Implementing Evidence-Based Practices: Experiences of the 2007 and 2008 Science and Service Award Recipients

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Table of Contents

Executive Summary 1

Introduction 3

Purpose and Methods 3

Results 4

- Characteristics of the Organization 4
- Relationship With the Program Developer and Technical Assistance Received 5
- Intervention Modifications 5
- Implementation Drivers 6
- Facilitators and Barriers 10
- Lessons Learned 11
- Impact of the Award 12

Appendix: 2007 and 2008 Science and Service Award Recipients 13

Executive Summary

In 2007, the Substance Abuse and Mental Health Services Administration (SAMHSA) created the national Science and Service Award program to recognize community-based organizations and coalitions for exemplary implementation of evidence-based services. Awards are conferred in five areas: mental health promotion; treatment of mental illness and recovery support services; substance abuse prevention; treatment of substance abuse and recovery support services; and co-occurring disorders.

In the first 2 years of this program, 47 organizations received the Science and Service Award. To better understand the experiences and lessons learned by these organizations in implementing the evidence-based programs (EBPs) for which they were recognized, the awardees were asked to provide information in seven areas: characteristics of the organization; relationship with the program developer and technical assistance received; modifications made to implemented programs; implementation drivers; facilitators and barriers; lessons learned; and the benefits of having won a Science and Service Award.

The 2007 and 2008 awardees included not-for-profit organizations, State mental health authorities, county-level agencies, community-based mental health and substance abuse treatment facilities, and school systems. Most awardees reported they implemented the evidence-based program with fidelity and did not adapt the program content or materials. In general, organizations chose to redeploy existing staff, or hire some new staff in addition to redeploying existing staff, to implement the program. Almost all organizations provided in-house supervision to guide program implementation, and the majority evaluated staff on fidelity or adherence to the model. Many organizations indicated that initial success with the program has led to expansion and the hiring of additional staff.

Awardees identified several keys to the successful implementation of an evidence-based program. Most emphasized implementing the EBP with fidelity, monitoring fidelity and outcomes, and using fidelity and outcome data for program improvement. Other keys to successful implementation included:

- Leadership and the involvement of top-level management
- Training staff prior to implementation of the EBP
- Educating staff about the importance and utility of the EBP as a way of establishing buy-in and ownership

- Time for planning implementation
- Developing relationships with stakeholders and community members from the beginning
- Establishing a relationship with the program developer or purveyor

According to awardees, some consequences of winning the Science and Service Award included: assistance in promoting program sustainability and securing additional program resources; enhanced interest in the organization from prospective employees; and greater recognition and respect for the organization's work within the community.

Introduction

In 2007, the Substance Abuse and Mental Health Services Administration (SAMHSA) created the national Science and Service Award program to recognize community-based organizations and coalitions for exemplary implementation of evidence-based services. SAMHSA's Science and Service awards are bestowed in five categories:

- Mental health promotion
- Treatment of mental illness and recovery support services
- Substance abuse prevention
- Treatment of substance abuse and recovery support services
- Co-occurring disorders

Both public sector (i.e., State, local, territorial, tribal) and private sector organizations and coalitions may apply for these nonmonetary awards. To be eligible, the organization must have successfully implemented an intervention that has been recognized as evidence-based. Recognized interventions include those that have been published in the scientific literature and those that are listed in Federal and State registries of evidence-based interventions. The organization should be able to demonstrate positive outcomes from the intervention in at least one of the five award categories.

Purpose and Methods

The purpose of this report is to better understand the lessons awardees learned in implementing the interventions for which they received the Science and Service Award. By compiling and sharing this information, SAMHSA hopes to extend the benefits of this knowledge gained to others considering implementation of evidence-based programs (EBPs).

The 2007 and 2008 winners of the Science and Service Award provided information in the following areas:

- Characteristics of the organization
- Relationship with the program developer and technical assistance received
- Intervention modifications

- Implementation drivers (recruitment and selection; training; supervision and coaching; performance evaluation; decision support data systems; systems change efforts)
- Facilitators and barriers
- Lessons learned
- Benefits of the Science and Service Award

Information was provided approximately 1 year postaward for the 2007 cohort and immediately following receipt of the award for the 2008 cohort. Information from both cohorts was then aggregated and analyzed for common themes and patterns.

Results

Characteristics of the Organization

The 2007 and 2008 awardees (see Appendix for a list by award category) represented many different types of entities, including not-for-profit organizations, State mental health authorities, county-level agencies, community-based mental health and substance abuse treatment facilities, and school systems.

The numbers served by these organizations on any given day range from fewer than 25 people to 1,000 people or more, with the majority of organizations serving more than 150 people per day.

Among the 2007 award winners, implementation of the cited EBP began as early as 1989 and as late as 2005, with the majority of these organizations beginning implementation in 2001 and 2002. Among the 2008 cohort, implementation began as early as 1993 and as late as 2007, but most frequently between 2005 and 2007.

Examples of the EBPs the awardees implemented are: Assertive Community Treatment, Cognitive Behavioral Therapy, Functional Family Therapy, Incredible Years, Illness Management and Recovery, Integrated Dual Disorders Treatment, Motivational Interviewing, Multi-Systemic Therapy, Nurse-Family Partnership, Project Alert, Promoting Alternative Thinking Strategies, Project Towards No Drug Abuse, and Second Step.

Relationship With the Program Developer and Technical Assistance Received

As might be expected given the nature of the award, many of these organizations indicated that their relationship with the developers of their respective EBPs were positive. In most cases, the primary form of support received from the developer was training on program delivery. In addition to training, some awardees also received consultation, technical assistance, and fidelity monitoring support during the course of implementation. Very few reported that they did not receive support beyond the materials provided by the program developer.

Intervention Modifications

Most awardees indicated they did not adapt the program content or materials during initial implementation. Among those that did, the changes generally were made to better fit the target population, to combine the EBP with another program, or because the organization did not have a practitioner on staff to deliver the program as intended. Few awardees indicated that these initial adaptations were made in consultation with the program developer.

Awardees also were asked if they made any adaptations to content or materials after initial implementation, based on their experience with the program. Those making adaptations after initial implementation indicated that additions were made to better fit the target population (e.g., cultural and language adaptations, additional scenarios). Some organizations shifted to using adaptations provided by the program developers, and others developed their own adaptations in conjunction with the program developers and purveyors (i.e., individuals or group of individuals representing a program or practice who actively work to implement that program or practice with fidelity and good effect). A few organizations reported changing the duration or number of lessons delivered. One organization, however, identified potential negative repercussions of shortening the program: "We tried shortening the treatment to provide treatment to more individuals. Our ongoing evaluation suggested that the changes in length of treatment were less effective for the primary outcome of interest, so we returned to the originally investigated treatment length."

Organizations that did adapt content were asked if they had evaluated the effects of these changes. The majority had not evaluated their adaptations, although in a few cases, independent evaluations had been conducted or were underway.

Implementation Drivers

Recruitment and Selection

> *"It is important to select staff with an open mind, who can buy-in to the models … many times individuals with the most experience may not be the best person to implement the EBP."*

The majority of awardees chose to redeploy existing staff in implementing the cited program. Some organizations, such as schools, indicated they did not have the luxury of recruiting new staff given the limitations of their setting, while others opted to train existing staff in the evidence-based program so "the EBP became a part of routine service delivery."

Other organizations chose to hire some new staff while also redeploying current staff. As one organization explained, "Staff originally were able to self-select in a redeployment effort when the practice was first implemented. As the program has grown, new staff were hired and at times older staff left because they preferred to work in a more traditional practice."

When awardees were asked whether they had changed how staff are selected since EBP implementation began, many acknowledged revising their selection process (e.g., case scenarios, role play, evaluations) and criteria (e.g., experience implementing the EBP or willingness to learn the EBP, certain degree qualifications, trained in the model). As one organization explained, "We emphasize our agency's use of the EBP during the interview process and pretty much demand that any new hires be willing to learn and implement them. If they are still committed to using their alternative treatment models, they are invited to seek other employment options."

Thus, as their understanding of the evidence-based program and its implementation grows, organizations better know what specific types of staff resources they need. For example, many organizations reported that they were interested in applicants with knowledge of EBPs and how to implement them and who had skill sets consistent with the EBP being implemented in their organization. However, a few awardees said hiring new staff or staff new to the field actually might serve them better; as one commented, "We have found it beneficial to hire persons who are new in the field that do not have experience in doing things the old way."

Training

Practitioners were most often trained to deliver the evidence-based program by the program developers or purveyors. Trainings were variously conducted onsite, via distance learning, or offsite with practitioners traveling to the developer's location. In some cases, practitioners were trained in the model by existing staff in the organization.

The majority of awardees indicated that they changed their method of training since they began implementing the EBP. Most of the organizations require all new staff be trained and also require booster and annual training for existing staff. Other organizations now have a master trainer or trainer of trainers on staff (a person directly trained by the developer) to support in-house trainings. One organization sends therapists to the field for 3-4 weeks prior to training, as they have found that "exposure to the position prior to the training increases the therapists' retention of materials and ability to implement what they have learned."

Supervision and Coaching

Almost all awardees reported that their own staff (e.g., a direct supervisor or program manager) supervised the practitioners. Supervision most often occurred on a weekly basis, although some reported biweekly supervision, and was conducted both individually and in group meetings. Approximately half of the awardees noted that supervision included direct observation of clinical skills.

Very few awardees mentioned using coaching per se, although some referred to using consultation. Of those who did report using it, coaching was a required part of the treatment model or EBP being implemented (e.g., Multi-Systemic Therapy, Functional Family Therapy).

Surprisingly, the majority of awardees reported making few or no changes in coaching and supervision based on their experience implementing the program. Organizations that did make adjustments in this area typically expanded or enhanced their supervision process (e.g., adding use of videotaping and supervisor review of videotapes, observation of peer implementation, use of data collection logs, and a focus on fidelity/adherence). Some organizations reported they decreased the level of individual supervision as practitioners became more skilled and experienced in implementing the program.

Performance Evaluation—Fidelity

The majority of awardees had mechanisms in place for monitoring fidelity, whether through the use of checklists (usually provided by the program developer or purveyor), supervision and direct observation, or external evaluation. It is difficult to assess whether staff were evaluated on adherence or fidelity to the model, as many awardees did not elaborate on how they used data collected from fidelity instruments and tools. Some indicated that fidelity data were submitted to program evaluators for analysis and feedback, while videotapes were reviewed by supervisors and discussed with practitioners, and when fidelity checklists indicated adaptations, staff were expected to explain the reasons for the adaptations.

Most of the organizations did not report changing how staff were evaluated after experience implementing the EBP. When changes in evaluation methods were made, typically these changes involved adding to or enhancing current fidelity tools or assessment procedures (e.g., addition of checklist to reviews of videotaped sessions, regulating adherence, and creation of new positions). Some awardees indicated that fidelity assessment was initially part of their grant funding, and so with the departure of that funding, new measures of fidelity had to be put in place. Other organizations shifted their focus to consumer outcomes, as opposed to practitioner adherence, to determine if the program was being delivered as intended.

One organization chose to implement an enhanced rate structure for delivering services in accordance with the evidence-based program model: "Once trained and upon request, a site is assessed using the fidelity scale. If the program meets the fidelity threshold … on the fidelity scale, they may receive the increased EBP rate. Thus, tying fidelity to higher rates … has built in a mechanism to prevent drift and assure continued fidelity."

Another organization's innovation was to revamp its system and develop a fidelity task force connecting preservice training, coaching, consultation, and staff performance evaluation. As the awardee described it, the development of this integrated system "allows for better communication of expectations as well as systematic feedback loops will lead to a more qualified staff."

Performance Evaluation—Outcomes

The majority of organizations reported they did not evaluate staff with respect to outcomes achieved, but rather by their adherence to the model. For many of the awardees, outcome-based evaluations focused on program or agency outcomes rather than on staff. When

evaluations did look at staff outcomes, assessments were most often based on knowledge gain (using pre/post measures) and client satisfaction or evaluation measures.

The majority of awardees did not change how they conduct their outcome-based evaluations based on their experience implementing the evidence-based program. Among those that did, one organization switched to a pay-for-performance model that rewarded employees based on their performance, and a few organizations established performance indicators. One awardee indicated that now "outcomes achieved by each staff person are factored in when conducting performance evaluations, and are used as a training and coaching tool."

Decision Support Data Systems

All awardees indicated they had a system for collecting data or had plans to put one in place. The methods used to collect and analyze data varied. Many of the organizations used pre/post test measures; some collected data using internal data collection systems (e.g. electronic charting systems), some used reports developed by program developers and purveyors, and others hired independent evaluators to collect data. More than half of the organizations reported they analyzed their data for program improvement purposes. As one organization put it, "data analysis is used for both program improvement and decision making for individual clients."

Systems Change Efforts

To promote effective use of the evidence-based program, many awardees made changes to organizational structures and roles. In some cases, due to the very success of the EBP within their organization, it was necessary to expand the program and hire additional staff (e.g., practitioners, trainers, consultants). In addition, many organizations developed new positions (e.g., prevention director, project supervisor, science to service coordinator) specifically for the purpose of overseeing implementation. Teams, workgroups, steering committees, and task forces also were created in these organizations for this purpose.

The role of administrators in the implementation of these EBPs has been to educate people on the model (e.g., training, presentations) as well as to develop relationships with external stakeholders, other organizations doing similar work, and referral agencies (e.g., schools, courts, city and state mental health, law enforcement). Administrators also have helped to champion the program locally and in the State, capitalizing on their own organization's example of success; as one awardee noted, "Once the effectiveness of the intervention is witnessed, it sells itself."

With respect to funding, administrators have helped to secure adequate resources to initiate and use the evidence-based program effectively by grant writing, building on the relationships discussed above, fundraising, expanding referral sources, and "delivering quality programming" (e.g., implementing the EBP with fidelity to produce good outcomes).

Facilitators and Barriers

Understanding there are always challenges involved in implementation, awardees were asked what facilitated the implementation of the cited EBP in their organization, and what most often got in the way. The following list highlights some of the more common responses.

Facilitators

- Prior organizational/staff experience implementing EBPs
- Belief that the EBP will benefit consumers
- Good fit between the EBP model and philosophy of the agency
- Availability of training (particularly onsite training)
- Ongoing coaching and consultation
- Understanding of the theory behind the model/EBP
- Understanding the importance of fidelity
- Staff commitment to fidelity
- Leadership
- Internal and external champions
- Program developer/purveyor support
- Agency-wide support
- Community support
- Financial support
- Evaluation

Barriers

- Funding reductions
- Time constraints
- Competing demands

- Limited administrative/supervisory time to spend on implementation challenges
- Staff turnover and insufficient staffing
- Status quo/reluctance to change
- Work required to attend to fidelity
- Maintenance of fidelity when not embedded in the EBP model
- Attitudes
- Lag time (while practitioners are being trained)
- Financial support

Lessons Learned

Awardees were asked what they would have done differently if they could go back to the beginning or had to implement the evidence-based program over again. Those reporting they would change nothing often made observations such as "In hindsight, the challenges and bumps in the road seemed to enrich the process." Although many organizations seemed satisfied with the way they had implemented the EBP, others felt that they might have benefited by:

- Creating excitement and buy-in
- Improving communication with agencies to keep them engaged
- Selecting staff more carefully
- Increasing the focus on model adherence/fidelity
- Offering preservice training
- Providing more coaching and feedback
- Allowing for more administrator time to oversee the implementation of the EBP
- Identifying accountability and compliance strategy for agencies
- Paying more attention to the climate and context in provider organizations (e.g., not implementing the EBP in an organization with multiple managerial vacancies or staff turnover issues)

When asked what advice they would give other organizations interested in implementing the EBP, most awardees emphasized implementing with fidelity, monitoring fidelity and outcomes, and using fidelity and outcome data for program improvement.

Other keys to successful implementation that were noted included:

- Leadership and the involvement of top-level management
- Training staff prior to implementation of the EBP
- Educating staff about the importance and utility of the EBP as a way of establishing buy-in and ownership
- Time to plan the implementation of the EBP
- Developing relationships with stakeholders and community members from the beginning
- Establishing a relationship with the program developer or purveyor

Impact of the Award

For the 2007 awardees, the effects of receiving the Science and Service Award have been substantial and entirely positive. Many noted that receiving the award assisted them in garnering grant funding from private foundations and Mental Health Services Act funds. In one case, the award helped keep a program in place when funding for mental health services was cut in the State. Awardees also reported that they have mentioned the award in their grant applications and believe it has helped secure grant funding. In addition, the award has brought recognition and respect from other organizations, stakeholders, and the community. One organization reported having been recognized as an expert in the State and receiving requests to conduct trainings on implementing EBPs. Other consequences of receiving the award included wider recognition of the EBP that they implemented and its benefits to consumers, attraction of highly qualified and motivated staff, and reinforcement to current staff that their work is valued and recognized.

For the 2008 awardees, who just recently received their awards, it may still be too soon to tell what the full impact of the award will be for them. However, 2008 awardees related what benefits they thought receiving the award would provide. Many awardees said they believed receiving the award would not only provide local and national recognition but also opportunities to secure financial support for their programs. Like the 2007 awardees, they believe winning the award validates the efforts they have made to implement evidence-based programs and to implement them with fidelity.

Appendix: 2007 and 2008 Science and Service Award Recipients

2007 Awardees

Mental Health Promotion:

- Care for Elders—Houston, TX
- DeKalb County School System Prevention/Intervention Department—Stone Mountain, GA
- Kremmeling Communities That Care—Kremmeling, CO
- Morrison Child and Family Services—Portland, OR

Treatment of Mental Illness and Recovery Support Services:

- Community Solutions, Inc.—Windsor, CT
- Department of Health and Mental Hygiene, Mental Hygiene Administration—Baltimore, MD
- Hempfield Behavioral Health, Inc.—Harrisburg, PA
- NAMI Maine—Augusta, ME

Substance Abuse Prevention:

- Granite Falls School District—Granite Falls, WA
- Santa Fe Adolescent Services—Fort Worth, TX
- Sutton Place Behavioral Health—Fernandina Beach, FL
- Council on Alcohol and Drugs—Houston, TX

Treatment of Substance Abuse and Recovery Support Services:

- Central Clinic, Court Clinic—Cincinnati, OH
- King County Mental Health, Chemical Abuse and Dependency Services Division—Seattle, WA
- THE LIFE LINK—Santa Fe, NM
- Travis County Juvenile Probation Department—Austin, TX

Co-Occurring Disorders:

- Scioto Paint Valley Mental Health Center—Greenfield, OH
- Mental Health Center of Greater Manchester—Manchester, NH
- Thresholds—Chicago, IL
- Ventura County Behavioral Health—Oxnard, CA

2008 Awardees

Mental Health Promotion:

- Chemung County Children's Integrated Services—Elmira, NY
- Forsyth County School System—Cumming, GA
- Saint Vincent Family Centers—Columbus, OH

Treatment of Mental Illness and Recovery Support Services:

- Adult and Child Mental Health Center, Inc.—Indianapolis, IN
- Allegent Health Mental Health Services and Psychiatric Associates—Omaha, NE
- Center for Urban Community Services—New York, NY
- Institute for Community Living (ICL) —New York, NY
- Portland Dialectical Behavior Therapy Program, PC—Portland, OR
- State of Missouri Department of Mental Health—Jefferson City, MO
- Western Psychiatric Institute & Clinic, The Intensive Outpatient Program for Children and Adolescents With Obsessive-Compulsive Disorder—Pittsburgh, PA
- West Michigan Community Mental Health Services—Ludington, MI

Substance Abuse Prevention:

- Broome County Mental Health Department (KYDS Coalition) —Binghamton, NY
- Family Service Association of San Antonio, Inc.—San Antonio, TX
- Five Town Communities That Care—Rockport, ME
- Integrated Treatment Court, Adult Criminal Track—Boulder, CO
- Saint Vincent College Prevention Projects—Latrobe, PA
- Valley Youth House, Youth Education Program—Bethlehem, PA
- Wood County Educational Service Center, ATOD Prevention Program—Bowling Green, OH

Treatment of Substance Abuse and Recovery Support Services:

- Amethyst, Inc.—Columbus, OH
- Maine Office of Substance Abuse—Augusta, ME
- Maryhaven—Columbus, OH
- Positive Directions, "Wilton Blitz" —Westport, CT
- Western Psychiatric Institute & Clinic, The Pittsburgh STOP (Stop TObacco in Pregnancy) Program—Pittsburgh, PA

Co-Occurring Disorders:

- Burrell Behavioral Health—Springfield, MO
- NEIGHBORING—Mentor, OH
- Park Place Partial Hospitalization Program—Asbury Park, NJ
- Residence XII—Kirkland, WA
- State of Florida, Department of Juvenile Justice, Redirection Project—Tallahassee, FL
- Western Psychiatric Institute & Clinic, Motivational Interviewing, Addiction Medicine Services—Pittsburgh, PA