



Use of research evidence and implementation of evidence-based practices in youth-serving systems



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ABSTRACT

Although the effectiveness of interventions for prevention and treatment of mental health and behavioral problems in abused and neglected youth is demonstrated through the accumulation of evidence through rigorous and systematic research, it is uncertain whether use of research evidence (URE) by child-serving systems leaders increases the likelihood of evidence-based practice (EBP) implementation and sustainment. Information on URE was collected from 151 directors and senior administrators of child welfare, mental health and juvenile justice systems in 40 California and 11 Ohio counties participating in an RCT of the use of community development teams (CDTs) to scale up implementation of Treatment Foster Care Oregon over a 3 year period (2010–12). Separate multivariate models were used to assess independent effects of evidence acquisition (input), evaluation (process), application (output), and URE in general (SIEU Total) on two measures of EBP implementation, highest stage reached and proportion of activities completed at pre-implementation, implementation and sustainment phases. Stage of implementation and proportion of activities completed in the implementation and sustainment phases were independently associated with acquisition of evidence and URE in general. Participation in CDTs was significantly associated with URE in general and acquisition of research evidence in particular. Implementation of EBPs for treatment of abused and neglected youth does appear to be associated with use of research evidence, especially during the later phases.

1. Introduction

Despite substantial evidence of their effectiveness, interventions for the prevention and treatment of mental health and behavioral problems of abused and neglected children and adolescents are not widely used in publicly funded child-serving systems (Hoagwood & Olin, 2002; Horwitz, Chamberlain, Landsverk, & Mullican, 2010; Raghavan, Inoue, Ettner, Hamilton, & Landsverk, 2010). Identification of the factors that serve as barriers and facilitators to evidence-based practice (EBP) implementation in service sectors that cater to abused and neglected children and adolescents has relied upon several theories, models and frameworks (Aarons, Hurlburt, & Horwitz, 2011; Damschroder et al., 2009; Hanson, Self-Brown, Rostad, & Jackson, 2016). Some models and frameworks usually include characteristics of the intervention itself (Aarons et al., 2011; Damschroder et al., 2009), while others focus on the interactions that occur between intervention developers and consumers (Rogers, 2003). Still other models focus on the transfer of research evidence from knowledge producers to knowledge consumers or from EBP developers to potential users (Landry, Amara, & Lamari,

2001a, 2001b; Landry, Lamari, & Amara, 2003; Lavis et al., 2003). In fact, the definition of the field of implementation research itself makes references to “methods to promote the systematic uptake of research findings and other evidence-based practices (EBPs) into routine practice, and, hence, to improve the quality and effectiveness of health services” (Eccles & Mittman, 2006).

However, for the most part, these models and frameworks do not explain the mechanism by which use of research evidence (URE) is linked to the likelihood of implementation and sustainment of an EBP. There are several models that focus specifically on the use of research evidence. Nutley, Walter, and Davies (2007), for instance, identify four factors associated with the outcome of using research evidence: the nature of the research to be applied, the personal characteristics of both researchers and potential research users, the links between research and its users, and the context for the use of research. Honig and Coburn (2008), emphasize process (searching for evidence, incorporating or not incorporating it in decision making), and predictors (features of the evidence, working knowledge, social capital, organization, normative influence, political dynamics, and state and federal policies) of evidence

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use.

Among the best-known models of evidence use are the variations that fall under the rubric of knowledge transfer and exchange (KTE) (Lavis et al., 2002; Lavis, Lomas, Hamid, & Sewankambo, 2006; Lomas, 2000; Mitton, Adair, McKenzie, Patten, & Wayne Perry, 2007). The foundation for these models is Caplan (1979), which posits that the utilization of research by policy analysts and decision makers is poor because the assumptions and cultural practices of the two groups differ greatly, so effort is required to bridge the research-policy interface. A common approach to addressing these challenges is regular and direct contact between those who produce knowledge and those who use it (Lavis, Moynihan, Oxman, & Paulsen, 2008; Lomas, 2000). Direct interactions have improved user perception of research's value (Kothari, Birch, & Charles, 2005) and correlate significantly with the consultation of research material by potential users (Ouimet et al., 2010). Another approach is the tailoring of presentations to meet users' needs; customization of knowledge is important to potential users (Cherney, Head, Boreham, Povey, & Ferguson, 2012), as is the researcher's understanding of the needs and ability to speak the language of practice or policy (Haynes et al., 2011). A third approach is knowledge brokerage. "Knowledge brokerage refers to efforts to make research and policy-making more accessible to each other with various mechanisms of knowledge sharing and transfer" (Hukkinen, 2016, p. 321). Knowledge brokers include individuals and organizations that serve as intermediaries between knowledge producers and consumers and engage in a variety of activities, including dissemination, matchmaking, consulting, engaging, collaborating, and capacity-building (Meyer, 2010; Michaels, 2009; Ward, House, & Hammer, 2009). Although the evidence for the effectiveness of knowledge brokerage is somewhat equivocal (Knight & Lightowler, 2010; Phipps & Morton, 2013), there is some evidence that knowledge brokerage can improve comprehension of the evidence and increase the intention to use it (Kothari, MacLean, Edwards, & Hobbs, 2011).

Among the many strategies employed to facilitate KTE are the following: face-to-face exchange (consultation, regular meetings) between decision makers and researchers; education sessions for decision makers; networks and communities of practice; facilitated meetings between decision makers and researchers, interactive, multidisciplinary workshops, capacity building within health services and health delivery organizations, web-based information and electronic communications, and steering committees to integrate views of local experts into design, conduct and implementation of research (Mitton et al., 2007). Most if not all of these strategies can also be found within a group of implementation strategies known as quality improvement collaboratives (QICs) or learning collaboratives (LCs) (Nadeem, Olin, Campbell, Hoagwood, & Horwitz, 2013). One of the best-known illustrations of the QIC approach to implementation is the Institute for Healthcare Improvement's Breakthrough Series Collaborative (Institute for Healthcare Improvement, 2003). In a typical QIC/LC, individual sites organize staff into multi-disciplinary teams that participate in a series of in-person, phone, distance learning, and independent activities that are led by LC faculty who serve as content and QI experts (Nadeem, Weiss, Olin, Hoagwood, & Horwitz, 2016). The QIC/LC structure provides sites with access to experts in the field, often including treatment developers and QI experts.

Although these models and strategies have been widely used in implementation research, to our knowledge, there has been no research to date that has demonstrated that URE by policymakers or practitioners is associated with the extent to which implementation of an EBP has been successful or unsuccessful. A few studies have focused on the implementation of KTE strategies (Mitton et al., 2007) but not on specific interventions, programs or practices based on research evidence. Thus, it is unclear whether a decision to adopt, implement and sustain a particular EBP is based on the quality and quantity of evidence supporting its effectiveness, its relevance to the population served, from where and how the evidence was obtained, and how the evidence is

used to make or support such a decision. Further, it is unknown whether knowledge brokerage implementation strategies like QICs result in a significant increase in URE.

The study described in this paper examined the use of research evidence among leaders of county-level child welfare, specialty mental health and juvenile justice systems in California and Ohio participating in a randomized controlled trial of a specific QIC strategy for scaling up the use of an EBP for youth in foster care. Previous studies of these leaders revealed the importance of social networks in exchanging information and resources to support EBP implementation (Palinkas et al., 2011) and URE to vary based on demographic characteristics such as gender, level of education and type of agency (Palinkas et al., 2017). Systems leaders also exhibited significant differences by type of use. They were most engaged in evaluating the evidence, least engaged in accessing it, and more likely to ignore the evidence than to apply it in making decisions whether or not to adopt an innovation. Leaders also consider other forms of evidence, including resources necessary and available to support EBPs, demand for research evidence, and personal experience (Palinkas et al., 2017). The current study had two specific aims: 1) to determine whether use of research evidence was independently associated with stage of implementation of an EBP and proportion of activities completed at the pre-implementation, implementation and sustainment phases; and 2) to determine whether URE was significantly associated with the QIC strategy used to scale up the EBP.

2. Methods

2.1. Setting

The setting for present study was the CAL-OH Study, a randomized clinical trial of Community Development Teams (Saldana & Chamberlain, 2012) to scale-up the use of Treatment Foster Care Oregon (TFCO; Chamberlain, Leve, & Degarmo, 2007), an EBP for treatment of externalizing behaviors and mental health problems in youth. The CAL-OH study targeted 40 California counties and 11 Ohio counties that had not already adopted TFCO. They were matched by county characteristics such as size and number of foster care placements to form four nearly equivalent groups. The matched groups then were randomly assigned to four sequential cohorts in a waitlist design with staggered start-up timelines (at months 6, 18, or 30). Within each cohort, counties were randomly assigned to CDT or the standard implementation conditions, thereby generating eight replicate groups of counties with four assigned to CDT.

2.2. Participants

Data for this study were collected from 151 of the 221 (67.9% response rate) available child-serving system leaders, supervisors, and administrators who were participating in the RCT at the time this study was conducted (2010 – 2012). Participants had an average age of 49 years, and were predominately non-Hispanic white (84.4%), female (69.4%), and living in California (61.6%), with a Master's degree or higher (62.6%). A little over one-third of the participants (35%) were child welfare system directors; the remaining participants were leaders of mental health (24%), juvenile justice (18%), and other social services (23%) (Palinkas et al., 2017).

The study was approved by the Institutional Review Boards of the investigators' institutions prior to participant recruitment, and informed consent was obtained prior to data collection. Participants were emailed an invitation to participate as well as a link to a web-based survey, which took approximately 15 to 20 min to complete.

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