

To Adapt Interventions to Serve Youth Who Have Been Marginalized, Service Providers Can Seek Funding from Public Agencies

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Introduction

Tailoring interventions for groups that have been marginalized

In the past several decades, there has been a significant increase in the number of behavioral health interventions for children and adolescents with rigorous evidence to support their effectiveness. For example, the [Results First Clearinghouse Database](#), compiled by the Pew-MacArthur Results First Initiative, currently includes information on nearly 3,000 interventions—over 70 percent of which have moderate or high evidence of effectiveness. Despite this abundance of evidence-based programs, many interventions do not have evidence of effectiveness for specific populations (Barrera et al., 2012). As a result, relying exclusively on rigorously evaluated interventions can further disadvantage groups that are often marginalized by the systems intended to support them—such as youth of color and youth involved in child welfare or juvenile justice systems—for whom few evidence-based interventions exist (Lorenc & Oliver, 2014; McNulty et al., 2019).

One potential solution to the scarcity of interventions with demonstrated success among groups that have been marginalized is to adapt interventions with proven track records to meet the needs of those groups. Some researchers refer to the process of leveraging well-established interventions to create versions better suited to underserved groups as “scaling out” (Aarons et al., 2017). Scaling out is defined as the process of adapting a well-established, effective intervention for a new setting, a new population, or—when there is particularly strong evidence about the core components of an intervention—for both a new population and a new setting.

Scaling out has the potential to address a disconnect between the typical methods of establishing evidence and the needs of practitioners working with communities that are often both marginalized by the systems intended to support them and absent from the literature. It does this by leveraging existing evidence to allow a greater focus on contextual factors that are particularly relevant to historically underserved populations through case studies and analysis of practice-based evidence (Alvidrez et al., 2019). Evaluations of scaled-out interventions are likely to be conducted in settings where program developers and evaluators must manage partnerships and establish buy-in; therefore, they must understand how stakeholders such as service providers and public agencies might respond to delivering, referring to, or paying for as-yet unproven services (Jaramillo et al., 2019).

Case study: Multisystemic Therapy for Emerging Adults (EA)

Behavioral health and judicial systems are generally divided into those that serve children and adolescents and those that serve adults. For this reason, youth enrolled in systems of care who are transitioning into adulthood—sometimes referred to as emerging adults—represent a particularly vulnerable group. Emerging adults are likely to have developmental needs that are not well-addressed by either of these systems. As a result, it can be challenging for service providers to identify interventions with strong evidence of effectiveness for youth who would benefit from additional supports to make a successful transition. Multisystemic Therapy for Emerging Adults (MST-EA) was developed to bridge the gap in behavioral health services that exists between the youth system and the adult system (Sheidow, McCart, & Davis, 2016).

To address the question of how service providers and public agencies might respond to a request to invest in an untested adaptation of an existing intervention, Child Trends conducted a series of interviews with stakeholders engaged in a process to establish evidence for MST-EA. This intervention is an adaptation of Multisystemic Therapy (MST), one of the most rigorously evaluated behavioral health interventions targeting youth and their families (Henggeler, 2016). MST-EA was first developed within juvenile justice settings, and the move to deliver it within child welfare is itself a scaling out (Aarons et al., 2017; Davis, Sheidow, & McCart, 2015). MST-EA had not yet been rigorously evaluated in a completed randomized controlled trial at the time of our interviews, although an open trial provided preliminary evidence on the effectiveness of the model (Davis, Sheidow, & McCart, 2015). Of note, two large-scale, federally funded randomized controlled trials of MST-EA are also in progress.

This brief summarizes the experiences of stakeholders involved in implementing MST-EA in two neighboring jurisdictions. Overall, the public officials and private service providers that participated in this initiative described a willingness to test an adaptation of a well-established intervention. Ultimately, only one of the two jurisdictions chose to fund MST-EA services over time. This case study suggests that—given the right circumstances—public officials are open to paying for services as a part of real-world evaluations of adaptations (i.e., those that require partnerships and community buy-in), particularly those with promise for meeting the needs of underserved populations.

Key findings

- Public officials and service providers were willing to refer youth to the adapted intervention for services, despite limited evidence of its effectiveness, because of the **rigorous evidence behind the original intervention**.
- Public officials and service providers were willing to refer youth to an adaptation with limited evidence because they viewed it as **filling a critical gap** in services for a historically underserved population.
- The strength of **existing relationships** between public officials and service providers helped them work together to address challenges.
- **High-quality implementation** on the part of the service provider—due in part to a strong track record implementing evidence-based programs, including MST—contributed to confidence among public officials.
- Addressing the **unique needs and approaches of multiple jurisdictions can be a challenge** when scaling out involves partners from several agencies and/or jurisdictions.
- While the partners ultimately obtained funding from multiple sources, a lack of **ongoing, transparent communication about financing** resulted in uncertainty and heightened concerns about the viability of the project.

Methodology and Data

Child Trends researchers conducted interviews with public agency staff in two neighboring jurisdictions, staff at the service provider organization that delivered MST-EA to youth in both jurisdictions, and the program developers. For simplicity, we will refer to one jurisdiction as Jurisdiction 1 and the other jurisdiction as Jurisdiction 2. In Jurisdiction 1, one public youth-serving agency referred youth for MST-EA services. In Jurisdiction 2, three public youth-serving agencies referred youth for MST-EA services. In Jurisdiction 1, services were funded by a private foundation; in Jurisdiction 2, they were funded by a public agency that administered funds for many different social services. A total of 17 youth participated in the MST-EA adaptation across both jurisdictions. The majority of the youth (10 participants) were Black; five were White, one was biracial, and one was Hispanic. See Table 1 for a description of all organizations involved in the MST-EA initiative.

Table 1. Description of Organizations Involved in the MST-EA Initiative

ORGANIZATION	DESCRIPTION
Foundation	Funder—a private foundation that funded services for youth in Jurisdiction 1
Jurisdiction 1 agency	Referral source—a public agency that referred youth to service provider for MST-EA services; there was one youth-serving agency involved in Jurisdiction 1
Jurisdiction 2 funding agency	Funder—a public agency that administered funding to pay for MST-EA services for youth in Jurisdiction 2
Jurisdiction 2 agency	Referral source—a public agency that referred youth to service provider for MST-EA services; there were three youth-serving agencies involved, some of which had existing or prior experience with traditional MST
Service provider	A national behavioral health organization that delivered MST-EA services to youth in both jurisdictions with experience implementing traditional MST
Developer	The professionals that developed the MST-EA adaptation

We conducted initial interviews in spring 2018 with 10 individuals, including leaders of public agencies as well as leadership and clinical staff at the service provider organization. These initial interviews occurred prior to MST-EA service delivery and were focused on motivations for participating in MST-EA implementation. In fall 2018, the same individuals were interviewed a second time to explore their experiences with MST-EA implementation; at that time, three additional public agency staff members and one additional service provider leader were also interviewed about their experiences. The two MST-EA developers were also interviewed at that time to ascertain their assessment of the initiative. In all, 26 interviews were conducted. Child Trends researchers also attended a number of in-person and virtual discussions at which the implementation team provided progress updates.

To analyze interview data, the research team used a grounded theory approach in which themes were identified during team debriefs after all interviews were complete (Glaser & Strauss, 2017). The team then examined the ways in which the timing of the interview (i.e., early or late in the implementation) or the respondent’s organization interacted with their perceptions of these themes. Information on perceptions were combined with factual and timeline information from meetings and calls that the Child Trends team attended, as well as other updates stakeholders provided to the team, to provide additional context related to the implementation of MST-EA across the two jurisdictions.

Findings

Child Trends' discussions with program developers, funders, public agencies, and service providers highlighted the complex nature of implementing an initiative that relied on a partnership among multiple funders and public agencies across two jurisdictions. Below, we present common themes that emerged with respect to the facilitators and barriers our informants identified as influential in the ultimate success of the initiative.

Factors that facilitated scaling out

During this initiative, a number of partners came together to scale out and implement MST-EA in their region. In our discussions with these partners, respondents identified a number of factors that motivated their participation—in other words, factors that facilitated the scaling out of MST-EA. These factors fall into three major categories: favorable perceptions of the MST-EA program, pre-existing relationships among some partners, and conditions that facilitated high-quality implementation on the part of the service provider.

Stakeholders expressed optimism that the adaptation would be effective based on the rigorous evidence for the original intervention. Buy-in, at the organizational and individual level, has been identified as an important factor in making and sustaining practice changes (Walker, Bumbarger, & Phillippi Jr., 2015). For scaling out to take place, it is critical for stakeholders and partner organizations to buy in to the proposed adaptation. In cases where these parties perceive that the new features of the adaptation—which have not been evaluated with the same rigor as the original intervention—do not add enough value over and beyond the original intervention, they may view scaling out as not “worth it,” compared to replicating the version with the stronger evidence base.

Nearly across the board, respondents valued the fact that MST-EA was an adaptation of MST, an intervention that they considered to have significant evidence to support its effectiveness. Respondents were familiar with standard MST and appreciated the connection with such a well-known and rigorously evaluated intervention with strong implementation supports provided by the developer. One public agency official summarized this view clearly, saying, “I guess there’s some automatic buy-in when you mention MST just because of the wealth of research behind it—and the infrastructure behind it is just incredible.” Another public agency official did note that the adaptation had substantially less research behind it than MST did, and expected that there “might be some lessons to be learned, because it seemed to be relatively new—there was only minimal research.” Despite the limited evidence of effectiveness for the MST-EA adaptation, this individual emphasized that they were “definitely positive” about MST-EA from the start.

Stakeholders described an interest in the adaptation because they viewed it as filling a critical gap for a historically underserved population. Beyond its association with MST, many respondents noted that MST-EA would fill a gap in effective services for the target population. A worker from a referring agency saw it as “an incredible opportunity for intervention for some of our hard-to-reach youth,” while another stated that “several people came to mind right away that fit the criteria.” Another public agency staff member explained how they viewed MST-EA after hearing about it for the first time, saying, “The parts that I liked the most was, of course, the population they were serving because we have limited services for those youths.” One respondent from a public agency provided important context related to their experiences trying to serve the MST-EA target population:

The issue of youth and young adults with diagnosed behavioral health issues and involvement with the juvenile justice system and social services system has been on our map in [Jurisdiction 2] for a long time. . . . It's been on our radar to look for evidence-based interventions that specifically serve that population.

Another public agency official agreed, noting that MST-EA appeared to be a good fit for young people who were hard to engage in other interventions, and was appropriate for the young adults they work with, many of whom have high levels of trauma. MST-EA's focus on a historically underserved population appealed not only to public agency staff, but also to the service provider. A manager at the service provider described finding the adaptation "exciting" and stated that it "was enticing to work with that [emerging adult] population."

Pre-existing relationships among public and private partners helped foster trust in the initiative. A number of the partner organizations, in both jurisdictions, had pre-existing relationships with one another. The major pre-existing relationship in Jurisdiction 1 was between the foundation partner that funded the services and the Jurisdiction 1 referring agency. In fact, one respondent from the Jurisdiction 1 agency described the foundation partner's involvement as the *only* reason they became engaged in the initiative. Per this respondent, the strong, pre-existing relationship between the two organizations meant that the Jurisdiction 1 agency trusted the foundation's judgment enough to take a chance on a new initiative.

In Jurisdiction 2, a number of local actors had previously worked with the service provider. One referrer stated that they had been working together "for some time, I think since 2007 or [200]8," and noted that they had "a lot of confidence" in the provider. A respondent from the Jurisdiction 2 funder also described a positive relationship with the service provider:

Well, I think we have a good working relationship with the provider. I think we have open communication. And whenever there are issues or concerns, we feel comfortable in talking openly with the provider. We meet on a regular basis in a variety of different ways.

Another respondent from a Jurisdiction 2 public agency praised the service provider's dedication to evidence-based practice:

We've tried to implement a number of evidence-based services or practices in [Jurisdiction 2]. Standard MST, Functional Family Therapy for example—even [Building Strong Families Training]. And we have worked with a number of vendors on those different projects. [Provider] stands out in my mind because they have, I would say, evidence-based services in their DNA, and they're, from my experience, in a different league than pretty much anybody else that I've worked with on an evidence-based practice.

The Jurisdiction 2 funding agency's close working relationship with Jurisdiction 2 referring agencies facilitated the initial engagement of the referrers into the MST-EA initiative. Had these relationships not been in place, more outreach work and relationship building on the part of the program developers and the service provider would have been needed, and it may have been a far bigger challenge for the initiative to get started.

The service provider's implementation supports facilitated high-quality implementation of MST-EA.

Finally, staff at the service provider described a number of factors that facilitated high-quality implementation of MST-EA. These factors broadly align with two categories of "implementation drivers" (supports for effective implementation) discussed by the [National Implementation Research Network](#) (2016): competency drivers and organizational drivers. These drivers work across multiple domains to support successful implementation of an intervention. In the context of the MST-EA initiative, implementation drivers support the intervention to improve the critical mental and behavioral health outcomes it targets. The MST-EA developers were also aware that provider capacity was paramount to successful implementation; they described having a "site assessment checklist" used to check the readiness of potential providers.

Competency drivers support staff's ability to implement practices as intended. The service provider had numerous competency drivers in place. As an organization, the service provider had delivered MST numerous times, and felt comfortable with the model's rigor and intensity. Further, the clinical supervisor had professional experience delivering standard MST. Other competency drivers that were in place

included strong staff selection (many respondents from other organizations spoke highly of the MST-EA supervisor hired by the agency), effective training delivered by the intervention developer, as well as strong quality improvement and ongoing coaching conducted both by the developer and within the MST-EA team. Aspects of the training that MST-EA clinicians especially liked were the inclusion of role-plays, “very helpful” examples from cases, and the fact that the program developers “were very intentional about making sure we get answers to our questions.” Meanwhile, program developers spoke highly of the clinical supervisor’s performance and described how the supervisor’s facility with MST-EA supported implementation overall:

The one thing that I do notice here is that the supervisor is quite skilled. . . and that has, I think, facilitated this model of implementation in [the region] relative to some other places we've been. Typically, we are needing to spend more time with the supervisor, providing guidance and coaching and support. This particular supervisor is able to operate almost independently, more so than other supervisors we've worked with.

Organizational drivers create hospitable environments for effective service delivery (NIRN, 2016). In the MST-EA initiative, these included a referral system that was positively received by individuals across many agencies in the initiative, as well as necessary supports for clinical staff (such as help with paperwork and mileage reimbursement) at the service provider. One therapist also described an “emphasis on self-care” in the team. Organizational drivers also included clear buy-in of MST-EA among executives in the service provider organization. When discussing their thoughts on MST-EA, multiple executives at the service provider referenced their past experience with standard MST. As one stated, “I didn’t have any concerns, and we had been funding. . . the original intervention for many, many years. So, we’re really confident in the outcomes, and we’re pleased with the services that our providers are getting [from the MST-EA program developers].” In addition to their positive statements, leaders at the service provider demonstrated support for MST-EA with their presence at part of the intervention training. One therapist also noted that agency leadership was responsive to issues they brought up, leading to their staying on the team instead of leaving.

Major challenges to scaling out

Although there were numerous factors in place that led to scaling out of MST-EA in the two jurisdictions, the initiative also faced challenges. A primary factor was the difficulty of managing relationships between multiple partners across two jurisdictions that, historically, have not always worked together closely. Further, the initiative was characterized by uncertainty with respect to sustainable funding sources, and experienced delays at multiple points. In conjunction, these factors created challenges to achieving longer-term funding for the initiative across both jurisdictions, and may point to potential pitfalls for partnerships seeking to scale out interventions in their communities.

Managing the neighboring jurisdictions’ differing needs and approaches was challenging. Staff at the service provider noted that the two jurisdictions worked in ways that were “very siloed from each other” throughout the initiative, and took distinctly different approaches to engaging with MST-EA. In Jurisdiction 1, leadership from the child welfare agency was heavily engaged in identifying and making referrals to the program. On the other hand, Jurisdiction 2 engaged a consortium of public agencies that identified youth, a central funding agency, and a “gatekeeper” behavioral health authority that managed the flow of referrals to the service provider. As a result, the service provider had to balance a large set of priorities across these multiple stakeholder groups.

Further, respondents from each jurisdiction expressed preconceptions about the other jurisdiction. One respondent from Jurisdiction 2 expressed that, compared to Jurisdiction 1, they felt overlooked by external funders:

[Jurisdiction 2] is not as resource-rich as Jurisdiction 1 is, unfortunately. . . . But [Jurisdiction 2] just is not seen as having the same level of need, which doesn't really necessarily bear out in what we know of the two jurisdictions, but it sometimes makes it harder for us to get funding for things.

Because of this, the individual respondent felt it necessary to partner with Jurisdiction 1 in order to achieve the necessary economies of scale to serve cases in Jurisdiction 2. As one Jurisdiction 2 funder explained, “This is an expensive program and we’re certainly willing to invest in it. If [Jurisdiction 1] hadn’t partnered with us, we would not have invested in it.” The fixed costs for an MST-EA team, including training and supervision, were not within budget for Jurisdiction 2 alone. When split with foundation funding for Jurisdiction 1 cases, however, the remaining expenses were affordable.

This dynamic—Jurisdiction 2’s reliance on Jurisdiction 1 for any cases to be served—was noted and negatively perceived by Jurisdiction 1 leadership. A respondent from Jurisdiction 1 described feeling like “we were the startup people,” where the experiences of youth in Jurisdiction 1 could be used to improve implementation and that youth from Jurisdiction 2 would then be able to benefit from those lessons learned:

I think it was that they saw that the [foundation] money was a way to get people trained to start up, to work through the kinks while they were going to serve [Jurisdiction 1] kids. And then, after a period of time when they thought things were straight, then they'd start really doing [Jurisdiction 2].

This negative perception was compounded by a belief among Jurisdiction 1 staff that Jurisdiction 2 had requested changes to the MST-EA model to better suit their cases. As one staff member explained:

We tried to have joint conversations about [MST-EA implementation] because the model is one way, and all of a sudden [Jurisdiction 2 staff] says, "Oh, we want to change this model." [...] I'm not willing to do that because my expectation is if we buy into someone's model, we're going to follow the model the way it should be because we want the outcome that you guys are guaranteeing.

In addition to differing expectations with respect to implementation and varying stakeholder groups across jurisdictions, cases in each jurisdiction were financed through funds from different sources. Some of the funding was not firmly in place at the beginning of the initiative, while other funders had not provided timelines for disbursement of funds. Despite the complex nature of the financing, there was a lack of ongoing, transparent communication with respect to the effective braiding of funds across the two jurisdictions. The resulting uncertainties in financing heightened perceptions of risk among all partners and likely exacerbated tensions. For example, a government official from one jurisdiction noted:

Trying to figure out the expenses, initially, required a little bit more thought than we usually have to. Now, we're about to go into the second year and we have our funding in place but [the other jurisdiction] does not have their funding in place. We're in this situation to come up with plan B, C, and D if the [the other jurisdiction] drops out of the program for FY 2019.

These differences in the jurisdictions’ needs and approaches were difficult for the service provider staff to navigate; one manager stated that managing the relationship between the two jurisdictions was “the most challenging part” of their work in the initiative. In a systematic review of the literature on how innovations diffuse in systems, Greenhalgh and colleagues (2004) noted that communication across organizations makes it more likely for implementation to succeed and become routine in a system. Due to the historically siloed nature of the relationship between the two jurisdictions, however, there was a lack of communication between these two critical partners in the initiative.

The rollout was slow, and stakeholders were sometimes frustrated by the lack of progress during the planning period. Stakeholders expressed frustrations due to slow progress moving the initiative forward, and uncertainties about funding and partner commitment throughout the initiative. Service provider leadership described this frustration, saying, “It almost seemed like there were times where we weren’t really sure it was going to launch.” Because neither jurisdiction could provide all of the funds needed to

start up, there was substantial back-and-forth related to budgets and funding. With respect to getting money from the foundation, a respondent from the provider described that “we were talking about it for well over a year before it actually came to fruition.” Introducing further uncertainty was the fact that the funding Jurisdiction 2 could provide to pay for MST-EA cases was contingent on being awarded a grant from a state agency. Not only was it impossible to proceed before the funds were awarded, but it was also not a given that Jurisdiction 2 would receive the grant (although, in the end, it did).

Delays were not limited to funding. Hiring at the service provider organization also took longer than expected. Therapist and supervisor positions were found to be challenging to fill due to state licensure requirements that limited the pool of applicants and drew out the process of hiring a qualified applicant. Further, once it became clear that funding for the intervention would last for only a limited period of time, hiring became even more difficult. There were also other, more individual challenges related to hiring. For example, a therapist who had been hired notified agency staff, on what would have been their first day, that they had accepted a different position and would not be taking the MST-EA job.

Once delays were resolved and implementation was underway, program implementation went smoothly. On the whole, respondents from both Jurisdiction 1 and Jurisdiction 2 reported very positive perceptions of the services and the team delivering them. A leader at the Jurisdiction 1 referring agency reported they received “really positive” feedback about the day-to-day operations of MST-EA; similarly, a staff member at a Jurisdiction 2 referring agency said they “have a favorable impression of the efforts.”

Still, the delays in the program start-up represented an opportunity cost for Jurisdiction 1, which had federal funds it considered devoting to MST-EA; ultimately, these funds were used to support a different program. This decision was made within six months of the start of services; staff from Jurisdiction 1 cited the need to designate its funds within a shorter timeframe than allowed by the drawn-out MST-EA initiative. Later, they reflected on this issue, saying, “We believe in the model. . . I think they did an incredible job. It was just unfortunate that the vendor wasn’t in place and able to start serving children in the timeframe which we originally discussed.” This decision was, essentially, the beginning of the end of the cross-jurisdictional MST-EA initiative: Foundation funds that had subsidized Jurisdiction 1 cases were non-renewable, and the service provider terminated all Jurisdiction 1 clients by early August 2018. Jurisdiction 2, however, did secure additional funding to continue treating MST-EA cases even after Jurisdiction 1 withdrew from the initiative.

For Jurisdiction 1, a swifter rollout might have led them to commit time-sensitive federal funds to support MST-EA cases. Due to the series of delays that occurred, however, they ultimately had to allocate those funds to another project. Scholars such as Bryson and Crosby (2015) have indicated that cross-sector collaborations should take advantage of “windows of opportunity” where multiple independent actors looking for solutions exist. The timing of the MST-EA initiative meant that whatever window of opportunity was there may have been too narrow for a lasting, multi-jurisdiction partnership to emerge.

Study Limitations

This study offers important insights from a number of different stakeholders. However, there are a few important limitations to highlight. First, the start-up of MST-EA spanned more than a year and one jurisdiction experienced a change in leadership prior to the start of services. Similarly, the service provider experienced a change in leadership at the national level prior to implementing services. As a result, individuals that we interviewed in leadership positions of some organizations had limited involvement in initial planning decisions; however, these leaders were involved prior to the launching of MST-EA services and could speak to their experiences with the initial roll out of services. Additionally, one jurisdiction discontinued participation with MST-EA services prior to youth completing the full course of treatment; as a result, public agency staff from that jurisdiction were not able to comment on their experiences with youth who completed a full course of MST-EA. Finally, the number of youth who engaged in MST-EA services was small, and stakeholders that participated in our final interviews noted that they could only

comment on their experiences up to that point, recognizing that they could not speak to the final outcomes achieved by youth.

Recommendations

Our interviews with individuals who were deeply engaged in the MST-EA initiative suggest that it is feasible to bring aboard motivated public agencies in an implementation partnership to scale out an adaptation of an existing evidence-based program. However, as with any effort to implement a new program or set of services, there were also challenges. Ultimately, multiple elements influenced the outcomes of the initiative in the two jurisdictions. While contextual factors are likely to vary by location and program, some takeaways from the MST-EA initiative may be applicable for other communities interested in scaling out interventions.

Build on the strong reputation of a well-established intervention to foster confidence among partners.

Many of the partners in this initiative expressed some form of immediate buy-in to MST-EA because they associated it with the strong research base and high effectiveness of the standard MST model. Although MST-EA did not have the same level of rigorous evaluation support as its base program, stakeholders appeared to trust that it would also be a high-quality and effective program. This was key in establishing immediate buy-in from those who would eventually become partners in the initiative. Interventions with a strong body of evidence are likely to be the best-positioned for achieving the buy-in required for scaling out.

Ensure that the adaptation fulfills an unmet need. A number of respondents remembered hearing about MST-EA's target population and immediately thinking that it would fill a gap in the services currently provided. Public agencies that offer only a few evidence-based interventions may be receptive to a high-quality, documented adaptation that gives them a more complete service continuum. This finding lends further credence to scaling out as a viable approach for expanding services, given that the scaling-out approach focuses on spreading a well-established intervention to new populations or settings (Aarons et al., 2017).

Leverage existing networks to form effective partnerships. Although there were challenging relationships between some partners in the MST-EA initiative, there were also partners who had already enjoyed collaborative relationships for years. Without these strong relationships—between the Jurisdiction 1 referrer and the foundation partner, or between the service provider and its various Jurisdiction 2 contacts—it is possible the initiative would have never moved forward. For organizations interested in scaling out, it may be beneficial to focus on partners that can champion the initiative and engage their existing networks to do the same.

Establish and maintain ongoing, transparent communication about funding from the beginning of the initiative. Financing is an important part of a successful collaboration. While funding from multiple funders can support sustainability, it can also introduce additional complexity to the partnership. For the MST-EA initiative, the two jurisdictions relied on funds from different sources. In both cases, it was uncertain whether some of the sources of funding would be awarded, and the timeline for disbursement was unclear. Such financial uncertainties can introduce a level of risk and contribute to strained relationships between partners if not addressed in a transparent manner. Partners should dedicate time early in the process to determine an equitable approach to funding the joint initiative and engage in ongoing, transparent communication to identify and address potential financial challenges—thereby allowing for proactive, joint problem-solving.

Invest adequate time and resources into maintaining effective working relationships across all partners.

Once a broad network of stakeholders is established, partners should work to determine shared priorities for the initiative. Without a shared understanding of the project, tensions can arise that result in a

premature dissolution of the partnership. If partners feel that they are working toward a singular vision, on the other hand, they may be more likely to engage deeply to solve a problem, rather than pull back. Additionally, those partners who do the work of convening multiple stakeholders—such as the service provider in the MST-EA example—should pay close, continual attention to the relationship dynamics of those they are bringing together and foster transparent communication across all partners. While establishing shared priorities early on is helpful, partners must also have opportunities to periodically check in to ensure that expectations are being met and to engage in constructive dialogue when challenges arise.

Ensure that providers have the capacity for high-quality implementation. One challenge of scaling out is the newness of the implementation; delivering an intervention with adapted components, in a new setting or with new populations, will always involve uncertainty regarding effectiveness. Some potential partners may be (rightly) concerned that they will not experience the same impacts as seen in rigorous evaluations of the original intervention. Therefore, it is critical that the service provider have the capacity to support high-quality implementation. For service providers, this likely means having a proven track record with the intervention the adaptation is based on, as well as bringing training and coaching, leadership involvement, performance management, and fidelity monitoring to ensure high-quality and responsive implementation. When providers demonstrate this capacity, partners in the initiative will be confident that course correction can be done quickly and effectively, should the adaptation appear less successful than hoped.

Discussion and Conclusion

When scaling out an intervention, partner organizations are asked to take a chance on an adaptation with no—or limited—evidence of effectiveness. Given the perceived risk of trying something new, the mere existence of a program based on a well-established intervention may not offer partners sufficient confidence that the risk is worth the potential benefits. Some factors that can contribute to increased buy-in among potential stakeholders include evidence that the intervention will fill a gap in existing services, a service provider with a track record of high-quality implementation of similar interventions, and existing trusted relationships with one or more partners.

As an additional consideration for child welfare agencies, the Family First Prevention Services Act (FFPSA) was passed in 2018, after this project started. Under the Family First Act, child welfare agencies can use federal funds to finance prevention services, as long as those services meet the rigorous evidence criteria outlined in the act (McKlindon, 2019). While this legislation makes it easier for child welfare agencies to fund critical prevention services, its passage has also highlighted the dearth of rigorously evaluated programs that aim to prevent children from entering foster care. Under the current evidence requirements, child welfare agencies would not be able to leverage federal funds to implement and evaluate adaptations such as MST-EA until they have been rigorously evaluated.

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