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IMPROVING COMMUNITY BASED BEHAVIORAL HEALTH INITIATIVES THROUGH PARTICIPATORY IMPLEMENTATION AND EVALUATION

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"The success of participatory implementation and evaluation designs rests on mindful stakeholder planning and involvement."

Stakeholders are individuals with an interest in or who are affected by programs, activities, or interventions, including those embedded in integrated behavioral health. Cross-cutting representation of multiple community sectors (education, health, behavioral health, public health) is required for effective service delivery; but it is not enough to merely have the 'right' stakeholders at the table. *Engaged* stakeholders are key to the ability of any community-based, behavioral health (BH) effort, whether it be a mobile community resource team, a coalition of multi-sector organizations, or a Certified Community Behavioral Health Clinic (CCBHC), to meet diverse prevention and intervention needs. This is especially true when the demonstration of targeted outcomes, such as lowered addiction rates or reduced emergency room visits, stems from a care coordination model of integrated services across vulnerable populations (veterans, children, gender-diverse adults, older adults).

Analyzing stakeholders to sustain their engagement improves project execution. A stakeholder engagement plan can serve as a guide for ensuring their active participation over the life cycle of a behavioral health collaboration.

I. Stakeholder Analysis

BH leaders and managers can integrate their understanding of roles and responsibilities to better involve stakeholders for planning, implementation, evaluation, and reporting. First, listing stakeholders by their respective types, or functions, is a foundational piece of long-term engagement. Planners can identify the *implementers* (those directly involved in program operations) and the *decision makers* (those who can decide the future of the program). They should delineate *participants* (those being served) from *partners* (funders, academic organizations, faith-based entities, advocacy groups, government officials, clinic directors, professional associations, corrections representatives, school leaders) for mutually satisfying benefits. The analysis may be reviewed and revised, with stakeholders providing rounds of comments on feasibility and additional nominations to optimize community representation and address evolving behavioral health needs.

Once listed in a summary table or roster, expectations for stakeholder involvement can be confirmed in initial and recurrent meetings. Objectives may include discussion of functional (*implementers, decision-makers, action planners, evaluators*) interests around implementation, monitoring, evaluation, communication, and reporting. Expectations may be clarified, while appealing to stakeholder interests to remain involved. Meeting facilitators may open dialogue

through strategic, capacity-building questions with stakeholders: Will clients be involved in helping create surveys that are culturally competent? How frequently, and for how long? Will partner agencies give provider training support or other pertinent resources? Is there a limit to what they can provide? How do stakeholders view the purpose of community-based behavioral health efforts? Do stakeholders agree on the mission and vision to expand and sustain care pathways? These are just a few considerations for effective stakeholder engagement planning, the first step in building and sustaining critical relationships for program delivery across the spectrum of community-based care.

As discussed in Community Resource Teams – Bridging the Gap Between Public Health And Behavioral Health, team leaders emerge from stakeholder committees to become advocates and champions for projects, increasing their viability and visibility in the community. As also stated, integrated behavioral health teams are prime contexts for participatory evaluation designs where both clients (recipients of services) and providers can guide efforts. The success of participatory implementation and evaluation rests on mindful stakeholder planning and involvement.

II. Participatory Implementation and Evaluation

Participatory approaches differ from others in three unique ways, although this section is not inclusive of all differences. First, the recipients of programs help shape implementation. Clients become part of the stakeholder group, attending meetings with other stakeholders, providing input to feasibility of action plans, or informing planners of cultural disconnects in outreach and education activities. Second, the utility of this approach relies upon a thorough needs assessment of discrepancies between current (high opioid use; low treatment plan adherence) and desired conditions (low opioid use; strong treatment plan adherence). These client needs are then mapped to specific interventions (medication management, crisis planning, patient education, shared decision making, or SDM). Third, participatory evaluation data, collected according to pre-planned time points through a program's duration, includes anecdotal progress and results. For example, the shared observations (reduced overdoses, reduced emotional disturbance in classrooms) of police or teachers on a stakeholder committee are equal in validity to numerical, electronic health data or documented wait times.

Facilitating stakeholders from across community sectors to improve care access is not without challenges. Stakeholders may have competing priorities in funding or governance within the group, differing perspectives on mission and vision based on their sector (education, clinical, public health, community resident), and time constraints, to name a few. Case management success stories may reflect that the benefits of a participatory governance and evaluation model outweigh any initial hurdles.

The next issue brief in this series will further discuss the use of stakeholder-based logic models in monitoring and evaluation. Integrated behavioral health activities can impact multiple areas of the Social Determinants of Health (SDoH) within the same six-month to one-year timeframe, a situation conducive to the use of nested logic models. These models guide simultaneous, and varying efforts (educational, clinical, public health, corrections, housing) that interact to produce common outcomes.