The role of clinical champions in facilitating the use of evidence-based practice in drug and alcohol and mental health settings: A systematic review

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Abstract

Background: The dissemination and adoption of research into clinical practice in health care settings is a complex and challenging process. Clinical champions have been increasingly used in health care to facilitate the implementation and adoption of evidence-based practice and to overcome organizational barriers. In relation to substance use and mental health disorders, translation of new evidence into practice is an ongoing challenge. The utilization of a clinical champion to motivate staff to implement evidence-based practice in these settings may improve treatment quality and reduce the burden of disease. We thus aimed to conduct a systematic review to examine the role and efficacy of clinical champions in the drug and alcohol and mental health settings.

Methods: We conducted a systematic literature search (1980-present) using the following databases: PubMed and PsycINFO. Additional studies were identified using reference searches of relevant reviews.

Results: Thirteen separate studies were included in the final review. Clinical champions were typically selected rather than emergent, including clinical staff members engaging in a professional clinical role (e.g., physicians, psychologists, social workers). Training provided for these roles was often not stated. Clinical champions assisted with faster initiation and persistence in the application of novel interventions, facilitating overcoming system barriers, and enhanced staff engagement and motivation.

Conclusions: In the substance use and mental health field, clinical champions appear to be an important component to facilitating practice changes. Future studies should provide specific details regarding attributes and training and also examine the relevant combination of personal characteristics and training sufficient to facilitate implementation of evidence-based practice in drug and alcohol and mental health settings.

Plain language abstract

Treatment delivery in drug and alcohol and mental health settings may not always be based on best available evidence. Organizational context and individual factors are important in determining whether new practices will be adopted.

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Passive approaches such as websites or treatment manuals do not necessarily lead to change in practice. The clinical champion model has been shown to be effective in aiding implementation of evidence-based practice in health care settings. However, there is limited evidence evaluating its use in drug and alcohol and mental health settings. The current review aims to synthesize and evaluate the use of clinical champions in implementation research in drug and alcohol and mental health settings. We found that clinical champions were typically clinical staff members engaging in a professional clinical role. Training provided for these roles was often limited. Clinical champions may assist with faster initiation and persistence in the application of novel interventions, facilitating overcoming system barriers, and enhanced staff engagement and motivation.

Keywords
Clinical champion, substance use, drug and alcohol, treatment, community based, training

Substance use and mental health disorders are a major public health concern. They are associated with a range of medical and other psychological comorbidities and significant burden of disease (Whiteford et al., 2015). There is evidence for the use of pharmacological and psychological interventions in these clinical populations. However, specific treatments delivered in clinical settings may not always be based on best available evidence (Powell et al., 2014). When evidence-based interventions are applied beyond the context of a research project, difficulties in translation can arise. Behavior change by clinicians in adopting new practices appears to be only weakly related to the strength of the evidence base (Dopson et al., 2002). The adoption of evidence-based practice into clinical practice in health care settings is thus a complex and challenging process (Bauer et al., 2015).

Implementation science has attempted to understand and improve how research findings can be applied into routine practice (Eccles & Mittman, 2006), including in substance use and mental health settings (Louie et al., 2018, 2020). There are many factors that may influence successful implementation of an innovation, as outlined in the Consolidated Framework for Implementation Research (CFIR) (Damschroder & Hagedorn, 2011). Organizational context and individual factors are important in determining whether new practices will be adopted. Potential barriers to adoption include clinician preferences, resistance to change, staff turnover, workload demands, communication issues and ineffective leadership (Dale et al., 2015; Dudgeon et al., 2012). A number of strategies can be used to implement evidence-based practice at an organization level, including staff training. However, “passive” approaches such as websites or treatment manuals have been found to not necessarily lead to change in practice or clinician behavior (Powell et al., 2014).

Clinical champions are increasingly used in health care to facilitate implementation and adoption of evidence-based practice, and to overcome organizational barriers (Miech et al., 2018). A clinical champion is typically defined as an individual within an organization who has a responsibility to advocate for change, motivate others and use their position and expert knowledge to facilitate the adoption of a particular innovation (Cranley et al., 2017). Clinical champions are most often front-line clinicians who can advocate for and influence practice-driven change. They do this by leading by example and being a resource for other staff members. Previous studies have shown that front-line clinicians are an essential influential factor in the implementation of practice change (Byers, 2017). Driving practice change from the front-line may be more effective in creating organizational change as it can diffuse the adoption of an innovation throughout organizations, instead of imposing change from senior management (Byers, 2017).

The clinical champion model has been shown to be effective in aiding implementation of evidence-based practice in health care settings. Examples of where this has occurred include cancer care (Bowman et al., 2015; Dimoska et al., 2012; Dudgeon et al., 2012), medical and nursing best practices (Graham et al., 2002; Rangachari et al., 2015; Schorr et al., 2016; Thomason et al., 2016; T. A. Williams et al., 2013), stroke management (Dale et al., 2015); pain management (Rosenberg et al., 2016; A. M. Williams et al., 2012) and e-health and technology (Knight et al., 2014; Miller et al., 2004). Clinical champions have been identified in the literature as an essential component in facilitating practice changes (Miech et al., 2018).

Despite the increasing number of publications in recent years demonstrating the effectiveness of clinical champions in facilitating practice change in health, there is limited evidence evaluating its use in drug and alcohol and mental health settings. There are particular issues in the drug and alcohol and mental health settings that suggest that implementation in these contexts is unique in comparison to other areas of health care. These clinical settings typically employ staff with diverse training and backgrounds, including recovered service users to those with more professional qualifications including medical, allied health and nursing. Thus, implementation of evidence-based practice can be challenging in this context due to lack of common professional leadership hierarchies and siloed work practices. Furthermore, these settings have traditionally had difficulty...
implementing and using evidence-based practices (Saunders et al., 2014). Therefore, the nature of the clinical champion role may be different to that required in other areas of health care. For example, given the above, it is possible that effective clinical champions in these settings may not require certain professional clinical backgrounds and may need to be emergent, due to interest, rather than selected by a manager and may require more face-to-face training than what is observed in other settings. The current review thus aims to synthesize and evaluate the use of clinical champions in implementation research in drug and alcohol and mental health settings.

**Methods**

A comprehensive review of the literature was undertaken to examine the role, responsibilities, characteristics, strategies used, and effectiveness of clinical champions in drug and alcohol and mental health settings. We followed the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidelines for systematic reviews (Moher et al., 2009). The systematic review was registered with the international Prospective Register of Systematic reviews (PROSPERO).

**Eligibility criteria**

Studies were eligible if (1) they were written in English, (2) they were published from 1 January 1980 until January 2020, (3) they used a clinical champion who was a clinician in a clinical setting, and (4) the study took place in a drug and alcohol or mental health (excluding dementia and geriatric cognitive disorders) treatment setting including inpatient, outpatient, community or primary care settings.

**Search strategy**

We searched PsycINFO via OVID SP and PubMed using the following key search terms: ([champion] OR (champion) OR (change agent) OR (opinion leader) OR (liaison)) AND (implementation) AND ([health] OR (drug and alcohol) OR (addiction)). We conducted reference searches of relevant reviews and articles.

**Study selection**

After duplicates were removed, titles and abstracts were screened, and one author reviewed full text articles for those that potentially met inclusion criteria. If there was any uncertainty around inclusion for review, a second author was included. Any disagreements were adjudicated by a third author (there were nil disagreements). Data for each article that met inclusion criteria were extracted by one author and included in the synthesis.

**Data extraction and synthesis**

Data extracted included year of publication, study setting and design, treatment or intervention to be implemented, details about the clinical champions (role, responsibilities, selection, training and effectiveness). A synthesis of the data was performed following data extraction.

**Results**

**Study details**

See Figure 1 for PRISMA flowchart. The initial database searches yielded 309 results, 275 after duplicates were removed. Six articles were identified through reference lists searches. Following title and abstract screening, 25 full-text articles were screened for potential inclusion (the remaining articles were primarily excluded due to no use of a clinical champion, or no use of intervention in drug and alcohol or mental health). Eight articles were excluded after full text screening due to insufficient information about clinical champions (Chang et al., 2013; Cohen et al., 2013; Kathol et al., 2010; Sunderji et al., 2019), and use of an intervention not focused on drug and alcohol or mental health treatment (Banks et al., 2014; Bentz et al., 2007; Haynes et al., 2011; Shumway et al., 2018) or in a mental health or drug and alcohol treatment setting (Ballard et al., 2018; Leathers et al., 2016; McCabe et al., 2013). Two selected studies reported on the same trial (Hagedorn et al., 2019; Harris et al., 2017) whereby the Hagedorn et al. study is presented here given that it reported on clinical champions although some information was extracted from Harris et al. Thirteen (13) articles were included in the final synthesis. Papers included in this review were published between 2009 and 2019, with the majority published in the last 5 years. This shows the relative infancy of implementation research on the use of clinical champions in drug and alcohol and mental health settings.

**Study design**

Studies included in the review are depicted in Table 1. The majority of the studies used qualitative or mixed methods while two were quantitative studies. Studies investigated implementation of clinical champions in drug and alcohol services or populations, mental health services or populations, and integrated drug and alcohol and mental health settings. The majority of studies were implemented in the United States of America (n = 9), with the remaining in Australia (n = 1), Canada (n = 2) and the United Kingdom (n = 1). Studies took place across a wide variety of clinical settings including primary care, Veterans Health Administration sites, forensic mental health, inpatient mental health, aged care, community
treatment, child welfare agencies and medical residency programs.

Outcomes

Who were the clinical champions? Nearly all of the studies \((n=13)\) described what types of clinicians were in the role of “clinical champion” for a particular intervention (see Table 1). Champions included drug and alcohol professionals, primary care mental health integration clinicians, senior psychologist or clinical psychologist (Cook et al., 2009; Hagedorn et al., 2019), addiction medicine specialists (Hagedorn et al., 2019), clinical pharmacy specialists (Hagedorn et al., 2019), social worker (Hagedorn et al., 2019), clinicians or managers in the service (Forchuk et al., 2013; Gordon et al., 2011; Green et al., 2014; Guerrero et al., 2015; Kipping et al., 2019; Pigot et al., 2019; Rycroft-Malone et al., 2019). In many cases \((n=5)\) the clinical champion was someone in a senior position within the service. For example, a team leader (Avalos et al., 2016; Green et al., 2014), senior medical staff specialist (Hagedorn et al., 2019), or a medical or program director (Hargraves et al., 2017; Helseth et al., 2018; O’Sullivan et al., 2018).

Clinical champions were classified as either selected/recruited for the role \((n=8)\), or emergent or self-designated \((n=4)\) in the studies that did provide description of the role designation. Only one study did not provide an explanation about who was in this role (Goren et al., 2016). Emergent champions were individuals who emerged as a champion for a particular innovation or intervention due to interest, expertise or passion about the project/innovation. In one study, emergent champions were typically new staff with fresh perspective/ideas (Gordon et al., 2011). Studies with selected champions included those who primarily had experience in the use of the intervention/innovation. In the study of mindfulness implementation across mental health services (Rycroft-Malone...
| Study | Intervention | Setting | Research design | CC: who were they? | CC: training | CC: role | CC: effectiveness |
|-------|--------------|---------|----------------|-------------------|-------------|---------|-----------------|
| Hagedorn et al. (2019); Harris et al. (2017) | Pharmacological treatment for alcohol use disorder (AUD) | Primary care USA | Qualitative methods (interviews pre-implementation) | Addiction medicine specialists - Primary care mental health integration champions (clinical pharmacy, social worker or psychologist) | 1.5 day face-to-face collaborative learning session including education about the intervention as well as skills in facilitating uptake at their sites - Ongoing monthly teleconferences - Access to library of materials and champion network | Provide education and support to primary care providers - Provide consultation, educational outreach, information and advice to staff | CC identified as important to implementation. CC time spent on project not related to implementation success. Importance of stability in staff and leadership noted. |
| Hargraves et al. (2017) | Screening, Brief Intervention and Referral for Treatment (SBIRT) of substance use, depression and anxiety | Primary care USA | Mixed methods: quantitative and qualitative | Medical director - Program leaders | - | - | Problem solving and coordination - Obtaining and monitoring resources - Securing “buy-in” from . . . |
| Kipping et al. (2019) | Aggression reduction in forensic mental health facilities (“Safewards” program) | Inpatient mental health facilities Canada | Descriptive and qualitative methods | Selected by the unit - Interdisciplinary - Permanent staff members - Likely to be enthusiastic, potential adopters | Extensive training (5 + days) - Face to face and online - Leadership, implementation strategies - “Co-creations” principles | Develop implementation strategy - Create intervention materials - Liaise with staff and patients - Consult with other teams and champions | |
| O’Sullivan et al. (2018) | Screening, Brief Intervention and Referral into Treatment (SBIRT) for substance use | Medical residency programs USA | Case study; qualitative methods | Clinical faculty - Program directors | Training in the intervention - Library of training materials | Customize curriculum and draft implementation plan for their specialty - Coordinate educational events | |
| Cook et al. (2009) | EMDR for the treatment of PTSD | Department of Veterans Affairs Health Clinics USA | Comparative case study; qualitative methods | Emergent - Senior psychologist | No training | No defined role | Not directly evaluated. The site that adopted the intervention had a CC, whereas the non-adopting site did not |
| Gordon et al. (2011) | Buprenorphine for opioid dependence | Veterans’ Health Administration sites USA | Qualitative methods | Emergent - Clinical staff - Often new, proactive staff members | - | - | CC identified as a facilitator of implementation. CC identified as important in overcoming barriers and “status-quo” |

(Continued)
| Study | Intervention | Setting | Research design | CC: who were they? | CC: training | CC: role | CC: effectiveness |
|-------|--------------|---------|----------------|------------------|--------------|---------|------------------|
| Rycroft-Malone et al. (2019) | MBCT Depression relapse prevention ("mind the gaps") | Mental health services UK | Qualitative, exploratory study | MBCT teachers, clinicians, service managers | – | Teaching and implementing MBCT | Champions or “implementers” were identified as key to successful implementation |
| Pigott et al. (2019) | Stepped care for personality disorder | Mental health services Australia | Qualitative interviews | Emergent, self-designated | No specific training | No defined role | CC reported as key facilitators of change and pivotal to implementation |
| Forchuk et al. (2013) | Transitional Relationship Model (TRM) to enhance continuity of care in psychiatric settings | Psychiatric hospital wards, Canada | Qualitative ethnographic study | Clinical staff member | – | Project leadership | Presence of an internal CC identified as a facilitator of implementation, staff considered it to be important. |
| Goren et al. (2016) | Clozapine prescribing for treatment resistant schizophrenia | Veterans Health Administration sites USA | Qualitative | – | – | – | Change in CC became a barrier affecting degree of implementation. |
| Guerrero et al. (2015) | Implementation of co-located mental health and primary care settings | Veterans Health Administration primary care USA | Quantitative (survey) | Primary care clinicians | – | Championed depression screening and treatment | Not directly evaluated. |
| Helseth et al. (2018) | Contingency management for opioid addiction in community based treatment, using Science to Service Laboratory (SSL) implementation strategy | Community treatment clinics for opioid use disorder USA | Quantitative, secondary data analysis | Clinical director | Four day workshop on organizational change and implementation strategies for evidence-based practice | Staff training, Overcoming organizational barriers, Raising awareness | Not directly evaluated. SSL providers more quickly adopted the intervention, thus champions may assist providers in overcoming barriers to use |
| Green et al. (2014) | Implementation of buprenorphine treatment for opioid dependence | Two, not-for-profit integrated health plans USA | Qualitative | Clinicians, often a clinical leader | – | Introduction of treatment to the clinic, Changing clinician, organizational and system characteristics to support use of treatment, Facilitated staff training, Planning roll-out | Not directly evaluated. CC considered a facilitator of uptake of the intervention within organizations. Once adopted, clinician experience with, and discussion within organizations of the intervention became more important in sustaining use than CC presence. |

CC: clinical champion; AUD: alcohol use disorder; SBIRT: Screening, Brief Intervention and Referral for Treatment; EMDR: eye movement desensitization and reprocessing; PTSD: post traumatic stress disorder; MBCT: mindfulness-based cognitive therapy; TRM: Transitional Relationship Model; SSL: Science to Service Laboratory; --: no information provided.
Champion training. Most of the records \( (n=9) \) did not describe if champions received specific training for this role (see Table 1). Of the records that did provide this information \( (n=4) \), training was provided through face-to-face workshops covering general information about the intervention, organizational change, and implementation and leadership strategies (Hagedorn et al., 2019; Helseth et al., 2018; Kipping et al., 2019; O’Sullivan et al., 2018). In two records, education and training of champions was also facilitated through access to library resources and online training (Kipping et al., 2019; O’Sullivan et al., 2018). In Rycroft-Malone et al. (2019), it was noted that champions developed particular implementation skills yet these were not necessarily developed through specific training but as a result of involvement in the implementation project more generally or skill previously acquired.

Clinical champion role and responsibilities. There was not one particular job description for the role of a clinical champion in the studies examined. On the contrary, multiple roles and responsibilities have been identified as facilitators of practice change implementation in the health care system, with responsibilities varying between different implementation projects. (see Table 1). Of the 13 papers included, 6 provided a clear description of the clinical champion role in their study (Green et al., 2014; Hagedorn et al., 2019; Helseth et al., 2018; Kipping et al., 2019; O’Sullivan et al., 2018; Rycroft-Malone et al., 2019). Of these papers, leadership, provision of education and training to clinicians to enhance skills or knowledge, and acting as a mentor and resource person in their facility, were described as being inherent in the role of a clinical champion (Green et al., 2014; Hagedorn et al., 2019; Helseth et al., 2018; Kipping et al., 2019; O’Sullivan et al., 2018). Other key roles and responsibilities included clinical champions being responsible for creating an implementation plan based on the specific needs and structure of their organizational setting (Green et al., 2014; Kipping et al., 2019; O’Sullivan et al., 2018), or for coordinating and troubleshooting the implementation process (Hargraves et al., 2017). One study used “co-creations” principles where clinical staff and patients were involved in the development and adaptation of the implementation strategy (Kipping et al., 2019). One study additionally included responsibilities such as organizing activities to support implementation and creating informal and formal support networks (Rycroft-Malone et al., 2019).

Effectiveness of champions. Table 1 depicts study information regarding effectiveness of clinical champions. Clinical champions were perceived as playing an important role in facilitating the implementation process in six of the studies (Cook et al., 2009; Gordon et al., 2011; Hargraves et al., 2017; Kipping et al., 2019; Pigot et al., 2019; Rycroft-Malone et al., 2019) whereby some studies specifically demonstrated effectiveness of the clinical champion in contributing to change of practice (Forchuk et al., 2013; Gordon et al., 2011; Hagedorn et al., 2019; Hargraves et al., 2017). One study described champions as being important in the initial adoption of an intervention, and as clinician self-efficacy increased, clinician experiences and that of colleagues became more important to sustained use (Green et al., 2014).

In addition, the importance of stability in the clinical champion role as determining its effectiveness was also observed (Hagedorn et al., 2019). One study found that a change in the clinical champion in the implementation phase became a barrier to adoption, and immediately affected degree of implementation (Forchuk et al., 2013). Furthermore, reliance on few clinical staff members can be a barrier when staff are away or there is turnover (Goren et al., 2016). However, length of time spent in the champion role may not necessarily be associated with implementation success (Hagedorn et al., 2019). Several studies observed that clinical champions assisted faster initiation of and persistence in the use of new interventions, in overcoming systems barriers regarding increasing staff engagement and in developing greater clinician enthusiasm, which may be associated with more persistence in adoption (Forchuk et al., 2013; Gordon et al., 2011; Helseth et al., 2018).

Discussion
This is the first study to conduct a comprehensive review of the role and efficacy of clinical champions in drug and alcohol and mental health settings. Across all studies examined, clinical champions were from varying professional clinical backgrounds including physicians, psychologists and social workers, across a wide variety of clinical settings. These champions were usually selected for the role or they emerged as a champion during implementation due to their interest or experience. Few studies described the degree of training provided for individuals in this role. Some studies provided face-to-face training on intervention information and leadership strategies. Overall, the literature indicates that clinical champions assist in faster initiation and persistence in the application of novel interventions and are central to implementation. They also helped to overcome system barriers, enhance staff engagement and improve staff motivation. Finally, the importance of stability emerged whereby a change to the clinical champion could act as a barrier to implementation.
A major responsibility of clinical champions is to provide education and training to clinicians to enhance their knowledge in a particular area, or to build skills in using a new intervention or tool. Educational opportunities may be implemented formally through the use of structured workshops, clinical supervision, grand rounds or training programs (Green et al., 2014; Hagedorn et al., 2019; Helseth et al., 2018; Kipping et al., 2019; O’Sullivan et al., 2018). Education delivered informally by the presence of champions on site provided a source of information and support when necessary (Cook et al., 2009; Gordon et al., 2011). Clinical champions are typically given the role of being a mentor and resource person in their facility where other staff members can seek their advice and guidance in the specific intervention or tool being implemented.

For studies that provided information about training of clinical champions for their role, the main form of training was face-to-face workshops, where champions learnt about the intervention, implementation strategies, and were granted access to resources and supervision. This type of training may assist champions in understanding their role, equipping them with the skills necessary to perform responsibilities (such as in leadership, communication, negotiation and problem solving) and providing them with a support network. Characteristics that emerged as being critical included having personal interest and commitment, confidence, and good communication skills. Given that the majority of champions in this review were identified as being clinical staff, who may not necessarily hold management or formal leadership positions, formalized training may be important in facilitating effectiveness in their role. One study noted the relevance of a combination of skills and where the champion was placed in their service (Rycroft-Malone et al., 2019). Studies that aim to advance our understanding of what combination of personal characteristics and training are necessary for effective clinical champions specifically in mental health and drug and alcohol settings would be particularly useful.

Consistent with the broader research in health care, champions in drug and alcohol and mental health settings were identified as essential or significant factors in facilitating implementation. However, the unique effects of these champions on implementation have not been examined (Miech et al., 2018). Further research is needed to evaluate the effectiveness of clinical champions on implementation success, and to illustrate core components during implementation. In the wider general health field, positive champion characteristics that have been identified include communication skills (e.g., negotiation, collaboration, advocacy, skilled teacher), enthusiasm and belief in the innovation to drive and implement change, personal qualities (e.g., being personable, respected, credible), leadership skills, and providing feedback to staff (Miech et al., 2018). Indeed, although not examined quantitatively, this appears to be consistent with the current set of studies reviewed in the drug and alcohol and mental health field whereby it appears that these characteristics (e.g. personal interest, good communication skills, interest), may be more relevant than requiring certain professional or formal leadership backgrounds. Typically, in drug and alcohol settings, clinical staff have high workloads (including seeing patients, administrative tasks, meetings) which allow little time to invest in learning new interventions or changing practices. Therefore, these organizational settings may be particularly suited to having a clinical champion who has the interest and can advocate for and lead change within the workplace. Furthermore, ongoing sustained use of the intervention following implementation is important, and one study suggested that champions are particularly important in the initial implementation phase whereas sustained use occurred as clinicians became more experienced and confident in the use of the intervention (Green et al., 2014).

Limitations and recommendations

One of the main limitations is regarding the heterogeneous nature of the studies that have been conducted in the field. In addition, the focus of the majority of the studies was not to specifically examine the effectiveness of the clinical champions on implementation, but rather the inclusion of a clinical champion was part of a wider implementation strategy. While studies that assess the impact of clinical champions separate from other implementation components would be helpful, either by isolating the inclusion of the champion component or evaluated in comparison to implementation programs without clinical champions, this may not always be feasible. Future work may look to disentangling the roles of champions versus other implementation roles such as external and internal facilitators and how and why these roles may or may not differ. Indeed, the role of champion within implementation interventions themselves needs to be acknowledged whereby many implementation interventions have the role of champion embedded in the standard implementation process yet may not be easily identified in the literature.

Conclusion

This review identified studies that examined the effectiveness of clinical champions or characterized the role of clinical champions in drug and alcohol and mental health settings. Similar to general health care settings, champions appeared to be an important vehicle for facilitating practice changes by overcoming system barriers and enhancing staff engagement. Clinical champions in drug and alcohol settings have been typically selected rather than emergent and although some studies provided face-to-face and online training workshops, details regarding training were most often not provided. Given the key role of clinical champions in implementation research, future studies
should provide specific details regarding clinical champion attributes and training and also examine the relevant combination of personal characteristics and training sufficient to facilitate implementation of evidence-based practice in drug and alcohol and mental health settings.

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