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RESEARCH REPORTS FROM IBR

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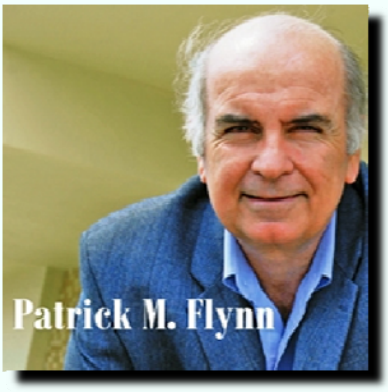
Announcing the new IBR Director



On April 1, 2009, ***Dr. Pat Flynn*** was appointed as the new Director of the Institute of Behavioral Research (IBR)—only the third Director since the Institute was established in 1962. He is approaching his 10th year at the IBR. As a Professor of Psychology, he is strengthening collaborative relationships with TCU's Department of Psychology as well as continuing a long-standing tradition of providing training opportunities for IBR graduate students in health services research. Early in his career, Dr. Flynn worked in therapeutic community, methadone, and outpatient drug-free treatment programs in several capacities. More recently, he has been an active consultant for the NIH and member of study sections responsible for peer review of grant applications. In addition, his research and services to the field have been recognized by the American Psychological Association and the American Educational Research Association through their conferral of Fellow status.

Dr. Dwayne Simpson has wrapped up 20 years of service as IBR Director at TCU and now looks forward to devoting more attention to innovation training and implementation issues. In the coming months (Sept-Oct-Nov), he will be in England working as a NIDA-funded Distinguished International Scientist (collaborating with Dr. Ed Day at the University of Birmingham) to assist with a large-scale adaptation and implementation of TCU treatment resources in the UK.

IN THIS ISSUE

Report on IBR Summer Mapping Training (July 14-16, 2009)

By Dwayne Simpson, Norma Bartholomew, and Don Dansereau

We are delighted with the evidence of success for the IBR Summer Mapping Training, as summarized in this report. It was designed as a "training of trainers" and registered participants came from far and wide—California to New York, Alabama to Illinois, and Canada to England. And many came from across Texas, of course. Government, public, and private provider networks were represented, including many from corrections-based systems. Registration reached capacity a few weeks before the 2 ½ day training event began and therefore had to be closed with a "stand-by" list. A total of 36 were awarded our "TCU Mapping Certificates of Training." We also were pleased to recognize ***Julie Bailey CADC*** with an "IBR Award for Excellence" based on her dedication to mapping applications at Preferred Family Health Care in St. Louis MO.

Based on inquiries about future training events, we are creating a waiting list via the IBR Website for another workshop, tentatively set for next spring.

"Pre-training Attitudes" about Program Needs and Readiness for Change

Participant surveys completed before the training began addressed perceptions of staff needs and organizational functioning of the treatment systems they represented. (These procedures were reviewed and approved by the TCU Institutional Review Board.) Two sections of the **TCU Organizational**

Readiness for Change scales (ORC; Lehman et al., 2002) were included, reflecting staff perceptions of "program needs and readiness for change" and "organizational climate." These are key organizational dynamics addressed in our conceptual model for innovation implementation (*Simpson & Flynn, 2007*).

Tabulations of training participant responses about "program needs" (see ***Table 1*** in PDF file from IBR Website)† show percentages of "agree" or "strongly agree" ratings for each item. These results indicate participant ratings describing "general clinical staff training needs" at the programs represented were very high overall, with 86% noting that guidance is currently needed in their respective programs for using *better client assessments* to document improvements (86%), guide clinical care decisions (81%), and match clients to appropriate services (78%). Trainees also emphasized (i.e., 67% to 81% agreements) the need for clinical tools that will improve client engagement and clinical progress through better thinking, cognitive focus, problem solving, rapport building, and behavioral management.

"Organization-level needs" given the highest ratings by participants included improving staff communications (67%), staff inter-relations (61%), evaluations of staff performance (58%), and record-keeping systems (58%). The most common "personal training need" they mentioned was for adopting new methods for clinical advancements (63%). Finally, questions on "pressures for program changes" showed that their supervisors or managers (67%) and funding agencies (53%) were regarded as principal agents for influencing change.

The second section of the ORC pre-training survey focused on "organizational climate." It included scales for *clarity of program mission*, *staff cohesion*, *autonomy*, *communication*, *stress*, and *openness to change*. Mean scores calculated across all workshop participants on these scales averaged between 33 and 35 (with possible ranges from 10-50, with 30 being the midpoint score). These are virtually the same as normative scores defined from multiple studies in the TCU research database. Because some participants scored higher and some lower than this "mean score," however, we examined each ORC scale in relation to the ratings of needs summarized above.

As expected, the scales for organizational climate were found to have predictable relationships with participant perceptions of their own program needs and pressures. Results of correlational analysis ($p<.05$), for instance, showed that ORC scores indicative of higher *staff stress* levels were associated with greater perceived program-level needs for *better client problem-solving* and *behavioral management strategies*. In other words, working with more hard-to-manage clients has the effect of increasing staff stress levels.

Even more significant (with some correlations as high as 0.65) were the relations found between ORC scale scores and participant concerns about program structure and operations. One of the clearest examples involved ORC scale scores for *clarity of program mission.* More specifically, participant ratings indicative of poorer staff clarity about their mission (defined by lower ORC scores on this scale) were associated with *greater needs for improving service goals*, *staff role definitions*, *job descriptions*, *performance evaluations*, and *staff relations and communications* in their respective programs.

This pattern of findings was similarly true for several other ORC scales as well—including *cohesion*, *autonomy*, *communication*, and *openness to change*. That is, poorer ratings on these scales were related to higher scores on a wide array of program needs. In regards to the stress scale, it was not surprising to see that higher ratings of staff stress were accompanied by greater needs for program guidance in dealing with service delivery and staffing dysfunctions. Collectively, these results are important indicators of behavioral health care because research shows that poor organizational focus and functional dynamics predict poorer quality of services to clients (*Lehman et al. 2002*; *Greener et al., 2007*). Efforts to improve "internal functionality" therefore appear to be needed in some programs.

† ***Tables***: www.ibr.tcu.edu/pubs/newslet/rr09sprsumTables.pdf

"Post-training Evaluation" of TCU Mapping Training

The focus of our 2 ½ day training moved from overviews of adaptive treatment process dynamics (involving interactions between assessments and interventions) and cognitive systems, to the clinical applications of node-link mapping that undergirds a broad set of TCU intervention resources (Dansereau & Simpson, 2009). Table discussions, role-playing exercises, case study reports, and clinical tip-sharing were viewed as highlights by workshop participants. Tabulations of their ratings for this training (see ***Table 2*** in PDF file from IBR Website)† showed percentages of participants who agreed with each item contained in the Workshop Evaluation (WEVAL).

General quality, satisfaction, and utilization of TCU Mapping were strongly endorsed items with 94%-100% agreement. Participants also generally believed *program resources and staff skills* in their respective programs were adequate for mapping implementation (72% to 89%); only 14% doubted that fellow counselors could use the technique effectively. *Training* activities were judged to have included effective practice sessions, adaptation strategies, and training preparation exercises (89% to 94% agreement). Only 22% thought more follow-up training would be necessary before they could effectively use mapping with their clients. These indicators suggest efforts in this workshop to train "new mappers" were generally successful.

Finally, ratings of the *support and commitment* participants anticipated from their programs leaders, fellow staff members, and clients were generally high (i.e.,75% to 94% agreed), although about 1 in 4 trainees expected to see resistance to this innovation from some co-workers. Nevertheless, their overall ratings on *common barriers* facing clinical innovations reflected high optimism in using the mapping-based counseling materials. Only 11% worried about a lack of time for preparation and applications. Other types of implementation barriers—such as having better options to use, adaptability to clients, or training inadequacies—seemed to be of virtually no concern (0% to 3%).

† ***Tables***: www.ibr.tcu.edu/pubs/newslet/rr09sprsumTables.pdf

Comments from Trainees . . . .

Written comments (below) from mapping trainees helped confirm favorable survey ratings.

This was one of the most innovative workshops I ever attended – just wish I had gotten it earlier in my career. I can see how to use mapping in my job, education, 12-step program, family, and even relationship issues of my personal life. It was superb.

I like skills-based learning, and this workshop was just right – very focused on developing skills for practical applications. The emphasis on practice exercises was great.

The training materials provided will be very helpful for incorporating mapping into my workplace – the take-away items are great. The need for more quality time with clients was made evident, and my counseling skills were strengthened through resources for integrating client needs assessment with treatment.

As a trainer, I can already envision how these maps can work in practice. I loved the free mapping and the emphasis on mapping process rather than just following a rigid structure.

Every 10 years or so something comes along that changes behavioral science. Mapping will revolutionize the field like MI did years ago.

I feel mapping will become the new face of alcohol and drug treatment.

Mapping will now be added into our formal clinical training curriculum, including treatment resistance and planning exercises (especially for relapse prevention and prevention issues). Our students will be better equipped as substance abuse counselors. Thank you so much.

Concluding Comments on Implementing and Sustaining Mapping-Enhanced Counseling

Delivering satisfying and effective innovation training is a challenge—but it is easy compared to the subsequent efforts required for field adoption and sustained implementation. Not only must an innovation be evidence-based and well trained for making it fit into its new environment, there are complex sequential stages required that need to be monitored and nursed over time. Thus, this training focused on enhancing clinical practice as well as using "maps" to document the process (and address related questions about fidelity of applications).

Results of the TCU Mapping training ratings summarized above suggest 1 or 2 participants out of 36 did not find mapping suited to their needs, but the rest rated the training very high and fully embraced its basic concepts. Some of the trainees expected to return to more "resistant" treatment settings than others, however, which is likely to mediate field-based progress in adopting and implementing mapping. Another round of assessments is therefore scheduled as part of our training follow-up evaluation, and further study is planned to evaluate this process (see similar evaluations by *Simpson & Flynn, 2007*).

There were dual goals for our TCU Mapping Training workshop. First, we wanted to deliver a high quality training experience for TCU Mapping, now listed with a helpful review on the **National Registry of Evidence-based Programs and Practices (NREPP)—**a service of the **Substance Abuse and Mental Health Services Administration (SAMHSA)**.

Second, we want to examine the training adoption process empirically and learn more about the practical aspects of innovation implementation. Mapping has front-line clinical implications, but has secondary value as well for addressing supervisory and organizational change objectives. Our initial focus centers on TCU Mapping-enhanced treatment resources, of course, but we expect findings on implementation progress will generalize to other innovations. By merging information from staff perceptions about program (environmental) needs and staff functioning with their attitudes about adopting innovations and implementation experiences, we hope to gain insights and identify warning signs that can help facilitate efforts to use evidence-based practices.

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