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RESULTS

Practice, Practice, Practice: Preliminary Findings From an Evidence-Based Practice Funding Initiative at The Peter and Elizabeth C. Tower Foundation

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Keywords: Evidence-based practice, assessment, evaluation, model fidelity, program implementation, sustainability.

Key Points

- The Tower Foundation supported a five-year initiative to support the implementation of evidence-based practices (EBP). The average award was a three-year award of \$84,050.
- The underlying grantmaking theory of change was that behavioral health providers could bring empirically tested protocols to their communities and sustain them over time if supported by long-term funding to support the real costs of implementation (e.g., training, technical assistance, adherence to program protocols, and cultural change).
- Grantees cited the high cost of training, certification, and recertification – especially in the face of high staff turnover – as a primary challenge to implementing EBPs. Several of the initially funded programs experienced higher than expected staff turnover, losing as many as half of the newly trained EBP practitioners quite early in the implementation process.
- The seven programs scoring in the exemplary range for implementation fidelity had no single success driver in common, but three indicated that building internal training capacity was key.
- Foundations can help to make communities more EBP ready and EBPs more generally viable and affordable. Efforts could include local training collaboratives for clinicians or advocacy to educate payer systems and referral networks. The philanthropic community can also support efforts to define the need for EBPs at a grassroots level.

In 2009, The Peter and Elizabeth C. Tower Foundation closed out a multiyear grantmaking initiative that had helped fund the implementation of 25 evidence-based practice (EBP) programs. The end of the initiative did not signal a change of direction or that EBPs had fallen from favor with the foundation. Rather, after funding EBPs in five consecutive grant years, it was time to take stock. Annual requests for EBP proposals, beginning in 2004, were built around the goal of increased access for troubled young people and their family members to scientifically proven mental health treatment protocols. From the outset, the Tower Foundation was careful to make it clear that it was not interested in “best practices” loosely defined, but in effective programs with client outcomes that have been replicated in multiple, independent research trials. Tower required that EBP programs under consideration have the highest possible ranking from at least one of three leading rating agencies. Because evidence-based programs can be expensive and challenging to implement, foundation leaders felt that an assessment of the success of the five-year initiative was in order.

The initiative had, from the beginning, attempted to directly confront the difficulty of embracing new service paradigms and highly structured therapeutic models. Accordingly, Tower’s interest was focused squarely on building grantee capacity to support EBPs, and not client outcomes per se. The underlying grantmaking

theory of change was the notion that behavioral health providers will be better equipped to bring empirically tested protocols to their communities and sustain them over time if supported by long-term funding that recognizes the real costs of training, technical assistance, adherence to program protocols, and cultural change. Funding was provided for three- to four-year grant terms (long enough to train staff, build in program supports, launch the service, and – ideally – work out some of the kinks). Funding was also provided to cover lost revenue, the opportunity costs incurred when counselors and therapists are learning new clinical approaches rather than seeing clients. But was this enough to set grantees on the path to long-term success in the delivery of more proven practices?

Often, evidence-based programs require agency realignment and cultural transformation for the service providers that commit to delivering them. Tower grant recipients over a five-year period have faced the challenges of implementing EBPs first hand. While some grantees' EBPs thrived, others struggled to achieve a degree of success and some failed outright. According to Tower Executive Director Tracy Sawicki,

taking some time off from grantmaking that specifically targeted research-endorsed models gave the foundation a chance to assess the drivers of program success and failure. Learning from these, we may better understand the demands and expectations that we put on grantees. An internal assessment of how these programs fare will help us advise future grant applicants and will inform grantmaking strategy going forward.

This article looks at Tower's experience as a funder of EBP programs and its work to measure the success of these initiatives. It is offered in the spirit of Booker T. Washington's view of success: "Success is to be measured not so much by the position that one has reached in life ... as by the obstacles which he has overcome while trying to succeed."

A Call for Evidence-Based Practices
Empirically tested methods of therapy and

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counseling are not new to the mental health and human services field. The roots of cognitive behavioral therapy, for example, can be traced to the 1920s. This therapy – and its approach to addressing emotional and behavioral problems by focusing on maladaptive thought processes – was widespread in clinical practice by the 1960s. What is new is the idea that, wherever possible, behavioral health service providers should actively champion approaches to treatment that have been demonstrated to work in controlled, clinical studies. To this day, many therapies and service delivery models are based more on traditions of practice than on methods that demonstrate results. Shock probation programs for potential juvenile offenders, for example, continued to receive funding in the face of evidence that they actually did more harm than good. Evaluators have found that Scared Straight, a program meant to deter participants from crime, actually increased the incidences of offending behavior (Buehler, Petrosino, & Turpin-Petrosino, 2003). Contrast Scared Straight with Functional Family Therapy, an EBP that works to reduce delinquency and recidivism rates for at-risk 11 to 18-year-olds through family-focused counseling sessions in the home or community-based settings. The Washington State Institute for Public Policy

estimated that each dollar invested in Functional Family Therapy returns a \$13.25 cost benefit, whereas Scared Straight will actually incur costs of \$203.51 for every dollar invested (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004).

To this day, many therapies and service delivery models are based more on traditions of practice than on methods that demonstrate results. Shock probation programs for potential juvenile offenders, for example, continued to receive funding in the face of evidence that they actually did more harm than good.

Armed with this kind of evidence, many early adopters of evidence-based practices were from the juvenile justice field, attracted by outcome-based EBPs that demonstrated success in reducing recidivism rates for delinquent youth. The financial impact of effective alternatives to incarceration for adolescents is profound. According to a report from the Children's Defense Fund (2007), one youth placement or incarceration is equivalent in cost to placing six to eight youths in EBPs. Not only is there a better chance of positive outcomes with an evidence-based program, it costs about \$30,000 less per child.

It was only in the mid-1990s that proponents of wider adoption of EBPs began to find a unified voice. One of the earlier and most prominent champions of EBPs, Blueprints for Violence Prevention, was founded in 1996 at the Center for the Study and Prevention of Violence at the University of Colorado at Boulder with funding from the Colorado Division of Criminal Justice, the Centers for Disease Control and Prevention,

and the Pennsylvania Commission on Crime and Delinquency. Blueprints quickly grew beyond a focus on juvenile justice to become a more general clearinghouse of information on EBPs in the behavioral and community health fields. To date, Blueprints has reviewed more than 900 programs seeking EBP designation. Blueprints' assessment is rigorous and its endorsement highly coveted by program developers. Only 11 programs have been designated as "model," the highest ranking, with 20 classified as "promising." Model and promising programs address such areas as prenatal counseling, child development, family counseling, bullying prevention, youth mentoring, and drug and alcohol prevention. Blueprints maintains a website (<http://www.colorado.edu/cspv/blueprints>) with information about the programs it endorses and the technical assistance it offers.

Other agencies rank aspiring and established EBPs, too. Beginning in 1997, the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) awarded "model" status to programs that were found to be effective by three or more independent studies.¹ The U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention has similar standards for its "exemplary" classification.

Many credit a 2000 U.S. Surgeon General's Conference on Children's Mental Health for raising the profile of EBPs. Three of the eight goals outlined at that conference (U.S. Public Health Service, 2000) sounded the call for wider access to scientifically tested practices:

- Goal 2: Continue to develop, disseminate, and implement scientifically proven prevention and treatment services in the field of children's mental health.

¹The Substance Abuse and Mental Health Administration modified this rating system in 2007. Through its National Registry of Evidence Based Practices and Programs, the administration offers comprehensive descriptions of interventions and now provides ratings based on individual outcome targets rather than an overall measure of a program's effectiveness. The registry also reports on what it calls "Readiness for Dissemination," an attempt to measure availability and quality of training and implementation materials for any given EBP.

- Goal 5: Improve the infrastructure for children's mental health services, including support for scientifically proven interventions across professions.
- Goal 7: Train frontline providers to recognize and manage mental health care issues and educate mental health care providers about scientifically proven prevention and treatment services.

The Tower Foundation and EBPs

In 2004, the Tower Foundation issued its first Request for Proposals (RFP) for EBP initiatives. While positive client-level outcomes were certainly desirable, the overall goal was to increase consumer access to evidence-based practices, offered by providers that could sustain them over the long term. The RFP was issued under Tower's "community" category and shaped by the core objective "to effect lasting, positive change in the lives of children, adolescents, and families affected by psychological disorders, developmental disabilities, and substance abuse." Tower's leadership felt that EBPs would complement the foundation's strategic grantmaking approach. Tower, though in operation for only 14 years in 2004, was known for its support of programmatic initiatives to generally improve and expand service offerings for children in the core areas of mental health and substance abuse, developmental disabilities, and education.

In the context of the Tower Foundation's strategic grantmaking portfolio, this series of five annual RFPs was admittedly – and intentionally – a foundation-driven initiative. Parallel, annual grant cycles that also focused on community mental and behavior health issues continued. The annual cycle grants supported capacity building and programmatic objectives for nonprofits in Tower's western New York and eastern Massachusetts catchment areas, with grantmaking that was more actively informed by Tower's ongoing conversations with providers in both regions. With the EBP initiative, Tower's trustees were signaling their interest in supporting the Surgeon General's challenge to make EBPs more broadly available.

For its initial foray into the EBP world, Tower selected eight EBPs for grant applicants to choose from, following discussions with each developer to confirm that the EBP was aligned with Tower funding objectives. Tower staff's research into potential EBP programs was conducted over 18 months and included an assessment of just how ready for dissemination each EBP appeared to be. This research notwithstanding, program applicants were expected to contact EBP developers directly for further confirmation of appropriate alignment with their organizational goals and culture. The EBPs included:

- Brief Strategic Family Therapy+
 - Functional Family Therapy++
 - Helping the Noncompliant Child+
 - The Incredible Years [Parent Training Programs]+
 - The Incredible Years [Small Group]++
 - Multidimensional Family Therapy+++
 - Strengthening Families Program+
 - Strengthening Families Program: For Parents and Youth 10-14
- + Denotes a program funded in year one
 ++ Denotes a program funded after year one
 +++ Denotes a program for which there were no applicants

In the context of the Tower Foundation's strategic grantmaking portfolio, this series of five annual RFPs was admittedly – and intentionally – a foundation-driven initiative.

These EBPs were selected for their focus on at-risk youth, apparently well-developed implementation strategies, accessible training and technical assistance, and evaluator endorsements. Tower required the highest possible rating from at least one of the major evaluators: Blueprints, the Office of Juvenile Justice and Delinquency Prevention (OJJDP), or SAMSHA.

In support of the 2004 RFP, Tower held several educational workshops to better acquaint potential grant applicants with the EBP concept. At that time, with federal agencies like SAMSHA and state-based think tanks like the Washington State Institute for Public Policy beginning to promote EBPs, the drive to implement these potentially complex and costly models came largely from the top. Some service providers in the mental and behavioral health field, particularly smaller nonprofits, found themselves behind the curve.² Tower's local workshops for providers provided a general introduction to EBPs and introduced the EBP funding initiative, emphasizing the empirical evidence for effective outcomes, but also describing the very real challenges of implementing and sustaining the programs. Tower funded eight applications in the first-year grant cycle, about twice the average for a typical RFP at that time.

What was different about this initiative were the outcomes that the grantees were asked to highlight in their reporting. Tower's traditional focus on successful therapeutic outcomes for clients was replaced with questions about staff certification schedules, peer reviews and videotaping, minimum class size for group therapy sessions, booster training requirements, and therapist checklists.

The applicants were attracted by the EBP programs' alignment with the trend toward community and family-based treatments. The evaluation of the Tower EBP initiative revealed, however, that the delivery models and institutional cultures of these providers did not necessarily suit the EBP models they chose to implement.

In each program year, the grantmaking process for the EBP initiative began with an invitation for brief letters of interest. Program announcements were sent to all known providers of mental and behavioral health services for youth in Tower's geographic funding areas. Regional press releases and the Tower website also included announcements of the RFP. Those sending promising letters of inquiry received an invitation to submit full proposals. On average, 75 percent of applicants were invited to submit full proposals.

The Tower staff role in the EBP grants was typical of other Tower grants. First, program officers led applicants through a proposal review process – generally six to eight weeks – in which applicants were encouraged to revise and strengthen program design elements. In 2004, four out of 12 invited applicants either chose not to complete the full review process or failed to produce work plans that demonstrated reasonable expectations for program sustainability. By the last two years of the initiative (2007 and 2008), 100 percent of invited applicants completed the review process and received grant awards, perhaps reflecting an improved understanding among providers of both advantages and challenges.

For successful grantees, Tower program officers reviewed annual progress reports and conducted yearly site visits. What was different about this initiative were the outcomes that the grantees were asked to highlight in their reporting. Tower's traditional focus on successful therapeutic outcomes for clients was replaced with questions about staff certification schedules, peer reviews and videotaping, minimum class size for group therapy sessions, booster training requirements, and therapist checklists. The thinking was that successful EBP implementations depend on following model protocols with fidelity, from which successful client outcomes follow.

² As recently as 2008, a National Alliance on Mental Illness publication noted: "The most significant challenge in more broadly implementing EBPs is the need to 'prepare the field' for EBP selection and implementation" (Feller & Kanary, 2008). The article goes on to cite the need to "increase education, training, and provider expectation to focus more on outcome-based treatments."

In 2005 Tower issued a second RFP that included the same eight programs, but by 2006 the menu had expanded to 38 programs, reflecting the growing awareness of EBPs, the availability of additional endorsed practices, and requests from potential applicants to include more options.

By 2007 and after three RFP cycles, Tower had funded 19 EBP initiatives, with a total investment of about \$1.6 million. While grants were typically for three-year initiatives, feedback from initial site visits and interim reports offered insights about EBPs in practice, implementation challenges, and service providers' ability to meet the demands of evidence-based practices. EBPs require organizations to enact sometimes substantial cultural changes, re-educate payers and referral networks, and commit to model fidelity and a focus on patient outcomes – to name just a few of the demands the EBPs place on service providers. As Tower staff became more familiar with EBP implementations and unique program requirements, the number of programs was scaled back to include fewer offerings. Programs that remained offered the best fit with Tower funding objectives and grantee needs and capacity to implement. Some prevention-only programs were dropped from the list to sharpen Tower's focus on innovative treatment. Other programs were removed because their modest scope and low implementation cost made it difficult to justify the fairly significant effort that both applicant and funder invest in the grant process. The EBP grant cycles in both 2007 and 2008 offered a menu of 16 programs.

A notable component of Tower's EBP initiative was the foundation's willingness to compensate grantees for lost revenues. In the course of an EBP implementation, training can tie up revenue-generating counselors and therapists for weeks at a time. For some Tower grantees, training commitments were as high as three to four weeks per participating staff member (representing as much as \$50,000 in forgone income over three years). Tower's grant dollars compensated for lost revenues based on the billing rates of direct service providers and the number of hours they were diverted from billable work by EBP training requirements. Grantee feedback indicated that

funding to replace lost billable hours was new to them, and that many organizations simply could not have participated without it.

Early Lessons

Full maintenance of "model fidelity" is what positions an EBP program to achieve results that replicate the effective results confirmed by controlled experiments. It is also what makes it a tall order for some organizations to implement. Practitioners of an EBP must follow the precise ground rules laid out by the developer of the model if they expect to achieve comparable outcomes. Noncompliant adopters of an EBP may actually achieve results that are worse than the control group. Adapting an EBP to local conditions risks changing a component that is critical to its success (Elliott & Mihalic, 2004).

A partial list of EBP components that may be required for fidelity includes use of scripts (for general instruction or role playing), highly manualized approaches, precise treatment sequences and dosage, session videotaping and review, developer oversight, therapist certification requirements, minimum numbers of trained clinicians, minimum caseloads, peer review and other monitoring requirements, family-member participation, and otherwise highly specified clinical settings.³

Two factors emerge from the literature as particularly common and thorny challenges: staffing and organizational culture. Tower grantees clearly had to deal with both, as site visits and annual progress reports repeatedly demonstrated. Several of Tower's initially funded programs experienced higher than expected staff turnover, losing as many as half of the newly trained EBP practitioners quite early in the implementation process. The learning model for many EBPs requires that practitioners fully employ the EBP methodology – often involving unfamiliar techniques – while very much in the midst of training. Without dedicated and readily accessible internal support (providing more prep time or reducing caseloads, for example), this can be overwhelmingly stress-

³A detailed examination of EBP implementation challenges is beyond the scope of this discussion. For a comprehensive treatment of the issues, see Mihalic, Fagan, Irwin, Ballard, and Elliott (2002).

ful. An unintended consequence of EBP adoption may be that established employees, sensing an organizational paradigm shift, decide it is time to retire or move on rather than learn new systems.

An unintended consequence of EBP adoption may be that established employees, sensing an organizational paradigm shift, decide it is time to retire or move on rather than learn new systems.

How can service providers make EBP implementation go more smoothly? The Tower experience backs up literature that suggests that there is no simple answer. Several Tower grantees reported that they increasingly see the need to tap staff members for EBP training and certification that are demonstrably enthusiastic about learning new treatment modalities. One grantee noted that it now bases hiring decisions on a candidate's suitability for the EBP that he or she will practice. Clearly, providers should plan for worst-case turnover scenarios. No Tower grantee complained of training too many staff members. Agencies might consider offering employee incentives for achieving EBP certification. Providers hoping to succeed with EBP service models would benefit from employee performance plans that value and recognize a commitment to upholding fidelity protocols. A Tower grantee in the second grant cycle now requires that staffers, in exchange for training in state-of-the-art therapy, commit to a minimum of two years continued employment.

Culturally, organizations must assess their readiness to accept the change that evidence-based practices demand. For example, will therapists or clients resist the videotaping that many EBPs require as part of the practitioner training and program fidelity monitoring?⁴ Some EBPs rely

heavily on role playing. There are clinicians that are not comfortable with role playing approaches and may never be. Involving staff in initial EBP review and selection can help improve buy-in. But an organization that employs fiercely independent therapists and counselors may not be capable of implementing a given EBP without transformative change. Many EBPs require that virtually all decisions about how a program is delivered (even minor modifications can jeopardize program fidelity) be routed through a program administrator. EBPs require continuous monitoring and control of what is necessarily a very uniform structure. Therapists accustomed to high levels of autonomy in their practice may have a tough time adjusting to higher levels of supervision and control. To achieve cultural readiness for EBP implementations, some organizations must overturn ingrained attitudes and practices.

The Tower Foundation recognized the importance of educating potential grantees about EBPs, particularly on the issue of associated cultural change and how to manage it. Beginning in 2005, Tower offered a series of community presentations for prospective grantees that offered general overviews and discussion of the challenges to organizational cultures. Staff shared lessons learned by participating in a 2006 Blueprints conference, delivering a talk entitled "Evidence Based Practice – a Funder's Perspective." This talk described many of the challenges that Tower grantees had encountered with their implementations. Tower's presenter also offered improvement suggestions for the benefit of EBP developers and their training and development arms. A key point: Developers need to be sensitive to the real-world constraints – particularly fiscal – under which service providers operate. For example, EBPs require a lot of "collateral" activities: peer and supervisory meetings, videotape review, scheduling and other logistical requirements. Insur-

cause problems for a surprising number of organizations. Providers should make the effort to test equipment and integrate the videotaping process with the clinical environment. The distractions of videotaping should be minimized where possible, and technical glitches anticipated. Several Tower grantees struggled with the process of recording and duplicating video, a problem that some planning and practice may have mitigated.

⁴ Videotaping and its associated technical requirements

ance companies and other third-party payers are generally not willing to pay for these.

Tower's presentation at the Blueprints conference also reported difficulties that grantees experienced with the logistics of scheduling and completing staff training. To facilitate planning and financing on the part of service providers, EBP programs need stable training-delivery structures and consistent pricing. Tower grantees had found that the program details of some EBP training providers were in flux and that developer and trainers were suffering their own growing pains. Trainers were reassigned in mid-training, scheduling processes proved cumbersome, fidelity-monitoring tools were scarce, and general response time was sometimes poor. On the positive side, most Tower grantees reported that they received excellent training from enthusiastic instructors who were committed to the models they taught. The Tower presenter cited several positive trends: more train-the-trainer options to support long-term sustainability, stabilized program content and fidelity-monitoring tools, and a greater general awareness of provider realities. Furthermore, organizations like Blueprints and the Association for the Advancement of Evidence-Based Practice – founded later that year – were creating a forum for increasingly productive dialogue around many of these issues.

Taking Stock

With the completion of the 2008 EBP grant cycle, Tower had funded 25 program implementations for 22 agencies. Awards were primarily three-year grants, though no-cost extensions have been approved in several cases. The average award was \$84,050; the median award \$84,595. With the exception of a hospital psychiatric clinic, all grantees were community-based, nonprofit mental health care providers. A total of \$2.1 million was awarded. In all, 12 different EBP models were funded. (See Table 1.)

But how robust and sustainable were these programs? EBPs are attractive to many because, if they are practiced with model fidelity, beneficial outcomes should follow. Ideally, little effort should be required to develop and deploy

program assessment processes. But Tower staff knew that some of its earliest grantees were either struggling to sustain EBP programs or had phased them out altogether. For others, the outlook for longer-term sustainability appeared better, but clearly, "EBP" wasn't synonymous with "easy." For some service providers, EBPs simply didn't fit. Questions of model fidelity vied with questions about general sustainability. Were there enough clinicians certified to deliver the service? Could providers get and retain sufficient parent or sibling participation for a family-counseling program? Did nonreimbursable collateral activities prove too great a financial drain?

EBPs require a lot of "collateral" activities: peer and supervisory meetings, videotape review, scheduling and other logistical requirements. Insurance companies and other third-party payers are generally not willing to pay for these.

State agencies and referral networks, while they may go on record as supporters of EBP, are not always quick to adopt practices that are accommodating to EBPs. One Tower grantee that had implemented a family-counseling model was frustrated by the state agency that represented the majority of its referrals. The agency continued to refer individual adolescents to the program with little regard for the model's basic requirement that a minimum number of family members be willing to actively participate in the therapy.

For several grantees, EBP implementations have significantly expanded capacity to deliver proven treatments. A provider of children and family behavioral health services in Massachusetts' Essex County has succeeded in making both Trauma Focused Cognitive Behavioral Therapy (TF CBT)

TABLE 1 Eligible EBPs (2006)

The EBPs listed below were eligible for consideration in at least one program year. EBPs funded by Tower are shown in bold text	
Across Ages	LifeSkills Training
AI's Pals: Kids Making Healthy Choices	Linking the Interests of Families and Teachers
All Stars	Lions-Quest Skills for Adolescence
Brief Strategic Family Therapy	Multidimensional Family Therapy
Class Action	Multidimensional Treatment Foster Care
Cognitive Behavioral Therapy for Child Sexual Abuse	Multisystemic Therapy
Coping Power Program	Parenting Wisely
Creating Lasting Family Connections	Parenting With Love and Limits
DARE To Be You	PATHS: Promoting Alternative Thinking Strategies
Early Risers: Skills for Success	Preventive Treatment Program
Families and Schools Together	Project ALERT
Family Effectiveness Training	Project Northland
Focus On Families	Project Toward No Drug Abuse
Functional Family Therapy	Reconnecting Youth
Good Behavior Game	Residential Student Assistance Program
Guiding Good Choices	Second Step
Helping the Non-Compliant Child	Strengthening Families Program
Incredible Years, Classroom	Strengthening Families Program: For Parents and Youth 10-14
Incredible Years, Parent Training	Too Good For Drugs
Keepin' It REAL	Trauma Focused Cognitive Behavior Therapy

and the Incredible Years Parent Training Series cornerstones of its service delivery strategy. All four of the agency’s outpatient clinics offer TF CBT, with 50 trained clinicians. Another grantee that works in central and western New York has trained 80 clinicians in TF CBT. They report that third-party payers (notably the New York State Office of Mental Health and county-level social services departments) now fully support the program. This provider also developed significant internal training capacity, with seven staff members qualified to train to the model. TF CBT is fast becoming a go-to therapeutic tool for an agency that works with 9,000 families a year.

To get a better handle on what was going right – or wrong – with its EBP initiatives, Tower designed a post-grant survey and tracking process, which it launched in the summer of 2009. For each grantee, the process kicks in one year after

the close of the initial grant period (most commonly, a three-year period). A program officer conducts a detailed telephone survey with the key project contact.⁵ First and foremost, the survey asks whether or not the EBP is still up and running. A “yes” response represents a sizeable win all around. The provider has been able, to some extent, to integrate the practice of an EBP into its structural, operational, and financial modus operandi. The EBP has become part of doing business for the provider and, most importantly, a results-oriented and client-centered service remains available to the members of the community

⁵ Tower explored the possibility of engaging third-party evaluators through a 2008 RFP issued to several program evaluators. Feedback from the RFP process suggested that, due to the assessment’s rather singular focus on post-grant sustainability and model fidelity, internally conducted surveys were acceptable. The Tower staff member who administered the surveys was relatively new to the organization, had not monitored any of the EBP grants, and had little or no prior familiarity with the grantees.

who need it. “No” responses are not necessarily cause for remorse. Service providers have been exposed to state-of-the-art methods, staffers have been challenged to grow and learn, and some organizations emerge better equipped to embrace change and innovation.

The survey also asks about program fidelity and long-term sustainability by including questions that address short-term program viability, financial resources, outreach and referral processes, staff training and certification, project management and administrative support, and cultural acceptance. The grantees have the opportunity to provide self-rated scores on a 10-point scale for each of these program components. The Tower survey also asks grantees to identify specific obstacles relating to these issues, success and failure drivers, and lessons learned from each funded program.

Cultural readiness for implementing an EBP is one of the areas of focus in the survey. Example questions that focus on this issue include:

- Has the EBP become an established way of doing business?
- Is the EBP internally regarded as “state of the art”?
- Is there still some resistance to adoption?
- Were the foundations for change successfully laid at the outset of the EPB initiative?
- Is cultural support for change complete now?
- Does internal education and cultural change continue to be a challenge?

Finally, grantees are asked to score themselves on a 10-point fidelity scale, reflecting how closely they feel they kept to the model blueprint. Tower staff also calculates an internal fidelity score, based on a custom scoring rubric designed to reflect the requirements of the EBP in question. This provides a balance to the self-reported scores and an independent measure of fidelity. For example, a provider may have graded itself highly on the staff training and certification measure because it put 10 clinicians through a training program. But if only three attained certification level – and the model requires that

all practitioners reach that level – the Tower rubric-based score will reflect a lower degree of program fidelity.

A typical rubric awards up to 10 possible points for each of six to eight categories that are uniquely germane to the EBP model in question. For example, an EBP treatment model with specific sequence and dosage requirements would require full agreement with the following statement to score a “10” in the category of “clinical progress and sequence”: “Ordered progression through the therapeutic components is highly valued by the therapist with the course of therapy complete in 12-16 sessions.” A rubric may include 10-point scales for team configuration and support, weekly supervision, licensure, quarterly boosters, quality assurance, and delivery sequence. The overall rubric-based score is the average score for these custom categories.

All survey results are aggregated and tracked by spreadsheet. For grantees that have sustained their program offerings, the survey will be conducted a second time (two years post-grant) to mine further insights.

Preliminary Assessment Results

Preliminary results are in for 16 programs. By the end of 2011, the full complement of two annual post-grant interviews was complete for two grantees (both were three-year grants for implementations that started in 2005). For eight other programs, the first post-grant interviews were completed. Six programs that received funds in the first two years of the initiative had been terminated, either at the end of the grant funding term or earlier. Of the two programs for which two interviews were conducted, implementation fidelity ratings either held steady in fair territory (a rating of 5.0-6.9) or declined from fair to poor (0-4.9). The remaining eight programs, generally started in the second or third year of the overall EBP initiative, fared better. One of these rated fair, while seven received exemplary scores (9.0 or higher).

Of the six terminated programs, two grantees canceled their implementations one year or less

into the grant, returning unused funds. In one of these cases, therapists simply balked at the basic requirements of the new methodology. The applicant had not laid sufficient groundwork for staff buy-in. For the other early cancellation, the grantee found that a key component of the EBP it had chosen – positive collaboration between birth parents and foster parents – ran counter to what it experienced in its client population. Communications between birth and foster parents in its programs were poor and the grantee felt that this dynamic was unlikely to improve sufficiently.

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Failure drivers (see Table 2) capture survey feedback about crucial obstacles to successful implementation. Terminated programs were most likely to cite high turnover among staff trained in the EBP as a significant challenge (five of the seven citations were from canceled programs). It should be noted that five of the grants in the first two years of the Tower initiative were for the same family-based therapy. Based on the survey feedback, the level of service from the developer created its own set of challenges. The approach itself – and the quality of the training – was well regarded, but trainers were frequently reassigned, schedules delayed, certification requirements in flux or poorly communicated, and the developer slow to respond when issues arose. Notably, three of the four programs that lasted only as long as the grant did were for this EBP. Grantees

could not reconcile the demanding (and costly) recertification process that this model required with the level of vendor support available at the time.

While the challenges of a single EBP may skew the initial findings somewhat, survey respondents identified a range of implementation obstacles. Many fell under the umbrellas of organizational readiness (e.g., client intake process not aligned, lack of program coordinator, poor sustainability planning) or cultural preparedness (e.g., general staff resistance to change, resistance to videotaping, competing service-delivery models). Cost and revenue challenges also loomed large with respondents. Several grantees scoring poorly on fidelity reported that certification/recertification requirements were too time consuming.

The seven programs scoring in the exemplary range had no single success driver in common. (See Success Drivers, Table 3.) Three cited the development of internal training capacity as a key to their success. One of the two grantees to score a perfect “10” pointed to the fact that it achieved (and maintains) site-based certification rather than certification limited to individual practitioners. This same grantee indicated that it now requires a two-year contractual commitment from new clinical hires to address the impact of staff turnover on sustaining an EBP. Several drivers were cited two or more times by grantees that scored in the good or exemplary range: effectiveness of fidelity tools (e.g., checklists), supportive leadership and supervision, a state payer system that values EBPs, flexible models that accommodate different clinical settings and therapist styles. Perhaps surprisingly, low turnover and cultural preparedness received only one citation each as positive drivers. It may be the case that these qualities are well ingrained – and, to an extent, taken for granted – in those organizations that are nimble and adaptive to change.

It is tempting to suspect that success or failure in EBP implementation could be largely a function of size and the organizational capacity associated with larger institutions. Is an organization that can afford to throw resources at an implementa-

TABLE 2 Failure Drivers

Driver	Total number of times cited	Number of times cited by terminated program	Number of times cited by program scoring 'poor' (4.9 or lower)
High turnover among trained staff	7	5	0
Certification/recertification requirements too time consuming	4	2	2
Certification/recertification requirements too expensive	3	0	1
Collateral, nonreimbursable expenses (planning, refreshments, incentives for family participants) too high	4	0	1
Developer/trainer not responsive, leading to delays in contracting and/or training schedules	4	2	0
Training generally too expensive	2	1	0
Internal resistance to change from clinicians	2	1	0
Staff burnout and fatigue with model	2	0	0
Developer/trainer "changes horses," assigning less effective trainer	2	1	1
Competing models within organization are challenge to implementation with fidelity	2	1	0
State agency (referral partner or payer) is not receptive to program	3	1	1
No funding for a program coordinator	1	1	0
No sustainability planning, "one and done" mentality	1	1	0
Payer doesn't cover home-based services, only clinic-based	1	0	0
Model requires caseload too small to generate needed revenue	1	0	0

Too much time between initial training and booster training	1	1	0
Intakes insufficient to maintain minimum caseload	1	1	0
Pressure from developer/trainer to rush the certification process	1	1	0
Family member participation too difficult	2	1	1
Session taping and peer review requirements too onerous	1	1	0

tion more likely to overcome the initial challenges to the status quo that EBP adoption can require? For the Tower grantees, it is true that three of the four smallest nonprofits (with annual revenues ranging from \$1 million to \$5.6 million and with 38 to 151 employees) were among the six canceled programs. But the other three canceled programs were among the largest of the providers assessed to date, with revenues of \$17 million, \$36 million, and \$37 million. These same providers had 309, 830, and 1,000 employees, respectively. The overall median revenue for the sample of 16 organizations was \$21 million, with a median of 315 employees. The medians for the organizations with “exemplary” scores fell below the overall medians: \$8.8 million in annual revenues, 158 employees. The organizations that scored “poor,” “fair,” or “good” (categories for which there was only one each) all exceeded the median for both revenue and number of employees. So, while smaller organizations may struggle, size is no guarantee of success.

It will be interesting to see if the seven grantees with one post-grant interview to date maintain their high scores for model fidelity. The assessment process will engage six additional programs through 2012. All grantees from the original 25 funded programs will have completed the two-interview process by the end of 2014.

At this point in the process, do Tower leadership and staff feel that the EBP initiative has proven successful? As noted, the benchmark for success

for grantees was continuing to provide the originally funded EBP with reasonably high fidelity at one- and two-year post-grant interviews. As 2011 wound down, seven years after the first grant dollars were awarded, 19 of 25 programs were still running and fidelity scores were trending up. The Tower initiative, while certainly not an unqualified success, is making an impact and continues to yield valuable insights and opportunities for reflection.

Grantmaking Implications

With the benefit of hindsight, the Tower EPB initiative would have gained from early conversations with a broader range of stakeholders than were represented at the workshops Tower conducted for potential applicants. One-on-one conversations, possibly site visits conducted before full proposals were invited, might have helped to better gauge the organizational readiness of applicants. Participation by representatives of state agencies might have paid significant dividends. Grantees, particularly in the first few years of the initiative, spoke of state- and county-based payers that declined to reimburse for the new programs. The likelihood of long-term sustainability is poor if local payers don’t recognize the value of a particular EBP. Referral networks (hospital staff, county agencies) need to be aligned, too, so that young adults in their late teens are not directed to programs designed for 10- to 14-year-olds. High turnover of trained staff was a key contributor to the termination of five EBPs. Perhaps grants could be structured to include more well-defined

TABLE 3 Success Drivers

Driver	Total number of times cited	Number of times cited by program scoring 'good' (7.0-8.9)	Number of times cited by program scoring 'exemplary' (9.0+)
Regular peer meetings and information sharing	4	1	1
Developed internal training capacity (e.g., train-the-trainer)	3	0	3
Effectiveness of fidelity tools (checklists, progress notes)	3	1	2
Supportive leadership and supervision	2	0	2
Flexibility of model to accommodate range of settings and clinician styles	2	1	1
State payer understands program value	2	0	2
Quality training provided	1	1	0
Advantages of certification on the basis of site, rather than individual	1	0	1
Low turnover among trained staff	1	1	0
Responsive trainer/developer	1	0	1
Attention to cultural buy-in at new sites	1	0	1
Model works with challenging families	1	0	0
Ease of integration with existing operations	1	0	1
Participated in a learning collaborative with other providers	1	0	1

planning and staff education phases. Some EBPs offer online short courses that introduce the model. Ideally, an organization's staff would participate in the research and selection of an appropriate EBP and training provider. Tower did provide funding for grantee staff to attend conferences that support EBP adoption, but it was after the fact. Staff turnover might be reduced through open discussion about possible incentives for completing certification, and about how the

time and workload demands of a new approach can best be accommodated.

Results to date have validated a number of the processes that Tower established for this initiative, but illuminate some omissions, too. In survey questions about the Tower grant process, the majority of grantees agreed that the six- to eight-week iterative process of working with Tower program officers on strengthening the work plan,

while rigorous, was worth the effort. A three-year grant period was generally sufficient, though some grantees exercised the option of a no-cost extension to accommodate delays. Tower staff provided budgeting templates for each approved EBP, and this helped applicants to request funds that were sufficient to cover expenses that might otherwise have been overlooked. For example, licensing fees, while not particularly common in EBPs, were identified in budget templates for the few programs that did require them. A few years into the initiative, but before the first awarded grants were closed, the Tower trustees granted staff the discretionary ability to increase EBP program budgets by as much as 10 percent.

Virtually every Tower grantee cited the high cost of training, certification, and recertification – especially in the face of high staff turnover – as a primary challenge. Foundations can assist, as Tower did, with direct support of implementations. But they can also do things to make communities more EBP ready and EBPs more generally viable and affordable.

This option was never exercised. Tower also permitted a modest overhead allowance (10 percent to 15 percent, depending on the complexity and size of a given program) that offered an additional cushion. While grant funds met short-term implementation costs fairly well, in post-grant interviews several grantees noted that the ongoing costs of training and recertification came as a shock. In future EBP grantmaking at Tower, more attention needs to be paid to the long-term costs of sustainability, with hard numbers identified up front.

EBP challenges have not eclipsed the success of many Tower-funded EBP programs. Building on this success, Tower issued RFPs in 2010 and 2011 that were modeled after the original EBP initiative and sought to expand the introduction of scientifically validated social and emotional curricula to early childhood educators in New York and Massachusetts. As a result, PATHS (Promoting Alternative Thinking Strategies), Second Step, Incredible Years, and Al's Pals – all programs originally eligible through the EBP initiative – have been implemented in a number of early childhood centers and district pre-kindergarten programs, 70 classrooms in all. Some of the lessons of the EBP initiative helped to shape this grant program. Applicants were required to communicate with curriculum developers, demonstrate how the program complemented existing instructional approaches, and budget for new teacher training as a response to anticipated teacher turnover.

Virtually every Tower grantee cited the high cost of training, certification, and recertification – especially in the face of high staff turnover – as a primary challenge. Foundations can assist, as Tower did, with direct support of implementations. But they can also do things to make communities more EBP ready and EBPs more generally viable and affordable. These could include local training collaboratives for clinicians or advocacy to educate payer systems and referral networks. The philanthropic community can also support efforts to define the need for EBPs at a grassroots level. A few of the Tower grantees imposed their chosen EBP on stakeholders that had not asked for them, meeting with therapist resistance and apathy from referral networks. Community-based collaborative work can help identify EBPs that truly respond to specific, local needs.

Looking Forward

EBPs are no passing fad. The development staff of nonprofits can point to EBPs as a way of demonstrating to foundation and individual donors that they are squarely focused on positive outcomes for their clients. Perhaps most significantly, the payer systems for behavioral health service delivery are getting on board. New York State's Office of Mental Health, the chief source of Medicaid funding for the state's mental health care provid-

ers, has established an Evidence Based Treatment Dissemination Center to improve the public's access to EBPs by providing clinician training.

There are indications, supported by the preliminary findings of the Tower assessment, that service providers are increasingly savvy about recognizing which EBPs fit best with their internal cultures and organizational capacity to implement. Service providers are helped by the fact that EBP programs and their training delivery systems have longer track records, making it easier to judge the quality of the support they offer and talk with other organizations that have implemented the model. Tower staffers have also found that the availability and more routine use of low-cost digital cameras have helped grantee organizations overcome cultural resistance to recording counseling sessions, a key tool for maintaining EBP program fidelity

The alternatives to offering EBPs in the community – often involving, by default, institutional approaches to working with at-risk youth – are not just ineffective, they are more expensive. EBPs are aligned with the trend toward community and family-based resolution of the problems that at-risk youth face. Institutionalization for mental health disorders and incarceration for juvenile offenders have been widely discredited as effective remediation. EBPs focus on promoting individual strengths and on shoring up the environmental supports that home and community can provide. Nevertheless, EBPs are currently unavailable to most Americans. Speakers at an Association for the Advancement of Evidence-Based Practice conference in the spring of 2009 repeatedly referred to the fact that only seven percent of the behavioral health treatment options generally available to children and adolescents are evidence based. The Tower Foundation shares the goal of organizations like AAEBP and Blueprints in advancing the cause of EBPs. Tower has awarded supplemental stipends to its EBP program grantees so that staff could attend AAEBP conferences and share best practices. The Tower Foundation looks forward to continued promotion of EBP implementations because, as the philosopher David Hume observed, “a wise man proportions

his belief to the evidence.” As researchers identify and test more effective methods, the move to improve the availability of scientifically validated treatments becomes a moral imperative. Young people in need deserve no less.

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