


## EBP Workforce Development: Bridging Academic & Behavioral Health Care Programs

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Co-directors



*The Child and Family*  
Evidence-Based Practices Consortium

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## Setting the Stage



- To what extent are masters level practitioners prepared to implement evidence-based practices?
- How should academic & behavioral health care programs collaborate to develop an implementation aware workforce capable of delivering effective, evidence-based practices?
- What data may help us anticipate and overcome challenges in these endeavors?

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## Child and Family EBPs Consortium

- Formed in 2004
- International participation from academia, administrators, policymakers, & purveyors
- A forum for education & networking of experience
- Goal: Expand dissemination & use of EBPs & implementation frameworks
- Much of our current focus is....

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### EBP Workforce Development

To what extent is evidence-based practice taught in graduate courses & field instruction?



Are implementation frameworks included in graduate curricula & applied at field sites?

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### Research & Dissemination

- Survey of North American behavioral health care administrators & supervisors (Barwick, 2011)
- Survey of EBPs in North American MSW programs (Bertram, Charnin, Kerns, & Long *(in press)*)
- Multi-method program implementation evaluation of 34 Kansas City MSW field sites (Bertram, King, Pederson, & Nutt, 2014)

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### Evidence Based Practices in North American MSW Curricula

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### Exploratory Survey

Series of EBP Consortium calls develop survey

Support of key leaders from National Association of Deans & Directors

Follow-up to Barwick (2011) exploration of EBP preparedness with North American behavioral health care leaders

EBP definition identical to Barwick (2011)

- Defined elements, activities, phases
- Proven effective with specific populations in RCTs

Includes Barwick (2011) EBP readiness questions

### Exploratory Survey

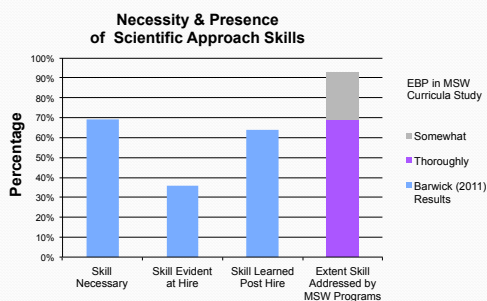
#### Demographic factors:

- Geographic location
- Number of students
- Number of faculty by position
- Number of faculty by position that teach EBPs
- Which EBPs are taught

To explore the extent to which each EBP is taught, survey also focuses through NIRN intervention component framework

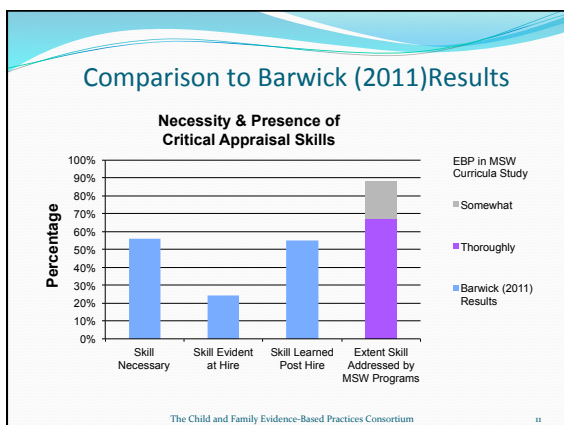
Qualitative exploration of supports, barriers, implications

### Comparison to Barwick (2011) Results



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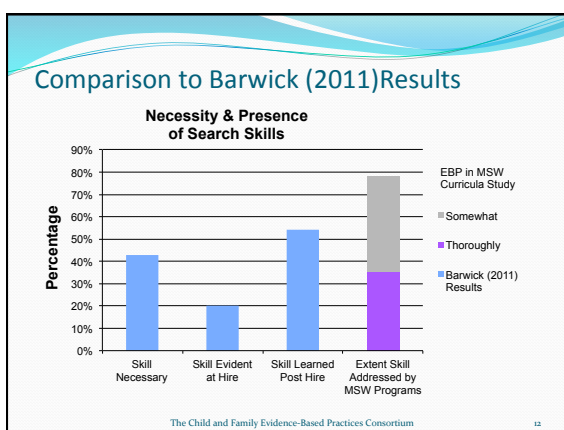
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### The EBP Debate in Social Work

- Questions regarding definition of EBP
- Concerns about client diversity & client choice
- Eclectic practice: Practitioner creativity vs. defined model
- Implementation concerns
- Ability of MSW faculty & programs to teach EBPs
  - Faculty Knowledge
  - Faculty Governance
  - Field Practicum Site Limitations
  - Limitations of Required Curriculum

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### Some Results

**Forty-three identified EBPs met study definition:**

Mostly CBT or family-centered models, Motivational Interviewing, Assertive Case Management, and a few more

Sixteen practices were incorrectly identified as evidence-based

Seven small programs did not teach EBPs

Theory of change of an EBP was often not taught

Effectiveness with specific populations was often not taught

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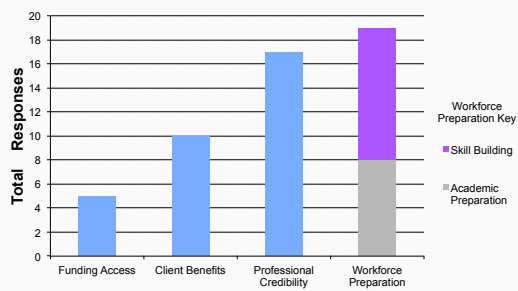
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### Perceived Positive Implications



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15

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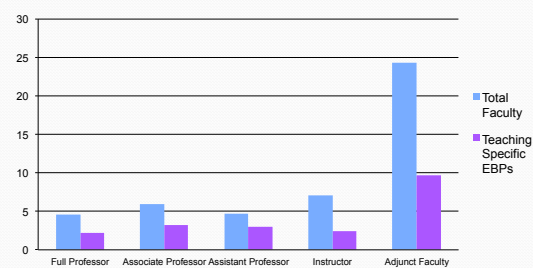
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### Faculty Teaching EBPs



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16

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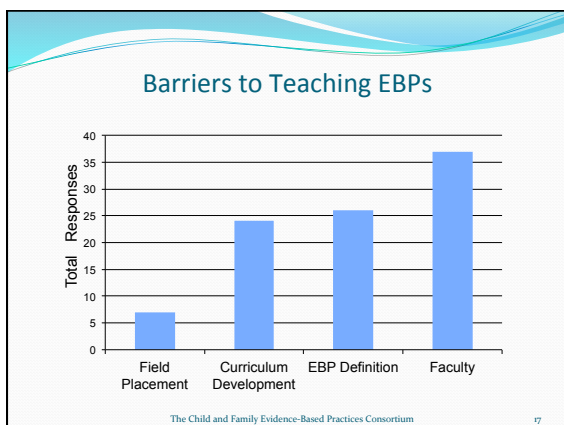
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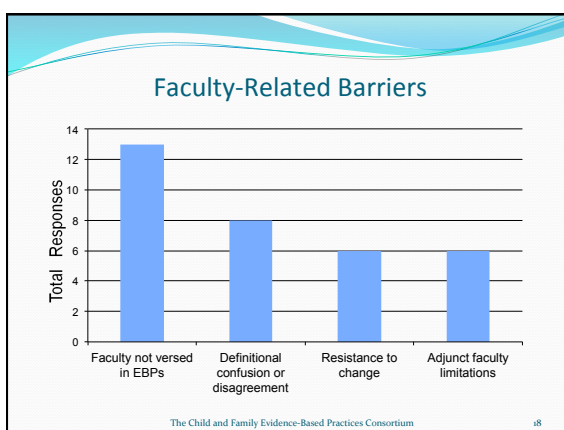
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### Some qualitative data themes

**Faculty-related barriers**  
 Comfortable with current course content  
 Faculty lack EBP knowledge  
 Adjunct faculty don't know research

**Faculty differences in theoretical orientation**  
 Faculty with psychodynamic orientation see EBPs as cookbooks

**EBP seen as additive vs. integrated throughout curricula**

**"EBPs are not tested for multi-problem populations"**

**Few field sites use EBPs**

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## What Stalls Curricula Innovation

### False beliefs

That specific EBPs have not been tested with diverse populations  
That treatment guidelines limit creativity or client choice  
That applying a blend of different theory bases & techniques is effective

### False dichotomy

EBP as a process vs. specific evidence-based practices

### False notion

That in an organization can effectively support eclectic EBP cannibalization

### The "private practitioner assumption"

That eclectic practice is possible when most graduates are employed by agencies that increasingly are expected to deliver specific EBPs.

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20

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## EBP Consortium Next Steps

- Final report distributed to MSW Deans & Directors (2/14)
- Develop & present webinar to North American MSW faculty
- Council on Social Work Education conference presentation (10/14)
- Manuscript submissions: *Research on Social Work Practice; Evidence Based Social Work; Social Work Education*  
(one in press as of 4/14)

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## Evidence-Based Practice: A Disruptive Innovation

- Innovation in a product or service disrupts
- Disruptive innovations create new markets & value networks  
(social & structural resources & knowledge)
- Value networks are interdependent  
(academic & behavioral health care programs)
- With common frameworks in the new value network,  
organizations can not only survive, but thrive

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22

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## NIRN FRAMEWORKS



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23

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## NIRN Intervention Components

- Model definition
- Theory base(s)
- Target population characteristics
- Theory of change
- Alternative models (why they were rejected)

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24

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## Model Definition

Who participates?

Key elements...e.g. strengths-based, child & family team, cultural competence, trauma-informed, etc.

Essential activities:  
Who does what with whom when and in what manner?

Phases of service delivery

What theory base(s) support this?

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25

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## Theory Base

Behavioral theories

Systems theories

Stage theory of individual development

Stage theory of family organization & development

Team theory

Are the activities, elements & theory base(s)  
a good & proven match to target population?

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26

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## Target Population Characteristics

Age, sex, gender, race, ethnicity, culture

Socio-economic & community factors

Behavioral characteristics

Multi-system involvement

Other?

How do activities, elements & phases of the practice  
model contribute to improved outcomes?

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27

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## Theory of Change

If delivered with fidelity,  
how do activities, elements, & phases of the practice  
model contribute to improved outcomes?

### Alternative Models

Based upon the previous steps,  
what is the rationale for choosing this practice model  
and for rejecting others?

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28

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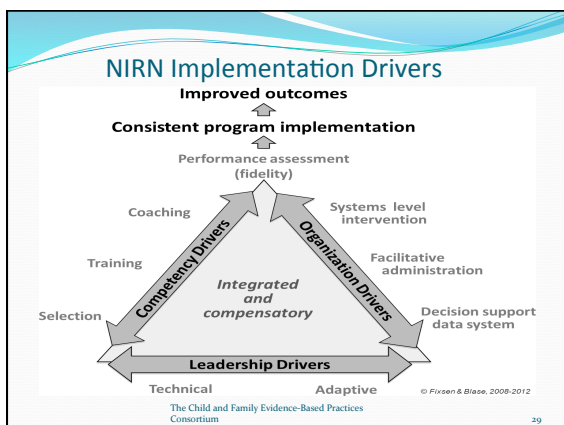
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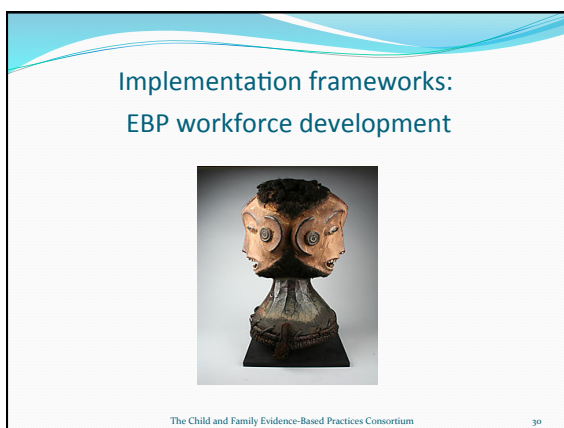
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### UMKC MSW program evaluation course

MSW students (n=40) learn & focus through NIRN frameworks to evaluate program implementation at their field placement sites (n=34)

Each multi-method evaluation examined

- Intervention components
- Competency drivers
- Organization drivers

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**Kansas City Program Implementation**

**Model Definition**

- Confusion or inconsistency between site sources
- “Eclectic” practice defined by individual practitioner

**Theory Base(s)**

- Very difficult for respondents to identify
- “Eclectic” staff identify incongruent constructs (ecological systems theory & psychodynamic transference & projection)

**Exceptions**

- Agencies with clearly defined practice models & training manuals (DBT, school-based PBS, & statewide community development serving homeless)

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**Kansas City Program Implementation**

**Population Characteristics**

- If funding sources required client demographic data, it was collected in aggregate format, & not used to inform or evaluate service delivery

**Theory of Change**

- Very difficult for most staff to understand or describe
- Most sites did not measure population outcomes, hence they could not say what changes occurred

**Exceptions**

- Sites with clearly defined models & training manuals

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**Kansas City Program Implementation**

**Alternative Models**

- Most sites could not recall making this choice
- Funding sources drove target population focus but not necessarily selection of practice model

**Exceptions**

- Sites with clearly defined practice models
- However these were distinctly a minority (N=5)

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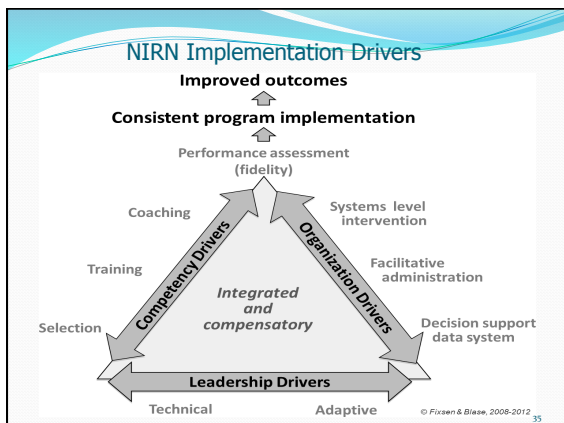
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**Kansas City Program Implementation**

**Staff Selection**

- Few clearly defined program models, so staff were not selected based on model-pertinent knowledge & skills
- Some selected based on passion for population served
- Most staff selected by professional degree or licensure

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**Kansas City Program Implementation**

**Training**

- Few clearly defined practice models = most training provided orientation to HIPPA, employee rights, etc.
- Support for pursuit of CEUs to maintain licensure, but no monitoring for pertinence to program model or to target population

**Exceptions**

- Psychiatric & medical services trained on population characteristics & use of medications (but not on group treatment that was delivered multiple times each day)

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## Kansas City Program Implementation

### Coaching

- No use of model pertinent data
- Reliance upon training in lieu of coaching
- Most provided ad hoc supervision focused upon risk containment, & administrative focus on documentation
- Sites with well defined practice models did not systematically coach to support model fidelity

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38

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## Kansas City Program Implementation

### Performance Assessment

- Most equated this with annual employee evaluation
- Some client satisfaction surveys but no fidelity data

### Exceptions

- If funding required: Track aggregate client outcomes
- If funding required: Track billable hours
- Child advocacy centers tracked outcomes of case investigation but not counseling or other services
- Sites with well-defined practice models did not pursue fidelity data

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39

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## Kansas City Program Implementation

### Facilitative Administration

- Bureaucratic policies & procedures, not model pertinent
- Funding & staff turnover shaped caseload size
- No data collected on competency drivers

### Systems-Level Interventions

- Most saw this as responsibility of direct service staff

### Exception

- State child protective service agency effort to improve Family Support Team model fidelity

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40

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## Kansas City Program Implementation

### Decision Support Data Systems

For funding sources some tracked client outcomes in aggregate format  
For funding sources some tracked hours or numbers of services

When customer satisfaction surveys were gathered, data was again  
used to support funding, not to improve service delivery

No data gathered on model fidelity

No data on effectiveness of implementation drivers

**Sites with well-defined practice models did not  
attend to or adjust implementation drivers**

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41

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## Kansas City Program Implementation

**“All organizations are designed intentionally or  
unwittingly to achieve precisely the results they get”**

R. Spencer Darling



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42

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## UMKC MSW students& field sites learn

**“All organizations  
are designed intentionally or unwittingly to achieve  
precisely the results they get”**

Model definition & selection

The disruptive & necessary integration of  
EBPs & implementation frameworks

Now systematically applied via NCWWI grant to establish  
Kansas City child welfare transformation zone

To then scale up improved workforce selection & development  
and EBP implementation lessons across Missouri

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43

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### Some “Janus” Innovations

- Connecticut & New York MSW programs EBP electives integration with behavioral health care provider organizations
- Interdisciplinary program at University of Washington’s School of Medicine for behavioral health care program staff
- Infusion of implementation frameworks & EBPs via University of Missouri-Kansas City MSW program NCCWI grant

### Others

- Washington University’s George Warren Brown School of Social Work’s infusion of EBPs throughout BSW and MSW curricula

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44

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### Child & Family EBPs Consortium Next Steps

- Social work publications, conferences & webinar to inform social work faculty discussions about integration of EBPs & implementation frameworks into curricula, including examples currently being utilized
- Fund & replicate MSW curricula study in examination of MFT, psychology & counseling masters degree programs
- Identify sites willing to embrace EBPs’ disruptive innovations. Help them build bridges between curricula transformation and EBP implementation.

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45

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What challenges have you experienced advocating for integration of evidence-based practice between academic & behavioral health care programs?




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47

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48

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49