Evidence-Based Practice Readiness

2023 Children's Behavioral Health EBP Readiness Report

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Survey Participants

Community Mental Health Centers
Center for Life Management, Community Partners, Greater Nashua Mental Health Center, Lakes Regional Mental Health, Mental Health Center of Greater Manchester, Monadnock Family Services, Northern Human Services, Riverbend Community Mental Health, Seacoast Mental Health Center, West Central Behavioral Health

Care Management Entities
Connected Families New Hampshire, NFI North

Intensive Service Option/Home-Based Providers
Ascentria, Becket, Educational and Behavioral Consulting, Home Base, Independent Services Network, Mountainview Counseling, Neurodevelopmental Institute of NH, NFI North, Northeast Family Services, Seacoast Youth Services

Residential Treatment Providers
Chase Home, Devereux, Dover Children's Home, Easter Seals, Mount Prospect, MPA at Hampton CAST, Orion House, Pine Haven Boys Center, Saint Ann's Home, Webster House

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Executive Summary

Purpose

The purpose of the Evidence-Based Practice Readiness Assessment was to better understand the readiness of agencies that are publicly funded to provide Tier 2 (Community-Based), Tier 3 (Intensive Community-Based), and Tier 4 (Residential) children's behavioral health services in NH to adopt evidence-based practices (EBPs). The assessment was conducted by the Children's Behavioral Health Resource Center (CBHRC). The New Hampshire (NH) Department of Health and Human Services (DHHS) established the CBHRC in part to support the use of evidence-based practices (EBPs) within the Children's Behavioral Health System of Care (SOC).

Process

Administrators, managers, and staff at Community Mental Health Centers (CMHCs; Tier 2/3), Care Management Entities (CMEs; Tier 3), Individual Service Option/Home Based Therapy (ISO/HBTs; Tier 3), and Residential Treatment Centers (RTCs; Tier 4) completed the Implementation Climate Scale (ICS).[i] The ICS measures an agency's 1) focus on EBPs, 2) staff educational support for EBPs, 3) recognition of staff for using EBPs, 4) rewards to staff for using EBPs, 5) selection and hiring of staff trained in EBP, and 6) selection and hiring of staff who are flexible, adaptable, and open to new practices. Each of the 18 items are rated on a 0 (low readiness) to 4 (high readiness) scale. A total of 274 administrators and staff from 36 agencies responded to the survey.

Results

The average score across all ICS items was 2.5, showing a moderate degree of readiness to implement EBPs. Rewards for EBP was by far the lowest-scoring domain, while Focus on EBPs was the highest scoring domain. NH child-serving agencies are invested in implementing EBPs, they generally select staff that are adaptable and open to new practices, and some also have sufficient professional development infrastructure. Agencies do not generally provide financial incentivizes for staff to use EBPs, and staff selection and hiring do not prioritize prior training or expertise in EBPs. Respondents employed 3-4 years had the lowest overall scores, while those employed less than one year had the highest. Results did not vary by agency type or staff role.

Takeaways

NH's mental health agencies recognize the importance of EBPs but lack the financial resources and workforce to fully meet the EBP implementation challenge. Faced with reimbursement structures that do not fully offset the costs of high-fidelity implementation and workforce challenges, agencies prioritize social recognition over monetary incentives, "soft" skills (openness) over EBP-specific staff qualifications, and professional development opportunities over other EBP-related materials. EBP transformation will require sustainable sources of funding that fully offset the unbillable costs associated with EBP implementation. Other improvement opportunities include: 1) emphasizing EBPs in settings like RTPs and ISO/HBTs that have more flexible

(i.e., daily rates) funding structures, 2) implementing the smallest possible number of EBPs to meet the population need, and 3) pooling resources and infrastructure across agencies to reduce duplication and costs, while enhancing consistency and quality.

Background and Approach

Purpose

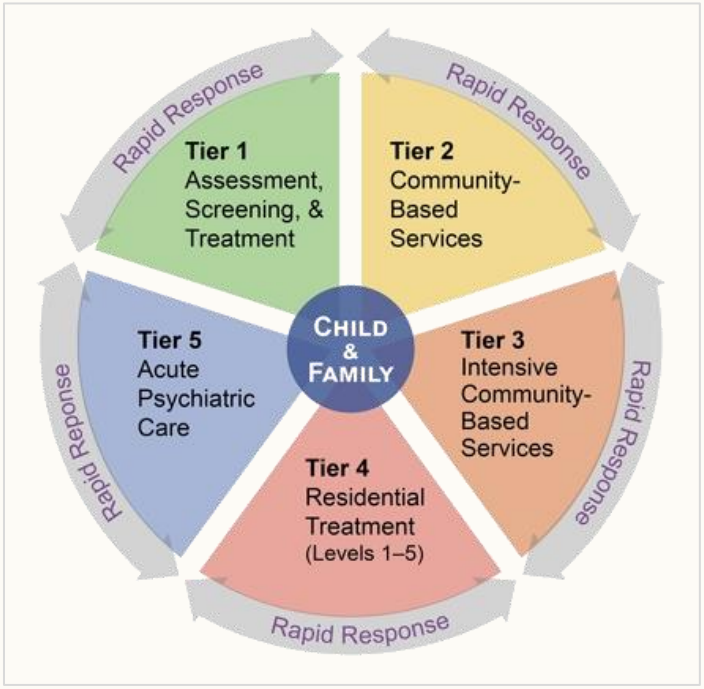
The Evidence-Based Practice Readiness Assessment provides a point-in-time assessment of the organizational capacity of agencies that are publicly funded to provide Tier 2 (Community Based), 3 (Intensive Community-Based), and 4 (Residential Treatment) children's behavioral health services (see Tiers graphic, right) to successfully adopt evidence-based practices (EBPs). For more information about the NH Children's System of Care service array, see the NH Children's Behavioral Health Resource Center website.

The primary aim of the assessment was to better understand the organizational readiness "profile" of NH's public mental health system. Other specific aims were to see if perceptions of organizational readiness for EBPs varied by type of agency, role, or number of years employed at the agency. As such, the assessment serves as an important barometer of the receptiveness of NH's children's system of care to EBPs – including system-wide strengths, needs, and gaps – that can be leveraged and addressed through CBHRC technical assistance.

Assessment team

The assessment was conducted by the Behavioral Health Improvement Institute at Keene State College, on behalf of the Children's Behavioral Health Resource Center (CBHRC). The NH Department of Health and Human Services (DHHS) established the Children's Behavioral Health Resource Center (CBHRC) in October 2021 in part to support the use of evidence-based practices (EBPs) within the Children's Behavioral Health System of Care (SOC).

Figure 1. NH's Five-Tiered Behavioral Health System of Care



Survey development

CBHRC collaborated with DHHS's Bureau for Children's Behavioral Health (BCBH) to develop the survey. After several discussions and reviews of potential tools, the Implementation Climate Scale (ICS)[ii] was selected as the

foundation for the readiness assessment. The ICS is an 18-item measure of EBP implementation climate. The Likert-type response scale ranges from 0 (not at all) to 4 (very great extent). The ICS items are evenly distributed across six dimensions or domains – see next page. The reliability, factor structure, and construct validity of the ICS have been supported through multiple studies. For instance, agency-level changes in ICS scores are associated with current and future clinician use of EBPs in mental health settings,[iii] with changes in ICS scores accounting for 14 percent of the variance in clinician uptake.[iv] To the ICS, we added items to capture the type of, years employed at, and role(s) within the agency of each respondent. You can preview the survey here.

Survey administration

A link to the survey was sent to administrator(s) in charge of child programming at each agency with a request to take the survey and distribute it to the rest of their staff. A total of 77 agencies were asked to participate: 10 Community Mental Health Centers (CMHCs; Tier 2/3), 2 Care Management Entities (CMEs; Tier 3), 20 Individual Service Option/Home Based Therapy (ISO/HBTs; Tier 3), and 45 Residential Treatment Providers (RTPs; Tier 4). Four increasingly targeted prompts to agencies were provided to agencies from which we had received no responses. The survey was in the field from 8/23/23 to 10/9/23.

Table 1. Implementation Climate Scale Domains and Items

Domain	Items
Focus on Evidence-Based Practice (Focus)	• One of this team/agency's main goals is to use evidence-based practices effectively (Desire for Effectiveness) • People in this team/agency think that the implementation of evidence-based practices is important (Importance of EBP) • Using evidence-based practices is a top priority in this team/agency (High Priority for EBP)
Educational Support for Evidence-based Practice (Education)	• This team/agency provides conferences, workshops, or seminars focusing on evidence-based practices (Learning Events) • This team/agency provides evidence-based practice trainings or in-services (Trainings & In-services) • This team/agency provides evidence-based practice training materials, journals, etc.
Recognition for Evidence-Based Practice (Recognition)	• Clinicians in this team/agency who use evidence-based practices are seen as clinical experts (Viewed as Experts) • Clinicians who use evidence-based practices are held in high esteem in this team/agency (High Esteem) • Clinicians in this team/agency who use evidence-based practices are more likely to be promoted (Promotions)
Rewards for Evidence-Based Practice (Rewards)	• This team/agency provides financial incentives for the use of evidence-based practices (Financial Incentives) • The better you are at using evidence-based practices, the more likely you are to get a bonus or a raise • This team/agency provides the ability to accumulate compensated time for the use of evidence-based practices
Selection for Evidence-Based Practice (Selection)	• This team/agency selects staff who have previously used evidence-based practice • This team/agency selects staff who have had formal education supporting evidence-based practice • This team/agency selects staff who value evidence-based practice
Selection for Openness (Openness)	• This team/agency selects staff who are adaptable • This team/agency selects staff who are flexible • This team/agency selects staff open to new types of interventions

Survey Participation

At least one employee from 36 of the 77 agencies participated, for a 47 percent agency response rate. We received at least one survey response from all ten CMHCs and both CME's. The largest number of CMHC respondents were from Mental Health Center of Greater Manchester and Greater Nashua Mental Health Center; the largest number of CME respondents came from NFI North. We received at least one survey response from 11 of 20 (55%) ISO/HBTs and 13 of 45 (29%) RTPs. The largest number of ISO/HBT respondents – by far – came from Home Base Collaborative; the largest number of RTP respondents came from Saint Ann's Home.

The total number of survey participants was 274. Since the denominator (the total number of possible respondents) is unknown, we cannot calculate a survey response rate at the individual level. We can, however, examine the number of respondents by role (top chart), agency type (middle chart) and number of years employed at the agency (bottom chart) – see dashboard below. Approximately 55 percent of survey respondents were direct service providers, whereas about 21 percent had supervisory or administrative roles. Agency role was a multi-select question – for analysis purposes, we categorized respondents according to the highest role they selected (e.g., if they selected all three roles, they would be categorized as an administrator). Most respondents (83%) endorsed one role, 10 percent endorsed two, five percent endorsed all three roles, and three percent did not endorse any role.

About 44 percent of respondents were employed by CMHCs (Tier 2/3), 23 percent from CMEs (Tier 3), 18 percent from ISO/HBT (Tier 3), and 16 percent from RTPs (Tier 4). Thus, Tier 2 (44%) and Tier 3 (41%) were better represented than Tier 4 (16%).

The number of years employed approached a normal distribution, with about 64 percent employed at their agency for three or more years. See the next page for participant levels by role, agency type, and number of years employed at their agency.

The decision of whether to participate in a survey is not random; rather, it is an indicator of interest in the topic and capacity to respond, among many other organizational and individual factors. While the sample appears to be relatively representative in terms of role and number of years employed, staff from agencies with relatively robust EBP infrastructures (i.e., the CMEs and the two largest CMHCs) appear to be overrepresented. As such, these results probably overestimate system wide EBP readiness.

Table 2. Number of Survey Responses by Agency Role, Agency Type, and Number of Years Employed at Agency (N=274)

Participation by Agency Role	Null: 9 Administrator: 57 Supervisor: 58 Direct Service Provider: 150
Participation by Agency Type	RTP: 43 ISO/HBT: 49 CME: 62 CMHC: 120
Participation by Number of Years Employed at Agency	Null: 10 Less than a year: 42 1–2 years: 47 3–4 years: 64 5–10 years: 59 11+ years: 52

Systemwide EBP Readiness

The chart on the next page displays average item (blue bars), domain (gray bars), and overall (dotted "Grand Mean" vertical reference line) scores. Rewards for Evidence-Based Practice was the lowest-scoring domain, with all three items at or just below the "slight extent" threshold. According to respondents, financial benefits are rarely conditioned on EBP use. The score of the next lowest-scoring domain – Selection for Evidence-Based Practice – was 2.2, just beyond the midpoint ("moderate extent") of the scale. Staff selection slants more toward applicants' general orienting characteristics than their EBP-specific experience or education. In the Recognition for Evidence-Based Practice domain, being viewed as experts and held in high esteem were more common forms of workplace recognition than promotions. Professional development offerings were viewed as in place to a "great extent" in the Educational Support for EBP Practice domain; other resources and materials needed for EBP implementation were perceived as less available. The three items in the Selection for Openness domain received identical 3.1 scores, just above the "great extent" threshold. Respondents may view these overlapping characteristics as functionally equivalent. Finally, the highest-scoring domain was Focus on Evidence-Based Practice. Using EBPs effectively is a high-priority goal system wide.

In sum:

1) Tangible/financial incentives for using EBPs are in short supply; social forms of recognition are more available

2) Staff selection is more driven by overarching qualities than EBP-specific experience or education

3) Professional development infrastructure is relatively robust

4) Agencies are very interested in high-quality implementation of EBPs

Table 3. Average Score by Item, Domain, and Overall

Scale: 0 = Not at all. 1 = Slight extent. 2 = Moderate extent. 3 = Great extent. 4 = Very great extent

Domain	Scores
Rewards	Bonuses & Raises: 0.9 Financial Incentives: 0.9 Compensated Time: 1.0 Domain: 0.9
Selection	EBP Experience: 2.0 EBP Education: 2.2 EBP Value: 2.6 Domain: 2.2
Recognition	Promotions: 2.2 Viewed as Experts: 2.8 High Esteem: 2.9 Domain: 2.6
Education	Materials: 2.7 Learning Events: 2.9 Trainings & In-services: 3.0 Domain: 2.9
Openness	Learning Orientation: 3.1 Adaptability: 3.1 Flexibility: 3.1 Domain: 3.1
Focus	High Priority for EBP: 3.3 Importance of EBP: 3.4 Desire for Effectiveness: 3.5 Domain: 3.4

Readiness by Agency Type, Staff Role, Number of Years Employed

Readiness by Agency Type

The chart below displays average domain scores by agency type (blue bars) with the agency and domain means in gray at bottom and right, respectively. Agency mean scores are relatively homogeneous, with two agency types (CMHCs and RTPs) at 2.4 and two others (ISO/HBTs and CMEs) at 2.7. CMHCs had relatively low Rewards and Selection but high Education scores. RTPs were relatively low on Education and Focus; their other scores were in line with those from other agency types. ISO/HBTs were relatively high on Rewards, Selection, Recognition, and Openness, but low on Education. CMEs were relatively high on all domains, except Selection and Education, which were in line with the scores for other agency types.

Table 4. Domain Scores by Agency Type

	CMHC	RTP	ISO/HBT	CME	Domain Mean
Rewards	0.5	1.0	1.3	1.4	**0.9**
Selection	2.0	2.3	2.6	2.3	**2.2**
Recognition	2.4	2.7	2.8	2.9	**2.6**
Education	3.1	2.6	2.6	2.9	**2.9**
Openness	3.0	2.9	3.4	3.3	**3.1**
Focus	3.4	3.1	3.3	3.6	**3.4**
Agency Mean	**2.4**	**2.4**	**2.7**	**2.7**	**2.5**

Readiness by Role

The chart below displays average domain scores by respondent role (blue bars). The average scores by role are at bottom and the average scores by domain are at right. The mean scores by role were homogeneous. Supervisor scores were relatively low in terms of Rewards and Selection. The Rewards, Selection, and Recognition scores of Administrators were relatively high. The scores of Direct Service Providers fell in between those of Supervisors and Administrators, directly in line with the domain averages

Table 5. Average Domain Scores by Role

	Supervisor	Direct Service Provider	Administrator	Domain Mean
Rewards	0.7	0.9	1.1	**0.9**
Selection	2.1	2.2	2.5	**2.3**
Recognition	2.6	2.6	2.8	**2.6**
Education	2.8	2.9	2.9	**2.9**
Openness	3.0	3.1	3.2	**3.1**
Focus	3.4	3.4	3.4	**3.4**
Role Mean	**2.5**	**2.5**	**2.6**	**2.5**

Readiness by Number of Years Employed at Agency

The chart below displays average domain scores by number of years employed at the agency (blue bars) with the mean by years employed at bottom and domain means at right. Staff employed 3–4 years had the lowest overall scores, especially for Education. Staff employed 11+ years had the lowest scores for Rewards and Recognition. Staff employed 5–10 years fell in the middle of the distribution. Staff employed 1–2 years had slightly higher Selection ratings than their more experienced counterparts. Staff employed less than one year, however, rated agency readiness for EBP higher across the board than their more experienced counterparts. The overall pattern of results suggests that the relative inexperience of this group of respondents may be contributing to slightly rosier and/or more idealistic ratings, but the idea that their elevated scores reflect recently improved conditions cannot be ruled out

Table 6. Average Domain Scores by Number of Years Employed at Agency

	3–4 years	11+ years	5–10 years	1–2 years	Less than 1 year	Domain Mean
Rewards	0.8	0.7	1.0	1.0	1.3	0.9
Selection	2.1	2.2	2.1	2.3	2.6	2.2
Recognition	2.5	2.4	2.7	2.8	2.9	2.6
Education	2.6	2.9	2.8	2.9	3.3	2.9
Openness	2.9	3.0	3.2	3.1	3.4	3.1
Focus	3.2	3.4	3.3	3.4	3.7	3.4
Duration Mean	2.4	2.4	2.5	2.6	2.9	2.5

Lessons Learned and Next Steps

Most Agencies Are Committed to EBP

These results confirm findings from the recent NH children's System of Care Assessments:[v,vi] most agencies believe in evidence-based practice, want to implement EBPs with high fidelity, and are keenly aware of when – and why – they fall short of that ideal. According to our respondents, the problem is not convincing mental health agencies that EBP is virtuous, but in equipping them to fully meet the challenge.

Rational Decision Making within Constraints

Faced with well-documented financial (e.g., billing structures that do not fully reimburse for costs associated with high fidelity implementation of EBPS) and workforce (shortages, inability to compete at the top end of the market, limited academic training in specific/desirable child EBPs among recent graduates) constraints,[vii,viii] agencies engage in rational trade-offs. They do so in this case by prioritizing social recognition over monetary incentives, "soft" skills over more specialized staff qualifications that are rare in the entry-level marketplace, and pre-requisite professional development opportunities over other EBP-related materials.

EBP Transformation Requires Additional Predictable, Accessible, and Sustainable Sources of Funding

As noted elsewhere,[ix] taking EBP to scale requires additional resources beyond those associated with "treatment as usual." These resources must fully offset the unbillable costs associated with EBP implementation – and be stable, sustainable, predictable, and easily accessible (resources that require more administrative time and burden than they are worth are not easily accessible). This provides agencies with the opportunity to attract, select, and retain a larger and more highly skilled workforce; build incentives and recognition and promotion systems that reward high-quality practice; acquire the necessary professional development and evaluation services and infrastructure, etc. Options include enhanced reimbursement rates or other value-based funding models for high-quality delivery of EBPs, supplemental grants or contract enhancements provided by the state, additional increases to the Medicaid rate, and/or benchmarking per member per month expenditures rates to those of gold model peer states.

Unlocking Latent Potential and System Efficiencies

These results, in combination with the CBHRC's recent System of Care assessments, suggest avenues for capitalizing on untapped potentials and systems efficiencies. First, some latent potential may exist in RTPs and ISO/HBTs. Historically, EBPs have been less prioritized and supported in RTPs and ISO/HBT than in CMHC settings. Further, RTPs and ISO/HBTs are typically funded through daily rates, which may allow more resource allocation flexibility. Indeed, recent efforts to install Trust-

Based Relational Intervention (TBRI) in RTPs show promise for enhancing care while promoting the development of EBP-supportive infrastructure. Second, focusing on the smallest possible number of the most feasible and efficient EBPs, implemented only in the most ready and appropriate setting(s), and delivered only to those populations most likely to profit from them would increase practice quality and outcomes while reducing the EBP-associated cost burden. Third, pooling resources and infrastructure across agencies would reduce duplication, lower costs, and enhance efficiency. Rather than requiring each agency to implement and/or build infrastructure for each EBP, some key capacities – such as training, supervision, and internal consultation groups – could be pooled across partner agencies or centralized through the CBHRC. Some redundancy across agencies to mitigate the regular loss of EBP expertise due to turnover will always be necessary. Still, one could imagine having, let's say, five rather than ten consultation groups across the CMHC system for one EBP, which would be less costly and could potentially increase practice consistency and agency cross-pollination.

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