Reviewer's report

Title: Toward a Policy Ecology of Implementation of Evidence-Based Practices in Public Mental Health Settings

Version: 1 Date: 23 November 2007

Reviewer: kimberly hoagwood

Reviewer's report:

General

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)

Review of “Toward a Policy Ecology of Implementation of Evidence-Based Practices in Public Mental Health Settings “

Reviewer: Kimberly E. Hoagwood

Date: 11/23/07

This debate article addresses an important set of divergent trends in the implementation of mental health practices in the public sector. It describes the dangers of mandating and incentivizing the uptake of evidence-based practices with narrow attention only to clinician training and suggests that this kind of decontextualized process will not support sustained quality improvement.

The article targets a very important set of problems and offers a “policy ecology” framework for broadening attention to a wider range of implementation issues. In providing a wake-up call for policy-makers considering EBP implementation, it describes an important set of issues for consideration.

The authors might consider the following suggestions as a way to strengthen and focus the central arguments.

First, the article is submitted as a “debate” article. Consequently I would encourage the authors to articulate the central argument and frame the controversy more precisely. This does not happen in the current draft. As a consequence, it is difficult to understand the poles of the controversy or debate. If the debate is that the trend towards states and large purchasers to mandate use of EBPs by clinical staff is likely to fail if funding, structural accommodations, or even political changes within the broader policy ecology are not supported, then this should be clearly stated.
Second, and related to the point above, it is not entirely clear whether the authors intend for the paper to provide a review of the status of implementation science applied to the current state of policies, to provide a policy analysis of the status of implementation efforts within the mental health field, or some hybrid. Perhaps as a result, the authors do not state their central premise until page 8, and even there it is not clear what kind of statement of the problem this paper is intended to provide. I would encourage the authors to state their premise earlier, to do so more emphatically in the context of what the controversy is, and to describe how the emerging science on implementation will be used to inform the discussion.

Third, the paper refers to the “science of implementation” and the fact that the emerging “science” does not support single policy decisions. For instance it states that “We argue that mandating the delivery of specific evidence-based practices, as described in the Background section, is poor public policy because it is not informed by the science of implementation” (p. 8). But the paper does not systematically review the science that exists, nor is it clear that it intends to do so. For example, the paper does not describe the few experimental studies that have examined issues of uptake, readiness or sustainability (i.e., Simpson; Schoenwald; Glisson; or reviews of it as in Greenhalgh’s et al Millbank Quarterly piece). If that is not the intent, then the authors should decide how they wish for the “science of implementation” to be used to frame the debate.

Fourth, the article would benefit from shortening. For example, there is lengthy discussion about agency policies, the role of purchaser agencies, and how the gathering of provider-level information had its origins in the Health Care Quality Improvement Act of 1986 (PL 99-660). This could be shortened. In addition, I would encourage major editing and elimination of some of the background discussion (for instance, the brief history of policy in 80’s; (p. 6, 7, 8)

Fifth, the paper refers to “several implementation scholars” (p. 6), “quality scholars” (p. 6), “scholars of organizations and institutions” (p. 7). The use of the term “scholar” is unclear and the categorization is rather vague.

Sixth, there are numerous recommendations sprinkled throughout the paper that if brought together and highlighted as a set of recommendations, tagged specifically to the framework, would lend greater clarity to the paper. For instance, recommendations are made about the role of licensing boards and the importance of restructuring CEUs. These recommendations appear on page 10 but not elsewhere. On page 16 there is discussion about loan forgiveness. These are but two examples of important recommendations that get lost in the text and that especially in a debate article could be highlighted and brought into full view.

Seventh, the paper describes new approaches to disease management that could be deployed to address the fractured policies of implementation. Concrete examples of a regionalized approach, drawing on other health fields (e.g., asthma, diabetes) would be very helpful as they might elucidate how a systematic and multi-level approach to quality improvement might address the deficiencies of the current narrow focus on merely clinician-training.
Eighth, some specific issues, such as mental health parity laws, are given short shrift. For example, on page 15 the paper mentions mental health parity laws but merely in passing. The implications of these laws for other issues raised in the paper (e.g., stigma, equitable financing) are important to consider.

Ninth, the logic of the argument about consumer hesitancy to embrace EBPs and the importance of family engagement was also given short shrift. If the intent is to argue for increasing political will through consumer advocacy, then the implications could be made clearer. If the intent is to argue for improving the science on implementation to include family and consumer agency and engagement, then a different set of implications could be drawn.

Tenth, the multi-level framework and the categories that are described are not clearly defined. As a consequence, some issues are described within multiple categories. For example, stigma is described in the social level, but structural stigma can also be seen in state-level policies; state activities to implement EBPs are described within the agency level, but are also apparent in the political level as well as organizational. The differences between organizational level and agency level is not entirely clear. A clearer definition of the boundaries of the categories would be helpful.

Eleventh, the summary includes both statements and recommendations. I would encourage the authors to provide a clear set of recommendations in this section. Tagging the recommendations to the policy levels would be helpful.

Finally I did not find either the Table or the Figure to be especially helpful in clarifying the paper’s arguments. The Table was barely discussed in the paper and while the issues of hidden costs are important, unless the authors wish to make this a more extended issue, I would consider dropping the Table. The figure was not helpful in that at least some of the issues identified (i.e., stigma, enhanced reimbursement rates) can be operative at different levels depicted in the figure. If the text of the paper is tightened, shortened, and reorganized as recommended above, the figure is likely to be unnecessary.

Discretionary Revisions (which the author can choose to ignore)

What next?: Accept after minor essential revisions

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.