Bridging the implementation gap

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CHAPTER 6

Stimulating quality of service delivery in mental health care settings for youth. Suggestions for integrating support systems

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Abstract

Frequent and targeted support to professionals is essential to control for quality delivery of services. In youth care settings, there is limited time and capability to implement all of the support systems that are suggested by program developers. With the pressure and responsibility to provide services with high quality and low costs, organizations strive to effectively and efficiently integrate different support systems. In this point of view we discuss the potential of integrating support systems around overlapping common, contextual and structural factors of interventions that are delivered in youth care setting.

Keywords

Support Systems; Quality Delivery; Interventions; Factors

6.1 Introduction

Over the last few years it has become clear that the quality of the delivery of services to youth with externalizing behavioral problems and their families is associated with client outcomes (Goense, Assink, Stams, Boendermaker, & Hoeve, 2016a; Lipsey, 2009; Schoenwald, Chapman, Sheidow, & Carter, 2009a; Tennyson, 2009). Quality of delivery indicates that it is not only important that services are being delivered (adherence to the manuals) but also that services are skillfully, timely and appropriately delivered (competence in delivery) (Barber et al., 2006; Barber, Sharpless, Klostermann, & McCarthy, 2007a; Barber, Triffleman, & Marmar, 2007b; Mcleod, Southam-Gerow, Tully, Rodriguez, & Smith, 2013b; Perepletchikova, Treat, & Kazdin, 2007). Most mental health care settings for youth in the Netherlands, as probably elsewhere, typically provide a wide range of services for an equally wide range of target groups. They offer practice-based approaches in the guidance of juveniles and/or families, practice-based group training programs, as well as evidence-based interventions that mostly have been developed abroad. It is common for the professionals working in these settings to provide multiple interventions and/or training programs. Professionals in a semi-residential setting for example, offer a practice-based approach in the guidance of the juveniles on the group such as the solution-focused approach, and at the same time provide an evidence-based intervention, such as the Washington State Aggression Replacement Training (Goldstein, Glick, & Gibbs, 1998), to specific juveniles.

There is a growing number of studies that indicate that the quality of the delivery of services can be positively stimulated by providing frequent and targeted support to professionals (Hogue, Ozechowski, Robbins, & Waldron, 2013; Kerby, 2006; Mikolajczak, Stals, Fleuren, Wilde, & Paulussen, 2009; Miller, Sorensen, Selzer, & Brigham, 2006; Schoenwald, Sheidow, & Chapman, 2009b). For quality control, most evidence-based interventions have incorporated specific support systems for the professionals that deliver the intervention. The manuals of the practice-based approaches and training programs also increasingly describe which support is needed. However, in the youth care settings, there is limited time and capability to implement all of these support systems. With the pressure and responsibility to provide services with high quality and low costs, youth care settings want to effectively and efficiently integrate the support systems. The aim of this point of view is to discuss the potential of integrating support systems around overlapping factors of interventions[8].

[8] From this point onwards we will refer to interventions as a collective word for practice-based approaches, training programs and evidence-based interventions.

6.2 Factors of interventions

The most conventional distinction in intervention literature is between specific and common factors of interventions. Specific factors apply in the context of specific goals and target populations. Specific factors are based on existing theoretical knowledge on the risk and protective factors that play a role in the onset and persistence of the specific problem that the intervention intents to target. The specific factors can be differentiated in contextual factors (i.e. target population, theoretical framework), structural factors (i.e. length, duration, format) and therapeutic techniques, see Figure 1 (Blasé & Fixsen, 2013; van Yperen, Veerman, & Van den Berg, 2015). Chorpita and Daleiden, (2009) define a therapeutic technique[9] as 'a discrete clinical technique or strategy (e.g., time out, relaxation) used as part of a larger intervention plan' (p. 569). Common factors contribute to client outcomes, regardless of the type of intervention and target population. Examples of common factors are the working alliance, creating positive expectancies and responsivity (see Figure 1) (Andrews & Bonta, 1994; McLeod et al., 2013b).

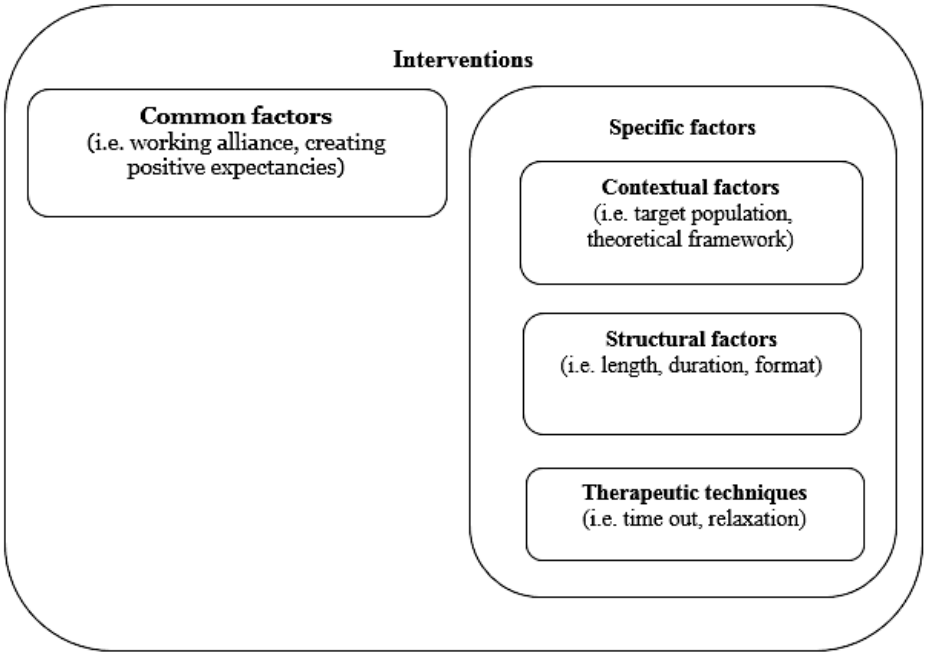

Figure 1. Factors of interventions

[9] Chorpita and Daleiden (2009) refer to therapeutic techniques as practice elements.

All interventions have the common factors. Many interventions also tend to overlap on the contextual and structural factor level. For instance, many interventions target juveniles with externalizing behavior problems (contextual factor) and many interventions are provided in group format (structural factor). The common and overlapping factors of interventions could be a starting point for a solution to the accumulation problem of support systems.

6.3 Support systems targeting factors

There are multiple ways to define interventions and thus many potential criteria for identification of factors that overlap between interventions (Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008). The identification of factors ranges between macro level analyses characterized by broad theoretical orientation of interventions, to micro level analyses of each verbal and nonverbal behavior that is part of the intervention (Garland et al., 2008). One of the difficulties the field is facing in its attempt to identify overlapping factors is the lack of knowledge about existing practices. As mentioned before, local providers do not solely provide evidence-based interventions but commonly provide a diverse set of care, programs and help to their clients. Although attempts are being made, there still is little research characterizing treatment process in usual care (Garland et al., 2008). This limits the ability of the field to identify overlapping factors that are applicable to local providers. At the same time, many interventions are proprietary of nature. In that light, it is important to discuss how realistic it would be for local providers (or anyone else in that respect) to develop support systems on the factors represented by these major interventions that are already providing such training and supervision.

First of all it is important to note that many local providers do not provide proprietary interventions (Barrett & Ollendick, 2004; Kazdin & Weisz, 2003; Weisz, Jensen, & McLeod, 2005). A number of reasons have been suggested for the nonuse of these interventions, including the expenses of training and supervision requirements (Weisz et al., 2005 In: Mazzucchelli & Sanders, 2010). For local providers, integrating support systems of proprietary interventions, is not possible yet. However, we think that the restrictions on training and supervision of proprietary interventions is untenable in the near future and it is important to anticipate on that. The emerging trend in the field towards the clustering of evidence-based interventions is an important indication to believe change is at hand. Many scholars are examining overlapping factors of interventions (i.e. Barth & Liggett-Creel, 2014; Chorpita, Daleiden, & Weisz, 2005; Garland et al., 2008). Some even have suggested to use the profiles of the clustered factors for training and supervision purposes of professionals (see Garland et al., 2008). The clustering of interventions is in line with the understanding that ‘one size does

not fit all' (Stewart, Felleman, & Arger, 2015) and that flexible use of interventions is necessary to meet the needs of clients. If this line of thinking continuous, we believe this will create opportunities to redesign the training and supervision of professionals in the field. Up to the point that local providers are involved in organizing the support around these interventions within their own settings.

An important guidepost for the integration of support systems, are the factors that most professionals have questions about or need support on, because they attain to the professionals' needs. Previous research suggests that some factors of interventions require competencies that are perceived by professionals as more difficult to learn and implement than others (Goense, Pronk, Boendermaker, Bakker, Ruitenberg, & Bertling, 2015b). These competencies are related to a) common factors of interventions, that require general competencies of professionals and b) factors that require competencies (skills) of professionals in the contextual and structural level (see Figure 1). For example, the most difficult part of delivering group interventions (structural factor) is handling group interactions, keeping pace, motivating the participants to work together in role-play and respond to individual needs within the group context (Goense et al., 2015b).

We suggest youth care settings to focus the support of professionals around these factors. Start for instance on providing a training on handling group interactions and motivating participants to work together in role-play, for all professionals in your youth care setting that provide interventions in group format to juveniles with externalizing behavior problems. After provision of support to professionals on overlapping common, organizational and structural factors, integrating support around overlapping therapeutic techniques would be the next logical step.

6.4 Discussion

Youth care settings are confronted with a multitude of support systems and professionals are confronted with an accumulation of support sessions. Settings strive to effectively and efficiently integrate these different support systems. As a first step, we suggest to integrate support around overlapping common, contextual and structural factors of interventions. Integrating support systems based on competencies that professionals need for the delivery of multiple interventions serves two purposes. First, it enables youth care settings to organize support more efficiently. This meets the desire of youth care settings and professionals to prevent the stacking of support systems and sessions. Second, it lays a foundation for improved practice. More efficient organization of support to professionals around these factors increases the likelihood that the implementation of these factors are stimulated on a broad scale within a setting.

Integrating support systems on overlapping factors is a total new way of stimulating quality of services delivery which brings about new research tasks. It requires a joint effort of program developers, disseminators, youth care settings and researchers. The results of integrating support systems for the settings, professionals and client outcomes, needs to be examined. We think the integration of support systems on overlapping factors does more justice to the capabilities of youth care settings to provide frequent and targeted support to their professionals. With that, it is the first step in the right way of stimulating quality of delivery on a broad scale.

Compliance with Ethical Standards

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