

Thursday, June 11, 2015

Implementation, Integration, and “Implegration”: Science and Practice

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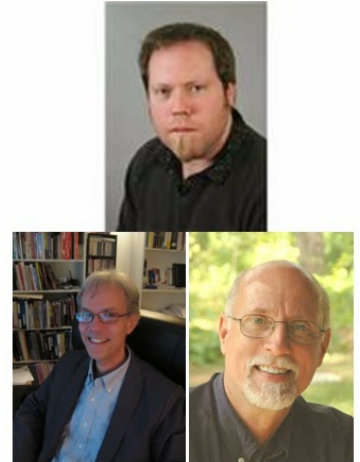
Many years ago, I had a bad experience with a consultant. She promulgated an evidence-based treatment curriculum for a specific condition that my programs treat. The curriculum was excellent; the consultant was not. She complained bitterly to others when cases were not improving rapidly, and blamed some therapists even as she attempted to hire others away from our employ. At no time did she critically examine her own contribution to these circumstances. Good treatment with bad implementation does not produce a good outcome for anyone.

Central to our implementation problems was that our therapists needed time to get their minds around the specific treatment processes. Unfortunately, she and the funders were not patient. This was before I became aware of [Dean Fixsen's research](#) on implementation efforts. He would argue that it takes two years to implement a treatment program with fidelity. In our case, this meant a good curriculum, good therapists, but poor consideration of implementation science.

Fast forward a few years and I have twice consulted to agencies this week on implementing treatments such as the good lives model and motivational interviewing. As you might expect, time is tight and money is short. From an administrator's perspective, it always seems like a good idea at the time: “there is a good new treatment method out there; let's get someone in to do training.” What often gets lost in the mix are some of the basics. For example, with every rollout of a new treatment method there is a minority of people who readily embrace change and another minority who wants nothing to do with it. One example of this took the form of “we've seen these new models come and go over the years. This one will probably go away as well.”

Even the greatest attempts at improving services meet with challenges along the way. An important consideration lies in how we can prevent implementation problems before they happen. Professionals sometimes do not want to change their behavior any more than mandated clients do.

Perhaps one place to start is in considering how best to get the program's context right for change. Are we considering full implementation of a specific approach such as motivational



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Chief Blogger Kieran McCartan, Ph.D. and Associate Bloggers David S. Prescott, LICSW and Jon Brandt, MSW, LICSW are longtime members of ATSA. We are dedicated to furthering the causes of evidenced-based practice, understanding, and prevention in the field of sexual abuse.

interviewing or the good lives model? To do so with fidelity can mean even more effort in curtailing old approaches than in learning new ones. It can also mean stopping a program in its tracks and changing course, which can result in as much or more tumult for the clients as the program staff.

On the other hand, one might try integrating program components piecemeal. For example, one might try to go in a good-lives-model direction through a series of steps:

- 1) Ensuring that the mission of the program is to build client capacities and wellbeing even as clients manage risks
- 2) Focusing on developing goals that every client can approach rather than avoid
- 3) Developing a deep understanding of each client's [common life goals](#)
- 4) Collaborative work with clients to understand their past behavior in accordance with the [self-regulation model](#)
- 5) Consider full implementation of the good lives model

Another possible approach is to consider "Implegration." This is a term coined by Swedish prison psychologist Carl Åke Farbring and refers to an integrated implementation effort (see [here](#) for a series of presentations in English and Swedish). Farbring came to conclude that simple efforts at motivational interviewing implementation were doomed to be less effective when they did not take place in the cultural context of the program. From his notes, he describes Implegration as involving:

- An *intentional* process of implementation
- Bottom-up perspective
- An attitude of exploring and listening
- Local ownership of processes (separate from the centrally decided goal orientation)
- Balance between guidelines and mindlines
- Adjusting to local conditions means deliberate integration
- Positive monitoring and support

When considering the implementation of a treatment approach, it is often easy to overlook the potential contribution of local expertise. This can be achieved as simply as through the appointment of in-house experts who consult to both the model's developer and the front-line clinicians. It can also use in-house relationships, such as having an enthusiastic front-liner organize regular discussions about how implementation is progressing.

For many years, it seemed acceptable to view clinicians as widgets in the service of sophisticated treatment regimens established by experts who were too often in another region. Recent research has confirmed the importance of improving treatment services one client at a time through close attention to the [alliance](#). As our field continues its discussion of best treatment practices, it also seems vital to consider how we make these practices happen.