

# The National Implementation Research Network

Frank Porter Graham Child Development Institute

University of North Carolina at Chapel Hill

Learn More:

<http://nirn.fpg.unc.edu/>

**William A. Aldridge II, Ph.D.**

919-966-4713

[will.aldridge@unc.edu](mailto:will.aldridge@unc.edu)

**Karen A. Blase, Ph.D.**

919-966-9050

[Karen.blase@unc.edu](mailto:Karen.blase@unc.edu)

**Melissa Van Dyke, LCSW**

919-966-7297

[melissa.vandyke@unc.edu](mailto:melissa.vandyke@unc.edu)

**Dean L. Fixsen, Ph.D.**

919-966-3892

[dean.fixsen@unc.edu](mailto:dean.fixsen@unc.edu)

**Allison J. Metz, Ph.D.**

202-714-4576

[allison.metz@unc.edu](mailto:allison.metz@unc.edu)

## IMPLEMENTING EVIDENCE-BASED PREVENTION PROGRAMS:

### FOUR THINGS POLICYMAKERS NEED TO KNOW WITH RELATED POLICY RECOMMENDATIONS

**#1 Fidelity predicts outcomes. Before you try to make changes to a prevention program or practice, first do it as intended (if you can!).**

*Fidelity: Is the evidence-based prevention program being delivered as intended?*

Without evidence of fidelity, we cannot be confident in achieving expected program outcomes supported by scientific trials.

Not all prevention programs have readily available or practical fidelity assessments that have shown to predict program outcomes. In such cases, practical fidelity assessments can be developed in service settings by allocating time and funding for usability testing.

#### *Policy Recommendation #1:*

Make sure you're getting the evidence-based prevention programs you're paying for: require regular reports of fidelity data.

### #2 The Formula for Success



The full and effective use (high fidelity) of prevention programs requires effective implementation; individuals cannot benefit from interventions that they do not fully receive. Available data show that the usual methods of transferring innovative interventions into service settings, when used alone, typically result in only 5 to 15% of consumers experiencing interventions as intended<sup>i</sup>. These methods include:

- Diffusion/dissemination of information
- Training
- Passing laws/mandates/regulations
- Providing funding incentives
- Organization change/reorganization

Over the past decade, applied implementation science has identified core sets of effective implementation strategies to transform human service systems and ensure full use of evidence-based prevention programs. At the National Implementation Research Network, we organize these strategies within the *Active Implementation Frameworks*<sup>ii</sup>:

- Usable Interventions
- Implementation Drivers
- Improvement Cycles
- Implementation Teams
- Implementation Stages

#### *Policy Recommendation #2:*

Initiatives to use evidence-based prevention programs need to incorporate effective implementation methods based on applied implementation science.



THE UNIVERSITY  
of NORTH CAROLINA  
at CHAPEL HILL

### #3 Full and effective use of evidence-based-prevention programs requires an active, supportive (and often transformed) organizational or systems environment.

The following Active Implementation Frameworks offer strategies for transforming service systems to purposefully and intentionally support the full and effective use of evidence-based prevention programs<sup>ii</sup>:

**Implementation Drivers:** embedding implementation infrastructure and best practices to build and maintain:

- service provider competency and confidence to deliver effective prevention programs as intended,
- organizational capacity to fully support service providers' success, and
- leadership ability to identify and successfully address adaptive systems challenges.

#### Policy Recommendation #3:

Set aside 15% of funding for developing effective implementation infrastructure and teams, and embedding active implementation practices.

**Improvement Cycles:** creating learning organizations and systems that continually improve on the local use of prevention programs using data.

**Implementation Teams:** creating or repurposing team structures that are accountable for installing and sustaining implementation infrastructure and practices and engage in data-based decision making.

### #4 Full implementation of usable evidence-based-prevention programs takes, on average, 2-4 years<sup>iii</sup>. Scaling fully implemented programs takes additional time.

**Implementation Stages:**

- **Exploration:** assess needs, create readiness, identify usable interventions, develop team structures, develop communication plans
- **Installation:** identify organizational and structural changes needed, select the first practitioners, train the first cohort, develop coaching plan, evaluate readiness of data systems, establish communication links
- **Initial Implementation:** assessment of practitioner supports; provide coaching; repurpose organizational roles and structures; use Plan-Do-Study-Act cycles; use policy-practice feedback cycles; use communication links
- **Full Implementation:** skillful practices by all staff, evaluation for expected outcomes, full use of implementation drivers, institutionalize the use of improvement cycles, share success

#### Policy Recommendation #4:

Initiatives to use evidence-based prevention programs need to allow for stage-based implementation activities (e.g., a planning year) and incorporate realistic time frames to achieve full implementation and expected outcomes.

**Benchmarks:**

- **Full Implementation:** 50% or more of intended service providers are delivering the program with fidelity.
- **Scaling-up:** 60% of consumers who could benefit from a prevention program are experiencing that program in their service environment.

<sup>i</sup> Nutt, P. (2002). Why Decisions Fail: Avoiding the Blunders and Traps That Lead to Debacles. San Francisco: Berrett-Koehler Publishers Inc.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, National Implementation Research Network. (FMHI Publication No. 231).

Green, L. W. (2008). Making research relevant: if it is an evidence-based practice, where's the practice-based evidence? *Family Practice*, 25, 20-24.

Wiltsey Stirman, S., Kimberly, J., Cook, N., Calloway, A., Castro, F., & Charns, M. (2012). The sustainability of new programs and innovations: a review of the empirical literature and recommendations for future research. *Implementation science* : IS, 7(1), 17-17. doi: 10.1186/1748-5908-7-17.

<sup>ii</sup> Fixsen, D., Blase, K., Metz, A., & Van Dyke, M. (2013). Statewide implementation of evidence-based programs. *Exceptional Children*, 79, 213-230.

Metz, A., & Bartley, L. (2012). Active Implementation Frameworks for Program Success. *Zero to Three*, 32, 11-18.

<sup>iii</sup> Bierman, K. L., Coie, J. D., Dodge, K. A., Greenberg, M. T., Lochman, J. E., McMahon, R. J., et al. (2002). The implementation of the Fast Track Program: An example of a large-scale prevention science efficacy trial. *Journal of Abnormal Child Psychology*, 30, 1-17.

Fixsen, D. L., Blase, K. A., Timbers, G. D., & Wolf, M. M. (2001). In search of program implementation: 792 replications of the Teaching-Family Model. In G. A. Bernfeld, D. P. Farrington & A. W. Leschied (Eds.), *Offender rehabilitation in practice: Implementing and evaluating effective programs* (pp. 149-166). London: Wiley.

Panzano, P. C., & Roth, D. (2006). The decision to adopt evidence-based and other innovative mental health practices: Risky business? *Psychiatric Services*, 57, 1153-1161.

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19, 276-287.

Saldana, L., Chamberlain, P., Wang, W., & Brown, H. C. (2011). Predicting program start-up using the stages of implementation measure. *Administration and Policy in Mental Health*, 39, 419-425.