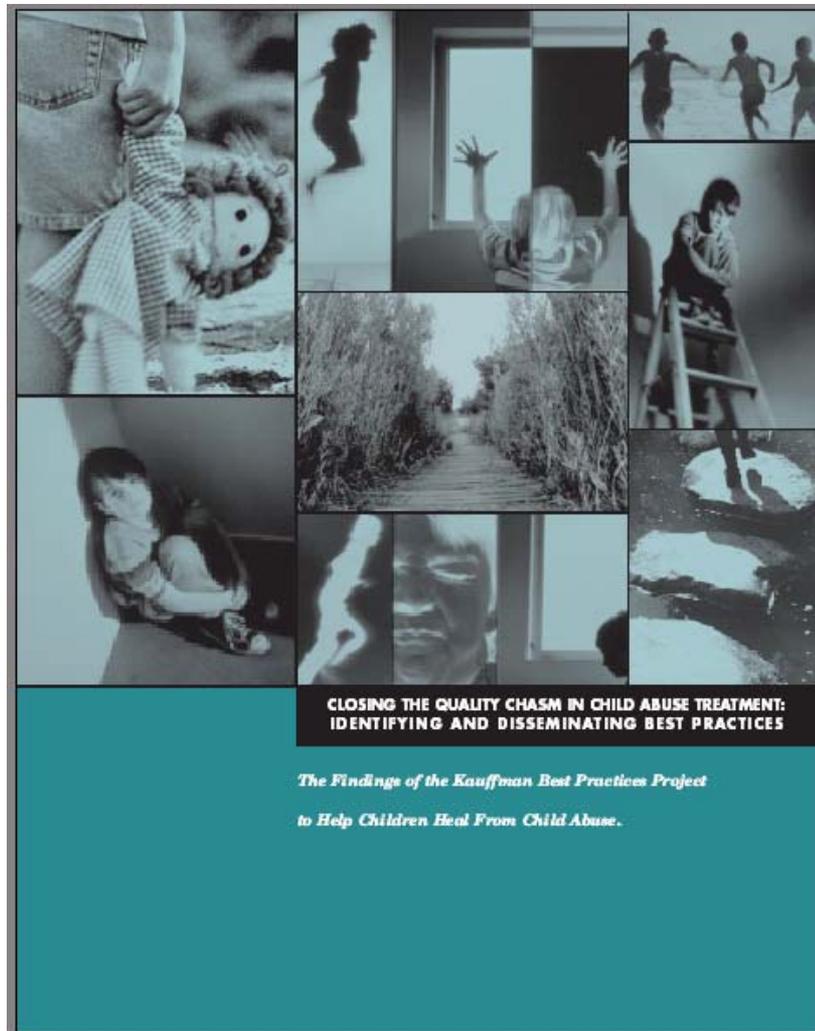
Sample of Key Works

NIMH Blueprints for Change
(www.nih.gov)



Sample of Key Works

Kauffman Best Practices
Project (www.musc.edu/cvc)



Sample of Key Works

Office for Victims of Crime
Guidelines Project
(www.musc.edu/cvc)

Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical and Sexual Abuse

Final Draft Report: July 30, 2001

Prepared by:

National Crime Victims Research and Treatment Center
Medical University of South Carolina
Charleston, South Carolina

Center for Sexual Assault and Traumatic Stress
Harborview Medical Center
Seattle, Washington

A cooperative agreement funded by the:

Office for Victims of Crime
Office of Justice Programs
U.S. Department of Justice

Why Care About EBP Implementation Now?

- A number of better supported, demonstrably effective treatment models have been developed and tested
- These better supported models are rarely used in actual field practice, or are used on an *ad hoc* basis or are used with weak fidelity
- Evidence that many current “standard community care” services deliver poor results
 - Often no better than placebo or no services in controlled trials
- Although there is lots of good, sound practice going on in public agencies, psychosocial services have seen more than their share of flaky stuff
- There is no FDA for psychosocial services—Anybody can develop and market their own treatment and claim anything.



EFT

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TESTIMONIALS: Personal Development **PERSONAL GROWTH TRANSFORMATION AND NEGATIVE BEHAVIOR PATTERN REMOVAL**

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I was most impressed with the personal growth I developed. The combination of physical and emotional treatments together gave me insight into different parts of myself, and the Bodywork "opened me up" so I could take advantage of the Netherton and Reichian verbal and emotional release therapy.

I have gained some personal growth that has helped me in my work as well.

I gained insight into some of my behavior and feelings. And I got in touch with the unfinished business that originated in my earliest childhood. Through the Bodymind release processing I've been able to let go of the different feelings and attitudes that were limiting me, and that I didn't like having but wasn't able to release before.

personal experiences, and professional training to help adoptive and foster families with attachment concerns. The Center for family Development has focused much of its efforts on helping adoptive and foster families. The needs of adoptive families are unique and very few professionals understand these families and their special problems. The Center for Family Development was founded by Dr. Arthur Becker-Weidman to provide answers to questions, solutions to problems, and the expert support necessary for families to thrive in these turbulent times.

Dr. Arthur Becker-Weidman and his associates are dedicated to helping adoptive families achieve their potential. All members of the Center For Family Development are licensed, skilled, and highly trained professionals with at least twenty years experience helping families. **Arthur Becker-Weidman, CSW-R, PhD. DABPS** received his doctorate Human Development from the University of Maryland, Institute for Child Study. He achieved Diplomate status from the American Board of Psychological Specialties in Child Psychology and Forensic Psychology. He is a member of the American College of Forensic Examiners. Dr. Becker-Weidman has received extensive training in Dyadic Developmental Psychotherapy, an attachment-based therapy, including training at the Attachment Center at Evergreen and training with Daniel Hughes, Ph.D., author of Building the Bonds of Attachment and Facilitating Developmental Attachment.

At the Center For Family Development we only begin working with families after completing a thorough assessment. We carefully evaluate the child and the family. Our success rate is now over 95%. Success means that the child has developed the capacity to love and be loved and is functioning at least at about 80% of the level you'd expect for a child that age. See our [Research](#) page for the results of our follow-up study.

Dyadic Developmental Psychotherapy, an attachment-based therapy is the only evidence-based treatment for children with Trauma-Attachment Disorders, Reactive Attachment Disorder, and other disorders of attachment that are complicated by severe trauma or histories of maltreatment. Other forms of treatment are ineffective with children who have disorders of attachment and complex post-traumatic-stress-disorder because all these therapies require a trusting relationship between the therapist and child. But how can you have a trusting relationship with a child who has no capacity, or a damaged capacity to trust and form a working alliance? You cannot. Dyadic Developmental Psychotherapy, an attachment-based therapy is experiential and effective. After the trauma has been resolved and the child is developing a healthy and secure attachment, other forms of treatment that strengthen an attachment can be quite helpful. The following [references](#) and [treatment protocols](#) document this.

Parents of attachment disordered children experience a high level of stress and need support and understanding in order to help their children and survive as a family. The Center for Family Development offers a support group which is intended as an opportunity for parents to share parenting strategies, learn about approaches that work, support others, find support, and develop cooperative respite arrangements. This is not a treatment group or therapy.

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Nite-Lite provides the nutrition your body needs for the safe release of human growth hormone while you sleep. The ingredients in this MultiDimensional formula have been shown to naturally:

- Help accelerate the burning of excess and stored fat
- Help promote cellular healing and tissue repair
- Help build muscle tone
- Help flush free radicals, toxins and wastes
- Help diminish water retention

As we age, the Pituitary Gland releases less and less human growth hormone (hGH) which causes our metabolism to slow down and our weight to increase. With the correct nutritional support, the body can safely release hGH while we sleep, thus burning fat and helping to lose weight even while we sleep...

This is a Scientifically Advanced Metabolic Nutraceutical Dietary Supplement specifically designed to provide the body with the necessary nutritive materials which are known to be used in order to promote the natural release of recombinant Human Growth Hormone while you sleep.

It is known that most healing and new growth occurs in the evening while we sleep, and this occurs simply because that's when the largest amount of recombinant HGH is released, and that's when HGH begins to orchestrate the burning of fat for its energy source.

Interestingly enough, all the HGH we will ever need is stored within the Pituitary gland in the brain, but as we grow older, less and less is subsequently released. When less and less is released, our metabolism slows down and it's then much easier to put on weight.

When the correct nutritional factors can be supplied to the body, the pituitary can begin releasing this very precious hormone again into the system while we sleep, and then the notion of losing weight while we sleep can really start to make sense. Nite-Lite supplies the known nutritional factors thought to be important for supporting the body's release of HGH back into the system. And when that happens, the pounds begin to naturally disappear.

The Downside of Traditional Mental Health Practice Culture

- Historically, practice has been driven by changing practice fashions, lore, ideologies, novelty, inference from general knowledge, subjective experience or political/social values rather than good objective evidence of effectiveness
- “It is simply a sad fact that in soft psychology, theories rise and decline, come and go, more as a function of baffled boredom than anything else, and the entire enterprise is characterized by a disturbing lack of cumulative character.” (Paul Mehl, 1978).
- Thus, in the traditional psychosocial practice culture, we can expect only that tomorrow's interventions will look different from today's—we cannot confidently expect that they will work any better

What is "Evidence" in an evidence-based practice culture?

- Data from well designed, adequately controlled, studies (e.g., controlled trials, multiple baseline studies, etc.) that test intervention effectiveness for yielding an intended bottom-line outcome
- Directly relevant to practice questions
- Directly related to aspects of service quality as it relates to outcomes

What Isn't Quite "Evidence"

- "Evidence-Informed" or "Evidence-Suggested" Treatment
 - Inferential or indirect scientific evidence—NOT direct efficacy testing
 - Based on a plausible rationale
 - Supported by bits and pieces of scientific evidence from which one might infer effectiveness ("because of what we know about the brain, it makes sense that.....")
 - Based on clinical impressions or clinical experience of effectiveness
- Virtually any intervention can qualify as "evidence-informed." The bar is set too low.

What looks like "Evidence" of effectiveness, but isn't

- Lots of traditional program evaluation data
 - Pre-post data (virtually un-interpretable in any clear way)
 - Benchmark comparisons unless the benchmark is well established and robust
 - Process evaluations (how many clients seen, what qualifications, etc.). Process is important, but is not the same thing as outcome evidence
 - "Soft" outcomes or logic-model evaluations. Speculative proxy measures. Unproven mediators of outcomes, etc.
 - Client satisfaction, testimonials, case histories and anecdotes. Again, client satisfaction is important, but it should not be confused with outcomes. Even demonstrable quackery or harmful services can produce satisfied customers and testimonials of miracle cures.
 - Note—this is the type of evidence that the public, journalists, lawyers and legislators may most persuasive, so don't throw it out.

Why Doesn't Clinical Experience Count As Evidence?

- It's nothing personal. Really. Clinical experience is great for some things (i.e. understanding context and nuance) but is lousy for estimating effectiveness
- The “clinically proven” standard (as seen on TV!)
 - Means “people seem to me to get better....”
- Why is it lousy for estimating effectiveness? Clinical experience is based on pre-post, completers only data
 - Lack of comparison or control conditions
 - Cannot separate effectiveness from spontaneous improvement
 - Cannot separate ineffectiveness from prevention of deterioration
 - Cannot know what would have happened with no treatment or a different treatment
 - Vulnerable to a variety of biases

What doesn't even come close to being evidence?

- Everybody thinks this is a good thing to do
- We've always done it that way
- Somebody famous wrote a book about it, or gave a charismatic conference lecture about it
- Its new and different
- It makes sense or feels right
- It resonates with my social and political values

Five Steps of EBP

- Convert clinical practice needs into answerable questions
- Track down the best good evidence with which to answer them—or generate the evidence yourself
- Critically appraise that evidence for its validity (closeness to the truth) and usefulness (clinical applicability)
- Apply the practice with fidelity and quality
- Evaluate outcomes with maximum possible rigor and use this information to identify new clinical practice needs

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
Source of Knowledge	Accumulated subjective experience with individual cases. Opinion about practice outcomes emphasized. "In my experience....."	Well designed, randomized trials and other controlled clinical research. Facts about practice outcomes emphasized. "The data show that...."

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
Basis for Treatment Techniques	Inferred from ideologies (e.g. "strengths-based"), political values, the <i>theory-du-jour</i>	Behaviorally specific techniques drawn from tested protocols

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
Treatment Technique Selection	Mix and match. Eclecticism. "Bag of tricks." Each practitioner assembles their own personal approach on-the-fly with cases	Protocols, although allowing for variations, are applied far more consistently across practitioners and model competency is emphasized

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
Knowledge Location and Access	Hierarchical. Knowledge is possessed by opinion leaders and gurus. Charismatic expert driven	Democratic. Knowledge is available to anyone willing to read the published scientific research or research reviews. Information technology driven

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
Method of Achieving Progress	Haphazard, fortuitous, based on changing values, fads, fashions and leaders	Systematic, predictable, based on incremental and cumulative programs of outcome research

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
Practitioner Expertise	Quasi-mystical personal qualities and intuition	Specific, teachable, learnable skills and behaviors

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
View of Practice	Art. Creative artistic process with fluid boundaries.	Craftsmanship. Creativity within the boundaries of the supported models and protocols.

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
Research Practice Link	Indirect. Inferential	Direct. Integral and fundamental to practice

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
How is Research Summarized and Applied to Practice	Individual subjective practitioner synthesis of whatever literature is consumed	Best practices workgroup or collaborative summary based on exhaustive reviews of the outcome research and meta-analysis

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
Quality Control	<p>Focuses on how well service rationales are conceptualized and the credentials of who provides them</p>	<p>Focuses on how well services are behaviorally delivered <i>vis a vis</i> a well-described model</p>

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
Practice Visibility	Actual practice is seldom observed by anyone other than the practitioner and the client.	Direct peer or consultant observation of actual practice, and specific feedback is common

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
Assumptions About Outcomes	Faith. Service programs in general are seen as good and are assumed to be beneficial	Skepticism. Knowledge that interventions may be inert or even harmful. Benefit must be empirically demonstrated, not assumed

Contrasting EBP with Traditional Practice Cultures

	Traditional Clinical Practice	Evidence-Based Practice
View of Outcome Evaluation Data	An external requirement. "We know our program works, but we need to have some data to prove it." Bad news must be explained away	High buy-in. "We need to know how its working." Bad news is better than no news.

What EBP and Traditional Practice Cultures Share in Common

- Ethical and good practice standards
- Valuing core aspects of good practice
 - Working collaborative relationship with clients
 - Respect for clients
- Appreciation for basic practitioner skills and competencies—EBP models require good general skills and cannot substitute for good practice skills
- EBP is more structured, but should retain a human touch and remain an intrinsically human activity

What is the Role of Values in EBP?

What is the Role of Consumers in EBP?

- Absolutely critical for choosing what outcomes are desired
 - What goals are set
 - What benefits need to be delivered
- What means are acceptable for reaching those goals
- The role of evidence is to determine what means are best for achieving those goals and providing those benefits, within the parameters of what is acceptable to stakeholders

Developing an EBP Culture

- Unfortunately, implementing EBT is not itself an entirely evidence-based endeavor
- We have some basic ideas about what may be important
- Some data on what works well and what doesn't
- However, much remains unknown

Implementing EBP—THE DREAM

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY WILL COME

Implementing EBP—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY WON'T KNOW

Implementing EBP—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY WON'T CARE

Implementing EBP—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY MAY LIKE THE ONE THEY BUILT BETTER

Implementing EBP—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY MAY THINK THEY ARE
ALREADY THERE AND DON'T NEED
TO COME

Implementing EBP—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY MAY WANT TO COME,
BUT DON'T HAVE THE TIME

Implementing EBP—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY ARE INTERESTED IN COMING,
BUT YOU REQUIRE TOO MUCH
PAPERWORK

Implementing EBP—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY WILL WANT TO COME TO ONE SOMEWHERE, BUT CAN'T DECIDE WHERE TO GO

Implementing EBP—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY WILL WANT TO COME, BUT
ITS TOO RISKY TO LEAVE HOME

Implementing EBT—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY WILL TRY TO COME, BUT THE MAP YOU SENT WASN'T WRITTEN IN THEIR LANGUAGE

Implementing EBT—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY WILL TRY TO COME, BUT
CAN'T AFFORD ADMISSION

Implementing EBT—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY WILL TRY TO COME, BUT YOU DON'T HAVE ROOM

Implementing EBT—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY WILL TRY TO COME,
BUT END UP NEXT DOOR

Implementing EBT—THE REALITY

IF YOU BUILD IT.....



Thanks to Jim Emslie and Linda Anne Valle

THEY WILL COME.....

THEN DECIDE TO REMODEL IT UNTIL IT NO LONGER RESEMBLES WHAT WAS INTENDED

Some Lessons Learned in Moving Toward an EBP Culture

- Leadership
- Local Champions
- Organizational Culture and Climate
- Example of a Research-Practice-Governance Partnerships

State Agency Leadership

- Some research on what leadership factors promote a stronger EBP Culture
 - Laissez-faire or crisis oriented management associated with poorer attitudes toward EBP and less EBP uptake
 - Risk tolerant
- Leadership lessons learned in Oklahoma
 - A committed, stable middle-management at the state agency is a huge plus
 - Political stability of the agency—not continually under the gun in the legislature and in the papers
 - A collaborative learning and quality improvement atmosphere between state leadership, agency leadership, researchers, and practitioners
 - Outcome data is used to learn from and improve quality. It is not used to punish. Its not “your agency has low test scores—you get less money”

Some Lessons Learned in Moving Toward an EBP Culture

- Leadership
- **Local Champions**
- Organizational Culture and Climate
- Example of a Research-Practice-Governance Partnership

A local champion or change agent promoting the EBP

- Needs access to agency leadership and able to impact policy and procedures
- Perceived by front-line practitioners as credible
- Knowledgeable and competent in the particular set of EBP practices being implemented
- Example—Oklahoma SafeCare
Implementation took well-regarded front-line providers from the agencies, trained them to be ongoing model coaches and monitors

Some Lessons Learned in Moving Toward an EBP Culture

- Leadership
- Local Champions
- **Organizational Culture and Climate**
- Example of a Research-Practice-Governance Partnerships

Organizational Culture and Climate

- Organizational culture—shared norms, values, behavioral expectations and degree to which conformity is demanded
 - Some investigators have characterized public sector service organizations as having cultures that are resistive to innovation
 - Negative organizational cultures (demanding conformity to an inflexible ideology, low risk tolerance, defeatist outlook, etc.) associated with low interest in EBP

Organizational Culture and Climate

- Organizational culture—Characteristics of “learning organizations”
 - Strong leadership
 - Open and inclusive management culture
 - Stable resource base
 - Oriented toward performance and OUTCOMES
 - Transparent (i.e. visible and open) performance and outcome data
 - Openness to innovation and change
 - Willing to use performance and outcome data to constantly improve services

Organizational Culture and Climate

- Organizational Climate—individual staff perception and emotional response to the organizational environment. Includes things like:
 - “Burned out” vs. energized
 - Perceive the organization as promoting their own professional development
 - Paranoid about “making waves”
 - Role clarity
 - Work group cohesion
 - Better climate → More positive attitudes toward EBP



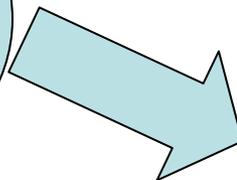
Some Lessons Learned in Moving Toward an EBP Culture

- Leadership
- Local Champions
- Organizational Culture and Climate
- Example of a Research-Practice-Governance Partnerships

Example of Implementation Process: Oklahoma SafeCare Implementation

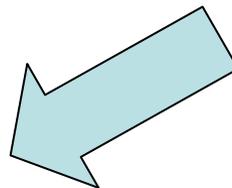
Phase I—Outcome eval

- Establish evaluation-provider collaboration
- Data collection habit



Phase II—Policy Planning

- Planning with DHS
- Feedback from providers
- Feedback to providers



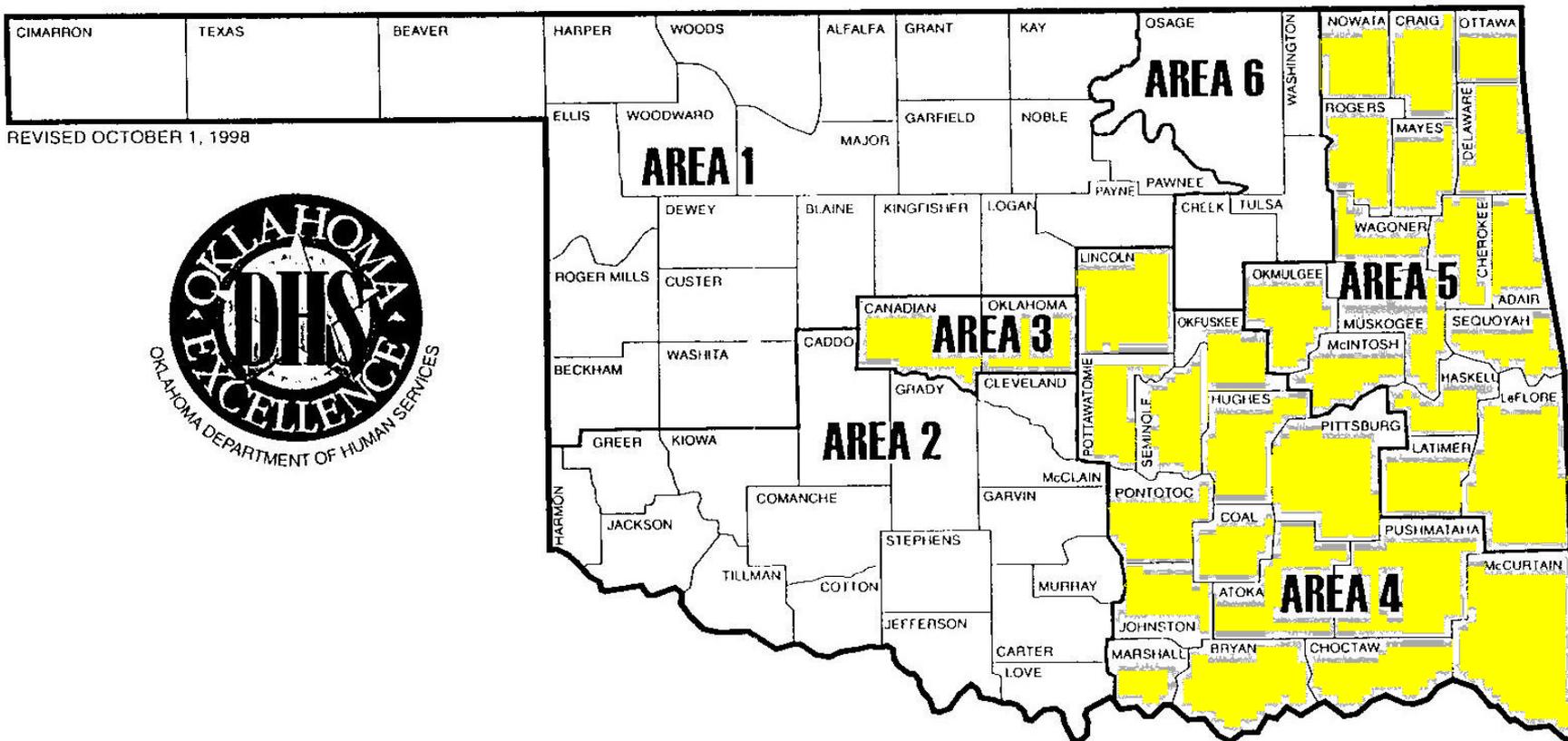
Phase III--Dissemination

- Mutually agreed evidence based model
- Implement statewide controlled trial

2 X 2 Design, evaluating both the treatment model, the implementation approach and their interaction

SafeCare Monitored/Coached Implementation	SafeCare Unmonitored
Standard Unmonitored	Standard Monitored/Coached Implementation

Regions and Service Models



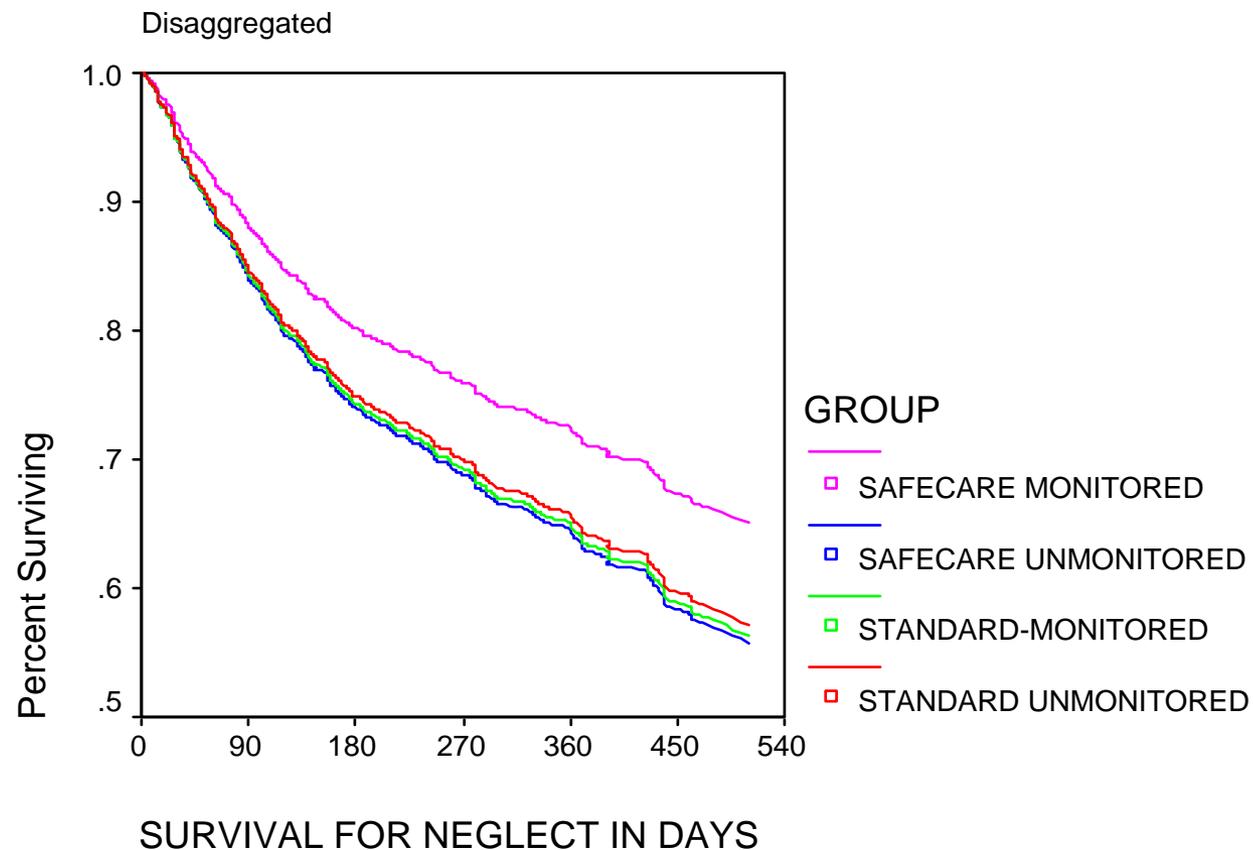
 SafeCare Regions

Aspects of the SafeCare Collaboration

- Governed by a Board comprised of DHS, provider agency directors, OUHSC researchers, external members
- Consultation from model developers
- Planning for future directions is collaborative
- As data accrues, providers and state agency leadership have direct input into what questions are asked of the data, what new types of data need to be collected, etc.
- Funding includes state dollars and federal grant dollars

Preliminary Findings

Preliminary Findings



Provider Responses to EBP Implementation (ORIN)

- Web-based survey of providers (94% participation rate)
- Qualitative interviews with providers
- Data collected, analysis underway
 - Greg Aarons, Ph.D.
 - Larry Palinkas, Ph.D.
 - CASRC, San Diego

Provider Responses to EBT Implementation (ORIN)

- Early Findings
 - Reactions to EBP implementation are generally positive
 - The more familiar providers are with SafeCare, and the more they have delivered it, the more positive their attitude ($r = .43$)
 - More positive organizational cultures and climates are associated with more positive attitudes toward EBP implementation

Provider Responses to EBT Implementation

- But,
 - Reactions are not universally positive, and a few are strongly negative
 - “Faking” the implementation, or implementing the EBT only when the monitor is present in a few providers
 - Viewed as “just another change” or the newest “flavor-of-the-month”
 - Pseudo-adoption or half-hearted adoption may be especially problematic with EBP’s given that EBP’s usually require more active and planful provider behavior
 - Currently examining relationship between organizational factors, implementation approach and downstream fidelity and client-level outcomes

SafeCare Study

Future Directions

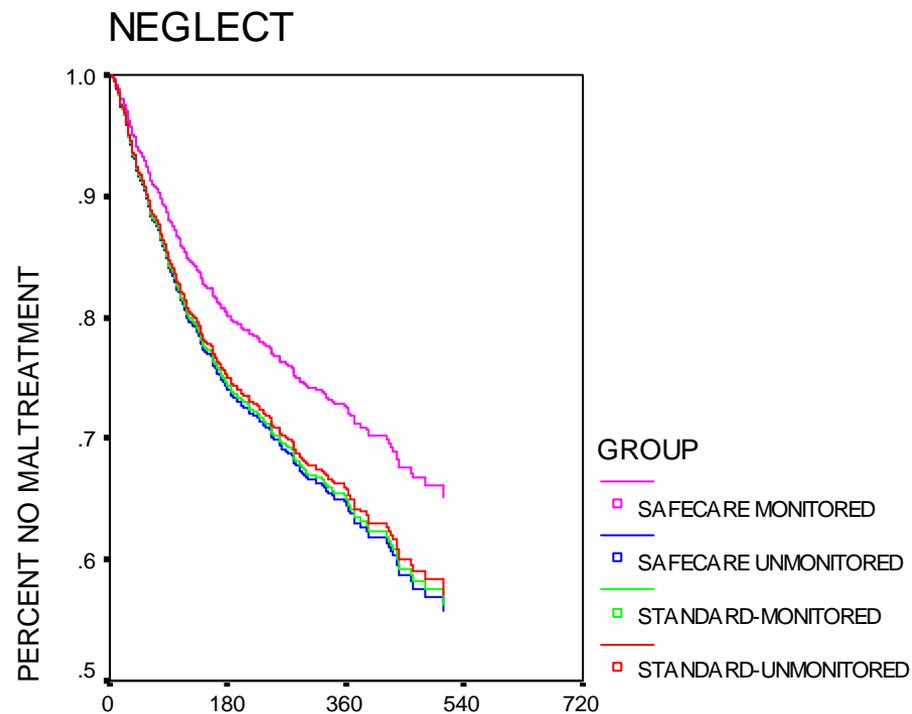
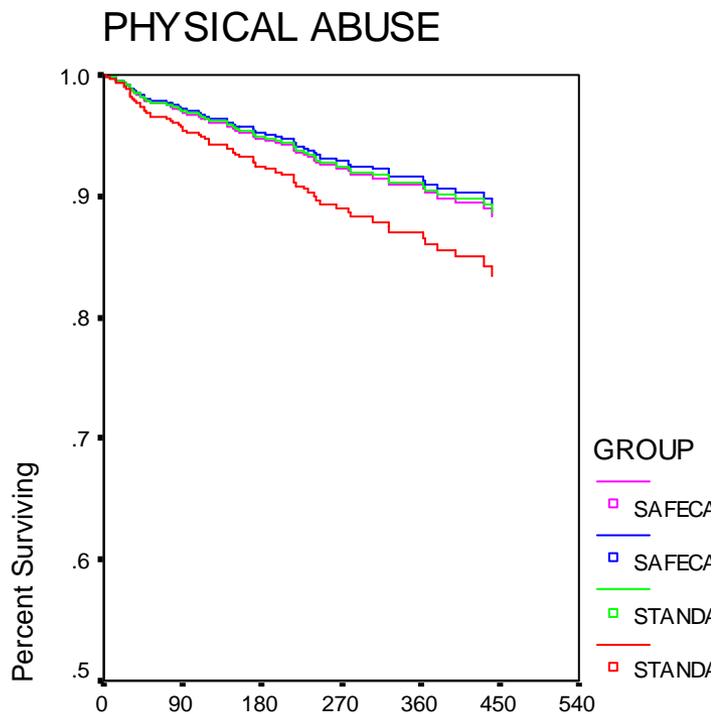
- Assuming that the model, when implemented with monitoring and coaching, yields improved outcomes, are there clues in the data, in provider perspectives, in client perspectives, and in emerging literature for how to incrementally improve or adapt the model?
- Can we triangulate between the data, provider input, client input and developer input?

SafeCare Study

Future Directions

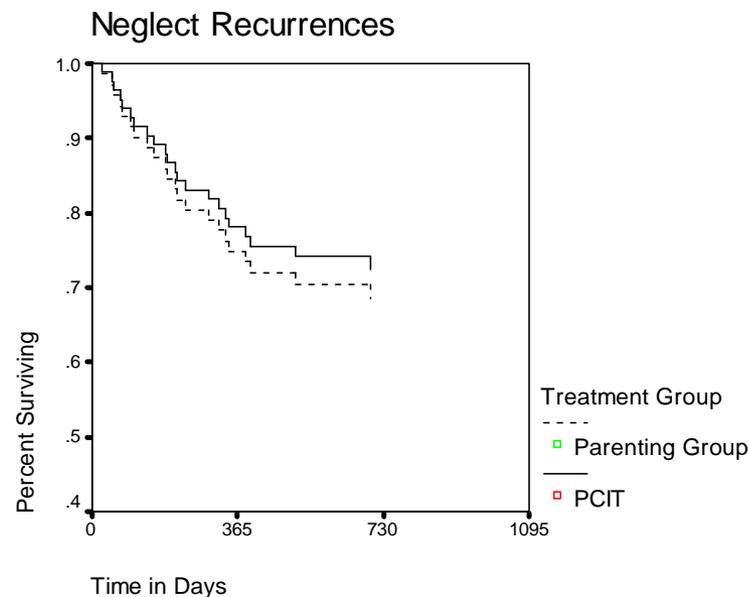
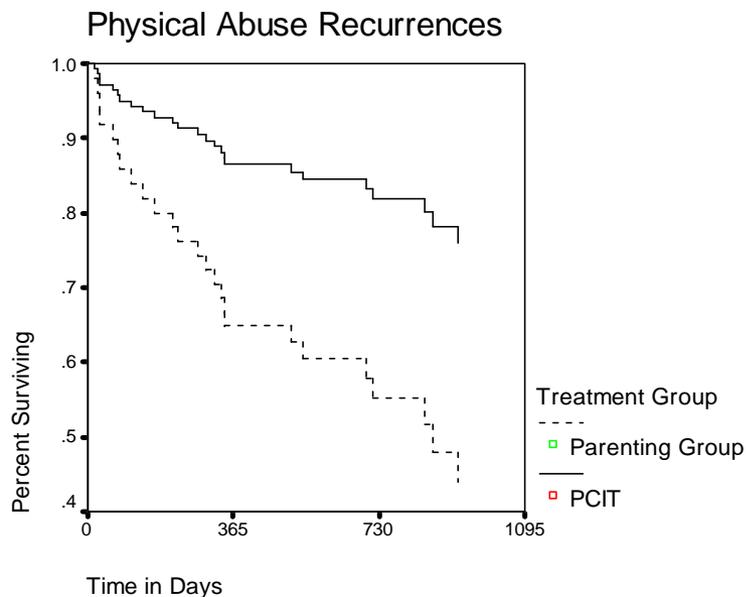
- Initial directions
 - Client input shows broad satisfaction with the model
 - Provider input suggests that the model is far more effective for environmental neglect cases than for physical abuse cases, especially physical abuse cases involving older children
 - This triangulates well with the emerging data

Preliminary Outcome Findings Comparing Environmental Neglect and Physical Abuse Cases



If a Gap in Effectiveness Exists for the Model, What Might Fill It?

- Findings from our prior trials have suggested potentially dove-tailing outcomes for other intervention models



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Future Directions

Integrated Evidence-Based Practice Systems

- Distilled elements and matching approach
(Chorpita, Daleiden & Weisz, 2005)
 - Relies on identifying common functional elements shared across outcome literature for a particular target problem
 - Crossed with client and context factors, and matched to the case
 - Involve a decision tree or matching algorithm for selecting elements applied in a given case
 - Applications of modular or integrated EBP systems outside of child welfare
 - Elements and matching projects--MacArthur Clinic Treatment Project; Hawaii Child and Adolescent Mental Health System
 - Matching of intact EBT's project—Casey BlueSky Project.

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Future Directions

Integrated Evidence-Based Practice Systems

- What potential benefits do matched, modular, components-based, or elements-based systems hold over more fixed or focused EBT protocols
 - May be more acceptable to providers who sometime object to the narrowness of protocols. Feels more practice friendly
 - Accommodate case diversity
 - Potential efficiency—does not apply elements that are not needed
 - Can be custom designed to fit a particular service system (e.g., might design systems specific to in-home family preservation, or child abuse prevention, or delinquency)
 - But, not *ad hoc*, loose or free-styling practice—elements are drawn from proven effective practices and are limited in number. Implementation approach would be similar to that for a simple, single EBT

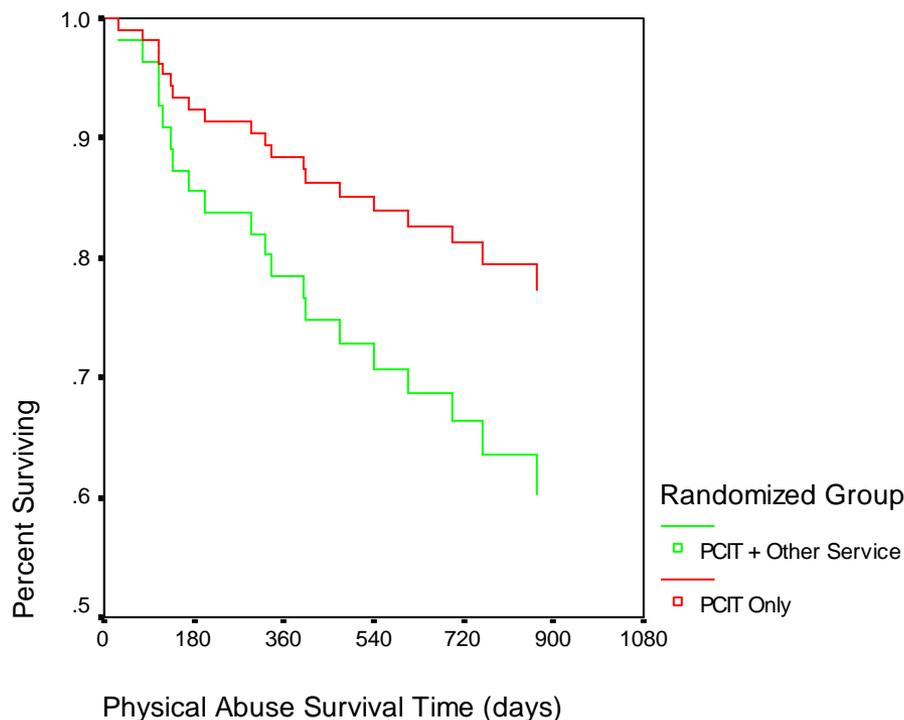
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Future Directions

Integrated Evidence-Based Practice Systems

- But.....
 - Effectiveness is largely untested
 - Are they feasible?
 - Greater training and competency demands
 - Highly co-morbid cases
 - How to set priorities
 - Avoiding 'poly-services' and loss of focus--more may not be better
 - Possible inconsistencies or "wash-out" when applying multiple elements

SafeCare Study Future Directions Integrated Evidence-Based Practice Systems



Example of how simply adding individualized additional service elements, ad hoc, to an EBT can go wrong

Participants randomized to additional services tended to meet fewer parent skill goals and had higher recidivism

Collaboration Schematic

