Challenges in implementing evidence-based practice into mental health services

Frank P Deane, Trevor P Crowe, Robert King, David J Kavanagh and Lindsay G Oades

Abstract

This paper highlights challenges in implementing mental health policy at a service delivery level. It describes an attempt to foster greater application of recovery-orientated principles and practices within mental health services. Notwithstanding a highly supportive policy environment, strong support from service administrators, and an enthusiastic staff response to training, application of the training and support tools was weaker than anticipated. This paper evaluates the dissemination trial against key elements to promote sustained adoption of innovations. Organisational and procedural changes are required before mental health policies are systematically implemented in practice.

Aust Health Rev 2006: 30(3): 305–309

What is known about the topic?

It has been difficult to implement initiatives that are successful in changing practice among mental health workers.

What does this paper add?

This paper describes a training program designed to foster greater application of recovery-orientated principles and practices within mental health services. While it appeared that this program was based on appropriate change management principles, the lack of sustained uptake has made the authors speculate on what might have been done differently to improve the success of this program. Most importantly, the authors suggest that effective implementation requires active practitioner process management, suggesting the need for culture change given strong traditions of practitioner autonomy.

What are the implications for practitioners?

This case study can assist others in planning change by ensuring a comprehensive focus on both organisational and practitioner procedural changes. ◆

IT IS NOTORIOUSLY DIFFICULT to ensure that appropriate innovations in mental health care are taken up and routinely implemented.[1] Problems of diffusion are essentially the same as those found in organisations generally,[2,3] including factory settings.[4] For effective and sustainable dissemination, innovations need to:[1,5,6]

- Key into current organisational and individual staff objectives. Support from upper management and early adopters speed initiation; widespread support by middle management and staff increases effectiveness and sustainability.
- Be consistent with existing practices and easily applied. Time and competition with other work priorities are commonly cited barriers to uptake.
- Be communicated clearly and accurately, with implementers acquiring key skills and high self-efficacy for their implementation.
- Have appropriate resources for implementation, including structures for cueing, and checking and rewarding fidelity.
- Be accepted by consumers.

This paper relates a cautionary tale, in which an attempt to implement these principles has had only partial success.

Traditionally, mental health services have focused on symptom reduction and improved role functioning. However, the Australian National

Frank P Deane, PhD, Professor
Trevor P Crowe, PhD, Associate Fellow
Lindsay G Oades, PhD, Senior Lecturer
Illawarra Institute for Mental Health, University of Wollongong, Wollongong, NSW.

Robert King, PhD, Associate Professor
David J Kavanagh, PhD, Professor
University of Queensland, Department of Psychiatry.

Correspondence: Dr Frank P Deane, Illawarra Institute for Mental Health, University of Wollongong, Northfields Avenue Building 22, Wollongong, NSW 2522. **fdeane@uow.edu.au**

Mental Health Plan 2003–2008 (NHMP)[7] adopts a primary principle that "A recovery orientation should drive service delivery". Anthony[8] describes recovery as

> . . . a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Adoption of this goal and its routine application in mental health services may require some reorientation of objectives and practices.[9]

This case study examines the implementation of the Collaborative Recovery Training Program (CRTP), which provides training and support tools to assist mental health staff to implement recovery-based care with people affected by chronic mental illness, who have high levels of unmet need and require ongoing care. The objectives and strategy of the CRTP are congruent with the current NHMP[7], a factor that contributed to partner organisation involvement.

Methodology/sequence of events

Details of the ethical, theoretical and empirical rationale for the Collaborative Recovery Model (CRM), the focus of the CRTP, were described elsewhere.[10] Training of mental health workers was face-to-face over 2 days, followed by 6- and 12-month booster sessions. Sessions used manuals comprising:

- communication of guiding principles emphasising collaboration in clinical and support work, and nurturing of hope regarding recovery for people with chronic or recurring mental illness; and
- clinical skills training on facilitating motivation, assessing needs, establishing recovery goals, negotiating relevant tasks, designing and setting homework, and monitoring progress.

Workers were given related homework assignment and written support tools to help clients formulate goals.

Setting/participants

Participating organisations were public sector mental health services from four separate area health services and six non-government organisations providing support services for people with mental illness from four Australian states (South Australia, Victoria, New South Wales and Queensland). Participating organisations demonstrated a high level of management commitment to the project by contributing funds and/or substantial other resources towards implementation. Participation of workers and clients was voluntary. The study protocol required that services recruit interested staff, who then participated in the training processes and recruited suitable clients.

Initial staff recruitment and training impact

Response to the CRTP training was positive at management and individual participant levels and participation was high across all partner services. Services requested additional training for staff recruited after the initial sessions, or sent them to other sites for training. Some 400 mental health workers have been trained and both formal and informal feedback indicated that the immediate impact of training was substantial and positive — especially in relation to staff attitudes to recovery-orientated practice.[11]

Implementation of applied skills in clinical practice

The primary aim of implementation was to have clinicians use the skills learned in the initial 2-day training program in practice with at least three clients over a year. This represented a sustained practice change with a subset of their consumers. The program attempted to address the key dissemination issues in the following ways:

Management and staff commitment

As already mentioned, CRTP was highly consistent with national objectives, and had strong organisational support, including financial commitment. Senior management and team leaders were involved in developing implementation processes for their sites. Staff meetings expressed strong support for the program. Team leaders attended

training days with their teams and explicitly agreed to support implementation in practice.

Consistency with current practice

CRTP components were designed to be highly consistent with existing mental health work practices across a range of service contexts. A focus on goal planning and monitoring was highly consistent with care planning processes that were almost universal in services. Time points for our evaluation and goal plan reviews mapped onto the routine 3-monthly assessment cycles that reportedly were used in participating government organisations; as well, our assessments relied heavily on existing measures. All of the organisations had an expectation that clinicians would work long term with clients (although the specific duration was not specified in most services). While the demands of CRM procedures may be more demanding than usual practice, we increased feasibility by limiting the number of assessed consumers to three per clinician.

Clear communication

The training procedures and their evaluations suggested that the training was effective. Clinicians were provided with a manual to assist with consolidation of training, and each site had project officer support to reinforce training and provide guidance with respect to implementation.

Resources to support implementation

Each clinician was provided with goal and homework planning forms which were carbonated in order to provide file, client and research copies. All sites were encouraged to review goal plans and progress at team meetings.

Consumer acceptance

Consultation with consumer groups and the consumer-driven philosophy of the program suggested that consumers would view the approach favourably. The Queensland sites had a consumer representative on the Implementation Committee who was a strong advocate for the program.

Despite these planning efforts, there were difficulties with each of the elements in practice. Of the 400 mental health workers who were trained, only around half agreed to formally participate in the voluntary evaluation, and most participating workers recruited just one client. Concerns about additional workload and competing demands on time, claims of rarely working long term with consumers, and perceived lack of organisational support were commonly cited reasons for non-participation or low client numbers. Workers also indicated the project's extra paperwork prevented further recruitment. One reason for the perception of additional burden was that routine outcome assessments often were not completed consistently, despite being a workplace requirement (particularly in the government services).

Preliminary evidence also suggested that less than half the clients participating in the program were making regular active use of the key goal-setting and homework activity tools. Anecdotal reports to site coordinators indicated that this reflected a failure of workers to implement CRM processes, rather than client resistance to them. However the degree of CRM application may be an underestimate, since anecdotal evidence suggested that some participants who were applying CRM processes did not record them or did not make them available to the evaluation.

Discussion

Poor uptake of specific skills highlights the challenge for sustaining even relatively minor modifications to work practices among the mental health workforce. In retrospect, much more was needed in our project to increase the success of implementation and changed practice. Clearly, there are major challenges with regard to uptake and transfer of training to practice[12] that need to be addressed.

More structure may have been needed to support organisational change. Becker et al[13] describe the role of the executive director in communicating a recovery ideology and charge middle managers and senior clinical staff to support this vision. They emphasise the need for middle managers to not only understand the model, but to communicate this effectively and execute change with clinicians and other stakeholders. In the current study, implemen-

tation may have been greater if there were regular reviews of progress in implementation by senior management (eg, participant recruitment, file audits) and if there were formal structures to review fidelity to CRM in team meetings and case reviews. Team leaders could be trained to praise early adopters of CRM. Establishment of CRM supervision, or integration of CRM into existing supervision may also have increased implementation.

Implementation in the context of research sends mixed messages to participants. Implementation outside a research context enables full operation of quality management mechanisms, including both formal and informal clinician performance appraisal. By contrast, the ethical requirements for implementation of a research protocol emphasise participant autonomy and do not permit any kind of coercive practices, even those that would be standard in routine service management. This meant that clinicians could easily perceive the project as an optional "add-on" to routine practice rather than core business, despite clear organisational endorsement.

There appeared to be a high level of support for CRTP in meetings, but it is also possible that this project suffered from scepticism concerning the relevance of research findings to real-world practice, or the belief that evidence-based practices are passing fads that will be quickly replaced with something else.[14] The evaluation of CRTP may itself have impeded involvement of staff on the ground, because of concerns about threats to professional autonomy or clinical judgement.[14]

Consistency with current practices was also an issue. Aspects of our planning were flawed, because we relied on what staff said they already did, or on what managers said they were required to do, rather than verifying what they actually did in practice, by regularly attending team meetings, and auditing files and activity records. A review of workload and time management by clinicians could also have informed plans. Forms should have been more fully integrated into existing file systems rather than being viewed as "extras". Some clinicians indicated that they did not complete goal planning forms because they already completed organisational care plans (even though informal audits of files indicated that often this was not the case).

Consistency with perceived roles was a problem in some services. For example, concerns were raised about whether CRTP skills (needs assessment, motivational enhancement, goal planning, etc) were "clinical", and that support workers in non-government organisations who used CRM were delivering "clinical" services. Most people with chronic and recurring mental disorders such as schizophrenia actually receive similar types of case management and services from both "clinical" and "disability support" providers. Arguments about who provided what services added to challenges faced in this project. As recognised by the current NMHP,[7] there is a need to bring together a diverse range of government and non-government organisations if we are to be successful in making significant mental health reforms. Role boundary issues create major challenges for such reforms.

While the evidence suggests that the training was sound, previous research suggests that workshop training is soon forgotten[1] unless it is reinforced by attempts to use the skills. In the current project, some participants did not apply the skills immediately, and this may have affected both their self-efficacy and their fidelity to CRM protocols.

Resource issues were also raised in this project. Perhaps routine record keeping should include both process and outcome measures relating to recovery values (eg, self determination, growth potential).[15] For example, the consumers' recovery vision and goals could be documented, with consumers given copies and encouraged to add comments. However, our observations suggest that merely adding such a form to procedural requirements will not ensure that it is used: monitoring of its use and incentives for use will be needed.

Other resource issues are raised by the need for sustainability. Several other mental health services and non-government organisations have requested CRTP based on early promising findings. The program has been integrated into some of the university programs in both the University of Wollongong and the University of Queensland, but this does not address the needs of existing providers, including a rapidly expanding non-government organisation

workforce. Ongoing investment in workforce development is essential and should cover not only mental health workers but also managers and clinical leaders. Since CRTP encourages the involvement of consumers as part of the training team, there is a need for training and support of consumers and consumer advocates to support the transfer process. Health care accreditation bodies may also need to review their criteria to incorporate consistency of mental health services with the recovery vision of the NMHP. Instruments to assess the application of recovery practices across services could assist this evaluation (eg, Recovery Self Assessment[16]).

Conclusions

Lessons from our trial on training staff in recovery-oriented practices and integrating them into everyday work practices exemplify challenges for implementation of mental health policy. Even when there is high congruence with national policy priorities, a high level of management support, strong participation in training and only moderate changes to usual practice, implementation cannot be assured. Effective implementation is likely to require more active practitioner process management, which may require a degree of culture change given strong traditions of practitioner autonomy. Robustness of the intervention[17] is also a consideration. Given the likelihood that there will be some violation of fidelity, we need to build interventions that will remain effective even when implementation is less than optimal.

There are success stories, demonstrating that effective dissemination of a high fidelity mental health intervention is possible.[6] However, we need to understand dissemination better if we are to ensure that good practice becomes routine practice and short-term initiatives bring long-term improvements.

Acknowledgements

This project was conducted as part of the Australian Integrated Mental Health Initiative (AIMhi), and was jointly funded by an NHMRC Strategic Mental Health Partnership Grant (# 219327) and by partner organisations.

Competing interests

The authors declare that they have no competing interests.

References

1 Kavanagh DJ, Piatkowska O, Clark D, et al. Application of a cognitive-behavioural family intervention for schizophrenia in multi-disciplinary settings: what can the matter be? *Aust Psychol* 1993; 28: 181-8.
2 Klein KJ, Knight AP. Innovation implementation. Overcoming the challenge. *Curr Dir Psychol Sci* 2005; 14: 243-6.
3 Rogers EM. Diffusion of innovations. 5th ed. New York: Free Press, 2003.
4 Seppälä P. How to carry out sustainable change. An analysis of introducing manufacturing cells in a Finnish engineering company. *Human Factors and Ergonomics in Manufacturing* 2006; 16: 17-37.
5 Melin I, Karlström B, Berglund L, et al. Education and supervision of health care professionals to initiate, implement and improve management of obesity. *Patient Educ Couns* 2005; 58: 127-36.
6 Turner KMT, Saunders MR. Dissemination of evidence-based parenting and family support strategies: learning from the Triple P-Positive Parenting Program system approach. *Aggress Violent Beh* 2006; 11: 176-93.
7 Government of Australia. Australian Health Ministers. National Mental Health Plan 2003–2008. Canberra: Australian Government Publishing Service, 2003.
8 Anthony WA. Recovery from mental illness: the guiding vision for the mental health service system in the 1990s. *Psychosoc Rehabil J* 1993; 16: 11-23.
9 Torrey WC, Rapp CA, Van Tosh L, et al. Recovery principles and evidence-based practice: essential ingredients of service improvement. *Community Ment Health J* 2005; 41: 91-100.
10 Oades LG, Deane FP, Crowe TP, et al. Collaborative recovery: an integrative model for working with individuals that experience chronic and recurring mental illness. *Australas Psychiatr* 2005; 13: 279-84.
11 Crowe TP, Deane FP, Oades LG, et al. Training recovery-oriented mental health teams. *Psych Serv* (in press).
12 Milne D, Gorenski O, Westerman C, Leck C. What does it take to transfer training? *Psychiatr Rehabil Skills* 2000; 4: 259-81.
13 Becker DR, Torrey WC, Toscano R, et al. Building recovery-oriented services: lessons from implementing Individual Placement and Support (IPS) in community mental health centers. *Psychosoc Rehabil J* 1998; 2: 51-4.
14 Essock SM, Goldman HH, Van Tosh L, et al. Evidence-based practices: setting the context and responding to concerns. *Psychiatr Clin North Am* 2003; 26(4): 919-38.
15 Farkas M, Gagne C, Anthony W, Chamberlin J. Implementing recovery oriented evidence based programs: identifying the critical dimensions. *Community Ment Health J* 2005; 41: 141-58.
16 O'Connell M, Tondora J, Croog G, et al. From rhetoric to routine: assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Psychosoc Rehabil J* 2005; 28: 378-86.
17 Duan N, Braslow J, Weisz J, Wells K. Fidelity, adherence, and robustness of interventions. *Psychiatr Serv* 2001; 52: 413.

(Received 13 Feb 2006, accepted 4 Jun 2006) □