

Establishing an Implementation Network: Lessons Learned from Community-Based Participatory Research

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ABSTRACT

Background

Implementation of evidence-based mental health assessment and intervention in community public health practice is a high priority for multiple stakeholders.

Methods

With older adults with psychosis as a focus, we have developed a partnership between a university research center and a public mental health service system based on community-based participatory research. The long-term goal of the partnership is to establish an evidence-based implementation network that is sustainable within the public mental healthcare system.

Results

In this paper, we discuss our approach to implementation and present six lessons we have learned from the experience: changing attitudes; sharing staff; expecting obstacles and formalizing solutions; monitoring and evaluating; adapting and adjusting; taking advantage of emerging opportunities.

Conclusions

The formation of academic-public partnerships is crucial for the development and implementation of state-of-the-art approaches to assessment and interventions to improve the functioning and quality of life for persons with serious mental illnesses. These partnerships provide necessary organizational support to facilitate the moving of the results of clinical research into community practice. Consumers, researchers, and providers all benefit.

Introduction

Effective approaches to implementation of evidence-based practices in community settings necessarily involve close collaboration between the research team and the stakeholders, end-users, and policy-makers responsible for sustaining the new practices [1-3]. The need for such collaboration has been recognized by policy makers at the highest levels of executive decision-making, including, in the United States, the President's New Freedom Commission on Mental Health [4].

To initiate an implementation network that bridges the gaps between an academic research center and a large public mental health system to create a collaborative implementation research network, we used the principles of community-based participatory research (CBPR) [5]. The overall purpose of the network is to enhance care for older people with schizophrenia and other psychoses by implementing evidence-based approaches in community settings. CBPR is solidly established in many areas of public health research. It features a process of shared decision-making that empowers the community as an equal partner in the research process. By promoting action, CPBR builds capacity for initiation of research and for implementation of findings. In an important addition to the CPBR literature, Wells and colleagues [6] have proposed an evidence-based community partnership model that adds a commitment to evidence-based assessment and treatment to traditional principles of CBPR.

We describe an approach to adapting evidence-based CBPR to create an implementation network between the Adult and Older Adult Mental Health Services (AOAMHS) division of San Diego County and the Division of Geriatric Psychiatry of the University of California, San Diego (UCSD). Details of the CPBR process have been described elsewhere [7]. The partnership was created as part of a grant from the National Institute of Mental health for an Advanced Center for Interventions and Services Research.

The Setting

AOAMHS provides public supported, linguistically and culturally appropriate mental health services for a large and diverse county equal in geographic and population size (3 million) to the State of Connecticut. Just over half of the clients (52.5%) are Caucasian, with 19.0% Latino, 11.3% African American, 4.8% Asian American, 0.6% Native American, and 11.8% mixed, other or unknown. Historically, no formalized structure was in place between UCSD and the County for the support of research, although some joint projects have been conducted [8,9].

Developing the Infrastructure for Implementation

Public-academic partnerships combine two very different organizational systems, each with its own goals, values, styles, problems, limitations, and pressures [10]. We approached the formation of the partnership as an exercise in “cultural exchange” that occurs when different groups engage in a process of debate and compromise [11] to achieve a valued goal [12]. The process is necessarily bi-directional; both parties contribute and both derive benefit.

In developing this implementation network, concerns were raised with respect to liability, confidentiality, and added responsibilities for already busy clinical and research staff. As is often reported to be the case with university-community ties [13-15], academic researchers often found the additional bureaucratic processes that are necessary in public service organizations to be cumbersome. Then, too, County staff had difficulty with the university’s organizational and administrative systems. Previous interactions had created a set of expectations and barriers that needed to be overcome to achieve a more effective partnership [5,10]. Forming a collaborative and productive partnership in the face of such barriers is complex and time-consuming and requires mutual trust and respect [14,16,17]. We report, below, on the lessons we have learned in this process.

Lesson 1. Changing Attitudes. As part of formalizing the structure for the partnership, we held a series of meetings to educate ourselves about the other’s culture. We then formed

three committees with equal representation of UCSD and County Staff to discuss ongoing operations and projects, Administrative to discuss policy issues and resource allocation, and Executive to discuss overall priorities and progress.

Lesson 2. Sharing Staff. We jointly hired staff specifically for the partnership. A NIMH funded Center grant provided funds for a community mental health liaison and a data analyst to provide support to the County. These staff members were housed at County offices for the express purpose of increasing communication. We also hired a research assistant whose time was shared between the UCSD and the County to aid in the development of reports and educational materials.

Lesson 3. Expecting Obstacles and Formalizing Solutions. In the development of the partnership, fiscal and administrative problems emerged. For example, we initially planned to have the County administer the budget for the partnership through a subcontract with the university. Because of administrative and procedural issues specifically related to the grant, however, the County was unable to contract with the university. Through negotiation and compromise, requiring that each institution look beyond its distinct set of organizational priorities and loyalties [18,19], the partners decided that the university would manage the entire budget. The university became the designated employer of all staff. The partners retained joint determination of budget allocations, personnel selection, and supervision. This agreement and others were documented in a formal Memorandum of Understanding that outlined the terms of the collaboration and provided for annual review and revision, if necessary. The Memorandum was developed with NIMH input and submitted as a formal amendment to the Center grant award.

Another lesson learned in establishing the implementation network was the importance of formalizing solutions. For example, it was important to develop efficient mechanisms to enhance recruitment of representative community samples of County clients in research

protocols., The shared staff facilitated identification of new recruitment sources and reduced the time spent on duplicative administrative aspects of obtaining approval to recruit at different county-affiliated sites. A major initiative involved collaboration with the County Public Conservator's Office, which is responsible for persons judged to be in need of the extra protection of guardianship, to develop policies that would allow participation of such individuals in minimal risk research projects. In the past, a person under public conservatorship was not permitted to participate in any type of research. The work of the partners changed this policy and enabled enrollment of conservatorized persons (with individual assent and conservator consent) in minimal-risk research as defined in 45CFR46,[20][REF] helping to make the study samples more representative and increasing the potential applicability of findings to clinically fragile or disabled individuals.

Lesson 4. Monitoring and Evaluating. UCSD and the County each had institutional mechanisms to track research projects. The formal mechanisms included the University's Human Research Protections programs and the County's Research Committee. Because the County had limited capacity to review and monitor projects, the number of projects active in county programs was restricted. The partners worked to harmonize these processes in order to reduce the burden on the organizations and investigators, and created a database to track projects from initial proposal through study completion. Other databases were created to track subject participation and publications and reports. In general, the organizational expertise of the County complemented the scientific expertise of the academic investigators and created a monitoring and evaluation structure that assists investigators in the preparation of necessary documents, reduces the demand on county resources, and mitigates excessive subject burden by tracking the research participation of County clients.

Lesson 5. Adapting and Adjusting. Public-academic partnerships are established within a fluid context of political processes, changing priorities, and other events all of which require a flexible and adaptive approach not typically required in academic research. The

partnership encountered three such challenges: changes of the County leadership; natural disaster; and significant budget cutbacks. Each of these resulted in a resetting of project timetables while staff accommodated to the requirements of the moment. That the partnership survived and flourished indicates the strength of the arrangement and the validity of the pursuit. A good example is the implementation of the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA)[21] regulating the use of medical data. This necessitated development of a new Data Use Agreement and several other procedures to ensure that the data transfer between the partners was HIPAA-compliant. This Agreement enabled investigators to retain access to de-identified information from the County's database and a number of reports and publications have resulted (see below).

Lesson 6. Taking Advantage of Emerging Opportunities. In November 2004, Californians passed Proposition 63, the Mental Health Services Act (MHSA). The MHSA generates new tax revenue specifically earmarked to expand mental health services for the seriously mentally ill. The guiding purpose of this program was to transform the delivery of mental health services in California by instituting a recovery-oriented vision for new and expanded services and placing it into the real world of homes, peer-run centers, clinics, and schools. For San Diego County, this has resulted in a budget increase of nearly \$29 million through fiscal year 2007/2008. One of the key features of the MHSA was that each county was required to prioritize its own mental health needs, and in collaboration with a range of stakeholders, including consumers and family members, providers, and advocates, determine how the money would be used, emphasizing the need to deliver comprehensive services to a limited number of people rather than just broadly increasing services across the whole system. The UCSD-County partnership was instrumental in gathering, consolidating and analyzing needs assessment and service utilization data that formed the core of the San Diego plan that was approved with highest enthusiasm by the State's review committees.

Outcomes and Benefits

Along with special analyses that were prepared as part of the County's MHSA application, investigators in the partnership have collaborated to complete nine studies; eight of these have been published on topics such as gender differences [22], ethnic disparities [23], and diagnostic- and age-related factors [24,25] affecting service utilization for patients with schizophrenia, risk factors for homelessness [26], and the differential occurrence of substance and alcohol use disorders among different ethnic groups [27]. We conducted two studies linking the County's database with state Medicaid data. In one study, we found that residents of assisted care facilities had greater use of outpatient mental health services and lower rates of psychiatric and non-psychiatric hospitalization [28]. In the other study, we found that 41% of patients with schizophrenia were fully adherent and 16% were partially adherent to their prescribed antipsychotic drug schedule and that both psychiatric and medical hospitalizations were strongly related to the degree of drug adherence [29]. The Center provided a unique environment for the combination of academic and programmatic expertise necessary to pursue these analyses.

Discussion

In establishing a network for implementation between an academic center and public mental health system, we encountered several issues that may generalize beyond our goal of the development and implementation of state-of-the-art approaches to assessment and interventions to improve the functioning and quality of life for persons with serious mental illnesses. The set of six "lessons learned"—changing attitudes; sharing staff; expecting obstacles and formalizing solutions; monitoring and evaluating; adapting and adjusting; and taking advantage of emerging opportunities—most likely will be applicable to the formation of other partnerships designed to provide necessary organizational support to facilitate the moving of the results of clinical research into community practice.

Starting with successful models of other academic-public collaborations and modifying them to the specific needs of the partners and the population, UCSD and San Diego County created a partnership focused on older adults with psychosis. The organizing rationale for this Center was to establish an evidence-based partnership approach that adapted the principles of community-based participatory research in order to facilitate implementation of evidence-based approaches to assessment and intervention. The cultural exchange between two organizations that differed vastly in values orientations, bureaucracy, and function required a substantial investment of time, a strong commitment to the process, an openness to change, flexibility in the face of shifting contexts and priorities, and willingness to compromise and accommodate. The partnership received the endorsement of the top leadership in both organizations, an important factor in promoting cohesiveness and cooperation. Through this process, San Diego County has developed an infrastructure to support research, educational programs, and the development of the mental health delivery system for older adults. The University has gained knowledge and awareness of community mental health services conditions, and improved its ability to develop and implement effective community-based research projects for older persons with serious mental illnesses. In 2007 the implementation network constituted an important part of an application to NIMH for support of an Advanced Center for Innovations in Services and Interventions Research. The application was funded and continuation of the partnership is assured.

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