

Increasing access to best practice mental health interventions on a national scale



Australian Centre for
**Posttraumatic
Mental Health**

Lessons learned from an implementation program based on a theory-informed model

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The problem

PTSD 2nd most common mental health disorder in Australia

Effectiveness of EBPs demonstrated in clinical settings

Widely disseminated through guidelines and training

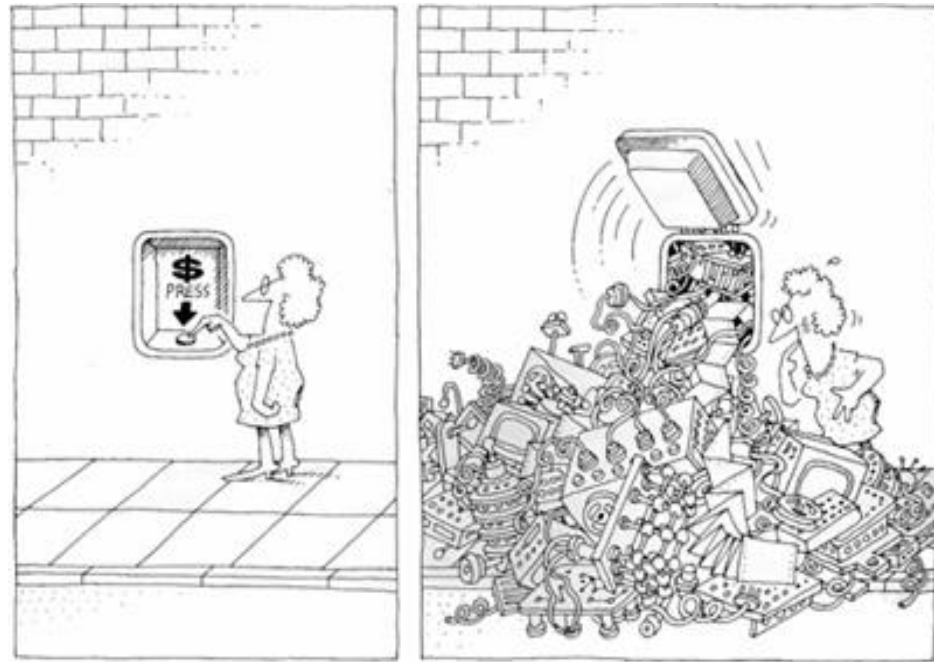


In Australia, only 25 % of people with PTSD receive evidence-based treatment

Only 17- 20% of practitioners deliver one of the most researched EPB

Implementing a complex intervention

- Cognitive Processing Therapy is a best practice treatment for PTSD
- Complex intervention: facing feared memories & 12 week manualised treatment
- Awareness campaigns and workshops traditionally used-lead to 6-8% increase in use
- Training in EPBs for PTSD do not necessarily lead to increased choice to use them



Challenges in promoting adoption

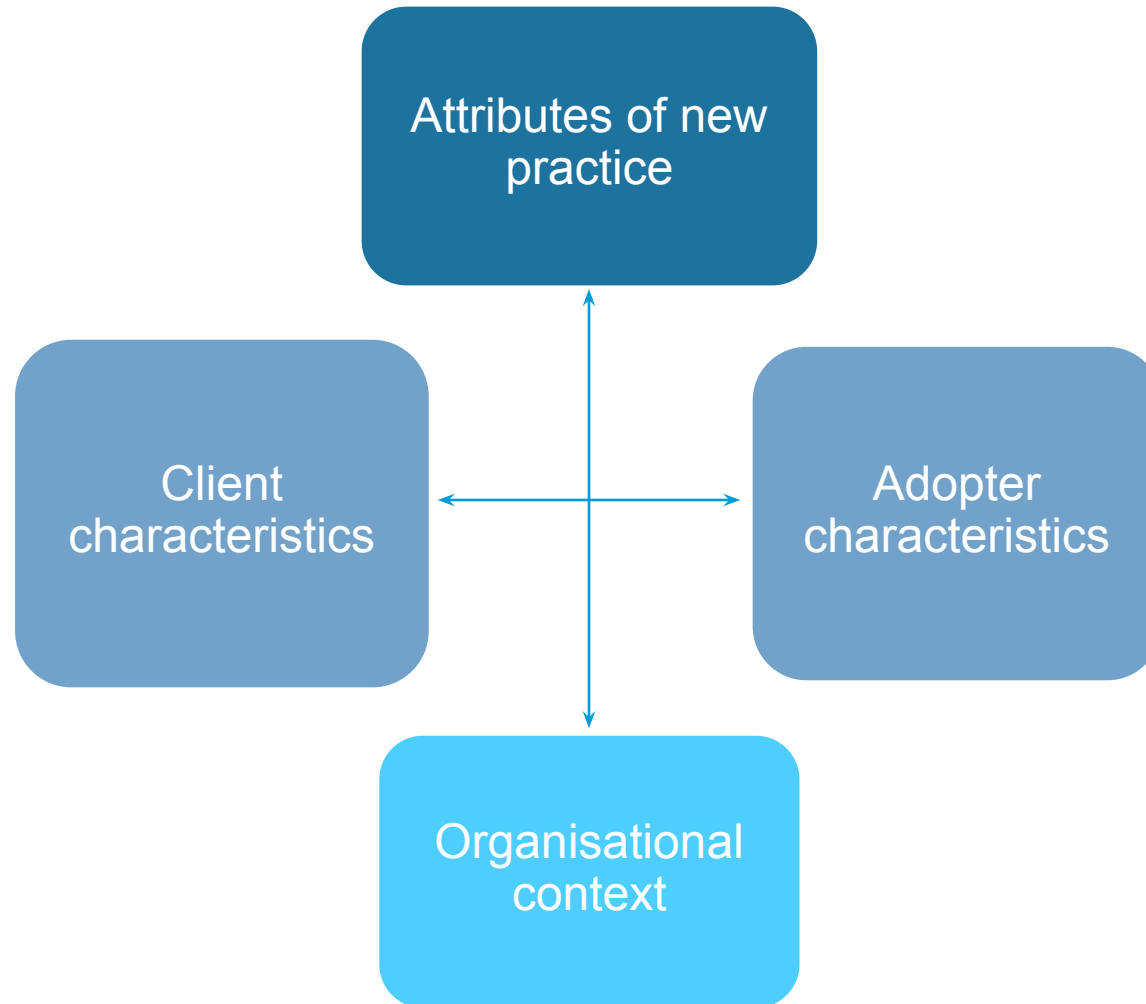
Effectiveness of strategies vary across settings and target groups

—————> Which barriers and incentives need to be addressed to best promote adoption in a particular context?

—————> Mixed finding for tailored approaches

—————> How do you select theoretical frameworks that explain what leads to change? E.g. Michie et al. (2005) identified 128 constructs

Promoting the adoption of best practice- what really matters?



The evidence in the mental health & trauma field- organisational context

Climate & culture

- Organisational climate & culture influence perception of EPB & intent to use
- Implementation of EPB influences organisational climate & retention

Leadership & team

- Limited research
- Active involvement of leadership/leadership type
- Team-based learning and shared goals in teams associated with sustainability

Systems & Policies

- Little research-calls for change in organisational processes to be included in evaluation of implementation programs
- Some indication that clear policies & guidance have some impact on adoption

The evidence on adopter & client factors

Therapist attitudes & intent

- Therapist surveys identify fears related to impact of trauma-focussed interventions as a major barrier
- Self-efficacy and outcome expectations predict intent & adoption
- outcome expectations do not appear to shift after implementation

The role of norms and habits & emotions

- Norms not as influential as self-efficacy & expectancies about outcome
- Little research on role of attention, habits or emotions

Client factors

- Limited research on impact of client-therapist decision making process
- Complexity and co-morbidity identified as barrier

Measuring implementation

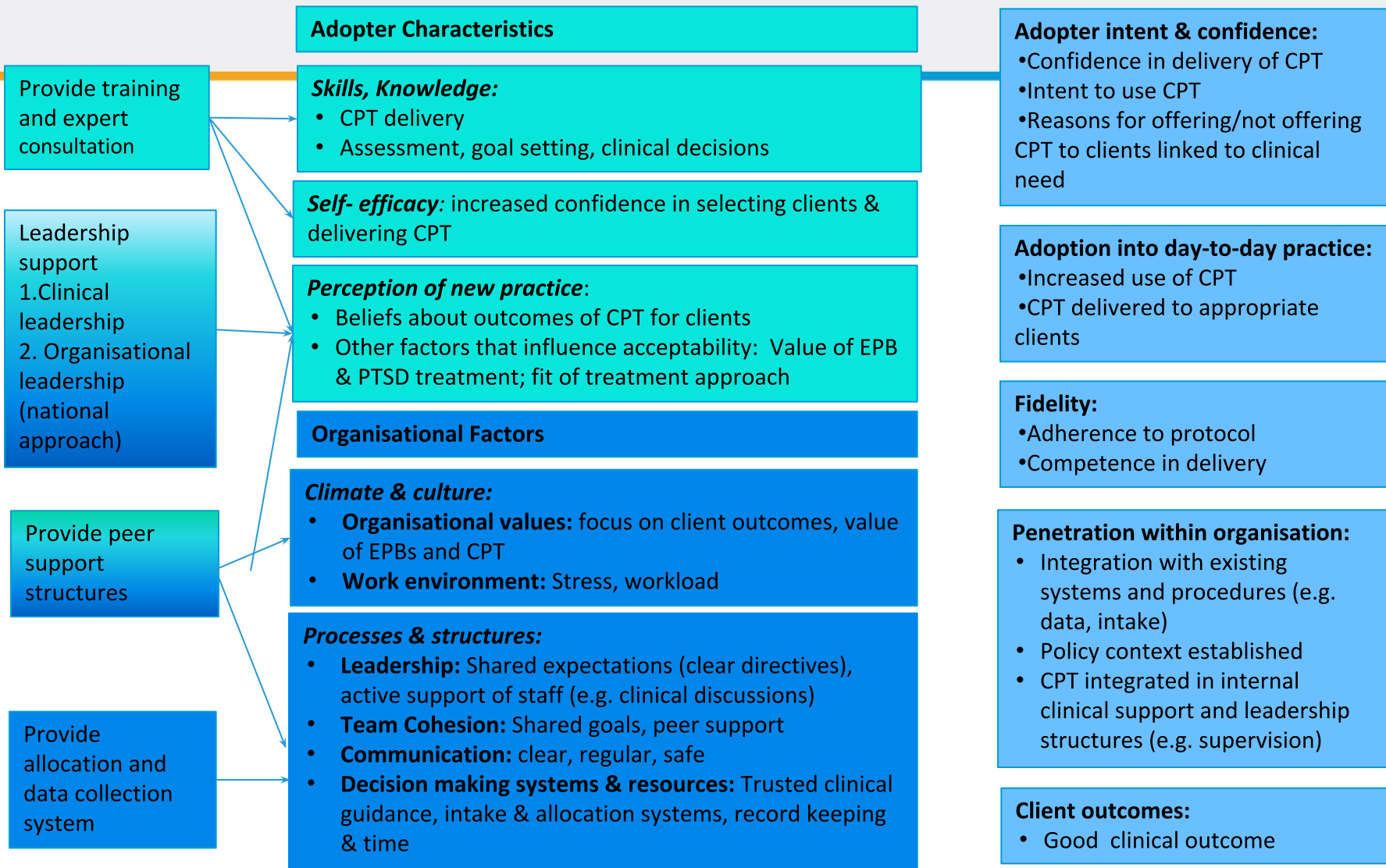
Not enough to measure increase in treatment delivery

- Organisational readiness- culture (e.g. values and expectations in line with EPB) and climate (e.g. work satisfaction and stress)
- Adopter intent- including factors that influence intent (e.g. beliefs about outcomes; acceptability)
- Adoption- delivery of treatment
- Fidelity- is the EPB used as intended, were adaptations made?
- Penetration – spread or reach; integration within existing systems
- Client outcomes; acceptability & access
- Cost-effectiveness

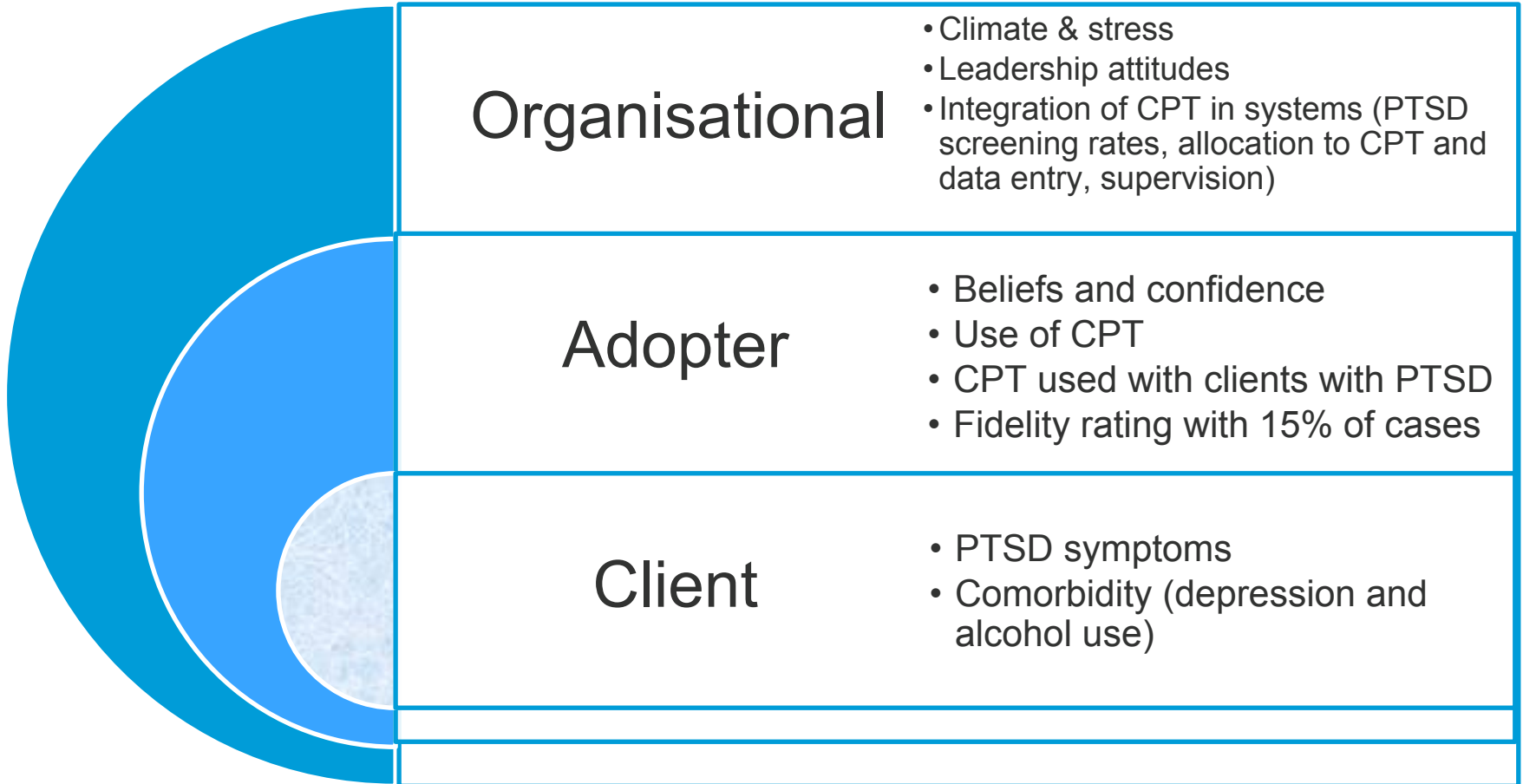
Implementation interventions

Factors that influence implementation

Short-medium term outcomes (12 months)



Measures used



Pre-implementation preparation & assessment



Organisational Readiness

Organisational climate

- 41% reported that stress was a significant issue
- access to sound clinical supervision, colleagues were generally supportive of each other, communication adequate, good job satisfaction

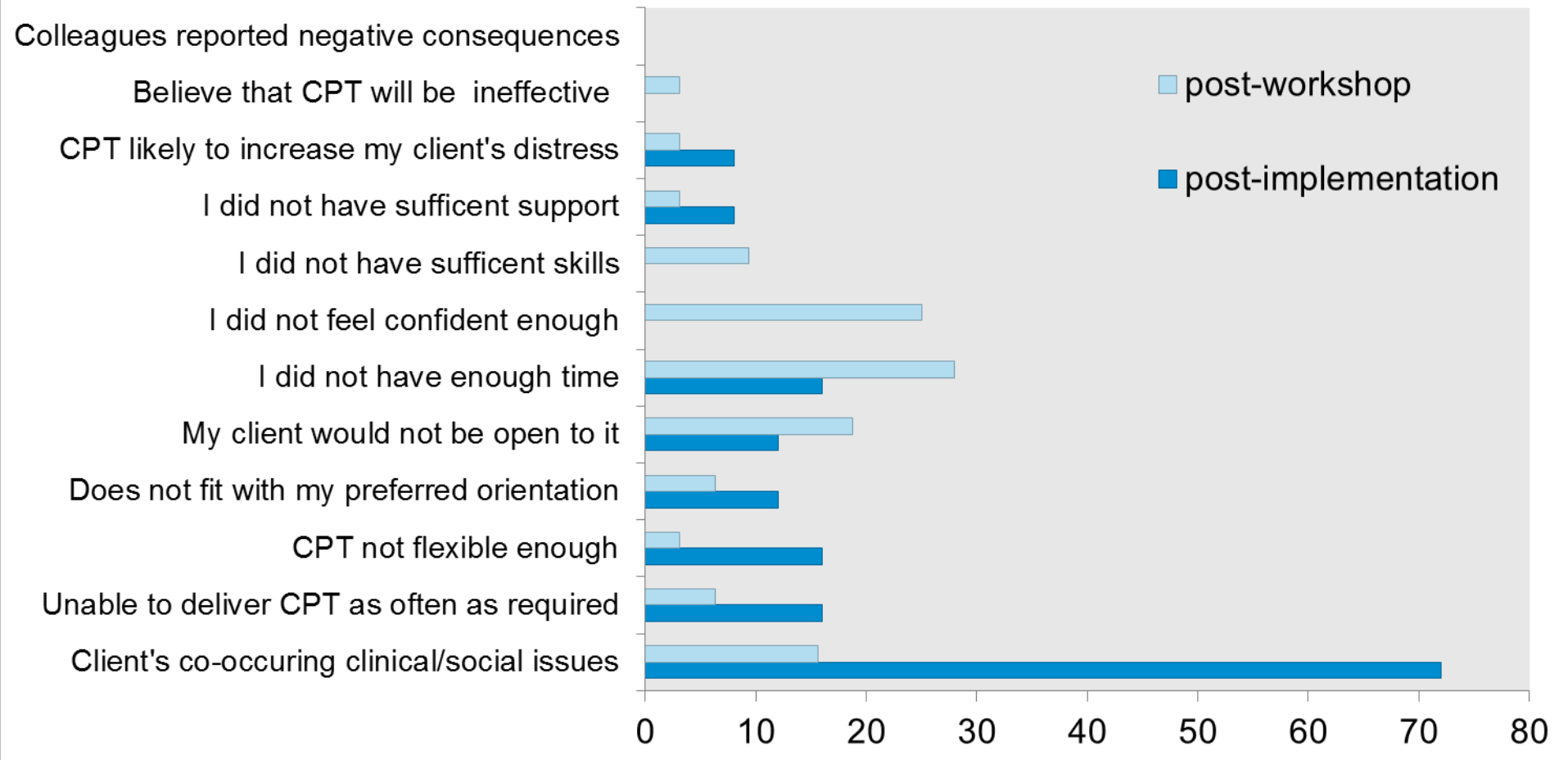
Organisational culture

- Strong fit with organisational goals
- Client outcome oriented culture
- Leadership supportive of EBP & CPT

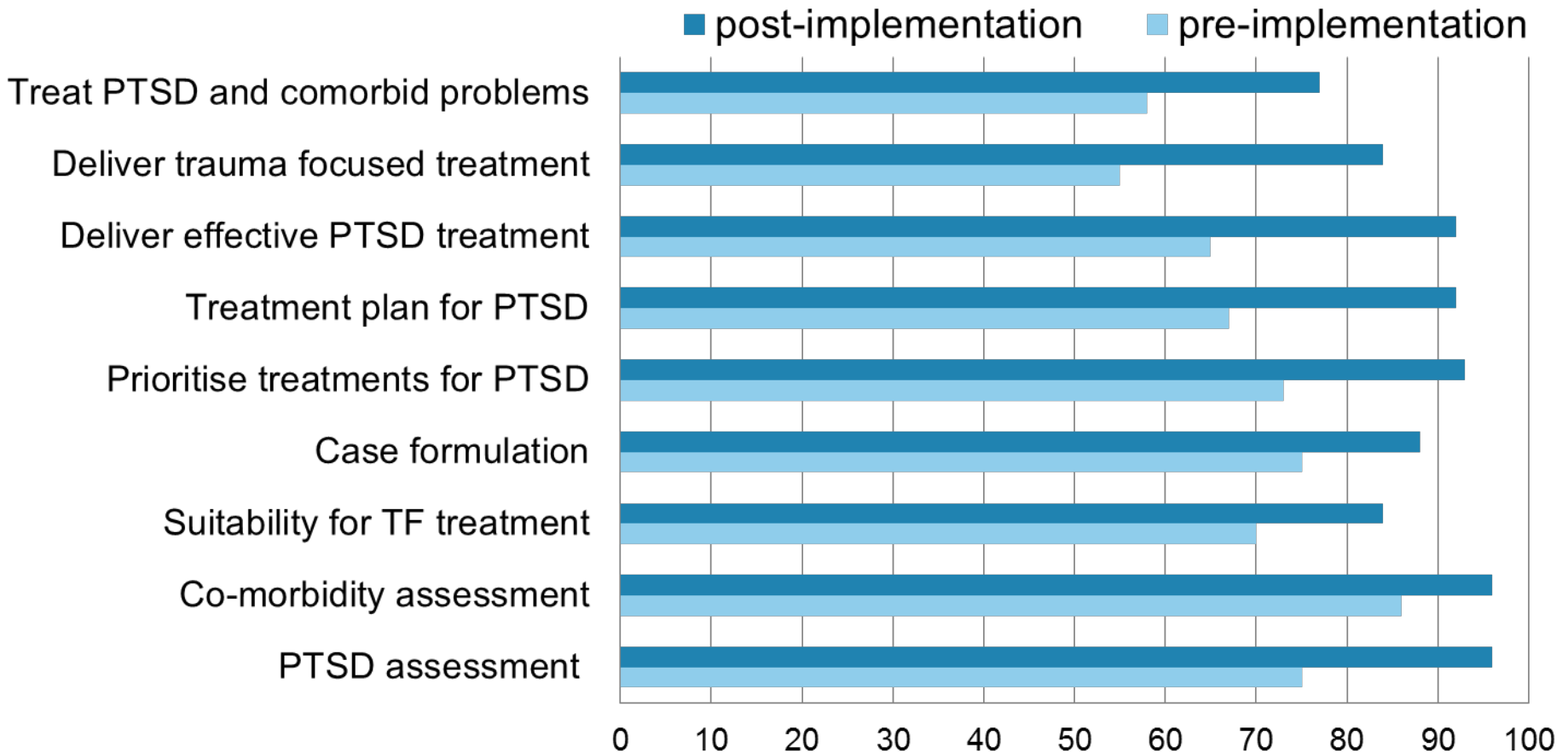
Therapists attitudes



Change in Adopter characteristics- perception of EBP



Adopter confidence



Delivery of CPT

Adoption

- Clients who screened positive for PTSD significantly more likely to be allocated to CPT ($\chi^2(1146)=14.21, p<0.001$).

Fidelity

- Adherence to protocol- 79% as opposed to 92% in RCT; competence: 88% CPT elements >satisfactory (91% in RCT)

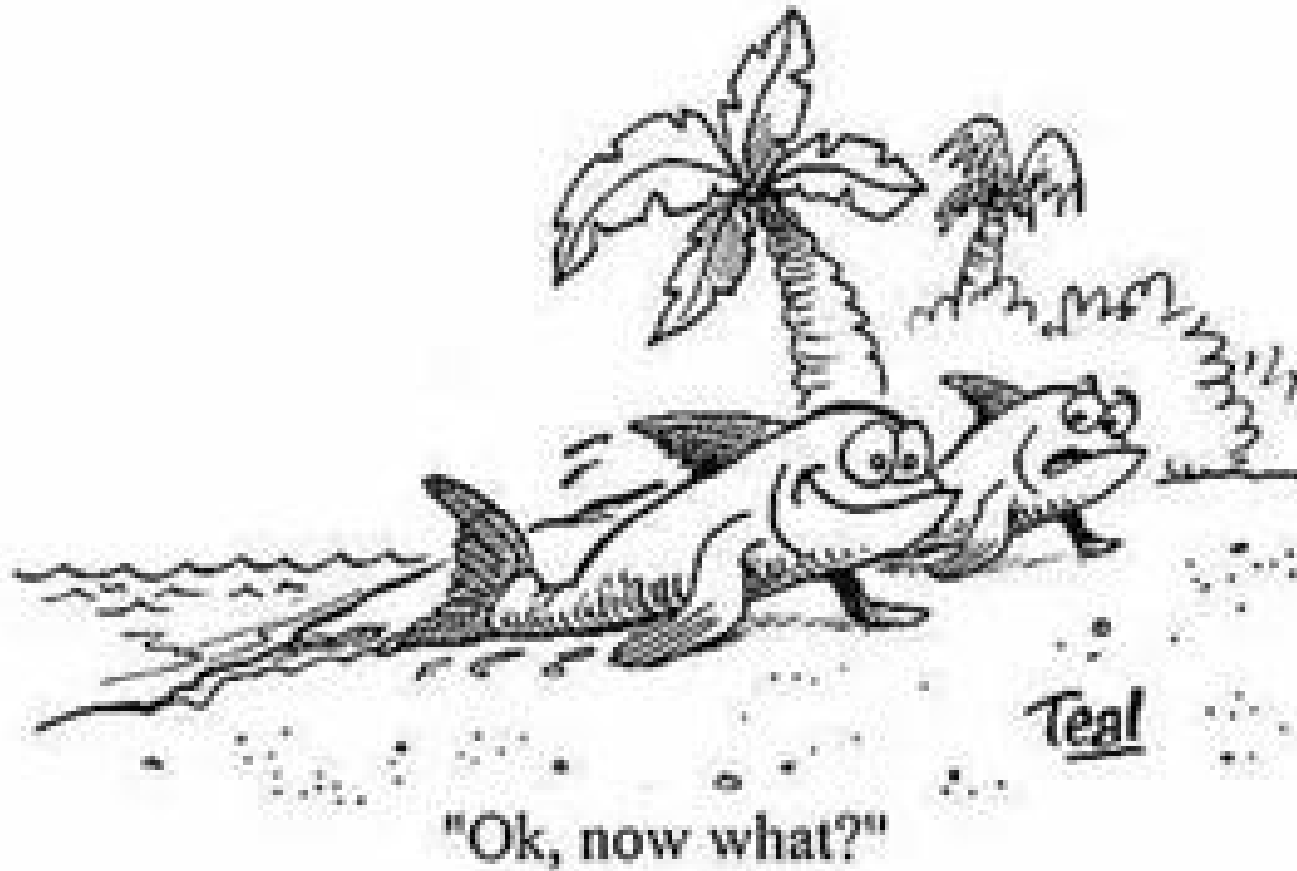
Client outcomes

- CPT clients made significant treatment gains in self-reported PTSD ($t(70) = 8.712$, $p < .001$, $g = 1.01$ 95% CI: 0.66-1.36)
- The mean difference between PCL scores at baseline and final time point was 14.38 points (SD=13.91).
- Clinically meaningful improvements on the PCL (more than 10 points) were achieved by 63.4% of clients.

Penetration – organisational change

- PTSD Screening adopted- a 40% increase when in most implementation programs, changes are modest (around the 8-20% mark)
- 61% of CPT cases allocated through this process
- Clinical leaders in each states expressed strong support for PTSD and all offices included review of CPT cases in either peer or individual supervision processes
- Supported by creation of data collection system to track PTSD outcomes
- VVCS developed a sustainability plan and instituted a national supervision program to ensure long-term use of CPT.

Sustainability



Successful elements of CPT implementation

Manager interviews:

- ***Sustained clinical support***
- ***Integration of processes and systems*** that support routine use of interventions
- ***Use of data*** (outcome and/or screening) and integration into existing routines and systems to support and monitor practice change (although resource intensive- resented additional data collection)
- ***Regular involvement of leadership*** in decision-making & update (wanted more)
- ***Team-based learning*** that provide a sense of shared goals and support

Threats to sustainability

Manager interviews:

- CPT not embedded in policy & procedures
- Training and support for new staff; loss of skills through staff turnover
- Lack of integration with overall service model which includes contractors