

The California Institute for Mental Health
**Community Development
Team Model**

Supporting the Model Adherent
Implementation of Programs and Practices

A Report by

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Foreword

This manual represents a significant milestone for the California Institute for Mental Health (CiMH). It is the culmination of a body of work that has evolved over the last seven years, as CiMH has increasingly invested in providing training and technical assistance to directly support measurable system and service change at the local level through the implementation of evidence-based practices. While this work has progressed through a number of interrelated projects, supported by a variety of entities, the consistent support of the Zellerbach Family Foundation (ZFF) has been the constant driver of this innovation.

In 1998, the ZFF began supporting CiMH projects aimed at improving access to, and the quality of, mental health services for children in foster care. We eventually partnered to publish a report that has had considerable influence upon the California mental health and child welfare systems – Evidence-Based Mental Health Practices for Children in Foster Care. Following publication of this report, CiMH initiated a series of projects designed to promote implementation of these effective practices. Out of this work the CiMH Community Development Team Model evolved.

ZFF's vision and commitment in supporting this series of projects made this possible. The foundation's guidance, coupled with its willingness to support creative solutions, has been the catalyst for this critical work. As of September 26, 2006 CiMH projects support the model-adherent implementation of eight evidence-based practices. These projects involve twenty-nine California counties, several of which are implementing multiple practices. The increasing availability of highly effective, model-adherent practices is a substantial movement toward transformation of the state's mental health system.

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Introduction

There is a clear need to span the gap between science and practice in the delivery of mental health care. The routine availability of evidence-based practices in public mental health service systems holds tremendous promise for improving outcomes for consumers and their families.

“Mental disorders are treatable, contrary to what many think. An armamentarium of efficacious treatments is available to ameliorate symptoms. In fact, for most mental disorders, there is generally not just one but a range of treatment of proven efficacy” (p. 64-65). So concludes the U.S. Surgeon General’s Report on Mental Health (1999). “Based on this finding, the report’s principal recommendation to the American people is to seek help if you have a mental health problem or think you have symptoms of a mental disorder” (p 48).

However, the report also notes that “Studies reveal that less than one-third of adults with a diagnosable mental disorder, and even a smaller proportion of children, receive any mental health services in a given year” (p. 92). Moreover, “A wide variety of effective community-based services, carefully refined through years of research, exist for even the most severe mental illnesses, yet are not being translated into community settings. Numerous explanations for the gap between what is known from research and what is practiced beg for innovative strategies to bridge it” (p. 49).

Extending the work of the Surgeon General, the New Freedom Commission on Mental Health — Subcommittee on Evidence-Based Practices: Background Paper (2005), notes that “The gap between routine mental health care practice and evidence-based practice represents a significant public health problem. According to the Institute of Medicine, the lag between discovering effective

treatments and implementing them in routine practice is 15 to 20 years (2001). Despite the enormous increase in the field’s scientific knowledge base and the development of more effective treatments, consumers and their families do not always benefit from these advances... Services and treatment programs based on the latest scientific advances are not routinely available to meet the needs of individuals who have mental illnesses” (p. 10).

CiMH has responded to this gap between science and practice by developing the Community Development Team Model. This model is an innovative multifaceted intervention to promote the sustainable, model-adherent use of evidence-based practices in public mental health usual-care settings, and in turn, to improve outcomes for child and adult consumers.

The Community Development Team Model is intended to achieve the following interrelated goals:

1. Increase the pace at which evidence-based practices are routinely available through the public mental health system.
2. Promote the sustainable, model-adherent implementation of evidence-based practices.
3. Improve outcomes for child and adult consumers.

Background

The Community Development Team Model was initially proposed by the CiMH Cathie Wright Technical Assistance Center, a cooperative effort of the California Department of Mental Health and CiMH to improve child and family mental health services. CiMH is a private, non-profit, public-interest corporation established

in 1993 by California's County Mental Health Directors Association to promote excellence in mental health services through training, technical assistance, research, and policy development. County mental health directors, consumers, family members, and public-interest representatives serve on its Board of Directors.

The CiMH Cathie Wright Technical Assistance Center was originally created to assist counties in their efforts to develop children's system of care programs. Early efforts focused on training in team building, inter-agency collaboration, parent/professional partnerships, and cultural competency. As an outgrowth of helping counties develop systems of care, and in response to the findings of the Surgeon General's report on mental health, the CiMH Cathie Wright Center launched a strategic initiative to promote the adoption of evidence-based practices by county-operated Mental Health Plans. The Community Development Team Model grew out of this initiative.

CiMH is currently involved in the proactive dissemination and implementation of numerous child and family evidence-based practices using the Community Development Team Model, including: Multidimensional Treatment Foster Care, Functional Family Therapy, Multidimensional Family Therapy, Depression Treatment Quality Improvement, Aggression Replacement Training, and Wraparound.



The Challenge of Implementing Evidence-Based Practices

Many of the developers of evidence-based practices have established training centers to teach practitioners, who work in usual-care settings, their practices. The ability to learn and use a practice with the same integrity and quality as the developers themselves is referred to as model-adherence or fidelity and appears to be critical to replicating, in usual-care settings, the enhanced outcomes achieved in controlled efficacy and effectiveness trials. However, attaining model-adherence can be very challenging.

Although differences are apparent, developers of various evidence-based practices tend to use a common set of general strategies for teaching practitioners to learn and use their practices, including:

- Instruction — description of the practice, including the theory and techniques, often supported by a manual or textbook.
- Modeling — demonstrations of how the techniques are used.
- Practice — repeated efforts to use the intervention/techniques through role-play and in practice with usual-care clients.
- Performance feedback — constructive critique of the practitioner's skill level and possible need for improvement.

Although the transfer of clinical skills through these teaching strategies with motivated practitioners is well documented, establishing sustainable, model-adherent programs is also influenced by organizational factors, and has proven to be challenging to achieve. The challenges associated with establishing evidence-based practices are articulated in the results of a

survey of state mental health agencies conducted by the National Association of State Mental Health Program Directors (2004). The survey results found "...that all states are actively working

Attaining model-adherence can be very challenging.

to provide EBPs to mental health consumers. Every single SMHA¹ was implementing at least one EBP in 2002, and 23 states were offering at least six different EBPs. Many of the EBPs are being offered in parts of a state and fewer EBPs are being implemented state-wide. This is likely due to the many challenges that accompany EBP implementation (e.g. financing, training, fidelity measurement, the need to adapt for special populations and rural area, etc)" (p. 1).

There are a number of informative reviews of diffusion, dissemination, and implementation of innovation with relevance to implementing mental health practices (Fixsen, Blase, Naoom, Friedman, and Wallace, 2005; Greenhalgh, Robert, MacFarlane, Bate and Kyriakidou, 2004; Schoenwald and Hoagwood, 2001). Numerous factors thought to influence successful implementation of new practices are highlighted in these reviews. For example, the following factors have been investigated: complexity of the practice; perceived need; perceived benefit; perceived difference between the new and current practice; community strengths and values; stakeholder's and end-user's involvement and interest; organizational readiness; organizational

¹ State Mental Health Agency

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support, costs, planning, communication and influence-networks; and inter-organizational factors.

Investigators interested in enhancing dissemination and implementation of evidence-based practices have proposed highly instructive models based on their synthesis of relevant

The development and evaluation of these models for closing the gap between science and usual-care practice is in its infancy.

literature and/or experience of disseminating practices in community settings. Noteworthy are the models proposed by Greenhalgh et. al. (2004), Fixsen et. al (2005), and investigations being conducted by Glisson and Schoenwald (2005).

Greenhalgh et. al. (2004) have developed a conceptual model for considering the diffusion, dissemination, and implementation of innovations in healthcare service delivery. Their model, which is primarily intended to summarize the disparate literature, describes a user-system characterized by system antecedents, system readiness, adopter/assimilation factors, implementation and consequences, interaction with a resource system, knowledge purveyors, and change agencies.

Fixsen et. al. (2005) have proposed the Implementation Drivers Model, which posits

that practitioner behavior is created and supported by a set of drivers that include staff selection, pre-service and in-service training, ongoing consultation and coaching, staff and program evaluation and fidelity assessments, facilitative administrative support, and systems interventions. The combined influence of the drivers on practitioner behavior is thought to be integrated and compensatory such that the impact of the drivers is summative, but strength in one driver may compensate for weakness in another driver.

Glisson and Schoenwald (2005) are investigating the benefit of an organizational and community intervention model known as ARC (Availability, Responsiveness, Continuity) in facilitating the implementation of Multisystemic Therapy (MST), an evidence-based practice. The ARC model is guided by the following three assumptions: (1) implementation of practices is as much a social as a technical process, (2) the social context includes the service provider, organization and community, and (3) implementation is enhanced when the social context fits the objectives of the service technology. The ARC model includes a set of primary activities provided over four phases. The phases are problem identification, direction setting, implementation, and stabilization. Primary activities associated with each phase include the following: networking in the community to build relationships and to understand the community's perspective; developing shared understanding of how to address the targeted problem, change agent addressing barriers and ensuring that planned changes occur; and monitoring the success and use of continuous improvement strategies.

The development and evaluation of these models for closing the gap between science and

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usual-care practice is in its infancy. A recent review of the research evidence on the effects of organizational strategies for implementing innovation in healthcare (Wensing, Wollersheim, and Grol, 2006) concludes that “There is a growing evidence base of rigorous evaluations of organizational strategies, but the evidence underlying some strategies is limited and for no strategy can the effects be predicted with high certainty.” This is similar to the conclusion drawn by Goldman, Ganju, Drake, Gorman, Hogan, Hyde, and Morgan (2001) in which they note that “Although thousands of studies have been conducted on dissemination of innovation and implementation of health and mental health services, there is virtually no definitive evidence to guide implementation of specific evidence-based practices.”

Our work with the Community Development Team Model is also new; however, early experiences have been very favorable. Although primarily anecdotal, outcomes with the model have been positive. Participating agencies routinely comment on benefiting from the administrative support, particularly around staff selection and retention, supervision, financing, and developing the capacity for monitoring model-adherence and outcomes. Moreover, practice developers have been complimentary about their experiences with the Community Development Team Model, as well. They note benefits associated with attention to overcoming organizational barriers, advanced planning with sites, and ongoing support of model-adherence and sustainability.

Preliminary quantitative data indicates a high rate of established model-adherent sites across a number of evidence-based practices. Community Development Teams have supported

implementation of the following practices to date:

- ***Multidimensional Treatment Foster Care (MTFC)*** — two phases including ten sites started in spring 2004, six sites in early implementation in fall 2006.
- ***Functional Family Therapy (FFT)*** — three phases including seven sites started in the fall of 2004, four sites in early implementation, seven sites in planning stages in fall 2006
- ***Aggression Replacement Training (ART)*** — four phases including ten sites started in the summer of 2005, ten sites started in the spring of 2006, one site in early implementation, and 11 sites in the planning stages in fall 2006.
- ***Depression Treatment Quality Improvement (DTQI)*** — seven sites started in the winter of 2006.
- ***Multidimensional Family Therapy (MDFT)*** — four sites in early implementation in summer 2006.
- ***Incredible Years*** — four sites in early implementation in fall 2006.
- ***Trauma Focused Cognitive Behavior Therapy (TF-CBT)*** — four sites in early implementation in fall 2006.
- ***Multisystemic Therapy (MST)*** — four sites in early implementation in fall 2006.
- ***Wraparound*** — five sites in the early planning stages in fall 2006.

Only the Multidimensional Treatment Foster Care, Functional Family Therapy, and Aggression Replacement Training Community Development Teams have enough longevity to comment on the success in establishing new programs.

The Challenge of Implementing Evidence-Based Practices

The first phase of the MTFC Community Development Team began in the spring of 2004. At that time there were no established MTFC programs in California. All fifty-eight counties in

The model grew out of CiMH's experiences as a mental health training and technical assistance center, and is responsive to many of the factors cited in the dissemination and implementation literature.

the state were sent an invitation to join the MTFC Community Development Team. Twenty-three counties responded to the invitation and participated in a readiness conference call. Fifteen of these counties went on to participate in two implementation planning meetings. Ten of these counties proceeded to develop implementation plans and participate in clinical training. Nine of these counties placed at least one child in a MTFC foster home.

Two years later, five of the counties (50% of those who participated in the clinical training) have successfully graduated youth from their MTFC programs. All five of these MTFC programs are active, and one is planning to double the size of their program. Of the remaining five counties, three are interested in continuing MTFC but are struggling to sustain the program, one has suspended the program pending a revised implementation plan, and one has discontinued its program.

The first phase of the FFT Community Development Teams began in the fall of 2004. At that time there were no established FFT programs in California. All fifty-eight counties in the state were sent an invitation to join the FFT Community Development Team. Seventeen counties responded to the invitation and participated in a readiness conference call. Nine of these counties went on to participate in an implementation planning meeting. Eight of these counties developed implementation plans, and seven participated in the clinical training of FFT practitioners. Six of these FFT sites are active, and the remaining site has been reduced to a single therapist as plans to renew the program are being considered.

The first phase of the ART Community Development Teams began in the summer of 2005 and consisted of ten private provider agencies that approached CiMH with interest in implementing this practice. Numerous ART programs existed in California at that time. Two of the ten participating agencies had previously implemented ART. All ten agencies participated in a readiness conference call, an implementation planning meeting, and clinical training. Five of these agencies have active programs and have started a training-for-trainers process with plans to expand their use of ART. Three of the remaining agencies have active programs, and the other two have discontinued use of ART.

Given that there is virtually no systematic examination, to date, of the degree to which agencies pursuing implementation of an evidence-based mental health practice establish and sustain model-adherent programs, it is difficult to evaluate the merits of the Community Development Team Model. However, significant challenges associated with establishing new practices are

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clearly documented in the dissemination and implementation literature. Moreover, anecdotal comments from developers confirm that many agencies make inquiries but do not pursue clinical training, and many agencies that initiate clinical training fail to establish or sustain their programs. As a consequence, these early Community Development Team outcomes are promising, especially given that CiMH solicits and provides incentives for counties/agencies to implement these practices.

CiMH's proactive efforts to solicit participation, offer incentives (for example, subsidizing the cost of the clinical training), and support implementation planning is in contrast to the more typical situation in which only agencies with high levels of interest and demonstrated readiness independently approach developers for clinical training. These highly motivated and prepared organizations are sometimes referred to as "early adopters" and would represent a minority of California's public mental health providers. The Community Development Team Model targets all counties/agencies throughout the state's public mental health service system, and is intended to encourage counties/agencies to implement evidence-based practices sooner than might otherwise have been the case.

Bolstered by these early positive outcomes, CiMH, in partnership with the Center for Research and Practice (the developers of MTFC), the Prevention Science and Methodology Group, and TFC Consultants (MTFC training center), is in the early stages of investigating the efficacy of the Community Development Team Model. This NIMH- funded research project is designed to test the effect of the Community Development Team Model on the sustainable model-adherent implementation of an evidence-based practice

— MTFC. The study will involve 40 California counties being randomly assigned to one of two study conditions — the standard implementation model or the Community Development Team Model. Rates of program implementation, model-adherence, and effectiveness will be studied.



Community Development Team Model

The Community Development Team Model is intended to promote the dissemination and implementation of evidence-based practices. The model grew out of CiMH's experiences as a mental health training and technical assistance center, and is responsive to many of the factors cited in the dissemination and implementation literature, such as perceived need, benefit and fit of the practice, stakeholder involvement, organizational structures, planning, and inter-organizational factors.

The Community Development Team Model is a pragmatic strategy to bridge the gap between science and usual-care practice and to hasten the availability of evidence-based practices in the public mental health service system (a more detailed description of the model is presented in appendix A). Key characteristics of the model include:

- Informing counties/agencies about, and soliciting and providing incentives for, implementation of evidence-based practices.
- Partnering with evidence-based practice developers to provide clinical training and consultation.
- CiMH Training, Research, and Policy Associates providing concrete and tailored assistance in developing and executing implementation plans and overcoming organizational barriers.
- Forming peer-to-peer networks to support easy exchange of information about implementation challenges and solutions.
- Developing a sustainability infrastructure within the state's public mental health system.

In brief, information about evidence-based

practices is presented at statewide and regional conferences. These presentations emphasize the benefits associated with these practices and how they can fit within county-operated mental health service systems.

CiMH proactively seeks grants from private and governmental organizations, and funding from the California Department of Mental Health to support Community Development Team costs. When available, these funds are used to subsidize the training and technical assistance costs that would otherwise be borne by the counties/agencies.

CiMH initiates outreach to counties through communication (letters and email) directed to county mental health and private provider agency directors and administrators, as well as administrators of other county agencies (i.e. Social Services, Probation, etc.). The communications describe the evidence-based practice, target population, demonstrated outcomes, Community Development Team process, agency's cost for participating, any subsidy provided by CiMH, and next steps.

CiMH convenes individual conference calls with each county/agency expressing interest in the Community Development Team. The calls are intended for administrators and managers who will be responsible for implementing and sustaining the practice. During the calls, the specific practice and Community Development Team Model are described in greater detail. Distinguishing characteristics of the practice, important considerations regarding staffing, referrals, interagency collaboration, clinical training activities, organizational supports, readiness factors, and agency commitment are reviewed. Counties/agencies that are interested

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in pursuing the opportunity are invited to join an implementation planning meeting.

One or two implementation planning meetings are convened depending on the complexity of the practice. The meetings are for all interested agencies and again intended for administrators and managers, but representatives from stakeholder agencies like child welfare, probation or schools, direct service practitioners who have interest in the practice, and consumers/family partners are welcome. Participation by stakeholders, particularly consumers/family partners, is helpful in building community support for the practice.

The meetings are one to two days in duration. The practice developer is in attendance and provides an introduction to the practice, including a review of the research and description of the model, demonstrated outcomes, and clinical training components. The Community Development Team Model is reviewed and specific organizational supports described. Each of the agencies then presents a preliminary implementation plan. The plan is based on a guide provided by CiMH. The guided plan typically has the following six sections: integration into the organization's service array including identification of the referral population and procedure, staffing, program supervision, funding, fidelity monitoring and outcome evaluation, and administrative oversight.

CiMH Associates review preparation of implementation plans during a conference call prior to the planning meeting. The resulting plan is then presented during the planning meeting(s). Participating agencies benefit by learning about the plans from other agencies and from constructive critique offered by the developer, CiMH associates, and peer agencies. At the conclusion of the planning meeting(s),

agencies make a final commitment to join the Community Development Team. Counties/agencies amend implementation plans based on the critique provided and finalize arrangements for participation in the clinical training.

Following the initial clinical training, all participating agencies begin service delivery.

Facilitating and supporting a peer-to-peer learning environment is a key characteristic of the Community Development Team Model. Joint-planning and clinical training meetings, annual sustainability meetings, monthly administrator's conference calls, and a listserv facilitates peer-to-peer interactions.

Clinical consultation and site visits or booster trainings typically proceed for one to two years, depending on the practice. Simultaneously, CiMH Associates initiate organizational support. Support includes the following:

- Monthly conference calls with the administrative leads from each site. This is a joint call with all participating sites focusing on implementation successes, any challenges, and strategies for

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- promoting model-adherence.
- Development of a fidelity monitoring and outcome evaluation protocol and corresponding database for use by each site. Data is submitted to CiMH by each site. CiMH associates analyze the data and prepare both site-specific and aggregate reports.
- A listserv is established to support easy email communication among all the administrative leads in the Community Development Team. The listserv is used by CiMH associates for notices and updates, and by the sites to share successes, ask questions, and offer suggestions.
- Individualized technical assistance, either by phone or site visit, is provided as needed to address emerging barriers that jeopardize a site's implementation of the practice.

Facilitating and supporting a peer-to-peer learning environment is a key characteristic of the Community Development Team Model. Joint-planning and clinical training meetings, annual sustainability meetings, monthly administrator's conference calls, and a listserv facilitates peer-to-peer interactions. Support from peer sites appears to be instrumental in maintaining motivation and perseverance, and promoting creativity and problem solving. Although nearly all sites experience one or more barriers to implementation, rarely do all sites struggle with the same barrier. As a consequence, each site has some strategies to teach and some to learn, in a context of mutual support and cooperation, where sites are bolstered by the idea that if a peer site can do it, then so can they.

Participation in all Community Development Team meetings appear to be important to the overall success in implementing the practice. Based upon CiMH's experiences to date, the following conditions appear to predict overall success:

- The county/agency is strongly committed to implementing the new practice based on a full understanding of the practice model, programmatic requirements, training activities, and costs.
- The county/agency identifies an appropriate team of individuals to join the Community Development Team, often including stakeholders — consumers or family members, cross-agency partners, and responsible administrators.
- The county/agency team consistently attends all Community Development Team meetings.
- The county/agency has empowered an administrator with overall responsibility for insuring implementation of the practice. Moreover, this individual has the authority to dedicate the necessary human and financial resources.

Conclusion

The Community Development Team Model is a promising training and technical assistance strategy, designed to directly impact services and practitioner skills at the ground level. The approach has resonated with counties and agencies throughout the state, leading to numerous projects and anecdotal accounts of success. As a result of these positive accounts, CiMH has

formalized the model and is in the process of conducting controlled research on its effectiveness in promoting sustainable model-adherent implementation of evidence-based practices. This is an exciting process for CiMH and the county mental health departments, community-based organizations, family members, and others who are invested in improving the quality of our mental health service system.



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Appendix A:

Community Development Team Technical Manual

Supporting the Model Adherent
Implementation of Programs and Practices



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Background and Rationale

The Community Development Team (CDT) Model is designed to promote the sustainable, model-adherent adoption of mental health practices by public mental health providers.

CDT is a multi-phase intervention developed by the California Institute of Mental Health (CiMH), a private, non-profit public interest corporation established in 1993 by California's County Mental Health Directors Association to promote excellence in mental health services through training, technical assistance, research, and policy development. County mental health directors, consumers, family members, and public interest representatives serve on its Board of Directors. The CDT Model grew out of CiMH's efforts to promote innovation in the services and operations of publicly-run and administered mental health programs.

CiMH provides a broad continuum of training and technical assistance activities, including large statewide and regional conferences, individual (site-specific) training, and individualized technical assistance around specific program and operational products. CiMH publishes training materials in hard copy (for distribution by mail), downloadable (from the Web), and CD/DVD formats. Materials include literature reviews, conference summaries, policy briefs, and instructional manuals. Moreover, CiMH provides a continuum of low cost, convenient long-distance training and technical assistance events, including conference calls, web-based conferences, telecasts, and listservs.

CiMH staff has observed that these efforts appear to be largely successful. However, the challenges associated with sustainable, model-adherent adoption of a new practice are substantial and appear to require more significant levels of

assistance provided over a prolonged period of time. Traditional training and technical assistance activities appear to be insufficient to support the broad dissemination and implementation of sustainable, model-adherent evidence-based practices throughout the state's public mental health system.

In regard to evidence-based practices, CiMH conducted a series of training events, over several years, about the value of evidence-based practices in general, and the benefits of specific practices that are well suited to the state's public mental health system. These training events targeted county mental health administrators, managers, direct-service staff, family members/consumers, as well as their partners in probation, child welfare, and schools. With few exceptions, participants expressed enthusiasm about the potential benefit of evidence-based practices and interest in one or more practices. However, relatively few counties or agencies proceeded to implement any of the practices.

It appeared that awareness of, and interest in, an evidence-based practice (including detailed information on how to contact practice-specific developers for training and technical assistance), even when based on compelling information about the merits of the practice from credible and respected sources, did not result in adoption of new practices by the vast majority of participants.

A handful of counties and private providers, independent of or with the assistance of CiMH, did proceed to adopt one or more evidence-based practices. These counties/agencies may represent the group referred to in the literature as "early adopters" and appear to have developed the organizational capacity to overcome barriers that

Background and Rationale

otherwise obstruct agencies from successfully acting upon their interest to adopt a new practice.

CiMH staff observed that barriers to implementing new practices appear to fall into three broad categories: technical, procedural, and initiatory.

Barriers to adoption of a new practice are substantial. CiMH staff observed that barriers to implementing new practices appear to fall into three broad categories: technical, procedural, and initiatory.

- Technical barriers refer to programmatic or administrative policies, procedures, regulations, and so forth that define, specify, guide, or restrict the activities or funding of an agency. The nature and actual complexity of technical requirements vary by practice. Technical barriers are overcome by specific knowledge and expertise concerning relevant policies, procedures, and regulations.
- Procedural barriers refer to the complexity of programmatic and administrative processes needed to implement a new practice, including engaging staff and consumers, selecting staff and managers, training, facilities and equipment readiness, supervision, and administrative support. The actual

complexity of procedural requirements also varies by practice. Procedural barriers are overcome by organizational skill in developing coalitions, planning, and implementation.

- Initiatory barriers refer to the risk and effort associated with implementing a new practice (or change in general). Initiatory barriers appear to be overcome when an agency has a history of managing change well and/or the change is highly rewarded or compelled.

There appears to be a dynamic interplay between the three categories of barriers. For example, technical barriers are less significant when there is strong procedural skill. Presumably this is because agencies that have well developed planning and implementation skills can marshal resources (human and otherwise) to address technical requirements. However, when procedural skills are limited, even relatively minor technical requirements can appear insurmountable. When technical and procedural barriers loom large, the value of maintaining the familiar “tried and proven” is reinforced, and change is obstructed.

Ultimately, change may be initiated, independent of technical requirements or procedural skill and readiness, if required by policy makers or compelled by stakeholders. However, the willingness to initiate a change (perceived risk) appears to be related to the perceived success of the current system, perceived benefit of a new practice, and perceived ability to successfully implement the change.

- If the current system is perceived to be highly successful, or the perceived benefit of the change low, the need for change is diminished, and whatever risk exists appears relatively greater.

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- If the current system is perceived to be poor, or the perceived benefit of the change great, the need for change is heightened, and the risk of change appears relatively less significant.
- If the perceived ability to manage change is high, then the level of risk is perceived to be lower. If the perceived ability to manage change is low, then the level of risk is perceived to be higher.
- Perceived ability to manage change is a function of perceived technical requirements for adoption of the practice and perceived procedural skill of the organization.

In sum, willingness to initiate change appears to be related to an interaction between perceived technical requirements associated with the practice, self-appraisal of the agency's procedural skills around implementing/managing change, and need-benefit analysis of the practice relative to services as usual. Hypothesized barriers to implementation and the role of the CDT in overcoming those barriers are depicted in Figure 1.

Although willingness to commit to change appears to be largely related to perceived risk and benefit, successful change (sustainable model adherent implementation of a practice) appears to be related to actual (as opposed to perceived) technical requirements and procedural skills. Therefore, two sets of implementation outcomes are possible:

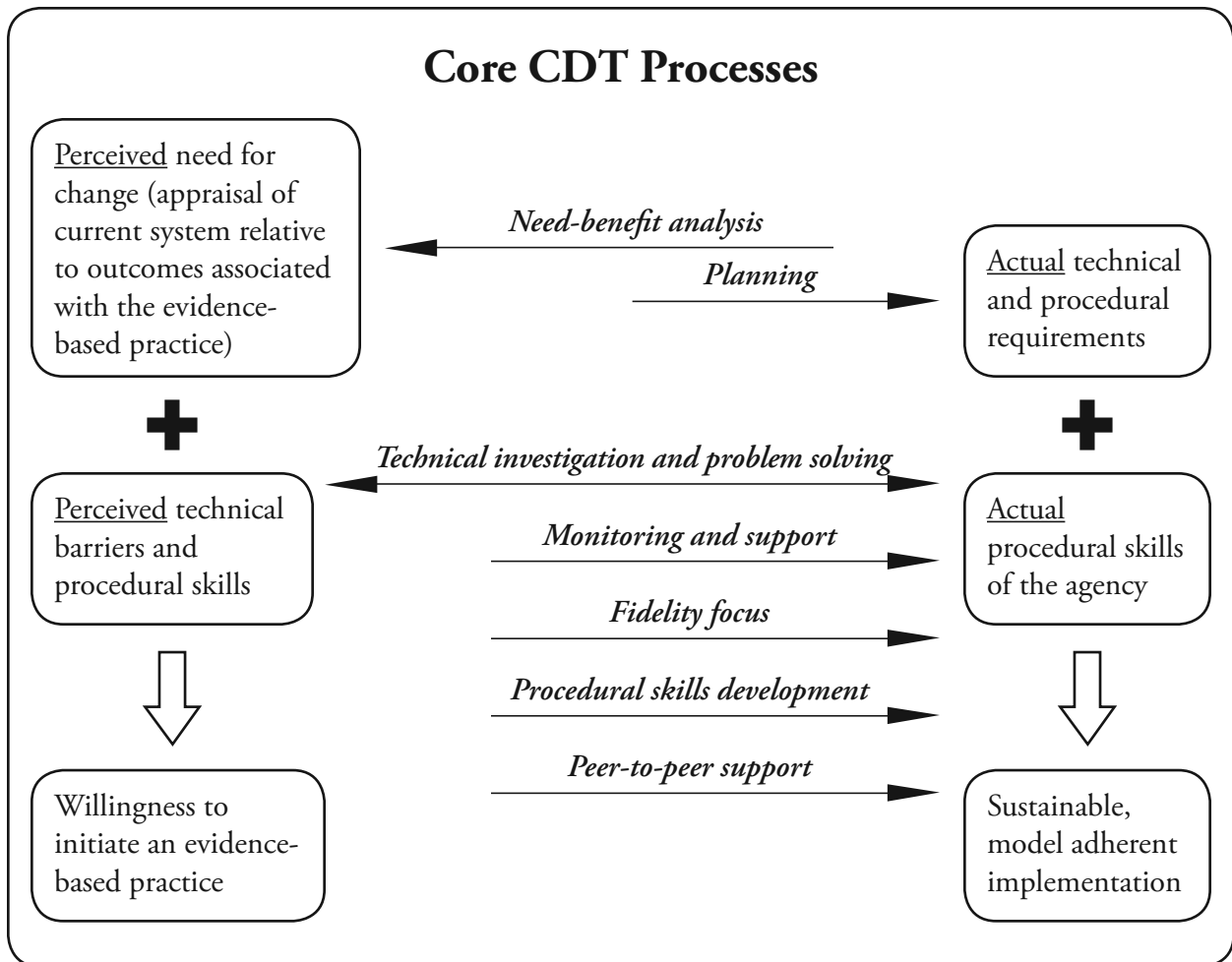
1. An agency perceives risks as high (low benefit, high technical requirements, low procedural skills) and does not initiate adoption.
 - a. If actual technical requirements are high and agency procedural skills

- a. If actual technical requirements are low, adoption will likely be in jeopardy.
 - b. If actual technical requirements are modest, and agency procedural skills are sufficiently high, adoption will likely be successful.
2. An agency perceives risks as low, or is otherwise compelled to implement a new practice (consumers demand it or it is a legislative requirement), and initiates adoption.
 - a. If actual technical requirements are high and agency procedural skills are low, adoption will likely be in jeopardy.
 - b. If actual technical requirements are modest, and agency procedural skills are sufficiently high, adoption will likely be successful.

Finally, CiMH staff has observed a “self-efficacy” phenomenon. Agencies that have successfully implemented new practices in the past appear to be more likely to initiate adoption of a practice in the future. Presumably, with each successful implementation of a new practice, the agency's perception of its procedural skill grows, which is likely related to actual development in change-management skills and infrastructure.

Figure 1

CDT Approach To Addressing Barriers To Adoption and Implementation



Intermediary Purveyor Organization

In sponsoring CDTs, CiMH functions as an intermediary purveyor organization (IPO) as articulated by Dean Fixsen and Karen Blase.² An IPO is an organization with specialized expertise in managing change that encourages and supports adoption of an evidence-based practice. CiMH is one of a growing number of IPOs that has been forming in states across the nation.

CiMH has well established relationships with the State Department of Mental Health, county mental health authorities, child welfare and juvenile probation agencies, and family/consumer organizations. These relationships, and the agency's role as a statewide training and technical assistance center, provide the necessary foundation for its role as an IPO and for sponsoring CDTs.

CiMH's credibility is likely an important factor for its success as an IPO. Adoption of evidence-based practices has differential appeal across stakeholders. CiMH's success in influencing perceived risk and willingness to initiate change and its ability to support and enhance an agency's procedural skills is related to the degree to which stakeholders view CiMH as a credible and capable training center.

CiMH's credibility as an IPO appears to be related to (1) relationships with public mental health stakeholders, (2) technical knowledge about evidence-based practices and the state's public mental health system, (3) familiarity with the daily operations of the county mental health authorities, (4) affiliation with the practice developers, and (5) a history of administering successful projects. Because each stakeholder

group values different relationships, knowledge, and skills, CiMH needs to assign Associates with broad, diverse backgrounds and skills to manage the CDT intervention. Key stakeholders and important areas of technical knowledge and procedural skills include the following.

Key Stakeholders:

- California Department of Mental Health
- County mental health authorities
- State and county child service agencies (child welfare, probation, schools)
- Family members/consumers
- Private organizational providers

Technical Knowledge:

- State and Federal laws and regulations
- State and county policies and procedures
- Quality management standards
- Funding sources
- Mental health disorders and treatments
- Evidence-based practices

Procedural Skills:

- Program planning
- Coalition building
- Hiring, training, and supervision of practitioners
- Outcome evaluation
- Human resource management
- Direct service roles and responsibilities
- Supervision and management responsibilities
- Establishing and sustaining interagency collaboration

² This is a term newly applied to dissemination/transport of mental health practices by Dean Fixsen, Karen Blase, and colleagues from the Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida.

CDT Staff

Two CiMH Training, Research, and Policy Associates, with the requisite service system experience, knowledge and skills, and the ability to establish credible relationships with stakeholders staff a CDT. Their qualifications include (or the above-mentioned attributes include) advanced degrees in mental health (MSW or PhD), training in evaluation, and extensive experience as providers, including at a minimum work experience as clinicians, supervisors, and managers/administrators for a public mental health or other human services agency. Combined experiences as a practitioner and program administrator are critical for the CiMH Associates to be credible and effective across stakeholder groups. Moreover, they are conversant in all aspects of the mental health, child welfare, and juvenile justice service systems, and

can translate the requirements of new practices into the familiar demands and functions of the typical- or usual-care service system.

Staffing each CDT with a pair of consultants is needed to ensure breadth of technical knowledge and procedural skills and to support responsiveness to site-specific needs. In addition, the CDT staffing includes administrative support for managing correspondence, scheduling activities, and event planning. Jointly, the consultants and administrative support staff are responsible for scheduling and conducting the CDT intervention activities. Two full-time consultants and a full-time administrative assistant can be expected to support three to four CDTs at one time (depending on the complexity of the specific practices).



Selecting a Practice and Preparing to Establish a CDT

Prior to initiating a CDT, a practice is selected, negotiation with the practice developers is conducted, and a feasibility analysis is completed.

Selecting a Practice

CiMH selects practices that have strong evidence of effectiveness and relevance to California's public child service systems. The specific criteria

Given the large effort required to implement a new practice with fidelity, it is important for sites that undertake these initiatives to achieve improved outcomes.

for selecting a practice are flexible, but always take into account needs identified by the state's public mental health system (county mental health authorities, providers, and consumers/family members) and input from stakeholders (e.g., child welfare, probation, schools, etc.). CiMH prioritizes practices that address an area of high need in the mental health system and offer the promise of significantly improved outcomes. CiMH Associates evaluate the practice based on literature reviews, correspondence with practice developers, and contact with others, inside or outside the state, who have experience using the practice.

Given the large effort required to implement a new practice with fidelity, it is important for sites that undertake these initiatives to achieve

improved outcomes. As a result, CiMH avoids promoting practices with low or unknown evidence of effectiveness, so that sites are not discouraged if a well-implemented practice does not result in significantly improved outcomes.

Establishing a Collaborative Relationship with the Practice Developers

Once a practice is selected, CiMH contacts the practice developers to consider a CDT project. When there is mutual interest, CiMH negotiates a plan for clinical training and consultation to be provided by the developers in the context of a CDT. CiMH then establishes a contract with the practice developers.

Feasibility Study

CiMH conducts a feasibility study (with the help of the practice developers) based on a detailed understanding of the practice (i.e. target clients, expected outcomes, levels of effectiveness, programmatic requirements) and the clinical training and consultation protocol. CiMH Associates seek to identify actual technical and procedural requirements of the practice and to anticipate potential barriers. The results of the feasibility study are used to prepare solicitation letters, introductory training materials, and implementation planning guidelines.

CiMH and Practice Developer Roles and Responsibilities

Each CDT is devoted to implementation of a single practice, and convened by CiMH in partnership with the practice developer(s). The typical roles and responsibilities for CiMH and the practice developers are as follows:

CiMH is responsible for:

- Promoting interest in and commitment to implementing a new practice among public mental health, juvenile justice and/or child welfare authorities, and/or private providers.
- Assisting participating sites in developing procedural skills (i.e. stakeholder engagement, planning, staff selection, supervision, client referrals, interagency coordination, outcome evaluation, funding).

CDTs involve a cohort of sites that implement a practice in concert, which requires that the practice developers adjust their training protocols from an individual agency focus to a focus on a group of agencies.

- Assisting participating sites in addressing technical requirements (i.e. adherence to laws, regulations, policies, or procedures).
- Contracting with the practice developers to provide clinical training and

consultation.

- Scheduling and convening training and technical assistance activities.
- Developing a California specific infrastructure to support long-term model adherence and sustainability.

The practice developers are responsible for providing clinical training and consultation in the context of the CDT. Although the type and level of training and supervision varies by practice, typical components include:

- Introduction (one day)
- Implementation planning (one to two days)
- Initial clinical training (two to five days) and booster trainings (one to three, one-day training events, or site visits during the first year)
- Clinical consultation (generally by phone, weekly, but may be in-person) lasting 6-12 months
- Monitoring model-adherence and outcomes (i.e. per contact documentation or other frequent documentation of activities, self- and other ratings, and/or videotape reviews)
- Protocol designed to ensure that the practice is sustained over time (i.e. credentialing, certification, training trainers, training supervisors)

CDTs involve a cohort of sites that implement a practice in concert, which requires that the practice developers adjust their training protocols from an individual agency focus to a focus on a group of agencies. CiMH and practice developers are jointly responsible for developing an adjusted protocol of mutual training, consultation, and technical assistance and for coordinating their activities.

Participating Sites

The CDT model is designed to promote adoption of evidence-based practices by public mental health providers, specifically including agencies that would otherwise be disinclined to initiate implementation of an evidence-based practice. Therefore, CDTs involve activities and processes designed to address perceived risk and actual procedural skills so that agencies are willing to initiate adoption of a new practice and are prepared to meet the technical and procedural requirements of the practice.

A CDT consists of a cohort of county agencies and/or private mental health organizations that implement a single evidence-based practice in concert. Each participating county or agency includes a team of individuals who are responsible for oversight and administration (administrators) and a team of direct-service practitioners who will be responsible for learning and providing the new practice (practitioners).

System Leaders/Administrators for each site are responsible for committing the county or agency to the CDT, planning implementing, ensuring that programmatic and administrative structures and resources to support model-adherence are available, overseeing completion of the plan, and sustaining the practice over time. Composition of the system leader/administrative group will vary according to the requirements of the practice; however, typical membership from each site includes agency directors or assistant directors, program manager(s), and individuals responsible for finance, quality assurance, and/or outcome evaluation. If the practice targets interagency-involved youth (juvenile justice-mental health, child welfare-mental health, school-mental health), then members also include administrators or managers from relevant partner agencies. In addition, family members/consumers and line

supervisors or direct service staff are also invited.

Practitioners from each site are responsible for providing the specific practice. Educational and experience requirements for practitioners vary according to the requirements of the practice and the site's implementation plan and may include licensed/licensed-eligible clinicians or paraprofessional practitioners from one or a collaborative of county and/or provider agencies.



Overview of Phases, Processes, and Activities

As illustrated in Table 1, there are three phases of the CDT model: pre-implementation, implementation, and sustainability. During these phases, seven core processes occur that are designed to facilitate implementation and

sustainability of a new practice. These processes are accomplished via a set of seven distinct activities. The activities are carried out by a pair of CiMH associates working in close collaboration with the practice developers.

Table 1
CDT Phases, Processes, and Activities

Phase	Goal	Typical Process	Typical Activity
Pre-Implementation	Engagement	<ul style="list-style-type: none"> • Need-benefit analysis • Planning • Fidelity focus • Procedural skills development 	<ul style="list-style-type: none"> • Site-specific correspondence and conference call
Pre-Implementation	Implementation Planning	<ul style="list-style-type: none"> • Need-benefit analysis • Planning • Fidelity focus • Procedural skills development • Peer-to-peer exchange and support 	<ul style="list-style-type: none"> • Community Development Team meeting • Titrated technical assistance, as needed
Pre-Implementation	Clinical Training	<ul style="list-style-type: none"> • Procedural skills development • Peer-to-peer exchange and support 	<ul style="list-style-type: none"> • Community Development Team meeting



Overview of Phases, Processes, and Activities

Table 1 (*continued*)
CDT Phases, Processes, and Activities

Phase	Goal	Typical Process	Typical Activity
Implementation	Model-Adherence	<ul style="list-style-type: none"> Monitoring and support Fidelity focus Technical investigation and problem solving Procedural skills development Peer-to-peer exchange and support 	<ul style="list-style-type: none"> CDT conference calls Prompted listserv Site-specific correspondence and calls CDT practice developer conference calls Titrated technical assistance
Implementation	Practitioner Competence	<ul style="list-style-type: none"> Monitoring and support Fidelity focus Technical investigation and problem solving Procedural skills development Peer-to-peer exchange and support 	<ul style="list-style-type: none"> CDT meeting CDT conference calls Prompted listserv Site-specific conference calls Fidelity monitoring and outcome evaluation templates CiMH and practice developer conference calls Titrated technical assistance
Sustainability	Autonomous Site	<ul style="list-style-type: none"> Monitoring and support Fidelity focus Procedural skills development Peer-to-peer exchange and support 	<ul style="list-style-type: none"> CDT meeting CDT conference calls Prompted listserv Site-specific conference calls CDT organization and practice developer calls Titrated technical assistance

CDT Phases

The CDT intervention is provided in three phases as follows:

Pre-Implementation Phase

The goal of this phase is to promote engagement and commitment by sites to implement the selected practice. The phase begins with solicitation correspondence and concludes when practitioners have completed their initial clinical training and begun to provide the practice (enroll clients). The duration of this phase varies by practice, but ranges from six to nine months.

The steps in this phase are engagement, readiness, preparedness, and staff training. The core processes of this phase are: need-benefit analysis, peer-to-peer exchange and support, planning, fidelity focus, and procedural skills development. The primary activities are CDT planning and clinical training meetings, site-specific correspondence, and titrated technical assistance.

Implementation Phase

The goal of this phase is for each site to establish and operate a model adherent program staffed by proficient practitioners. This phase begins when the sites establish the practice (enroll clients), and ends after a pre-determined level of practice-specific clinical training and consultation, intended to result in practitioner competence, has been provided. The duration of this phase varies by practice, but ranges from one to two years.

The steps in this phase involve coordinating referrals, enrolling youth and families, and using model adherent supervision (to build practitioner competence) and model-adherent administrative practices. The core processes of this phase are monitoring and supporting program staff

and administrators, fidelity focus, technical investigation and problem solving, procedural skills development, and peer-to-peer exchange and support.

The primary activities include administrator's conference calls, prompted listserv, site-specific conference calls, fidelity monitoring and outcome evaluation, practice developer conference calls, and titrated technical assistance.

Sustainability Phase

The goal of this phase is to promote autonomous, model adherent programs, including attainment of site certification or licensure when appropriate. The duration of this phase is ongoing.

The steps in the sustainability phase involve establishing procedures and mechanisms to support sustainable model adherence (monitor and prevent model drift), to build capacity to train new staff, and to retrain existing staff. Common sources of model drift include:

- Insufficient clinical training or supervision
- Practitioners with multiple or competing duties
- Failure to adhere to practice-specific caseload standards
- Insufficient intra- and inter-agency coordination around referrals or funding
- Little or no attention to fidelity monitoring or outcome evaluation
- Mid-managers/supervisors are wary, too busy, or not supportive of the practice
- Direct service practitioners are not interested in or oppose the practice
- Increased scrutiny and accountability associated with evidence-based practices
- Eagerness to expand use of or adapt the practice before it is well established

CDT Phases

- Attrition of trained practitioners
- Delays between training and referrals or start of program
- The service system is involved in multiple demanding reform efforts or competing change initiatives

The core processes of this phase are monitoring and support, fidelity focus, procedural skills development, and peer-to-peer exchange and support. The primary activities are CDT sustainability meetings, administrator's conference calls, site-specific conference calls, developer conference calls, prompted listserv, and titrated technical assistance.



CDT Core Processes

The CDT is composed of seven core processes thought to be essential to the successful implementation of a new practice. Specifically, the processes are designed to promote engagement, commitment, persistence, and competence within pre-implementation, implementation, and sustainability phases. In addition, the processes are designed to promote the development of organizational structures, policies, and procedures that support model adherent and sustainable programs. The seven processes are as follows:

Need-Benefit Analysis

This process involves sharing empirical information concerning the relative benefits of evidence-based practices in general and the selected practice in particular. The need-benefit analysis is intended to help overcome risk hesitancy and promote ongoing commitment by sites to first adopt and then stay committed to implementing the selected practice.

Specifically, this process is designed to affect the perception of risk by showing how (1) the new practice can result in significant benefit relative to usual care services; (2) technical and procedural barriers, although actual, may be exaggerated; and (3) through careful planning and implementation, technical and procedural requirements can be met. In addition, this process is used to affect perception concerning the importance of systems change and expenditures on training — specifically, that public mental health systems benefit from increased focus on and expenditures in support of practice-specific training and supervision.

Risk-benefit information may challenge strongly held beliefs concerning the effectiveness of current or usual care services and/or reinforce the enhanced benefit of the evidence-based practice

in achieving child, family, and community outcomes (and cost savings). This information often challenges traditional approaches to preparing practitioners and reinforces the importance of ongoing practice-specific training and supervision.

Planning

This process involves guided development of practical implementation, fidelity monitoring, and outcome evaluation plans. This process is designed to demystify the challenges associated with adopting a new practice and produce clear, comprehensive, concrete action plans that address actual procedural and technical challenges. As a consequence, perceived risk is reduced and actual procedural skills are enhanced. Typical procedural issues include the following:

- Identifying the target population for the intervention and establishing screening and referral procedures
- Nesting the new practice in the existing continuum of care
- Developing a coalition of support for the practice through need-benefit trainings with direct service staff, line supervisors, managers, family members/consumers, and other stakeholders
- Selecting practitioners and line supervisors who are motivated to implement the practice with fidelity
- Enacting policies and procedures and/or establishing supports and resources needed to comply with practice-specific requirements (caseload standards, clinical supervision, non-competing duties)
- Identifying and committing funding
- Monitoring and reinforcing fidelity
- Evaluating and reporting outcomes
- Synchronizing staffing, training, and referrals

CDT Core Processes

- Insuring accountable administrative oversight

Monitoring and Support

This process involves ongoing monitoring of each site's individual advancement, review of implementation steps, and supportive communication concerning progress. Persistence is encouraged and technical assistance in addressing emergent barriers provided. The strategy is designed to maintain enthusiasm over the lengthy course of implementing a new practice. Moreover, monitoring and support help maintain focus, identify and prevent early signs of drift, reinforce accomplishments, and reframe periods of slowing and occasional reversals as an expected part of the implementation process (a sign of success, not failure).

Model adherent adoption of a new practice is challenging. Progress tends to be characterized by forward movement, periodic episodes of slowing, and occasional reversals. Expected and unanticipated events develop that can contribute to drift away from practice standards. Common factors contributing to drift that were listed in the previous section on sustainability are often the focus of the monitoring and support process, including identifying when program staff need additional training or supervision, identifying when caseloads are growing too large or staff are expected to conduct non-program-related activities that interfere with their program duties, and so forth. CiMH Associates work with site administrators to resolve any threats to model adherence that may occur and reinforce their implementation efforts.

Fidelity Focus

This process involves emphasizing the importance of fidelity and framing programmatic and

administrative recommendations in the context of promoting fidelity. It is designed to prevent drift from practice standards and to settle disagreements that may develop regarding recommendations made by the CiMH Associates or practice developers.

The strategy is intended to support a site's effort to address factors that contribute to drift. During the lengthy course of adopting a new practice, numerous factors arise that can lead to practice drift. Practice proponents may struggle to repeatedly justify programmatic or administrative features of the new practice (e.g. caseload restrictions, or participation in weekly clinical supervision). The focus on fidelity is a helpful construct for respecting and reinforcing the integrity of the model and overcoming disagreements that may develop over programmatic or administrative recommendations.

CiMH Associates identify practice features that are critical to fidelity at the outset of each project. Throughout the course of the CDT intervention, subsequent assistance is routinely framed in terms of decisions and activities that either support or detract from fidelity and, in turn, that are important for achieving optimal outcomes.

Technical Investigation and Problem Solving

This process clarifies actual from perceived technical barriers and developing potential solutions to actual barriers (through investigation and use of CiMH's established relationships with policy makers). This strategy is designed to reduce unnecessary concern regarding technical barriers that are perceived as larger than actual, to develop practical solutions to actual barriers, and overcome any extra-agency barriers, such as those related to regulations (county or state) or funding.

CDT Core Processes



Procedural Skills Development

This process provides guidance to enhance organizational, management, and human resources skills that each site needs in order to develop and execute their implementation plan. This strategy is designed to provide focused technical assistance to individual sites if and when their implementation efforts stall, drift, or reverse. Under these circumstances, factors that contribute to these difficulties are identified, potential solutions considered, and a mini-action plan is initiated until implementation resumes the expected course.

Peer-to-Peer Support

This process involves implementation of the same practice by a cohort of sites. It is designed to promote engagement and commitment of sites to implement the practice, generate concrete strategies for overcoming barriers, and reduce risk hesitancy. This strategy is intended to reduce perceived risk, share solutions for technical and procedural barriers, and maintain enthusiasm during the lengthy course of adopting a new practice.

Community Development Teams deal with the adoption of the same practice by a cohort (five to eight) of counties or agencies. Group affiliation has the effect of reducing risk associated with implementation of novel practices. In addition, there is considerable concrete peer-to-peer assistance and some healthy competition that naturally develops when a cohort of sites is moving toward the same goal.

CDT Activities

Seven distinct activities are used across the CDT processes. Some of these activities are conducted with a cohort of sites and therefore build peer-to-peer support, while others are conducted with individual sites within a cohort. The seven activities are as follows:

Community Development Team Meetings

CiMH convenes a series of meetings in partnership with the practice developer(s). These meetings always involve a cohort of sites that are implementing the same practice. Each site, in turn, brings to the CDT process a team of constituents within their site who will oversee and/or implement the practice. Meetings during the pre-implementation phase are devoted to planning; during the implementation phase to clinical training and organizational supports; and during the sustainability phase to maintaining model adherence and sustainability.

Administrator's Monthly Conference Calls

These are cohort calls intended for site administrators, convened by the CiMH Associates in partnership with the practice developer. The calls involve monitoring, support, and assistance around overcoming implementation barriers or concerns. These calls are in addition to developer consultation calls for practitioners as part of their clinical training protocol.

Prompted Listserv

A Listserv is established and managed by the CiMH Associates and used to share notices and updates, as well as support spontaneous discussion across sites. Sites use the listserv to ask questions, raise concerns, share successes, and offer suggestions.

Site-Specific Correspondence and Conference Calls

CiMH Associates conduct periodic calls and correspondence with individual sites. These are devoted to monitoring and support, as well as to providing assistance regarding barriers to implementation, threats to fidelity, promotion of practitioner competence, or concerns around program sustainability.

Fidelity Monitoring and Outcome Evaluation Protocols

Fidelity monitoring and outcome evaluation protocols are developed based on consensus of the sites achieved through conference calls and/or meetings facilitated by the CiMH Associates. Each site is provided with a corresponding database. Sites collect and submit data, which is then analyzed by CiMH Associates, who generate site specific and aggregate reports. CiMH Associates help sites identify drift from practice components and make program adjustments. During the sustainability phase, sites develop the capacity to conduct their own data analysis and reporting.

Practice Developer's Monthly Conference Calls

Calls between CiMH Associates and the practice developers coordinate training and technical assistance activities and review each site's progress.

Titrated Technical Assistance (by phone or on-site visits)

CiMH Associates conduct conference calls or site visits, as needed, to address significant, unanticipated threats to the planned implementation.

