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A Mixed Methods Multiple Case Study of Implementation as Usual in Children's Social Service Organizations

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ABSTRACT OF THE DISSERTATION

A Mixed Methods Multiple Case Study of Implementation as Usual in Children's Social Service Organizations

by

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Professor Enola Proctor, Chair

Increasing the adoption and sustainment of evidence-based treatments (EBTs) in children's mental health and social service systems will require the development of evidence-based implementation strategies. In order to ensure that these strategies are feasible, acceptable, sustainable, and scalable, efforts to identify and develop implementation strategies will need to be grounded by a thorough understanding of real world service systems as well as organizational stakeholders' preferences for particular strategies. In other words, there is a need for a better understanding of usual care settings, and in particular, what constitutes "implementation as usual."

This study employed a mixed methods, multiple-case study of six organizations that provide social and mental health services to children and youth in a Midwestern city to describe the state of implementation as usual in children's social services, evaluate the extent to which implementation as usual reflects emerging best practices specified in the implementation literature, and inform the future development of implementation strategies that will be practical and effective. The specific aims of this study were: (1) to identify and characterize the implementation strategies used; (2) to explore how organizational leaders make decisions about

which treatments and programs to implement and how to implement them; (3) to assess stakeholders' (organizational leaders and clinicians) perceptions of the effectiveness, comparative effectiveness, feasibility, and appropriateness of implementation strategies; and (4) to examine the relationship between organizational social context (culture and climate) and implementation strategy selection, implementation decision making, and perceptions of implementation strategies. These aims were accomplished through semi-structured interviews, focus groups, document review, an online survey of stakeholders' perceptions of implementation strategies, and a standardized measure of organizational social context.

Organizations considered a range of factors when making treatment and implementation decisions. While some considered empirical evidence to make decisions about which treatments to implement, they rarely considered empirical evidence when considering how to implement interventions. Across organizations, provider-focused strategies (e.g., training, supervision) were dominant; however, many of these strategies were not offered at the frequency and intensity that is generally required to implement EBTs effectively. Multiple areas of implementation were not well addressed, including process, client, organizational, financial, and policy levels. Several problematic trends related to strategy use were identified, such as the inconsistent provision of training and supervision, monitoring fidelity in ways not thought to be helpful, and failing to measure or appropriately utilize clinical outcome data. Stakeholders generally perceived active implementation strategies to be more effective than passive strategies, and did not respond well to strategies that were punitive in nature. Findings demonstrate how organizational social context can impact implementation processes and stakeholders' perceptions of the effectiveness of implementation strategies. Important implications for practice, policy and research were derived.

Chapter 1: Specific Aims

Children in the U.S. continue to receive substandard mental health and child welfare services (Garland, Brookman-Frazee, et al., 2010; Kohl, Schurer, & Bellamy, 2009; Raghavan, Inoue, Ettner, & Hamilton, 2010; Zima et al., 2005), largely because we do not understand *how* to effectively integrate evidence-based treatments (EBTs; Burns, 2003; Kazdin & Whitley, 2006; Substance Abuse and Mental Health Services Administration, 2012; The California Evidence-Based Clearinghouse for Child Welfare, 2014; Weisz, Hawley, & Doss, 2004; Weisz, Jensen-Doss, & Hawley, 2006) into "real world" service settings. Evidence-based treatments are seldom implemented, and when they are, problems with implementation can diminish their impact. For instance, a review of nearly 500 studies in health, behavioral health, and education indicated that programs that were carefully implemented obtained effect sizes that were at least two to three times higher than programs that were plagued by serious implementation problems (Durlak & DuPre, 2008). To improve the quality of care for children, EBTs should be complemented by evidence-based approaches to implementation (Grol & Grimshaw, 1999). Thus, the National Institutes of Health (NIH) and the Institute of Medicine (IOM) have prioritized efforts to identify, develop, refine, and test implementation strategies (Institute of Medicine, 2007, 2009a, 2009b; National Institute of Mental Health, 2008; National Institutes of Health, 2009; Zerhouni & Alving, 2006), which are defined as "methods or techniques used to enhance the adoption, implementation, and sustainability of a clinical program or practice" (Proctor, Powell, & McMillen, 2013; e.g., training, supervision, audit and feedback, opinion leaders). This research is also consistent with the fourth objective of the National Institute of Mental Health's (NIMH) Strategic Plan to increase the public health impact of federally funded research (Insel, 2009; National Institute of Mental Health, 2008), and the priorities of several

federal agencies and private foundations such as the Agency for Healthcare Research and Quality (2012), the U.S. Department of Veterans Affairs (Stetler, McQueen, Demakis, & Mittman, 2008), the Doris Duke Charitable Foundation (2010), the Robert Wood Johnson Foundation (2012), and the William T. Grant Foundation (2012).

To successfully integrate EBTs, implementation strategies will not only need to be effective, but also *feasible* (able to be successfully used or carried out within a given agency), *acceptable* (agreeable, palatable, or satisfactory), *sustainable* (able to be maintained or institutionalized within the setting's ongoing, stable operations), and *scalable* (able to be broadly implemented in other settings) from the perspectives of implementation stakeholders such as organizational leaders and clinicians (Mittman, 2012; Proctor & Brownson, 2012; Proctor et al., 2011). Thus, it is imperative that efforts to identify and develop implementation strategies be grounded by a thorough understanding of real world service systems as well as organizational stakeholders' preferences. Hoagwood and Kolko (2009) warn that "it is difficult and perhaps foolhardy to try to improve what you don't understand" (p. 35), and note that program implementers and services researchers are often unable to anticipate implementation challenges largely because the context of service delivery has not been elucidated, operationalized, and deconstructed. In other words, there is a need for a better understanding of usual care settings, and in particular, what constitutes "implementation as usual." At present, very little is known about the implementation processes that occur in usual care (Garland, Bickman, & Chorpita, 2010; Hoagwood & Kolko, 2009; Schoenwald et al., 2008). This highlights the need for descriptive studies that define the range and context of current implementation processes in relation to what is known about "best implementation practice" (Fixsen, Blase, Naoom, & Wallace, 2005), which (for the purpose of this study) is characterized

as the planned use of multiple strategies to address barriers to change at various levels (Damschroder et al., 2009; Grol & Wensing, 2005; Solberg, 2000; Solberg et al., 2000).

Garland and colleagues (2010) acknowledge that "studies that 'simply' characterize existing practice may not be perceived as innovative or exciting compared to studies that test new innovations" (p. 16). However, these studies are "a necessary complement—if not precursor"—to studies that will strengthen knowledge on the implementation of EBTs (Hoagwood & Kolko, 2009, p. 35). Indeed, an increased understanding of implementation as usual will afford the opportunity to build upon implementation successes, address critical areas for improvement, and ensure that developed strategies will be feasible, acceptable, sustainable, and scalable in real world systems of care (Hoagwood & Kolko, 2009; Mittman, 2010). The value of learning more about usual care can be illustrated by Garland and colleagues' (2010) study of therapeutic services in community mental health clinics in which the investigators sought to determine whether the strategies and techniques that therapists used to treat children and their families were consistent with the common elements of EBTs for children with disruptive behavior problems (Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008). The study demonstrated that while some therapeutic strategies were used frequently, more directive strategies that are often found in EBTs (e.g., the use of homework, role playing, and modeling) were used infrequently. Furthermore, they found that all of the strategies (on average) were not used with the intensity that evidence-based treatment protocols would call for, "reflecting great breadth but not depth in therapeutic approaches" (Garland, Brookman-Frazee, et al., 2010, p. 792). The study provides concrete targets for improvement based upon what actually occurs in usual care. In a similar fashion, studies of implementation as usual have the potential to identify leverage points for implementation, specify targets for improvement, and generate useful

insights into the types of implementation processes that are likely to be successful in the real world.

This study used a mixed methods, multiple-case study design (Stake, 2005; Yin, 2009) within the context of the control group of an NIMH-funded randomized controlled trial (Glisson & Proctor, 2009). The sample was comprised of six organizations that provide social and mental health services to children and youth in the St. Louis, Missouri area. This afforded a unique opportunity to study implementation as usual. In particular, this study examined implementation strategy patterns, treatment and implementation decision making, organizational stakeholders' perceptions of implementation strategies, and organizational social contexts (i.e., cultures and climates) in order to describe the state of implementation as usual in children's social services, evaluate the extent to which implementation as usual reflects emerging "best practices" specified in the implementation literature, and inform the future development of implementation strategies that will be practical and effective in children's social service settings.

The specific aims were as follows:

Aim 1: To identify and characterize the implementation strategies used in community-based children's social service settings

Aim 2: To explore *how* organizational leaders make decisions about which treatments and programs to implement and *how* to implement them

Aim 3: To assess stakeholders' (organizational leaders and clinicians) perceptions of the effectiveness, comparative effectiveness, feasibility, and appropriateness of implementation strategies

Aim 4: To examine the relationship between organizational context (culture and climate) and implementation strategy selection, implementation decision making, and perceptions of implementation strategies

Aim 1 relied upon *semi-structured interviews* with organizational leaders (management and clinical directors) and *document review* to yield rich descriptions of the implementation strategies employed by six agencies. These data were compared to "best practices" in implementation derived from existing theoretical and empirical work (Beidas & Kendall, 2010; Grol, Wensing, & Eccles, 2005; Grol & Wensing, 2005; Herschell, Kolko, Baumann, & Davis, 2010; Straus, Tetroe, & Graham, 2009b) to inform future work developing strategies in areas that are currently poorly addressed. It will also allow researchers and administrators to build upon "practice-based evidence" and the strengths of "positive deviants" (i.e., organizations that are consistently effective in implementing change despite a myriad of implementation barriers; Bradley et al., 2009; Pascale, Sternin, & Sternin, 2010).

Aim 2 also used *semi-structured interviews* with organizational leaders and *document review* to generate new knowledge about *how* agency leaders use evidence and other sources of information to make decisions about implementation. Learning more about the type of information that organizational leaders seek, the sources they look to for that information, and the conditions under which they seek that information may inform efforts to ensure that implementation decision making is based upon the best available theoretical and empirical knowledge in the field. Moreover, querying organizational leaders about how they make decisions will likely uncover a number of ways in which the current knowledge base for implementation is inadequate and ill-suited to their needs, informing future work on the development of resources that will make implementation science findings more accessible.

Aim 3 utilized *focus groups* and an *online survey* to ensure that future work to develop and test implementation strategies will be informed by stakeholders' (organizational leaders and clinicians) perceptions about the types of strategies that are likely to be effective in the real world.

Organizational change can be viewed as a function of appropriate action (i.e., implementation strategies and processes) *and* receptive contexts (Ferlie, 2009). Two aspects of organizational context (culture and climate) have been linked to clinical and service system outcomes (Glisson, 2007; Glisson et al., 2010); however, the impact of organizational culture and climate on implementation processes is not well explored.

Aim 4 leveraged a *standardized measure of culture and climate* (Glisson, Landsverk, et al., 2008) to examine how organizational social context (culture and climate) impacts strategy selection, treatment implementation and decision making, and stakeholders' perceptions of implementation strategies.

Chapter 2: Background and Significance

The "Quality Chasm" in Children's Social Services

Mental health problems affect a staggering one in five children and youth each year (Department of Health Human Services, 1999; Merikangas, He, Brody, et al., 2010; Merikangas, He, Burstein, et al., 2010; Shaffer et al., 1996). Approximately one-third to one half of the children and youth with a mental disorder seek treatment (Merikangas et al., 2011; Merikangas, He, Brody, et al., 2010), and fortunately, effective treatments have been developed (Burns, 2003; Kazdin & Whitley, 2006; Substance Abuse and Mental Health Services Administration, 2012; The California Evidence-Based Clearinghouse for Child Welfare, 2014; Weisz et al., 2004, 2006). However, they are infrequently adopted in routine settings of care (Garland, Brookman-Frazee, et al., 2010; Kohl et al., 2009; Raghavan et al., 2010; Zima et al., 2005). Indeed, it can take an average of 17 years before even a small proportion of newly developed promising treatments are implemented in routine care (Balas & Boren, 2000). When EBTs are adopted, they are often implemented poorly, substantially reducing their effectiveness. A review of 542 studies found that mean effect sizes are at least two to three times higher when programs are carefully implemented and free from serious implementation problems (Durlak & DuPre, 2008). As Proctor and colleagues (2009) note, "the implementation gap prevents our nation from reaping the benefit of billions of U.S. tax dollars spent on research and, more important, prolongs the suffering of millions of Americans who live with mental health disorders" (p. 24).

The Emergence of Implementation Research

The implementation gap, deemed a "chasm" by the Institute of Medicine (2001, 2006), demonstrates the urgent need for EBTs to be complemented by evidence-based approaches to

implementation (Grol & Grimshaw, 1999). Implementation science has emerged as a promising means of building that evidence-base (Chambers, 2012). Implementation research is defined as "the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices, and hence to improve the quality (effectiveness, reliability, safety, appropriateness, equity, efficiency) of health care" (Eccles et al., 2009; Eccles & Mittman, 2006). It includes inquiries focusing on the influences on professional and organizational behavior (Eccles & Mittman, 2006), such as contextual factors like organizational culture and climate (Aarons, Horowitz, Dlugosz, & Ehrhart, 2012). Elsewhere, implementation has been defined as "the *use of strategies* (emphasis mine) to adopt and integrate evidence-based health interventions and change practice patterns within specific settings" (National Institutes of Health, 2009a). This definition highlights the active nature of implementation, and differentiates it from two related areas of research: *diffusion* and *dissemination* research.

Implementation Strategies

The field of IR is still considered a "young science" (Eccles et al., 2009; Proctor et al., 2009). While the health and mental health literatures describe many potentially promising implementation strategies (Powell et al., 2012), the evidence of their effectiveness remains imperfect (Grimshaw et al., 2006; Grol et al., 2005; Powell, Proctor, & Glass, 2011; Straus et al., 2009b). Most strategies deliver only modest effect sizes (Grimshaw et al., 2006), and are effective under some, but not all conditions (The Improved Clinical Effectiveness through Behavioural Research Group (ICEBeRG), 2006). Passive strategies, such as disseminating educational materials and continuing education courses, may be useful in increasing knowledge, but are generally not sufficient to change provider behavior (Beidas & Kendall, 2010; Davis & Davis, 2009; Herschell et al., 2009, 2010). Training approaches that incorporate ongoing

supervision and consultation can lead to therapist behavior change (Beidas & Kendall, 2010; Herschell et al., 2010), but it is increasingly recognized that strategies need to move beyond focusing solely on provider level factors such as knowledge and expertise (Flanagan, Ramanujam, & Doebbeling, 2009; Solberg et al., 2000; Wensing, Bosch, & Grol, 2009). Indeed, implementing EBTs with fidelity does not always improve outcomes (Weisz et al., 2012), suggesting that other barriers to quality service provision must also be addressed (Glisson et al., 2010). Implementation is a complex, multi-level process and existing theoretical and empirical work suggests that "best practices" in implementation would involve the planned use of multiple strategies to address barriers to change that can emerge at all levels of the implementation context (Aarons, Hurlburt, & Horwitz, 2011; Bero et al., 1998; Damschroder et al., 2009; Powell et al., 2012; Shortell, 2004; Solberg, 2000; Solberg et al., 2000; Wensing et al., 2009). A number of strategies that extend beyond the provider level exist (Powell et al., 2012); however, there are very few randomized studies that test the effectiveness of multi-level implementation strategies (ARC is one exception; Glisson et al., 2010, 2012; Glisson, Hemmelgarn, Green, & Williams, 2013). More research is needed to develop effective ways of tailoring strategies to target implementation barriers (Baker et al., 2010), and to develop innovative strategies that are efficient, cost-effective, and robust or readily adaptable (Mittman, 2010). Implementation scientists cannot develop these strategies "in a vacuum" (Hoagwood & Kolko, 2009); they must possess a thorough understanding of the service systems and organizational contexts in which these strategies will (hopefully) be adopted (Proctor & Rosen, 2008). This dissertation study contributes to the implementation science, mental health, and child welfare literatures by elucidating four elements of these service systems and organizational contexts that may play a large role in determining implementation, service

system, and clinical outcomes (Proctor et al., 2009): patterns of implementation strategy use, implementation decision making, perceptions of implementation strategies, and organizational social context.

Implementation Strategy Patterns

Data pertaining to basic contextual elements such as organizational operations, staffing patterns, and electronic technologies for tracking service visits in usual care settings are limited (Hoagwood & Kolko, 2009). Even less is known about implementation strategy patterns in children's mental health. One exception is Schoenwald and colleagues' (2008) examination of organizations' use of training, supervision, and evaluation. Encouragingly, they found that training and supervisory practices were more or less "in line" with the typical procedures in an effectiveness trial. However, there has yet to be a study that maps a fuller range of potential implementation strategies (Powell et al., 2012). Thus, very little is known about the types of strategies employed, the frequency and intensity at which they are used, and the conceptual domains and levels of the implementation context that they target. Descriptive studies that compare "implementation as usual" to best-practices in implementation (Fixsen, Blase, et al., 2005) would reveal areas in which implementation processes could be improved and could reveal "positive deviants" (Bradley et al., 2009; Pascale et al., 2010) who have used innovative strategies to successfully implement change in challenging environments. This dissertation study identified and characterized the implementation strategies used in six children's social service organizations and compared them to "best practices" as identified in the empirical and conceptual literature (Aim 1).

The Importance of Organizational Decision Making Related to Implementation Processes

Organizational leaders face tremendous challenges when it comes to determining which treatments will be implemented in their settings and *how* they will be implemented. As Ferlie (2009) notes, "implementation process is often emergent, uncertain, and affected by the local context and features of action" (p. 148). It would be ideal if organizational leaders would base their decisions upon the latest theoretical and empirical findings;[1] however, little is written about how organizational leaders approach implementation decision making. In particular, we need to know more about how organizational leaders use research related to management and implementation, and the conditions under which they may be more likely to use research (Ferlie, 2009). Furthermore, there is a need for more insight into the *types* (e.g., summaries of implementation barriers and facilitators, reviews of implementation strategies), *formats* (e.g., statistical or narrative summaries), and *sources* (e.g., academics, peers from other organizations) of information that organizational leaders find most valuable when making decisions about how to implement EBTs. This dissertation study generated these data by asking organizational leaders to reflect upon the process of making decisions pertaining to implementation and examining documents that contain information about organizational decision making processes (Aim 2). The knowledge gained has the potential to advance implementation science and practice by documenting organizational leaders' priorities and constraints and highlighting the ways in which the growing body of implementation research could be made more accessible to them. This knowledge may also be directly relevant to those who wish to develop decision aids that could facilitate the identification, selection, and tailoring of implementation strategies.

[1] Admittedly, evidence has a shelf life, and should periodically be assessed to ensure that it remains valid. Shebelle et al. (2001) cite changes in evidence, the values placed on evidence, the resources available for health care, and improvements in current performance as possible reasons for updating clinical practice guidelines.

Implementation Strategies Need to Be Acceptable, Feasible, Scalable, and Sustainable

The characteristics of interventions may play a large role in determining whether or not they are adopted and sustained in the real world (Damschroder et al., 2009; Grol, Bosch, Hulscher, Eccles, & Wensing, 2007; Rogers, 2003). Much of what we know about the impact of the characteristics of interventions is based upon theory rather than empirical research (Grol et al., 2007). Rogers' Diffusion of Innovations theory specified that innovations would not likely be adopted unless they were 1) superior to treatment as usual, 2) compatible with agency practices, 3) no more complex than existing services, 4) easy to try (and reject if it fails), and 5) likely to produce tangible results recognizable by authorities (Fraser, Richman, Galinsky, & Day, 2009; Rogers, 2003). Other potentially influential characteristics of interventions specified in theoretical models include the intervention source (i.e., the legitimacy of the source and whether it was internally or externally developed), evidence strength and quality, adaptability, design quality and packaging, and costs (Damschroder et al., 2009).

Some of these characteristics have been verified as influential through empirical research. Findings from the National Evidence-Based Practice Project in which five EBTs were implemented in multiple states suggested that some EBTs were easier to implement with fidelity than others due to variations in complexity between the different treatments (Bond, Drake, McHugo, Rapp, & Whitley, 2009). For instance, supported employment and assertive community treatment were easier to implement with fidelity because fidelity measures specified how many services should be provided, where they are provided, and to some degree how they are provided, while the clinical aspects of the practices were not emphasized. Conversely, integrated dual disorders treatment, illness management and recovery, and family psychoeducation had a much stronger representation of clinical elements on fidelity scales and

were generally viewed as more complex to implement (Bond et al., 2009). A pilot study focusing on the implementation of functional family therapy in New York State used clinician interviews to explore implementation barriers and facilitators (Zazzali et al., 2008). Many clinicians expressed concerns related to the characteristics of the intervention such as their perception of the fit between the organizational context and characteristics of the EBT, concerns about adaptability (the treatment was perceived by some as too rigid to meet their clients needs), and complexity (the intervention required more paperwork). Grol and colleagues (2007) cite research in health care settings demonstrating that recommendations that were easy to try and reject if they did not work were associated with higher compliance (Grilli & Lomas, 1994), and that compliance rates with guidelines were higher when they were based on evidence and were compatible with existing values, explicitly defined the desired performance, did not require new knowledge or skills, and had limited consequences for management (Burgers et al., 2003; Foy et al., 2002; Grol et al., 1998).

While these characteristics are often considered in relation to clinical interventions, they also readily apply to implementation strategies. Utilizing a web-based survey and a series of focus groups, this dissertation study generated rich descriptive data pertaining to organizational stakeholders' perceptions of the effectiveness, relative importance, acceptability, feasibility, and appropriateness of implementation strategies (Aim 3). This will help to ensure that future work developing and testing implementation strategies in children's social service settings will yield strategies that will be likely to "fly" in the real world.

How Do Organizational Culture and Climate Affect Implementation Processes?

The conceptual and empirical literature have underscored the importance of the organizational factors such as *culture* and *climate* in facilitating or impeding the uptake of

innovations (Aarons, Horowitz, et al., 2012; Aarons et al., 2011; Damschroder et al., 2009; Glisson, Landsverk, et al., 2008; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). Glisson and colleagues (2008) acknowledge that organizational social contexts impact stakeholders' expectations, perceptions, and attitudes in ways that may "encourage or inhibit the adoption of best practices, strengthen or weaken fidelity to established protocols, support or attenuate positive relationships between service providers and consumers, and increase or decrease the availability, responsiveness, or continuity of services provided…" (p. 99).

Organizational culture is what makes an organization unique from others, including its core values and its organizational history of adapting with successes and failures (Aarons, Horowitz, et al., 2012). It involves not only values and patterns related to products and services, but also how individuals within an organization treat and interact with one another (Aarons, Horowitz, et al., 2012). Glisson and colleagues (2008) write, "Culture describes how the work is done in the organization and is measured as the behavioral expectations reported by members of the organization. These expectations guide the way work is approached and socialize new employees in the priorities of the organization" (p. 100). Thus, culture is passed on to new employees and is conceptualized as a rather stable construct that is difficult to change. Both Glisson et al. (2008) and Aarons et al. (2012) emphasize the "layered" nature of culture. It includes outer layers that represent behavioral expectations and other more readily identifiable artifacts such as style of dress and characteristics of the physical layout of the organization, as well as inner layers comprised of more subjective organizational values and tacit knowledge that employees unconsciously possess (Grol et al., 2007). *Organizational climate* pertains to employees' perceptions of what goes on in the workplace, and is formed when employees have

shared perceptions of the psychological impact of their work environment on their well-being and functioning in the organization (Glisson, Landsverk, et al., 2008).

More constructive or positive organizational cultures and climates are associated with more positive staff morale (Glisson, 2007), reduced staff turnover (Glisson, Schoenwald, et al., 2008), increased access to mental health care (Glisson & Green, 2006), improved service quality and outcomes (Glisson & Hemmelgarn, 1998; Glisson, 2007), greater sustainability of new programs (Glisson, Schoenwald, et al., 2008), and more positive attitudes toward EBTs (Aarons & Sawitzky, 2006). Yet, it is less clear how culture and climate relate to implementation processes. Knowing more about this relationship would inform efforts to facilitate organizational change; thus, Aim 4 of this dissertation study examined strategy patterns (Aim 1), implementation decision making (Aim 2), and stakeholders' perceptions of strategies (Aim 3) in relation to organizations' Organizational Social Context (OSC) profiles (Glisson, Landsverk, et al., 2008) and their qualitative reflections of organizational social context. It was hypothesized that organizations with more positive social contexts will utilize a greater number of implementation strategies and have more coherent, well-planned, and formalized implementation plans.

Summary

Improving the quality of children's social services will require "making the right thing to do, the easy thing to do" (Clancy & Slutsky, 2007, p. 747) by providing organizational leaders and clinicians with the tools they need to provide evidence-based care. In order for this to be accomplished, there is much we need to know about the approaches to implementation that routinely occur, the "on the ground" perspectives of organizational stakeholders regarding the types of implementation strategies that are likely to work, and the ways in which

organizational context impacts implementation processes. By shedding light on "implementation as usual," this study informs efforts to develop and tailor strategies, propelling the field toward the ideal of evidence-based implementation.

Chapter 3: Conceptual Frameworks

This study was informed by three conceptual frameworks: the consolidated framework for implementation research (CFIR; Damschroder et al., 2009), Grol and Wensing's (2005) implementation of change model, and an adaptation of the implementation of change model that more succinctly represents the study aims. The CFIR was chosen because it represents the breadth of potential targets for implementation strategies, effectively shining a light on all of the "corners" in which potential implementation strategies might be found. Grol and Wensing's (2005) model was selected to highlight the structure of implementation processes (from the identification of gaps in care to the evaluation of implementation efforts), to inform the development of the interview guide that will inform Aims 1 and 2, and to represent the planned, deliberate aspects of implementation "best practice." Finally, the modified version of Grol and Wensing's (2005) model was used to depict the aims of the study conceptually. All three of the models are visually represented and described below in order to give a full rendering of their utility to the project.

Consolidated Framework for Implementation Research

The CFIR (Figure 1) was developed for the purpose of serving as a common reference to the many constructs that have been identified as important to implementation success in the published literature (Damschroder et al., 2009). It represents a synthesis of 19 different conceptual models, and identifies five major domains related to implementation, including: 1) intervention characteristics, 2) the outer setting, 3) the inner setting, 4) the characteristics of the individuals involved, and 5) the process of implementation (Damschroder et al., 2009). The CFIR captures the complex, multi-level nature of implementation, and suggests that successful

implementation may necessitate the use of an array of strategies that target multiple levels of the implementation context (Powell et al., 2012).

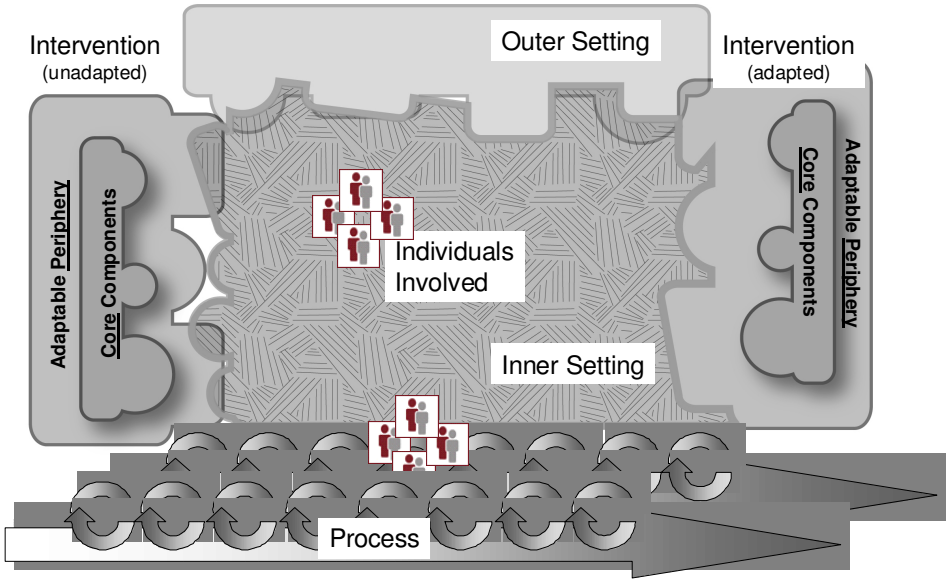

Figure 1. The Consolidated Framework for Implementation Research (Damschroder et al., 2009)

The CFIR has been used to guide a review seeking to identify the range of implementation strategies that have been reported in health and mental health literature (Powell et al., 2012), and it has also been used to categorize implementation strategies based upon the theoretical domains that they target (Powell, Proctor, & Glass, 2014; Williams et al., 2011). In the present study, the implementation strategy patterns identified within each organization were examined in relation to the domains of the CFIR in order to gain a better understanding of how comprehensively they are addressing multiple-levels of the implementation context and to identify areas in which there may be need to develop innovative implementation strategies. Each of the major domains of the CFIR is described below, though definitions of each domain and subdomain can be found at http://www.implementationscience.com/content/supplementary/1748-5908-4-50-s3.pdf.

Characteristics of the intervention. Several sub-domains are listed under characteristics of the intervention. The source of the intervention and the extent to which the intervention was externally or internally developed is important, as "buy in" may be easier to obtain if an intervention was internally developed. Additionally, the source of the intervention speaks to the credibility of the innovation, and can also be thought to influence "buy in." The authors draw upon Rogers' (2003) work, as they cite the strength of evidentiary support, the relative advantage, adaptability (degree to which the intervention can be altered to suit local needs), trialability, and complexity as intervention characteristics that can make or break an implementation effort. Finally, Damschroder et al. (2009) cite the importance of the perception of the design and quality of the intervention and the cost of the intervention. It is worth noting again that although the "characteristics of the intervention" generally applies to the clinical intervention, these principles can easily be leveraged when considering implementation strategies (i.e., the implementation interventions).

The outer setting. The outer setting consists of four sub-domains, including: 1) patient needs and resources, 2) cosmopolitanism, 3) peer pressure, and 4) external policy & incentives (Damschroder et al., 2009). First, an organization must be aware of patient need and make it a priority before the organizational motivation to implement an intervention can arise. Cosmopolitanism is defined as the extent to which an organization is networked with other external agencies. Certainly, connectedness with other organizations can open up opportunities to hear about novel treatment approaches and can provide needed guidance and support at all stages of the implementation process. Similarly, inter-organizational connectedness may also increase the probability that peer pressure may play a role in encouraging adoption of an innovation, either in a bid to gain a competitive advantage (Proctor et al., 2007) or to keep up

with peer organizations who have already adopted. Finally, external policies and initiatives is a broad domain that includes external strategies to spread an innovation, such as external mandates, pay-for-performance schemes, and public performance benchmarking (to name a few; Damschroder et al., 2009).

The inner setting. The inner setting is focused on the characteristics of the organization, including 1) structural characteristics, 2) networks and communications, 3) culture, 4) implementation climate, and 5) readiness for implementation. Structural characteristics include the social architecture, age, maturity, and size of the organization. Networks and communications are concerned with the nature and quality of formal and informal communications within an organization. Culture essentially speaks to the norms, values and basic assumptions of a given agency, or how things are generally done (Glisson & James, 2002; see Glisson, Landsverk, et al., 2008). Climate refers to the "absorptive capacity for change, shared receptivity of involved individuals…and the extent to which use of that intervention will be rewarded, supported, and expected within their organization" (Damschroder et al., 2009, p. 1 [Additional File 3]). Readiness for implementation can be assessed through the examination of tangible indicators of readiness such as leadership engagement, the availability of resources, and access to the necessary knowledge and information about the intervention, how it works, and how to integrate it into the organization (Damschroder et al., 2009).

Characteristics of individuals. Individual characteristics such as 1) knowledge and beliefs about the intervention (including knowledge of alternative interventions), 2) self-efficacy, 3) individual stage of change, 4) individual identification with the organization, and 5) "other personal attributes" (including tolerance of ambiguity, intellectual ability, motivation, values, competency, capacity, and learning style) are included in this domain. While not

explicitly mentioned in the model, risk tolerance (Pines & Szyld, 2007; Tubbs, Broeckel Elrod, & Flum, 2006) and cognitive biases (Croskerry, 2005; Sanhu & Carpenter, 2006) are also important characteristics of the individuals that could be targeted by implementation strategies.

Process. The process domain is perhaps the most explicitly related to implementation strategies. Damschroder et al. (2009) identify four key process elements in implementation, including: 1) planning, 2) engaging, 3) executing, and 4) reflecting and evaluating. Thorough planning is obviously imperative to implementation success, and thus requires little explanation. Engagement involves the process by which individuals that are paramount to implementation success are recruited through social marketing, education, role modeling, training, etc. This includes the engagement of opinion leaders (Carpenter & Sherbino, 2010; Flodgren et al., 2011), formally appointed internal implementation leaders, champions, and external change agents. Lastly, executing the implementation according the plan must be followed up with qualitative and quantitative feedback about the implementation process, including regular personal and team debriefing about progress and experiences (Damschroder et al., 2009).

Summary. The scope of the CFIR makes it the ideal model to frame this study. Its breadth compels researchers to examine implementation strategies in a holistic manner, rather than focusing narrowly on very commonly used implementation strategies such as training and educational materials (Beidas & Kendall, 2010; Farmer et al., 2011; Forsetlund et al., 2009; Herschell et al., 2010; O'Brien et al., 2007; Rakovshik & McManus, 2010). As Powell and colleagues (2012) note, "each mutable aspect of the implementation context that the CFIR highlights is potentially amenable to the application of targeted and tailored implementation strategies" (p. 130). This author used the domains of the CFIR to: 1) probe more deeply into organizations' uses of specific implementation strategies (see "Semi-Structured Interview

Guide" in Appendix C), and 2) to assess the comprehensiveness of organizations' approaches to implementation. For example, an organization that focused only on the "characteristics of individuals" while neglecting other domains such as "intervention characteristics" or the "inner setting" was conceptualized as having a less comprehensive approach to implementation than an organization that addressed all three (or more) of those domains.

Implementation of Change Model

Grol and Wensing's (2005) implementation of change model (Figure 2) informed this research by specifying a process of implementation that begins with identifying problems or gaps in care, identifying ESTs or other best-practices, carefully planning the implementation effort, developing a proposal with targets for improvement or change, analyzing current performance, developing implementation strategies, executing the implementation plan, and continuously evaluating and (if necessary) adapting the plan. The model was particularly useful for this research, as it provided a structure and a process to implementation that the CFIR lacks. It informed the development of the interview guide, and facilitated the process of obtaining organizations' implementation stories in relation to Aim 1 (what type of implementation strategies they employ) and Aim 2 (how they make decisions about *what* to implement and *how* to implement it). Specifically, questions were asked about how organizations decide to implement particular programs and practices, how they plan for implementation and select implementation strategies, the strategies they select, and to some extent how they evaluate the effectiveness of those strategies (i.e., through questions about the perceived effectiveness of strategies). The intent was to get participants to talk about these different steps of the implementation process and give them the opportunity to identify a wider range of implementation strategies that are less often emphasized in the literature, which typically

reduces the implementation strategies to a small number that are frequently used and tested (e.g., training, audit and feedback, reminders). For instance, a number of implementation strategies might focus on planning for implementation, such as conducting local needs assessments, surveying the non-research clinical community to more accurately define "best evidence," assessing readiness for change and identifying potential barriers, conducting local consensus discussions, and developing academic partnerships (for more strategies focused on planning, see Powell et al., 2012).

The implementation of change model is only one of many that map the process from knowledge generation to implementation (for another example, see Graham et al., 2006); thus, there was no assumption that organizations that did not follow the exact processes described in the model were diverging from "best practice." However, the model did inform the study by emphasizing an important aspect of implementation "best practice," namely, that while implementation processes may be complex, necessitating iterative and flexible approaches (Aarons & Palinkas, 2007; Pressman & Wildavsky, 1984), they should be planned and deliberate rather than haphazard. Grol and Wensing (2005) emphasize, "a systematic approach to and good planning of implementation activities is needed most of the time" (p. 42). Ultimately, it may be more important that an organization has a standard road map to guide implementation efforts than it is for them to follow any specific framework (Boaden, Harvey, Moxham, & Proudlove, 2008).

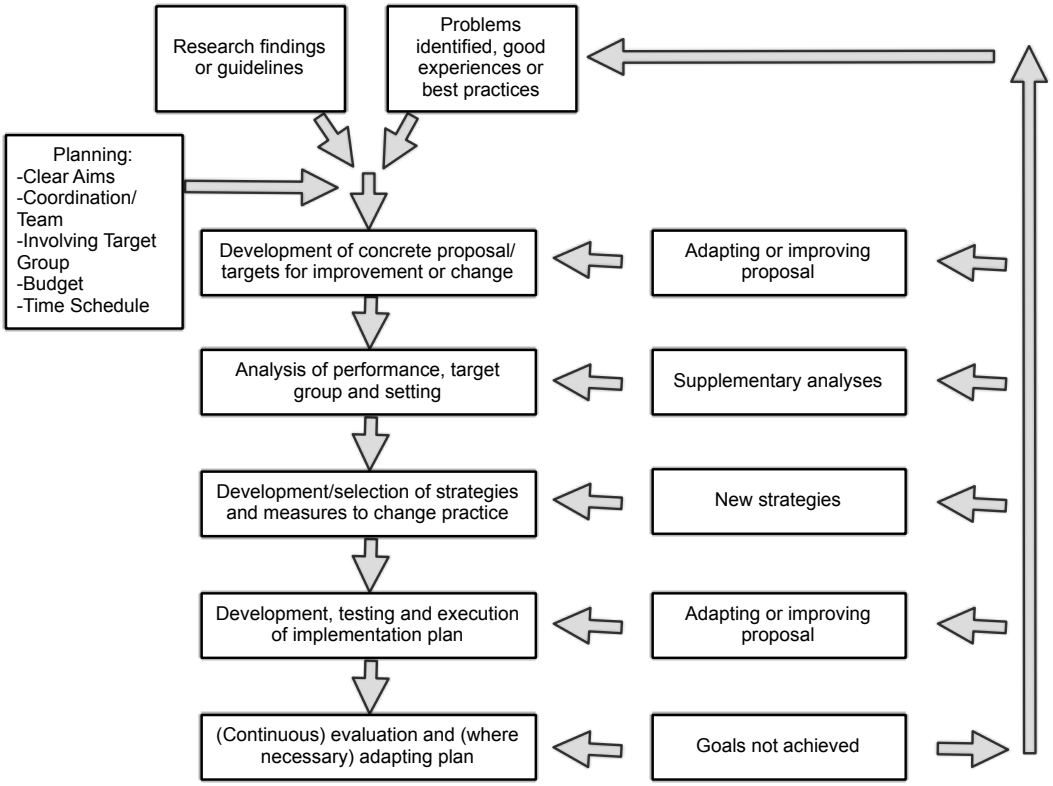

Figure 2. Implementation of Change Model (Grol & Wensing, 2005)

Project-Specific Conceptual Model

A project-specific adaptation of Grol and Wensing's (2005) model (Figure 3) succinctly depicts the aims of this study in relation to the overarching implementation process. Aim 2 examined beginning phases of the implementation process by focusing on both treatment and implementation decision making in order to understand *how* organizational leaders selected between different programs and practices, and subsequently, *how* they attempted to implement them. Aims 1 and 3 both focused on identifying the types of implementation strategies used as well as stakeholder perceptions of a wide range of implementation strategies. Finally, organizational social context (i.e., culture and climate) was depicted as influencing treatment decision making, implementation decision making, and the implementation strategies used in each organization, as Aim 4 assessed how organizational culture and climate relate to the

processes uncovered in Aims 1 – 3. The domains of the CFIR are not explicitly represented in this model, because the purpose of using the CFIR was to characterize the strategies used by participating organizations according to their conceptual targets (i.e., elements of the outer- and inner setting, characteristics of the individuals involved, characteristics of the intervention, and the process of implementation) after they were identified in Aims 1 and 2.

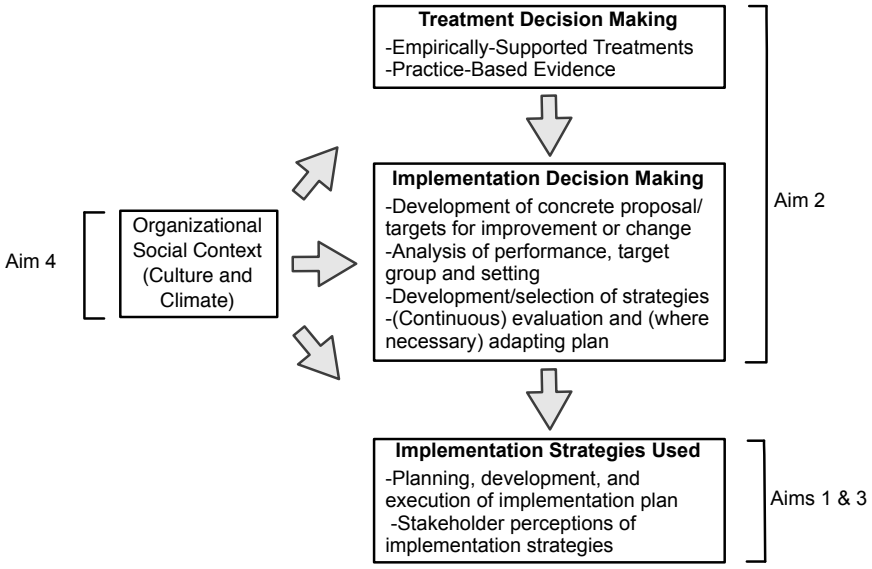

Figure 3. Project-Specific Conceptual Model (Adapted from Grol & Wensing, 2005)

Summary

The three guiding conceptual models were integrated in all stages of the research process, including *conceptualization* (e.g., selecting implementation processes on which to focus), *data collection* (e.g., using components of the conceptual models as interview questions and probes), *analysis* (e.g., determining how comprehensively organizations are addressing constructs essential to implementation success, comparing "implementation as usual" to "best practices"), and *dissemination* (e.g., framing findings conceptually so that they will be comparable to other implementation studies). In addition to determining the extent to which "implementation as usual" compared to "best practices," it is hoped that this research provides

new insights into the constructs represented in the Damschroder et al. (2009) and Grol and Wensing (2005) models that can be of use in the refinement and testing of implementation theory.

Chapter 4: Methodology

Overview

This study employed a mixed methods multiple case study approach, in which each participating organization was conceptualized as a "case" (Stake, 2005; Yin, 2009). Case studies are particularly helpful in understanding the internal dynamics of change processes, and including multiple cases capitalizes on organizational variation and permits an examination of how contextual factors influence implementation (Wensing, Eccles, & Grol, 2005). Leaders in the field of implementation science have emphasized the importance of using case study and other mixed methods observational designs to develop a more nuanced, theoretically informed understanding of change processes (Aarons, Fettes, Sommerfeld, & Palinkas, 2012; Berwick, 2008; Eccles et al., 2009; Institute of Medicine, 2007; Landsverk, Brown, Rolls Reutz, Palinkas, & Horwitz, 2011; Palinkas, Aarons, et al., 2011), and leading journals have readily published this type of research (Eccles & Mittman, 2006; Palinkas, Horwitz, Chamberlain, Hurlburt, & Landsverk, 2011; Palinkas, Aarons, et al., 2011). This study relied upon the "sequential collection and analysis of qualitative and quantitative data, beginning with qualitative data, for the primary purpose of exploration and hypothesis generation" or a QUAL → quan approach (Palinkas, Aarons, et al., 2011). This served the primary function of *development*, as collecting qualitative data in Aims 1-3 afforded the opportunity to examine the impact of organizational context in Aim 4 (Palinkas, Aarons, et al., 2011). It served the secondary function of *convergence* by using quantitative and qualitative data to answer the same question in Aim 3 (Palinkas, Aarons, et al., 2011). Figure 4 depicts and overview of the mixed methods, multiple case study design.

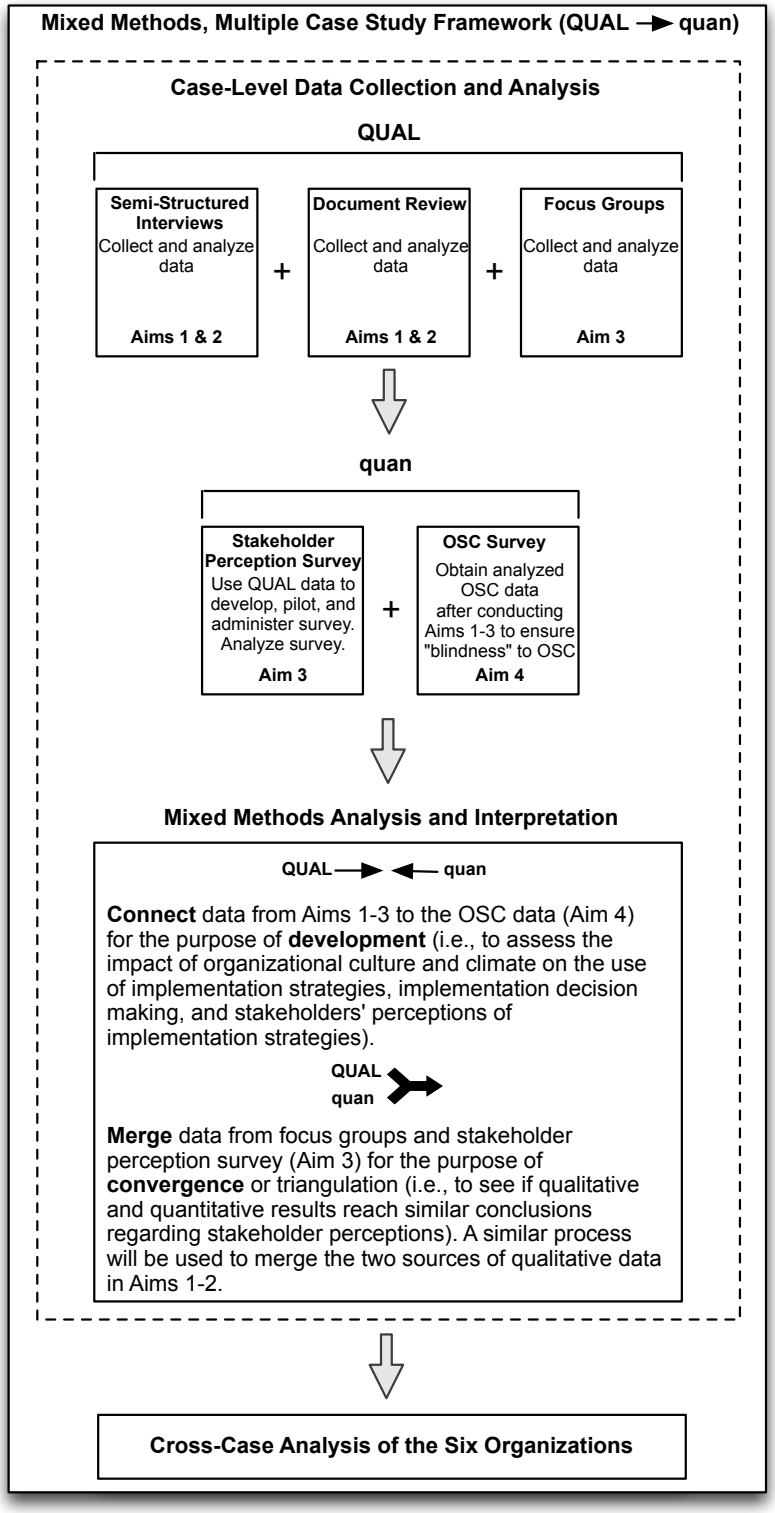

Figure 4. Overview of mixed methods, multiple case study design

Sample

This study was conducted in the control arm of a NIMH funded RCT (Glisson & Proctor, 2009) testing the effectiveness of the ARC organizational implementation strategy (Glisson et al., 2010, 2012, 2013). The R01 enrolled 14 organizations (7 intervention and 7 control) in the St. Louis area, and six of the seven organizations in the control group agreed to participate in this dissertation study. The organizations enrolled in the study reflected the characteristics of children's mental health service providers nationwide (Schoenwald et al., 2008) in that participating organizations were characterized by nonprofit organizational structures, therapists that had master's and bachelor's degrees, and a predominantly social work staff. Using a measure of organizational context that has been normed on a national sample ultimately helped determine the generalizability of study findings beyond the selected sites (Glisson, Landsverk, et al., 2008).

As anticipated, not all participating organizations were implementing EBTs; however, they were able to discuss strategies they have used to implement other clinical programs, services, or treatment models (Glisson, Schoenwald, et al., 2008). Thus, this author maintained an inclusive stance toward the types of programs and practices that organizations were implementing. This was warranted in part for pragmatic reasons (as cited above, not all organizations were implementing EBTs), but more importantly, because the primary scientific objective was to learn more about the *processes* and *contexts* of implementation rather than the particulars of implementing a specific EBT or class of EBTs.

While sampling logic *should not* be used in multiple-case study research (Small, 2009; Yin, 2009); six cases are sufficient to "replicate" findings across cases (Yin, 2009). Yin (2009) writes that each "case" (organization) is in essence treated as a separate study that either

predicts similar results (literal replication) *or* predicts contrasting results but for anticipatable reasons (theoretical replication). In the present study, organizations with the worst cultures and climates were expected to demonstrate similar implementation processes and perceptions of strategies (i.e., literal replication), whereas organizations with more positive cultures and climates were expected to embrace a much different set of implementation processes and perceptions of strategies (i.e., theoretical replication).

Conducting this dissertation project in the context of the control group offered four principal advantages: 1) it afforded a unique opportunity to capture implementation processes in usual care, 2) it maximized the use of federal funds and leveraged data on organizational context that were collected for the purpose of the ARC RCT, 3) it benefited the ARC RCT by illuminating strategy patterns in the control group which may aid in the interpretation of results, and similarly, 4) it avoided treating the control condition as a "black box" which is assumed to have no "action" related to treatment and implementation decisions and processes. The last point constitutes a considerable innovation over studies that focus solely on outcomes obtained by control groups thought to represent "usual care" without generating rich descriptions of what actually occurs in these settings.

Data Collection

This study relied upon qualitative data from *semi-structured interviews* (Aims 1 & 2), *document review* (Aims 1 & 2), and *focus groups* (Aim 3). Additionally, quantitative data from a project specific *survey* developed by this author (process described below) and the OSC (Glisson, Landsverk, et al., 2008) were used to accomplish Aims 3 and 4 respectively. A summary of methods and measures can be found in Table 1.

Table 1. Data Collection: Measures and Sources (QUAL ⇒ quan)

Conceptual Domains	Aims	Method or Measure	Measure Source	Data Source	Type of Data	Sample Size
Implementation strategies compared to "best practices"	Aim 1	Semi-structured Interview	Developed for Study	Managerial Staff	QUAL	27
		Document Review	Agency	Agency Documents	QUAL	39
Implementation decision making compared to "best practices"	Aim 2	Semi-structured Interview	Developed for Study	Managerial Staff	QUAL	27
		Document Review	Agency	Agency Documents	QUAL	39
Stakeholder perceptions regarding strategy characteristics	Aim 3 & Aim 1	Focus Groups	Developed for Study	Clinical Staff	QUAL	8 focus groups; 58 participants
		Survey	Developed for Study	Managerial & Frontline Staff	quan	52
Organizational context	Aim 4	Survey (Glisson et al., 2008)	Glisson & colleagues	Frontline Staff	quan	6 org. profiles; 77 participants

Qualitative Data Collection

Semi-structured interviews. Organizational leaders (e.g., management and clinical supervisors) from each participating organization were contacted and asked to participate in semi-structured interviews that explored the implementation strategies their agencies have employed within the past year (Aim 1) and their approach to treatment and implementation decision making (Aim 2). Through the process of snowball sampling (Marshall, 1996), each participant was asked to identify other employees who possess the requisite knowledge and experience to inform the study's objectives. It was estimated that each organization would identify between three and five key informants, resulting in approximately 18-30 total interviews. Many agencies may not have had more than this number of individuals who have direct knowledge of the use of implementation strategies (Golden, 1992), and more importantly,

the decision making processes surrounding implementation. Guest et al. (2006) cite a number of researchers who emphasize that very small samples can yield complete and accurate information as long as the respondents have the appropriate amount of expertise about the domain of inquiry. Further, a main benefit of the multiple case study design was obtaining different sources of information that were used to triangulate data from the interviews (Palinkas, Aarons, et al., 2011; Yin, 2009). Ultimately, 27 organizational leaders were interviewed across the six agencies (range = 3-6), and their demographic characteristics can be seen in Table 2.

Table 2. Demographic characteristics of leaders participating in semi-structured interviews (N = 27)

Characteristics	**N**	**%**
Female	23	85.2
Age (M±SD)	43.3±11.9	
Race – Ethnicity		
African American	3	11.1
Caucasian	23	85.2
Middle Eastern	1	3.7
Discipline		
Counseling	9	33.3
Psychology	4	14.8
Social Work	11	40.7
Other	3	11.1
Highest Degree Obtained		
Bachelor's	4	14.8
Master's	22	81.5
Doctoral	1	3.7
Years in Practice (M±SD)	17.9±11.1	
Years at Agency (M±SD)	9.5±9.3	
Full-Time	26	96.3

Interviews were conducted by this author and were structured by an interview guide (Appendix C) informed by a review of implementation strategies (Powell et al., 2012) and the guiding conceptual models (Damschroder et al., 2009; Grol & Wensing, 2005). Specifically, the interview guide contained questions and prompts that encouraged participants to consider the

implementation strategies that their organization had employed at multiple levels of the implementation context as specified by the CFIR (Damschroder et al., 2009) and the Powell et al. (Powell et al., 2012) taxonomy (e.g., whether or not their organization had used strategies related to the intervention, the policy or inter-organizational level, and the organization's structure and functioning in addition to more commonly considered individual-level and process-level strategies).

Interviews lasted approximately 60 to 90 minutes and were digitally recorded. Immediately following each interview, this author completed field notes that captured the main themes of the interview and any information that was pertinent to the study aims. Interviews and field notes were transcribed, and entered into NVivo Version 10 for data analysis. Participants were offered a modest incentive ($30.00) for participating in the interviews.

Document review. This study also involved a review of documents that had the potential to augment other sources of data pertaining to implementation processes. Potentially relevant documents included (but are not limited to) notes from a board meeting in which the implementation of a new program or practice was discussed, an organization's response to a request for proposals that seeks funding for a particular training or implementation related resource, annual reports, quality improvement plans, and program manuals. Though each organization was asked to provide relevant documents, this method of data collection proved to be relatively inconsistent as some organizations were unable or unwilling to share documentation related to implementation processes. In many cases this reflected an absence of such documents (e.g., most organizations did not have formal implementation plans). Nevertheless, agencies provided a total of 39 documents (range = 0 to 25), some of which proved useful as a means of augmenting and triangulating interview respondents' descriptions

of implementation strategies and decision making processes. For example, Agency A provided minutes from a meeting that detailed a process in which agency leaders identified implementation barriers and facilitators. That document served to triangulate semi-structured interview findings that detailed similar processes.

Focus groups interviews. Focus groups were conducted in each participating organization to capture the depth and nuance of frontline workers' perceptions of strategies. A total of 8 focus groups were conducted (one in Agency B, C, D, and E; two in Agency A and F), involving anywhere from four to ten frontline workers. The demographic characteristics of the 58 frontline workers who participated in the focus group interviews can be found in Table 3. The number of participants per focus group was largely consistent with Barbour's (2007) recommendation of a minimum of three or four participants and a maximum of eight. The number of focus groups (one to two per agency) was appropriate because of the relatively homogenous population (e.g., frontline workers at a given agency) and the structured and somewhat narrow scope of inquiry reduced the number of individuals needed to reach saturation (Guest et al., 2006). Further, the quantitative data served to triangulate the focus group data (Palinkas, Aarons, et al., 2011; Yin, 2009), reducing the need for a larger sample size. The focus groups were conducted by this author and took place at the participating organizations' offices. The focus group interviews were guided by a structured interview guide (Appendix C) informed by a conceptual taxonomy of implementation outcomes (Proctor et al., 2011). Although the primary purpose of the focus group interviews was to assess participants' perceptions of various implementation strategies, participants also had the opportunity to provide information about implementation strategies used at their organization that may not have been captured in the semi-structured interviews with organizational leaders. Each focus group lasted approximately

60-90 minutes and was digitally recorded. As with the individual interviews, this author completed field notes following the focus groups that documented the main themes of the session and any observations pertinent to the study aims. The interviews and the field notes were transcribed and entered into NVivo 10 for data management and analysis. Participation was entirely voluntary and clinicians were offered a modest incentive ($30.00).

Table 3. Demographic characteristics of frontline workers participating in focus groups (N=58)

Characteristics	**N**	**%**
Female	50	86.2
Age (M±SD)	37.0±12.0	
Race – Ethnicity		
African American	7	12.1
Caucasian	50	86.2
Hispanic/Latino	1	1.7
Discipline		
Counseling	20	34.5
Psychology	10	17.2
Social Work	19	32.8
Other	9	15.5
Highest Degree Obtained		
Associates	1	1.7
Bachelor's	7	12.1
Master's	47	81.0
Doctoral	3	5.2
Years in Practice (M±SD)	9.3±9.0	
Years at Agency (M±SD)	4.0±4.5	
Full-Time	26	82.8

Quantitative Survey Data

Implementation Strategy Use and Perceptions Survey. A project specific self-administered web-based survey was developed to assess organizations' use of implementation strategies as well as stakeholders' (organizational leaders' and clinicians/direct care staff members') perceptions and experiences with specific strategies (see Appendix C for the full survey).

The survey structure included an introduction that described the study and included all elements of informed consent, which was followed by a question allowing potential participants the chance to opt in or out of the study. The survey contained ten demographic questions (age, gender identity, highest degree, field of study of highest degree, race and ethnicity, years of paid experience in the social service sector, years employed at agency, current job title, and full or part-time status).

The demographic questions were followed by a section about implementation strategy use, which began with an open text-box about the specific programs and practices that they had experience implementing. Subsequently, 50 implementation strategies and definitions were presented, with each asking participants to respond either, "we have used this strategy at our organization" or "we have not used this strategy at our organization." The implementation strategies and definitions included in the survey were drawn from a published compilation of implementation strategies (Powell et al., 2012) that has subsequently been refined within the context of an ongoing study (Waltz et al., 2014). Each strategy included was vetted by a sample of implementation experts and clinical managers within the Department of Veterans Affairs (Waltz et al., 2014). Despite the difference in population (veterans vs. children), this process enhances our confidence in the face validity of the implementation strategy items. Though the refined compilation lists over 70 discrete strategies, the developed survey included only 50 in order to reduce response burden. Decisions about the inclusion of strategies were largely driven by the qualitative analysis (i.e., using the strategies mentioned by organizational leaders and clinicians, and excluding those that were never mentioned), while attempts were made to include strategies that address a number of different targets as specified in the CFIR (Damschroder et al., 2009). As an illustration, the Powell et al. (2012) compilation includes a

number of strategies that could not be reasonably adopted by the participants of this study (e.g., "start a purveyor organization," "centralize technical assistance"), and those strategies were eliminated.

After the respondents endorsed organizational use or non-use of the implementation strategies, they were asked about their perceptions of implementation strategies that their organization has used. Thus, if they only endorsed the use of ten implementation strategies, they would have ten additional questions that asked about their perceptions of those strategies. Each perception question contained four dimensions that clinicians were asked to rate on a five-point Likert scale (strongly disagree, disagree, neither agree nor disagree, agree, strongly agree). The dimensions included *effectiveness* ("This strategy was effective for our organization"), *relative effectiveness* ("This strategy was more effective than other strategies"), *feasibility* ("This strategy was feasible for our organization"), and *appropriateness* ("This strategy fit well with the way our organization operates"). These dimensions were informed by a conceptual taxonomy of implementation outcomes (Proctor et al., 2011) and emerging measurement models in implementation science (Cook et al., 2012). Originally, this author also intended to measure *acceptability* (i.e., How agreeable, palatable, or satisfactory is the strategy?); however, this construct was not included because stakeholders seemed to have difficulty understanding it during the semi-structured and focus group interviews. In particular, participants struggled to make fine distinctions between acceptability and appropriateness; thus, the latter was thought to be preferable for inclusion in the quantitative survey.

The survey was pilot tested to ensure face-validity and ease of use. It was then administered via email through the Qualtrics online survey platform. The target response rate was 50% of the staff at each agency, though the organizational literature indicates management

may be less responsive than clinical staff (Baruch & Holton, 2008). A $10.00 Amazon Credit was offered to respondents who completed the survey.

The survey was sent to 88 potential respondents, and 52 (21 organizational leaders and 31 frontline staff) responded and provided complete data for an effective response rate of 59%. Agency response rates were as follows: Agency A, 50% (8/16); Agency B, 50% (6/12); Agency C, 50% (5/10); Agency D, 70% (16/23); Agency E, 53% (8/15); and Agency F, 75% (9/12). Demographic characteristics for survey respondents can be seen in Table 4.

Table 4. Demographic characteristics of online survey participants (N= 52)

Characteristics	**N**	**%**
Female	43	82.7
Age (M±SD)	37.6±11.2	
Race – Ethnicity		
African American	2	3.8
Caucasian	48	92.3
Mexican	1	1.9
Middle Eastern	1	1.9
Discipline		
Counseling	17	32.7
Psychology	16	30.8
Social Work	12	23.1
Other	7	13.5
Highest Degree Obtained		
Bachelor's	7	13.5
Master's	44	84.6
Doctoral	1	1.9
Years in Practice (M±SD)	11.5±9.5	
Years at Agency (M±SD)	6.4±7.6	
Full-Time	48	92.3

Organizational Social Context (OSC) survey. The OSC measure (Appendix C) is a standardized measure that assesses organizational culture, climate, and work attitudes (which is not being used for the current study) using 105 Likert-style items. Culture is assessed in terms of its rigidity (centralization, formalization), proficiency (responsiveness, competence), and

resistance (apathy, suppression). The "best" organizational cultures are highly proficient and not very rigid or resistant, while the "worst" cultures are not very proficient and are highly rigid and resistant to change or new ideas. Climate is assessed with three second-order factors: engagement (personalization, personal accomplishment), functionality (growth and achievement, role clarity, cooperation), and stress (Glisson, Landsverk, et al., 2008). The "best" organizational climates are described as being highly engaged, highly functional, and low in stress (Glisson, Landsverk, et al., 2008). Cronbach's alphas for the OSC subscales (rigidity, proficiency, resistance, stress, engagement, functionality) range from .78 to .94. The OSC was administered (within the context of the parent study) to 77 frontline staff working in the six participating agencies. Supervisors and other organizational leaders were not present during the OSC administration. Response rates ranged from 69% to 94%, and the number of respondents per program ranged from 7 to 29. All data were collected between March and May of 2013.

Data Analysis

Qualitative Data Analysis

Overview. Qualitative data from semi-structured interviews, document review, and focus groups were imported and analyzed (separately) in NVivo using qualitative content analysis, which has been used successfully in similar studies (Forsner, Hansson, Brommels, Wistedt, & Forsell, 2010; Hysong, Best, & Pugh, 2007; Magnabosco, 2006). Content analysis enables a theory driven approach, and an examination of both manifest (i.e., the actual words used) and latent (i.e., the underlying meaning of the words) content (Bernard, 2011). Accordingly, the analyses were informed by the guiding conceptual models, with additional patterns, themes, and categories derived from the data (Bernard, 2011; Miles & Huberman, 1994). Much like with other approaches to qualitative research, data collection, analysis, and

interpretation occurred concurrently, as this researcher was immersed in these data from the start of data collection. However, it is useful to think of qualitative content analysis in three phases: immersion, reduction, and interpretation. The goal of each of these phases is to "create new knowledge from raw, unordered data. Content analysis requires looking at each case (e.g., participant, site, etc.) as a whole and breaking up and reorganizing these data to examine individual cases systemically, and compare and contrast data across cases" (Forman & Damschroder, 2008, pp. 46–47).

Immersion. The purpose of the immersion stage is to obtain a sense of "the whole" before rearranging it into smaller segments for analysis (Forman & Damschroder, 2008). A number of activities facilitated this process, including drafting the aforementioned field notes after each interview and focus group to record first impressions, comparisons to data collected previously, and analytic hunches (Forman & Damschroder, 2008). The author also listened to the audio recordings and read the transcripts several times in order to gain a better sense of these data. Initial thoughts on potential themes and relationships in these data were captured in memos that served as an audit trail throughout the analytic process (Forman & Damschroder, 2008; Padgett, 2012).

Data reduction. The purpose of the reduction phase is to break data into more manageable themes and thematic segments that can be reorganized into categories that address the study aims (Forman & Damschroder, 2008). Data reduction involved developing and applying a codebook to the interview transcripts to condense the data into analyzable units (text segments) that eventually were aggregated into broader themes related to implementation strategy patterns, implementation decision making, and stakeholders' perceptions of strategies. An initial version of the codebook was developed by drawing upon a priori themes drawn from

the guiding conceptual models (Damschroder et al., 2009; Grol & Wensing, 2005) and the interview questions. For example, the implementation of change model (Grol & Wensing, 2005) was used to develop a priori codes such as "treatment decision making" (i.e., identifying programs and practices) or "implementation decision making" (i.e., planning implementation strategies and processes). The CFIR (Damschroder et al., 2009) was used in a similar fashion by contributing a priori codes that served to distinguish different types of implementation strategies, such as strategies that focus on the "inner setting" or the "outer setting." Additional codes such as "barriers and facilitators," "drift" (i.e., any description in which clinicians unintentionally drifted from fidelity to the interventions), and "reflections on the impact of the EBTs or the implementation process" were developed through the aforementioned process of becoming immersed in these data. The codebook was refined in an iterative fashion through a process of co-coding a sample of transcripts with a researcher familiar with qualitative research. Both coders participated in a frame-of-reference training to ensure a common understanding of the core concepts related to the research aims (Hysong et al., 2007). The coders then independently co-coded 20% of the transcripts in order to increase reliability and reduce potential bias (Bernard, 2011; Krippendorff, 2003). Regular meetings were held to discuss and resolve any discrepancies in the coding and to make necessary revisions in the codebook. The author independently coded the remaining transcripts.

Interpretation. The data interpretation process involved reflecting upon the raw data as well as the associated field notes and memos that documented the author's impressions throughout the data collection and analysis process (Forman & Damschroder, 2008). The generation of case reports facilitated analyses by allowing the author to examine data specific to each study aim. In addition, descriptive and interpretive summaries were developed for each of

the study aims and cases (i.e., organizations). These summaries included direct quotations to support the descriptions and analytic assertions. The author also returned to these data to find evidence that supported or refuted the interpretation of study results. This included seeking out "negative cases" for which the conclusion(s) did not hold. This adds credibility to the findings by ensuring that the author is not seeking to confirm a certain hypothesis, bur rather is exploring a range of possible interpretations (Forman & Damschroder, 2008; Padgett, 2012).

Dealing with discrepancies. The use of multiple respondents to inform the study aims was intentional, as some individuals may have been more or less knowledgeable about certain aspects of their organization's approach to implementation; however, the use of multiple respondents from the same agency introduced the potential that individuals may not demonstrate consensus regarding the types of strategies used within a given agency (Bowman & Ambrosini, 1997). The approach to handling such "discrepancies" was one of inclusion, in that each unique strategy endorsed was recorded as "in use" at that agency (for an example of this approach, see Hysong et al., 2007). When qualitative and/or quantitative data revealed a wide dispersion of responses regarding strategy use it was thought to indicate that the organization may not have a coherent or consistent strategy (Bowman & Ambrosini, 1997), which is fitting with this study's hypothesis for organizations with poorer organizational cultures and climates. The ability to make sense of reported variation in strategy use was enhanced by the use of multiple types and sources of data. Qualitative results were augmented by the quantitative survey of stakeholder preferences and data from the analysis of organizational documents, affording the opportunity to determine the extent to which these sources of data converged (Bowman & Ambrosini, 1997; Palinkas, Aarons, et al., 2011; Voss, Tsikriktsis, & Frohlich, 2002; Yin, 2009). The use of multiple respondents and different sources of data was also

important in reducing the threat of bias that is sometimes associated with the collection of retrospective accounts of phenomena such as business strategy (Golden, 1992).

Quantitative Data Analysis

The developed survey, Implementation Strategy Use and Perceptions, captured stakeholders' perceptions of implementation strategies and yielded descriptive data that augmented qualitative data from semi-structured interviews, document review, and focus groups. In the cross-case analysis, these data were compared to determine differences and similarities between cases. Data were also pooled across all six cases to reveal an overall picture of strategy use, as well as perceived effectiveness, relative importance, acceptability, feasibility, and appropriateness of implementation strategies. Descriptive statistics (means, standard deviations) were presented for these data.

The scoring of the OSC measure was conducted at the University of Tennessee's Children's Mental Health Services Research Center (CMHSRC), and results were interpreted in consultation with its developer, Dr. Charles Glisson. T-scores ($\mu = 50$, $\eth = 10$) based on the norms from a nationwide sample of 1,154 clinicians in 100 mental health clinics were used to determine how each participating agency compared to the national sample on each of the culture and climate dimensions (Glisson, Landsverk, et al., 2008). The T-scores provide standardized scores for each dimension of culture and climate. A score of 50 represents the mean, and a difference of 10 from the mean indicates a difference of one standard deviation. Agencies with the best culture have proficiency scores that are substantially higher than the resistance and rigidity scores, whereas agencies with the worst cultures generally have proficiency scores that are substantially lower than their resistance and rigidity scores. Similarly, agencies with the best climates have engagement and functionality scores that are substantially higher than their stress

scores, and agencies with the worst climates have engagement and functionality scores substantially below their stress scores (Glisson, Williams, Green, Hemmelgarn, & Hoagwood, 2014; Glisson, Landsverk, et al., 2008).

In addition to T-scores for culture and climate dimensions, a composite profile score was also generated using latent profile analysis based on the norms from the national sample (Glisson et al., 2014). As described by Glisson et al. (2014), latent profile analysis (also know as latent class cluster analysis and mixture model clustering) is a special type of finite mixture modeling wherein a categorical latent variable is used to model heterogeneity among observed outcome indicators. In this case, "the categorical latent variable represents a set of subpopulations or classes of programs that explain programs' patterns of scores on the six culture and climate dimensions. Parameter estimates from the LPA provide means and variances for each class as well as the probability of class membership for each program" (p. 38). The latent profile analysis of culture and climate scores from the national sample identified a three class solution, in which organizational profiles were labeled positive (29%), average (49%), and negative (22%). Table 5 depicts the three different classes and where the dimensions of organizational culture and climate fall in comparison to the national average OSC profiles (Glisson, Landsverk, et al., 2008).

Table 5. Latent profiles of organizational social context

	Culture			**Climate**		
	Proficiency	***Rigidity***	***Resistance***	***Engagement***	***Functionality***	***Stress***
Positive (3.00)	High	Low	Low	High	High	Low
Average (1.98)	Average	Average	Average	Average	Average	Average
Negative (1.00)	Low	High	High	Low	Low	High

The latent profile analysis parameters from the national sample were applied to the organizations in this study to determine the probability of class membership for each program.

A weighted class membership variable was constructed for each organization that calculated the probability-weighted sum of class membership in the three classes with scores ranging from 1.00 to 3.00. Higher scores indicate a greater likelihood of membership in the class with the most positive cultures and climate profile. The OSC data served to characterize the organizations' culture and climate in individual case descriptions. Additionally, organizations were stratified based upon their latent profile analysis scores and linked to qualitative data to determine whether strategy patterns, approaches to decision making, and perceptions of strategies vary by organizational culture and climate (see "mixed methods analysis" for more detail).

Mixed Methods Analysis

As previously mentioned, the structure of this study was QUAL → quan, meaning that qualitative methods preceded quantitative and that they were predominant (Creswell & Plano Clark, 2011; Palinkas, Aarons, et al., 2011). This served the primary function of *development*, as collecting qualitative data in Aims 1-3 afforded the opportunity to examine the impact of organizational context in Aim 4. It also served the function of *convergence* by using quantitative and qualitative data to answer the same question in Aim 3 (Palinkas, Aarons, et al., 2011).

The processes of "mixing" the qualitative and quantitative data flowed directly from these functions. To serve the function of *development*, the quantitative data on organizational social context (Glisson, Landsverk, et al., 2008) were *connected* with the qualitative and quantitative results from Aims 1-3 regarding implementation strategy use, implementation decision making, and stakeholder perceptions of implementation strategies (Palinkas, Aarons, et al., 2011). Determining the extent to which there was a meaningful relationship between

organizational social context and data from Aims 1-3 involved the development of a joint display (Creswell & Plano Clark, 2011) that categorized the themes emerging from the qualitative and quantitative data based upon the OSC profiles (Glisson, Landsverk, et al., 2008) as described above (see Appendix D). Further examples of this approach can be found in Killaspy et al. (2009) and Hysong et al. (2007), and are also detailed in Creswell and Plano-Clark's (2011) methods book.

To serve the function of *convergence* qualitative data and quantitative data were *merged* in order to answer the same question, which for Aim 3 was, "What are implementation stakeholders' perceptions of implementation strategies?" These data were *merged* for the purpose of triangulation, in this case, to use quantitative data from the stakeholder perceptions survey to validate and confirm the qualitative findings from the focus-group interviews. Once again, this process was depicted through a table (see Table 13) that shows the qualitative themes side by side with the quantitative findings (Creswell & Plano Clark, 2011). This type of display was effective in that it can easily show agreement, lack of agreement, or mixed results between the qualitative and quantitative findings.

Cross-Case Analysis

A primary benefit of a multiple case study is the ability to make comparisons across cases. This study utilized cross-case synthesis (Yin, 2009), which treats individual cases as separate studies that are then compared to identify similarities and differences between the cases. This involved creating a word table (see Appendix D) that displayed these data according to a uniform framework (Miles & Huberman, 1994; Yin, 2009). For example, data from the first three aims (strategy patterns, implementation decision making, and stakeholder perceptions) were categorized based upon their OSC profiles (Glisson, Landsverk, et al., 2008) in Aim 4.

This approach was used to compare across cases for each of the study aims, allowing for meaningful similarities, differences, and site specific experiences to emerge from these data (Stake, 2005; Yin, 2009).

Strategies for Rigor

A number of "strategies for rigor" (triangulation, negative case analysis, peer debriefing and support, and auditing) were used in order to reduce potential bias and enhance confidence in the interpretation of research findings (Padgett, 2012). First, multiple types of triangulation were employed, including theoretical triangulation, methodological triangulation, data triangulation, interdisciplinary triangulation, and analytic triangulation (Denzin, 1978; Janesick, 2000; Padgett, 2012). Theoretical triangulation involves the use of multiple theories or (in this case) conceptual models to interpret data (Denzin, 1978). This study used the CFIR (Damschroder et al., 2009) and the Implementation of Change model (Grol & Wensing, 2005) to guide the interpretation of the data. Methodological triangulation involves the use of multiple methods to study a given topic (Denzin, 1978), and in this case, both qualitative and quantitative methods were used to shed light on the study aims. The study also employed data triangulation by relying upon multiple sources of data (e.g., semi-structured interviews, focus groups, documents, and quantitative survey data; Denzin, 1978). Drawing upon insights from multiple disciplines in a single study constitutes interdisciplinary triangulation (Janesick, 2000). This study benefited from an interdisciplinary committee of scholars with expertise drawn from social work, public health, anthropology, medicine (psychiatry and emergency medicine), health services research, and organizational behavior. Implementation science is also an inherently interdisciplinary field, as it consolidates knowledge from a host of disciplinary traditions (Greenhalgh et al., 2004). Accordingly, an interdisciplinary perspective drove the design,

conduct, and analysis of this study. Finally, the study benefited from analytic triangulation, which involves the use of multiple coders (Padgett, 2012). Though only a portion of transcripts (20%) were dual coded, the robustness of the findings was also bolstered through a number of meetings were held throughout the data analysis process that allowed for identified codes, analytic categories, and interpretations of these data to be checked and discussed with members of the study team (van Dongen et al., 2013).

The deliberate search for "negative cases" that might provide evidence contrary to initial analytic conclusions was utilized to minimize the chances that the author would become too enamored with a particular point of view (Padgett, 2012).

Another strategy that was used to reduce potential bias and provide fresh sources of insight for the study was a peer debriefing and support group (Lincoln & Guba, 1985; Padgett, 2012). The group was comprised of three doctoral candidates (including this author) who were conducting mixed methods dissertation studies. The group met regularly to discuss challenges and share ideas pertaining to the collection and analysis of qualitative (and quantitative) data, and served as a point of accountability and support.

Finally, the conduct and analysis of this study were documented through an audit trail in the spirit of transparency, and to enhance reproducibility (Padgett, 2012). It is in this spirit that the protocol for this study was published in an open access scholarly journal, *Implementation Science* (Powell, Proctor, et al., 2013). This serves to hold this author accountable to the stated aims and methods of this study, and demands that deviations from the published protocol are documented.

Chapter 5: Results from Case Studies and Cross-Case Analysis

Agency A

General Description of the Agency and the Departments Under Study

Agency A is a large agency providing a range of behavioral health services to both children and adults. The participants in the present study were largely drawn from the leadership team associated with the organization's child and adolescent mental health services, as well as case managers from two teams providing a specialized form of case management (hereafter Intervention A). The organization has been implementing the case management program for approximately three years, but as the Coordinator noted, they have been "…really aggressively rolling it out this past year."

Description of Program or Practice Implemented

Intervention A is a team-based approach to individualized service planning and case management for children and youth with severe emotional and behavioral disorders and their families. It is particularly relevant in situations in which the child or youth is currently in (or at risk for) a restrictive placement and/or involved with multiple service systems such as child welfare, mental health, juvenile justice, or special education (The California Evidence-Based Clearinghouse for Child Welfare, 2014). It is rated by the California Evidence-Based Clearinghouse for Child Welfare (2014) as a "3," indicating that it has "promising research evidence" to support its effectiveness, and it is also rated as highly relevant to child welfare populations. One focus group participant described Intervention A:

> Basically, in [Intervention A] we have to involve the family. You all have to come to a basic agreement. They have to have some trust there too. We are sitting there at the table talking to a family about all their needs, everything that

> is going on with them. That is really personal. They have to feel comfortable to be able to talk to us first of all. Then we put a team together based on if they have a family friend or somebody that they feel knows a lot about them, that can help them. What we are trying to do is implement a plan that can help the family, using people from the school system, everybody, counselors, teachers, that have a regular bond with the kids as well as with the parents. It can be a very rewarding thing, but at the same time it is still hard because you have to get a group of people to agree upon someone's needs and things they need to feel more successful.

Another organizational leader touted Intervention A's ability to empower families and garner a system of community supports. She remarked, "We use that process with our families and saw our family and children and had them integrate more of their own voice. They were able to say what they wanted in treatment, how they wanted treatment, and they were able to bring other family members too so we had formal and informal support."

Decision Making Processes

Treatment decision making. Agency leaders cited a range of factors and processes that contributed to their decision to implement Intervention A, including those related to the intervention itself and the outer setting.

Factors related to the characteristics of the intervention. Agency leaders discussed several factors that were related to the characteristics of the intervention, including reliance on the research literature, endorsements from experts and key mental health organizations, anecdotal evidence supporting the use of Intervention A, and the compatibility of the intervention with the agency's context.

Research literature. One leader remarked, "We looked at a lot of literature, a lot of research that he [one of the Intervention A's developers] was doing." However, it is notable that none of the leaders cited any specific reports, studies, or evidence-based clearinghouses to support the use of Intervention A. Despite the California Evidence-Based Clearinghouse for Child Welfare's endorsement of Intervention A as a program with "promising research evidence," one of the organizational leaders noted a challenge with establishing the effectiveness of Intervention A. She stated, "It is not on the federal roster of official evidence-based practices, but it's going through the hurdles. I know one issue they have is that DBT [Dialectical Behavior Therapy] takes on a very specific client population. They're able to demonstrate the outcomes. [In Intervention A], you take on multitudinal problems, and you can't show really good strong outcomes yet." Indeed, it seems that leaders relied more heavily upon other forms of evidentiary support, such as key endorsements from experts and mental health organizations and other forms of anecdotal evidence.

Endorsements from experts and key mental health organizations. Early on in the process, Intervention A experts were central to the agency's decision to adopt the approach. One leader said, "Actually [one of the treatment developers] came down like two or three times. He talked to people [at the state capital]. He went to the department of mental health and was able to you know, explain to them what they were doing and talk about results." She continued to describe how leaders were able to pave the way for the adoption of Intervention A by presenting anecdotes and conducting a case study using a case specific to Agency A. Another organizational leader stressed the importance of endorsements from mental health organizations:

I got a sense that maybe one of the mental health, other major organizations—I

> don't think it was NAMI but maybe Mental Health Institute—was maybe behind talking to the directors and saying, 'Look, this is something we need to pursue'…I know there are other things out there, like MST, but over the last 15 years, we definitely keep on getting the message from SAMHSA that, 'You need an intensive collaboration with your families where they're really feeling heard. It's the way to go.' Our clinical director is all about whatever SAMHSA is pushing and saying, 'This is the way to go.'

Compatibility with agency context. Organizational leaders acknowledged that the compatibility of Intervention A with the agency context was one reason that it was selected. Indeed, implementation theories and models have suggested that interventions are more likely to be implemented well when they are compatible with an organization's existing workflow and systems (Damschroder et al., 2009; Rogers, 2003). Agency leaders specified several factors that spoke to the compatibility of Intervention A with their agency's context. For example, Intervention A was viewed by at least one organizational leader as a better fit with the agency's goals vis-à-vis mental health than alternative approaches such as Multisystemic Therapy (MST).

> I think because the MST, what we see, and I know it's just because we might as well go to the courts, what I saw is that it's really that the evidence-base is saying that it's really good for the juvenile justice population. Mental health, I'm not saying you won't see good outcomes, but it's not necessarily indicated for that population, whereas [Intervention A] is…it was born out of treating these mentally ill kids.

Despite the perceived similarity between MST and Intervention A, Intervention A was also viewed as a better fit with the agency as it was seen as "…a lot more flexible and adaptable."

Intervention A was also considered a good fit with the organization's staffing patterns, or at the very least, the organization's ability to adapt accordingly to the demands of the approach. Due to the agency's previous partnership with Children's Division and juvenile justice, their staffing patterns were already aligned with Intervention A's demands for staff to be available on an on-call basis 24 hours a day. As one leader put it, this required "a very unique staff" that was capable of garnering the trust of children and families.

Factors related to the outer setting. Participants recalled several contributors to decision making that were related to the outer setting, including the availability of funding, evidence of client need, the opportunity to visit other sites and to observe outcomes from similar efforts locally, and the potential cost-savings to the community.

Availability of funding. A central motivator for Agency A to adopt Intervention A was the availability of funding. In fact, both of the primary organizational leaders involved with Intervention A immediately cited the availability of funding when asked how Agency A chose to implement the approach. Initially, the funding came through a SAMSHA grant, and subsequently additional funding was secured from the City Mental Health Board.

Client need. In addition to the availability of funding, organizational leaders continually stressed that Intervention A was implemented in response to client need. Agency leaders lamented the fragmentation so often endemic in the social service sector. One leader explained, "…we know that kids and families especially get very siloed. The agencies aren't talking to each other, and people are getting lost in the cracks." This concern was echoed by another leader, who stated:

There were a lot of kids that weren't getting service properly. I think we had and

> still do sometimes have that gap with a child that's in foster care without a guardian, without a legal guardian except someone from the state or a child that's been involved in some type of crime and they're with Juvenile justice. We looked at the population to see how we can work with them a little more closely and one of the things that we found is that there were piles and piles of charts that this kid was in the system and nobody went back to ever look at their file.

Client need was evident anecdotally as well as through the collection of internal data. An agency leader explained, "We would track…every week we would have like a tracking sheet and we would have team meetings and we would look at where the kid was at and where they were at during treatment all the way to the end." The evidence of client need motivated leaders to search for an approach to care that was more responsive to the needs and circumstances of children and families. "If we were able to help at risk children…if we were able to help them and move them to a least restrictive [environment] and they get all the services that they needed then we were all for that to see kids improve and to get out," concluded an agency leader.

Opportunities to visit other sites. The opportunity to visit other sites that were implementing Intervention A both nationally and locally was a very powerful motivator for organizational leaders to adopt Intervention A. This allowed them to see the positive results that some states and programs were able to achieve with Intervention A.

> We actually met some people that had [Intervention A in another state]. They were able to use that with getting children back into homes because there were quite a few children that were placed out in residential facilities. They had really good numbers of kids going home and staying home and working with the families.

The value of seeing Intervention A working in other states seemed to hold despite the fact that the populations weren't necessarily the same demographically. One agency leader emphasized, "…Well the other sites didn't have the population that we had and so we knew that it would be a challenge…I think visiting other sites, we looked at that and then we wanted to see if we could implement it and if it made a difference here in [our state] with the same concept." The value of learning from local agencies was also highlighted:

> There were other SAMHSA grants that had already rolled through [the state], and they were coming to the state meetings in [the state capital] and telling DMH, 'Look, we're seeing some good outcomes by doing this collaborative work.' Because I know, like I said, [neighboring cities] were ahead of the game in getting theirs rolled out, and we also maybe could have learned from their mistakes and stuff like that.

As will be shown below, the ability to continue learning from other agencies locally and nationally continued to be important for Agency A throughout the implementation process.

Cost savings to the community. The potential for Intervention A to result in cost-savings to the community was also cited as a major motivating factor, above and beyond evidence of the approach's ability to impact children and families clinically.

> I don't know that it was necessarily outcomes. The thing that I know the [national organization for Intervention A] research can show you is that it is fiscally a good fit in terms of it's not sending your kids away to costly placements. I think all agencies talk that same language that we don't want to send people away. We know that's going to cost anywhere from $20,000 to $30,000 a year to place that person outside the community. I think that was

probably the biggest appeal.

Implementation decision making. Agency leaders suggested a number of different sources of information that guided the selection of specific implementation strategies. Overall, they acknowledged that the process of implementation was not linear. "There were a lot of mistakes along the way, people made mistakes, and you just kind of tweak it and move on and build," said an agency leader. There did not seem to be a formal, cogent plan or overarching philosophy guiding the implementation effort or the selection of implementation strategies. When this author asked if they had developed an implementation plan, one organizational replied affirmatively, and proceeded to describe what was really a detailed outline of how clinical services would unfold in their service settings. When asked to clarify, she was unable to describe how the plan dictated specific implementation processes and actions. Further, when another leader was asked, she replied, "If there was, I wasn't aware of it. I think…a lot of it was rolled out through whatever was outlined in our grants to funders, and that was what guided us." Another stated, "I'm not sure," and when asked if there were plans for evaluating and reassessing the implementation process, she admitted, "I don't know that either, I know we're tracking data. I couldn't tell you exactly which elements." Similarly, when asked if there was any sort of formal model guiding their implementation effort, one leader spoke of the quality improvement department and a more generic overall effort to improve quality through monitoring charts and the like, whereas another leader admitted that "we went it alone in terms of just figuring this out from a grassroots level." There also did not seem to be a formal assessment of organizational performance that could be used to benchmark implementation. Participants did not report relying upon implementation or quality improvement literature to guide their efforts. Decisions about how to implement Intervention A appear to have been

largely driven by the availability of funding, expectations outlined in grants and contracts, opportunities to visit other sites, guidance from treatment developers and expert consultants, literature from the national organization for Intervention A, and drawing upon quality improvement processes.

Availability of funding. Just as the case with clinical decision making, the availability of funding was very influential in terms of dictating the types of implementation strategies that Agency A was able to select. Funding played a particularly important role in the in terms of the agency's ability to take case managers "off line" to attend training. One organizational leader recalled, "Obviously, they knew there was going to be a big training piece in terms of getting people trained up to what they need to know. I guess the funding, because we're putting all these people through training, we're losing productivity…so there has to be a fiscal piece to it." She went on to say that the funder was "really critical in terms of getting the training piece covered and letting us go and get the training so it could be sustainable."

Expectations outlined in grants and contracts. Funding also played a role in influencing the selection of implementation strategies through the grants and contracts themselves. "I think a lot of it was dictated through what we were able to write in grants," explained an agency leader. There was a sense that the stipulations outlined in the grants and contracts keep the agency accountable to implementing clinical services in a certain way. Though leaders were unable to articulate how funding dictated the choice of implementation strategies (with the exception of training), one leader stressed, "We consider finances making sure that we were doing the right thing when it came to the money not just spending money because it was there."

Visiting other sites. Again, just as with clinical decision making, implementation decision was informed by opportunities to visit other agencies that had already implemented Intervention A. Agency A's effort to learn from other agencies was deliberate and active:

> What we did was to get as much data as we could, talk to people to see from various states and we travelled to various states to see how they implemented, such as in Tulsa. They were really doing it in Tulsa and in San Francisco and Indiana. Those were three of the places I remember really talking to them and we looked at their strengths and their barriers and just lessons learned, different things to look at.

In addition to learning of barriers and other lessons learned, they were able to borrow liberally from what other agencies had developed. This was reportedly helpful in providing pragmatic resources that are needed to deliver the approach, and also in the sense of having other organizations to "look up to" that were delivering Intervention A in accordance with developer standards (i.e., to fidelity). As one leader remembered:

> Well, you borrow. We borrow…we looked at their forms and we looked at our forms and said, okay we're missing a whole piece of this. They were already certified…and so you know, you look at that. You look at your [national organization for Intervention A] and make sure you're doing it to fidelity the right way.

One leader underscored the utility of learning from other agencies, "I would say that people who were actually doing the work. I think their feedback is really helpful." These opportunities to learn from others were actively sought, not passively received. "We did a lot of calling in, checking in with them, 'What are you guys doing?' Also keeping up with the [national

organization for Intervention A], what are they doing, making sure we're in the loop with them. Our consultants always give us updates on what they're doing." While affirming the value of this type of implementation guidance, one leader acknowledged, "I don't know if it was necessarily strong evidence-based, but it was just this word of mouth and the sense and feeling of what they're doing to implement things."

Guidance from treatment developers and expert consultants. Some of the implementation strategies that the organization has employed to integrate Intervention A services into their setting are dictated by the treatment developers themselves. This was viewed positively at Agency A, as one leader affirmed, "We also got a lot of support and assistance from [the treatment developer] through our training materials, and he offers the credentialing system, some of their thoughts." Advice from treatment developers was particularly well received, as "they go to all states all over the country all the time doing nothing but [Intervention A] to hear the roadblocks that they are running into and stuff." The agency also was able to obtain expert consultation from individuals associated with the national organization for Intervention A, which was viewed as even more helpful than the compendium of written educational materials that the national organization provided. "I think the guidebooks from [the national organization] were definitely helpful," explained one participant, "but I think more helpful was hearing from the consultants…The [Intervention A Guide], it was very abstract, and it's conceptual, but to hear the stories of how it was applied and implemented, that definitely spoke to me more."

Literature as a guide to implementation decisions. One of the organizational leaders discussed turning to the literature to guide implementation processes, though she did not present specific examples of how the literature has informed the selection of different implementation

strategies. She noted an extensive guidebook containing all of the research and articles published on Intervention A, as well as other resources that are published on Intervention A's website. To be clear, the literature that she was seeking was not primarily focused on implementation processes or the science of implementation, but she did reference a guide for managers that was available through the national organization for Intervention A.

Drawing from quality improvement process knowledge. The same leader that spoke of seeking the literature also mentioned that she likes to draw upon established quality improvement processes. As she was doing a "dry run" of one of her trainings for Intervention A, her husband, who happens to be an engineer, mentioned the shared principles between her training approach and Six Sigma and Lean (Vest & Gamm, 2009). Her husband pointed out some resources through ASQ, American Society for Quality, which is an organization that provides training in various quality improvement processes. She recalled, "Yeah, good facilitation is a really key critical skill, and that's what you're certified in ASQ on, is these skills of how to manage a meeting and all that stuff." I looked over at his stuff. I was, like, "Wow. I could use this."

More formally, Agency A has a quality improvement professional that works with leaders and staff across the entire agency. She has utilized a variety of quality improvement tools and processes in the service of improving organizational functioning. Much of this has occurred outside of the context of Intervention A, and has not been utilized to guide implementation processes and the selection of implementation strategies per se. The quality improvement strategies that she highlighted will be discussed in the "implementation strategy use" section.

Implementation Strategy Use

Agency A used a host of strategies at multiple levels of the implementation context, which largely fell at the levels of the outer and inner setting, characteristics of individuals, and the process of implementation. They did not do much at the level of Intervention A itself (e.g., adapting the approach intentionally).

Strategies focusing on the outer setting. Agency A utilized at least three types of strategies focusing on the outer setting, including strategies to access new funding, client engagement and retention strategies, and collaborations with other agencies and systems.

***Accessing new funding*.** The primary financial strategies that Agency A employed were related to grant writing. Interestingly, Agency A also financially incentivized the use of some evidence-based treatments; those who were able to get credentialed in those approaches were able to receive a 2% raise in salary. However, Intervention A was considered a mandated treatment that was part of one's job description. The Intervention A credential was touted internally as benefit to frontline workers. It is acknowledged nationwide, so the Intervention A trainer at the agency attempts to promote this as a benefit and incentive to Intervention A training and use.

***Client engagement strategies*.** Intervention A is designed to engage families and other natural supports; thus, there are engagement interventions that are "baked in." However, there are also other strategies that they use to ensure that clients are "on board" with the approach, such as ensuring that they cater to multiple learning styles by presenting information verbally as well as through written booklets created by the developers. Some of the written materials are geared towards children, complete with cartoons. The Intervention A trainer at the agency teaches her case managers to be very flexible with clients, particularly when they are reluctant

to embrace the approach: "For families not on board with it, 'OK, what's going on? Maybe this is something we could do to help. Maybe this isn't a good time. We can defer it.' I teach that. Be flexible. Be adaptive, whatever they need to make this work." She also emphasized the importance of adapting "the pitch" for Intervention A to different client populations with varying levels of literacy and English language skills. A supervisor who has also provided Intervention A services stated, "…it sounds kind of silly, but providing a snack or asking the family to think of something to bring," can be "pretty important to build rapport and make it a little more comfortable."

Obtaining client feedback. One organizational leader emphasized that they always try to ask families how Intervention A is working for them in order to receive direct feedback on the treatment process. Additionally, the agency collects quality assurance surveys; however, the participant who mentioned this was unsure of whether or not Intervention A clients actually fill these out, and admitted, "…we look at outcomes and things like that," but "I know more of those cases anecdotally than I do hard numbers." Thus, it was unclear how much the survey data are actually used to improve the quality of services.

Collaborating with other agencies. Agency A collaborated with another social service agency to implement Intervention A, and in particular, to increase the reach of their services to a specific population in a geographic region that they were not previously serving. Given the nature of Intervention A, Agency A also frequently collaborated with staff from the education, juvenile justice, and child welfare systems to ensure that they were working well together. One leader noted, "It was very important for us in the beginning to all come to the table and collaborate and see how we can all help each other out." A number of meetings were held to develop these collaborations and partnerships. As emphasized above, Agency A leadership

mentioned frequently that they benefited mightily from communicating with other agencies that were implementing Intervention A.

Strategies focusing on the inner setting. At the inner-setting level, Agency A utilized strategies that involved mandating change, promoting shifts in treatment philosophies, infrastructure development, communication, and quality improvement.

Mandating change. It was very clear at Agency A that the use of Intervention A was mandated. This mandate is exemplified to one agency leader's response to whether there were any incentive structures facilitating or inhibiting the use of Intervention A. "Does threat of your job count?" she replied. She went on to say, "…it's a punitive thing at this point." Frontline workers' responses to this mandate will be discussed in more detail in upcoming sections.

Promoting shifts in treatment philosophy. A cultural shift associated with the delivery of Intervention A is the move from a focus on services, to a focus on needs. As one leader explained, "Case managers are trained to say, 'You need DBT,' or, 'You need to go to family counseling,' or, 'You need respite,' or, 'You need services.' [Intervention A] is, 'No, that's not the conversation we're having. What do you need? You need to go to family therapy because you need what? You need to go to respite because you need what? You need DBT therapy because you need what?'" This leader was not able to identify specific strategies that she used to address the need for this cultural shift; however, implicit in her response was that this has been a recurrent theme in training and supervision.

Infrastructure development. The importance of implementation strategies that target the infrastructure of service delivery should not be overlooked. One agency leader illustrated this:

> I spend a lot of time just on business practices that people have to do. When you need to authorize a cab for your client to get somewhere, or you need to order a

> bus pass, and you have to fill out this form and turn it in to this person, and then go fill out this spreadsheet. How can I take away some of that work from you so that you can just do one thing and move on but still have finance get what they need without any errors on it?

Agency A was attempting to address issues related to the infrastructure such as the burden (and duplication of paperwork. This was being addressed though the introduction of a new electronic medical record (EMR). Agency leaders were attempting to ensure that the EMR was compatible with the conduct of good Intervention A services, and were working to minimize the duplication of paperwork wherever possible. This was described as an ongoing issue, not one that was currently resolved by any means.

Networks and communications. Agency A utilized some implementation strategies to promote intra-organizational communication, such as the use of internal newsletters. However, one agency leader expressed how insufficient these were, and stressed the importance of standardizing communication across the agency. She shared, "I think a lot of people think they communicate stuff because they say it once or they publish it once. And people hear it, but they do their own sort of inference thing."

Quality improvement tools. One quality improvement professional discussed the use of several quality improvement tools. These were not necessarily mentioned in conjunction with the Intervention A implementation effort, but in a more general way of improving the quality of services. For example, she cited the use of a Kepner-Tregoe problem analysis process that she described as,

> a way of coming to rational decisions, so when there's a lot of emotions involved, you can step back and do a decision analysis. That's where we go through and list

> our musts and our wants, make the group come to some consensus and rank the importance of wants, how bad do we want it, is it a 10, is it a 2? Then we look at every option that's on the table and weigh them against those musts and wants and then say, this is the one that clearly scored the highest, or these two scored the highest.

She indicated that she sometimes stops meetings to suggest the use of a more systematic decision making process, and other times, organizational leaders will suggest that she step in and utilize a quality improvement process method. She admitted that these tools and processes (of which there are several) may not be used much when she is not directly involved, and she was not able to cite many specific examples of quality improvement tools that have been used in the Intervention A implementation effort.

Strategies focusing on characteristics of individuals. Implementation strategies directed at individual staff members were dominant, and included efforts to build buy-in, training, live supervision and feedback, Intervention A supervision, "regular" supervision, fidelity monitoring, the provision of educational materials, consultation from the training director, peer coaching, attempts to incentivize the use of Intervention A, random audits, and hiring for implementation.

Efforts to build buy-in. Agency A has worked at the broader organizational level to ensure that everyone is "on board" with Intervention A. This included educating psychiatrists and home health nurses, and other key organizational stakeholders who have a role in implementing and sustaining Intervention A. They have used something called a Goal Deployment Process to check-in with various stakeholders, including frontline staff delivering Intervention A, to determine stakeholders' attitudes toward delivering Intervention A. Though

this will be discussed in more detail below, they discovered that staff members were not yet "on board" with delivering Intervention A.

Training. Training focusing on Intervention A was one of the primary implementation strategies utilized, and was conducted by the director of Intervention A training for the agency, who has been certified as both a facilitator and a coach for the intervention. This initially involved seven months of training in Intervention A, though the agency is now attempting to shorten this training period with the goal of getting it down to 3 months. In addition to shortening the period of training the organization is attempting to automate as many aspects of the training as possible by recording training sessions and making them available electronically. The goal of both of these efforts is ultimately to ensure that staff members are "getting what they need when they need it," as having these trainings recorded would offer greater flexibility in terms of the timing and dose of training. One thing that was made clear was that the approach to training has changed from cohort to cohort, and seems to be consistently evolving. However, training generally involved two tiers. Tier 1 is conducted over three weeks and involves a conceptual introduction to Intervention A through didactic lectures, video demonstrations, role plays, and (in some cases) shadowing. The training director noted that she is attempting to minimize didactic portions of the training in favor of more interactive sessions. She noted, "Sitting and lecturing the people, they ain't having it. You need to have something interactive and engaging, and you need to have a two-way street in communication about what's working for them, what's not." There is also a workbook that is given to case managers during the first week of training. It provides an overview of the whole process, and case managers often met in groups to fill it out together. It was not clear if this was intended, or if the work was intended to be independent. One case manager recalled, "we were supposed to be in the room [filling out

the workbook] but then nobody did it on their end, and we just went and wrote out the answers in one afternoon. It was awful." Also, the messages that they were receiving in the training were incongruent with those that were represented in the workbook. A case manager pointed out, "The one thing about it was that if you did start doing the book on your own, the answers she would give were totally different. It wasn't adding up. The information we were reading, you get a whole different answer but when she went through the answer, it was different."

Training also involved watching videos of Intervention A sessions being conducted, as well as more active components such as role playing and shadowing. Role playing allowed case managers to practice "the pitch" for Intervention A, and to develop skills in facilitating meetings involving diverse stakeholders. Sometimes this was planned, and other times the trainer would introduce role plays when case managers brought up case-specific difficulties they were having. Though this was not an option for the first wave of case managers trained in case management, the most recent group to be trained had the opportunity to shadow other case managers as they delivered Intervention A services. Shadowing was not a required portion of training, but was an option for those who wanted to take advantage of it. Finally, the director of training emphasized the importance of story telling in the delivery of training. She shared the following to illustrate that point:

> Probably the best thing that I get the buy-in on is just the stories. Like I said, I wasn't a believer, but I had a girl who didn't go to school for two and a half years, severe anxiety, and we say, 'Go to therapy. You need therapy.' She wasn't having it. She absolutely hated the idea of someone talking to her, and she hated having people around. But when we go, she has eight siblings, and say, 'OK. Maybe you can take a walk around the block with your sister,' she was much

> more...'Go to the gym with your brother.' You know what? We're taking care of those anxiety symptoms. Within six months, it's no longer, 'I can't go to school because I have so much anxiety.' It's, 'I'm going to apply for a job, and I'm going to see what I can do to get a job.' If we're so organized around that mental health and the illness and treating that, we reinforce it, but if we focus on, 'Here is what you can do,' we got you better.

Live supervision and structured feedback. Case managers are required to be observed facilitating an Intervention A session with their clients. The director of training conducts these observations and provides the case managers with structured feedback sheets that capture their strengths and areas for improvement.

Intervention A supervision. Case managers received group and individual supervision in an alternating fashion every week for seven months. Group meetings would last approximately two hours, and individual meetings were generally 45 minutes to an hour. The director of training described this process, "one week we're doing group and we talk about the concepts, do the activities. The other week I'm meeting with them individually for an hour to talk about 'What's going on with your family? Let's look at your documentation,' and I do the [Intervention A] supervision with them so that they are thinking about things in different ways."

"Regular" supervision. In addition to Intervention A supervision, case managers regularly meet with their direct supervisors, all of whom have been trained in Intervention A and are working toward becoming certified coaches. Supervisors are supposed to be tracking to make sure that case managers are doing Intervention A, and they generate weekly reports that document what stage of the intervention process each case is in that gets routed to leadership. Case managers stressed that supervision often focused on completing Intervention A cases

rather than general clinical concerns that are more typically addressed in supervision. One case manager cited a common refrain from her supervisor, "why do you have more clients in [Intervention A]," and "what are you doing to get more?" Another case manager pointed out that it focuses less on process issues than one might expect. "It focuses on everybody doing it, not how it is going," she said. She added that the focus is "let's just do [Intervention A]. Let's get all these families doing [Intervention A]."

Fidelity monitoring. The director of training for Intervention A has been conducting fidelity monitoring regularly; however, she acknowledged that her "auditing isn't as in-depth" as she would like, because the number of case managers is getting too high to stay "on top of that." The auditing process doesn't focus on a formal fidelity checklist (which does exist), but on another assessment of documentation compliance. With about 169 families receiving case management services at a given time, the director did not believe that she had the time to complete the preferred method of fidelity rating. Thus, the audit process seems to focus more heavily on compliance and documentation rather than quality assurance. Each chart is given a compliance percentage. She explained that a percentage like 70 or 76% may indicate that the case manager is missing a few things, whereas a percentage like 36% makes her wonder if the case manager is really doing Intervention A at all. She expressed her belief that supervisors should be doing more to monitor quality, perhaps including regular fidelity monitoring with the more intensive method, however, this did not appear to be happening.

Provision of written educational materials. Agency A provided a range of educational materials that informed the process of implementation for Intervention A. For example, they provided excellent examples of completed paperwork that case managers could reference as they completed their work. They also provided a wealth of materials on the agency's internal

drive. One leader relayed, “there is a lot of stuff ready to go for you, like agendas ready to go, preparation checklists ready to go.”

Availability of Intervention A training director for consultation. In addition to conducting the Intervention A trainings, the training director is generally available for consultation when needed. Case managers confirmed that she is regularly available via telephone, email, or in-person meetings. This allows them to present difficult cases and receive feedback specific to Intervention A that their direct supervisors may be less well equipped to provide.

Peer coaching. Given that there are now multiple cohorts who have been trained in Intervention A, Agency A has attempted to leverage the expertise of trained case managers to serve as peer coaches. These peer coaches have gone to other sites and teams to lead them through the experience of delivering Intervention A services. They may also talk to individuals one-on-one if they are having a particularly difficult time with Intervention A. One organizational leader lauded peer coaches, as they can be more accessible to others who might reach out and ask, “When you were stuck with this, what happened?” Both the extent to which peer coaching was happening and its helpfulness was less clear from the perspective of case managers interviewed in the focus groups.

Attempts to incentivize the use of Intervention A. Agency A attempted to motivate case managers to use Intervention A by providing public praise for those who were delivering it well. The director of training noted, “Praising staff when we can and making it very public definitely is helpful.” However, it is important to note (as is emphasized elsewhere) that the overarching feeling of case managers was that the agency was very punitive and did not recognize their efforts to deliver quality services. There was also an attempt to motivate case managers by

pointing out the value of becoming certified in Intervention A in enhancing their marketability for other social service jobs. This has been noted as a potentially important motivator for EBT use in other qualitative studies of community mental health organizations (Powell, Hausmann-Stabile, & McMillen, 2013; Proctor et al., 2007).

Random audits. The director of training reported that they conduct a lot of quality assurance checks. She recalled, "One day, they were mad at me because…I said, 'OK. Let's just open a chart.' I said, 'Just randomly pick some numbers,' and I said, "I have not assigned this to anybody…Let's see what their chart looks like." They got the message that this needs to be done, and there is the way to do this."

***Hiring for implementation*.** Another strategy that was used was simply hiring the right people to deliver Intervention A. "You had to get sympathetic staff that believed in the process," stated one leader. Others emphasized that staff needed to be flexible enough to be on call 24 hours a day. Some of these people were found internally, but they have also recognized the importance of informally screening individuals for these characteristics in the hiring process. In fact, one leader referenced a strategy to capitalize on getting new staff into the organization. She stated, "we find that if we get them as new hires…they're not tainted by the team so we're trying to do that."

Strategies focusing on process. Participants reported the use of several strategies related to the process of implementation, including barrier collection and analysis, adapting implementation strategies, outcome monitoring, and reassessing and evaluating implementation processes.

Barrier collection and analysis. Agency A has worked to identify potential barriers to quality service delivery through a number of methods. One method simply involved

organizational leaders and supervisors, and involved identifying barriers encountered (e.g., high staff turnover, high caseload size, duplicate paperwork, and staff buy-in to the process) and brainstorming potential solutions. Another method involved forming groups of new hires, including clinical supervisors and trainers, to determine what is working, what is not, and what constitutes a "well trained" employee. Through this process, the group realized that they were training people on the assessment process way too early, before they were able to conduct assessments with their clients. This led to broader discussions about the importance of carefully sequencing training that will hopefully help the agency to conduct training and orientation processes more effectively and efficiently.

Barrier analysis also happens more informally, as the agency leader that conducted training described collecting data about common concerns from case managers attempting to implement Intervention A. "It was basically anecdotal, staff, just their perception. But I did really look over what they were giving, and I came up with five categories that I saw that things were consistently popping up as issues." She went on to describe issues with training, logistics, and the fit between case managers professional goals and the intervention approach. She did not share specific strategies that she used to address these barriers, though this was implicit in her response.

Adapting implementation strategies. At times, implementation strategies needed to be adapted to fit the needs of staff members. For example, Intervention A training activities that were developed to be appropriate for individuals of all educational levels could be insulting when they are directed at clinicians who are trained at the master's level. The agency leader responsible for training explained, "I had to speak to that. I had to speak to that clinical piece, and I also had to make it more relevant. I also had to pull the stories from what I've seen other

staff to do to, like, “This is what you do want to do and you don’t want to do because this, this, this, and this could happen.”

Outcome monitoring. The agency has adopted the DLA-20 as an assessment tool to measure clinical outcomes for their adolescent patients. This was mandated by the state’s Department of Mental Health. It seems as if other outcome monitoring required by funders was restricted to things such as the number of clients seen and the number of meetings held.

Reassessing and evaluating implementation processes. Agency A reported engaging in a number of strategies that allowed them to reflect upon and evaluate the implementation process. One leader said that they are evaluating how the implementation of Intervention A is going “constantly.” Another leader stated, “I think I constantly am doing my own self-checks. I am constantly doing surveys on staff, like “What are you getting out of training? What needs to be changed in training?” She continued, “I’m pretty open and flexible and approachable, and if you’re running into stuff, I definitely want to hear about it.” In addition to these more informal feedback mechanisms, Agency A also has a children’s work group meeting every month that often provides an opportunity to discuss the implementation of Intervention A. This involves the senior leadership of the agency’s children’s services department as well as supervisors and admissions staff. It did not appear that frontline workers were involved in that meeting; however, that was not entirely clear. Additionally, there is a quarterly meeting that all of the supervisors attend, and the director of training for Intervention A is able to solicit their feedback, institute clear expectations regarding supervisory performance, and ask if there is anything that they need from her.

Perceptions of Implementation Strategies

Qualitative results pertaining to perceptions of implementation strategies. Two focus groups at Agency A consisting of case managers were able to discuss their perceptions of various implementation strategies. The bulk of this section is drawn from their responses, though occasionally the perspectives of organizational leaders are also integrated. In general, participants viewed passive implementation strategies such as didactic training, the use of workbooks, and video demonstrations were generally viewed as ineffective (with some exceptions). Participants' perspectives on more active strategies was somewhat mixed. They generally appreciated strategies such as role playing, shadowing, and live supervision; however, they did not find strategies such as audit and feedback and outcome monitoring to be effective.

Perception of didactic training. Case managers viewed didactic training as ineffective. One case manager bluntly stated that training was "overwhelming, just a nuisance. It was just, here we go again." One reason for this was that some of the content of lectures was viewed to be common sense, which can be a training barrier (Powell, McMillen, Hawley, & Proctor, 2013). A case manager suggested there was sometimes a mismatch between the difficulty of the material and the amount of time spent on it. He noted, "there was a lot of the content of the lectures that was almost, not common sense, but you spent a lot of time on things that made sense, or didn't need to spend as much time on, and then gloss over things that could have spent more time on." The ineffectiveness of didactic training was acknowledged by case managers and organizational leaders alike, and of course is reflected in the implementation literature as well (Beidas & Kendall, 2010; Herschell et al., 2010; Powell et al., 2014; Rakovshik & McManus, 2010). The trainer herself admitted, "…sitting and lecturing people, they ain't having it. You need to have something interactive and engaging, and you need to have a two-

way street about what's working for them, what's not."

Perceptions of the workbook. The workbook that case managers were required to fill out was perceived to be ineffective and unhelpful. This is consistent with other studies that have documented the insufficiency of manuals and workbooks in leading to provider behavior change (e.g., Beidas, Barmish, & Kendall, 2009; Herschell et al., 2009). Participants made comments such as, "The book was the least effective," "I don't even know what the book is about," and "The whole process of that workbook, honestly a lot of us just felt like [it was] busywork. It has not felt like it is helping me learn [Intervention A]."

Perceptions of video demonstrations. Case managers had similarly negative perceptions of the videos, as they were thought to be too "staged" or "scripted." The small benefit that case managers derived from the videos was attributed to "…not having to talk during that part" and the opportunity to "laugh a lot at how fake it was."

Perceptions of written materials. Written materials were one of the few relatively passive implementation strategies that were deemed to be somewhat effective, as case managers expressed appreciating the examples of paperwork that were filled out as well as the availability of other educational materials.

Perceptions of role playing. Role playing various scenarios pertinent to the delivery of Intervention A was perceived to be effective, even if the process was sometimes awkward or anxiety producing. "And as much as I hated role plays, I think they were helpful," said a case manager. "I just think it's a very awkward interaction but I do think that it helped, especially watching others do the role play." Another case manager characterized the role plays as one of the most helpful strategies, as "being able to visualize step by step what it is supposed to look like and what the order of the meeting goes with every piece of what we have learned" was

essential to learning the approach.

Perceptions of shadowing. Shadowing was viewed as similarly helpful, and some of the case managers who were not able to benefit from shadowing others expressed their regret over not having that opportunity. Case managers seemed to agree that some of the cases represented in training materials were "above and beyond" (i.e., not realistic), and actually made Intervention A look harder than it actually was. Those that were able to shadow very early in the process seemed to have a particular advantage when it came time to train. As a case manager recounted, "I got to see all of that stuff first hand before hearing [the trainer] talk about it. I was able to follow along better and understand more of what was expected because I saw that before I started my training. I think that shadowing is really helpful to do ahead of time."

Perceptions of live supervision and structured feedback. Just as with role plays, live supervision and structured feedback was sometimes perceived as uncomfortable or intimidating. However, it was also viewed as very helpful in the end, and one participant noted how good the trainer for Intervention A was in generating ideas within the meeting.

Perceptions of group training sessions. Case managers viewed group training sessions and other opportunities to share tips and stories pertaining to successes and challenges of implementing Implementation A positively. Of particular import was the support garnered from peers; a case manager attested, "it's like a support, like an encouragement or something that is beneficial. Somebody actually knows what's going on instead of just someone higher up being like, this is what you need to do." It would seem that these opportunities to provide mutual support an encouragement would be particularly valued given the shared perception that the culture was often punitive and unsafe psychologically (more on this to come below).

Perceptions of individual supervision in Intervention A. Although case managers generally appreciated opportunities to share amongst their peers, some expressed preferences for the one-to-one attention of individual supervision in Intervention A. "The coaching, being able to talk through the issues I was having with implementing with my families…being able to process that [with the trainer] and try to come up with other ideas. The one on one individual attention is always better for me."

Perceptions of fidelity monitoring. In general fidelity monitoring was viewed as unhelpful and "annoying." One of the major concerns about fidelity monitoring was that it was too punitive and did not acknowledge their positive contributions or progress. "If it was monitored for the good and bad it would be better. I feel like it is, 'you are not doing this right, you need to do this...'" When asked what might make it more helpful, people had interesting things to say. One case manager suggested that a more solid focus on quality and process improvement rather on a perceived focus on just "getting it done" would be helpful:

> I think it would be helpful if the spirit of how you are going about it is genuinely to help people improve how to do it and sometimes it's that rush and just getting it done, that really is the forefront of what happens…it makes you feel like you don't want to do it. And so if someone was there strictly for support to like keep you on it or just be encouraging, then that would be different and it would be helpful.

Several case managers expressed a desire for that type of support, and one wanted a basic acknowledgement that "you may not be doing everything right, but you are doing some things right." Instead, the audit and feedback process can leave case managers feeling that there is simply "another area where you are not doing your job." This was viewed as particularly

problematic, as Intervention A is just one portion of their job. Another case manager stated unequivocally, “They don’t trust us.” Interestingly, organizational leaders and case managers didn’t necessarily share the same opinion about audit and feedback. One leader conceded that case managers don’t like being monitored. Another leader stated that although they don’t like it, the process is working. “They grumble, but I think they understand why its being done,” she stated. She did admit that this punitive approach may “come with a price,” though it wasn’t clear that she was aware of the widespread disdain for the approach from the case managers point of view.

Perceptions of consultation with Intervention A trainer. Case managers reported mixed perspectives regarding how helpful consultation with the agency’s Intervention A expert. On the positive side, a case manager praised the trainer and her availability, stating, “it’s also good to have that person to go to when, it’s like okay, I’m stuck with this family what’s next? ... I think having that person, because our supervisors are doing so many other things that they can’t be that ‘go to’ person.” However, others expressed that there can sometimes be a disconnect between the case managers and the trainer, and that they don’t sense a shared fundamental understanding of what it is like to do the work. One individual stated, “she doesn’t understand what’s like to do our job and so she puts these unrealistic expectations on what you should do. That’s kind of why I don’t go to her.” Despite the trainer’s high level of expertise (or perhaps because of it), some case managers reported feeling like they were inadequate after consulting with the trainer. “Sometimes it is helpful and sometimes it is really discouraging. I guess I am not smart enough to not be able to think of fifteen other solutions in thirty seconds,” expressed one case manager. Another echoed this sentiment, stating that sometimes it can make her feel like she “sucks” at her job. These mixed feelings highlight the importance of trainers and

consultants possessing not just technological expertise, but also the emotional intelligence to meet frontline workers "where they're at."

Quantitative results pertaining to perceptions of implementation strategies. The Implementation Strategy Use and Perceptions Survey was sent to 16 potential respondents from Agency A. Eight stakeholders (50%) chose to complete the survey, the results of which can be seen in Table 6. Each of the strategies was endorsed by at least two stakeholders, and 84% of the strategies were endorsed by at least half of the respondents. Means for the effectiveness rating ranged from 2.57 to 4.50 (1 = least positive; 5 = most positive). Only seven of the strategies received an effectiveness score of 4.00, and only two strategies endorsed as "in use" by at least half of respondents were rated a 4.00 or higher ("conduct local needs assessments" and "make training dynamic"). Eleven strategies endorsed as "in use" by at least half of respondents received mean effectiveness scores below 3.50 (i.e., closer to neutral at best), including: "mandate change," "identify and prepare champions," "develop a formal implementation blueprint," "involve executive boards," "conduct local consensus discussions," "provide ongoing consultation," "change record systems," "audit and provide feedback," "remind clinicians," "capture and share local knowledge," and "provide local technical assistance." Educational strategies were generally rated more favorably in comparison to the other categories. Overall, the quantitative results indicate that respondents' views of implementation strategies employed at Agency A are largely negative. This may indicate that the perceived effectiveness of implementation strategies was moderated by the relatively poor organizational context as will be discussed below.

Table 6. Agency A: Implementation Strategy Use and Perceptions Survey Results (N = 8)

Strategy	% Use	Effective-ness	Comp. Effective	Feasibility	Appropriat eness
Planning Strategies:					
Stage Implementation Scale Up	88%	3.86 (.69)	4.00 (.82)	3.71 (.49)	3.86 (.38)
Mandate Change	88%	2.57 (1.51)	2.43 (1.27)	3.57 (1.27)	3.57 (1.40)
Build a Coalition	75%	3.67 (.52)	3.50 (.55)	3.67 (.52)	3.83 (.75)
Assess for Readiness and Identify Barriers/Facilitators	75%	3.50 (1.05)	2.83 (.75)	3.83 (.41)	3.67 (1.38)
Identify and Prepare Champions	75%	3.17 (1.17)	3.17 (1.17)	3.50 (.84)	4.17 (.75)
Develop a Formal Implementation Blueprint	75%	3.00 (.89)	2.67 (1.03)	3.33 (.52)	3.33 (1.03)
Involve Executive Boards	75%	2.67 (1.37)	2.67 (1.37)	3.33 (1.37)	3.33 (1.37)
Tailor Strategies	63%	3.60 (.89)	3.60 (.89)	3.40 (.89)	3.60 (.89)
Recruit, Designate, and Train for Leadership	63%	3.60 (.55)	3.80 (.45)	3.80 (.45)	4.00 (.00)
Conduct Local Needs Assessment	50%	4.25 (.50)	4.25 (.50)	4.00 (.82)	4.50 (.58)
Develop Academic Partnerships	50%	3.50 (.58)	3.75 (.50)	3.75 (.50)	3.75 (.50)
Conduct Local Consensus Discussions	50%	3.25 (.96)	3.25 (.96)	3.75 (.50)	3.75 (.50)
Develop Resource Sharing Agreements	38%	4.33 (.58)	4.33 (.58)	4.00 (1.00)	4.00 (1.00)
Visit Other Sites	38%	3.00 (1.00)	3.00 (1.00)	2.67 (1.15)	2.67 (1.15)
Obtain Formal Commitments	25%	4.50 (.71)	4.50 (.71)	4.50 (.71)	4.50 (.71)
Educational Strategies:					
Shadow Other Experts	100%	3.50 (.76)	3.38 (.74)	3.63 (.52)	4.00 (.93)
Provide Ongoing Consultation	100%	3.38 (1.30)	3.13 (1.36)	3.38 (1.30)	3.25 (1.28)
Develop Educational Materials	88%	3.71 (1.25)	3.29 (1.25)	4.00 (.58)	3.86 (.90)
Conduct Ongoing Training	88%	3.71 (.76)	3.71 (.76)	3.57 (.79)	3.57 (.98)
Use Train-the-Trainer Strategies	88%	3.57 (.98)	3.43 (.79)	3.43 (.79)	3.57 (.98)
Distribute Educational Materials	88%	3.57 (.98)	3.29 (1.11)	3.71 (.49)	3.71 (.95)
Make Training Dynamic	75%	4.17 (.75)	3.83 (1.17)	4.00 (.63)	4.17 (.75)
Create a Learning Collaborative	75%	3.83 (.98)	3.67 (.82)	3.67 (.52)	4.00 (.89)

Strategy	% Use	Effective-ness	Comp. Effective	Feasibility	Appropriat eness
Conduct Educational Outreach Visits	75%	3.83 (.75)	3.83 (.75)	4.00 (.63)	4.00 (.63)
Conduct Educational Meetings	63%	3.60 (.55)	3.40 (.55)	3.60 (.55)	3.80 (.84)
Inform Local Opinion Leaders	50%	3.50 (.58)	3.25 (.96)	3.75 (.50)	3.75 (.50)
Develop an Implementation Glossary	25%	3.50 (.71)	3.50 (.71)	4.00 (.00)	4.00 (.00)
Increase Demand	25%	3.50 (.71)	3.50 (.71)	4.00 (.00)	4.50 (.71)
Financial Strategies:					
Access New Funding	88%	3.43 (.79)	3.57 (.79)	3.86 (.69)	3.71 (.49)
Alter Incentive/Allowance Structures	25%	4.50 (.71)	4.00 (.00)	4.00 (.00)	4.00 (.00)
Make Billing Easier	25%	4.00 (.00)	4.00 (.00)	3.00 (1.41)	3.50 (.71)
Restructuring Strategies:					
Change Record Systems	88%	3.00 (1.15)	3.00 (1.15)	3.29 (.76)	2.86 (1.07)
Change Service Sites	63%	3.60 (.89)	3.40 (.55)	3.60 (.55)	3.60 (.55)
Create New Clinical Teams	50%	3.75 (.50)	3.50 (.58)	3.50 (.58)	3.50 (.58)
Change Physical Structure and Equipment	50%	3.50 (.58)	3.25 (.50)	3.50 (.58)	3.50 (.58)
Revise Professional Roles	50%	3.50 (.58)	3.50 (.58)	3.50 (.58)	3.75 (.50)
Quality Improvement Strategies:					
Intervene with Consumers to Enhance Uptake and Adherence	100%	3.50 (.93)	3.25 (1.04)	3.63 (.52)	3.63 (.92)
Provide Clinical Supervision	88%	3.71 (.76)	3.57 (.98)	4.00 (.58)	3.86 (.69)
Develop and Organize Quality Monitoring Systems	88%	3.57 (1.13)	3.43 (.98)	3.57 (.97)	3.71 (1.11)
Audit and Provide Feedback	88%	3.29 (1.38)	2.86 (1.07)	3.29 (.76)	3.29 (1.11)
Organize Clinician Implementation Team Meetings	75%	3.67 (1.03)	3.67 (1.03)	3.83 (.75)	3.50 (1.05)
Use Advisory Boards and Workgroups	75%	3.67 (.82)	3.67 (.82)	3.50 (.55)	3.67 (.82)
Use an Implementation Advisor	75%	3.50 (.55)	3.17 (.98)	3.50 (.84)	3.50 (.84)
Remind Clinicians	75%	3.33 (.82)	3.33 (.82)	3.67 (.82)	3.67 (1.03)
Obtain and Use Consumer and Family Feedback	63%	3.80 (.84)	3.80 (.84)	4.00 (.71)	4.00 (.71)
Capture and Share Local	63%	3.40 (.89)	3.20 (.84)	3.60 (.55)	3.60 (.55)

Strategy	% Use	Effective-ness	Comp. Effective	Feasibility	Appropriat eness
Knowledge					
Provide Local Technical Assistance	63%	3.40 (.89)	3.40 (.89)	3.40 (.89)	3.60 (.55)
Purposefully Reexamine the Implementation	50%	3.75 (1.26)	4.00 (.82)	4.25 (.50)	4.25 (.50)
Conduct Cyclical Small Tests of Change	50%	3.75 (.50)	3.75 (.96)	3.75 (.50)	3.75 (.50)
Use Data Experts	38%	4.00 (.00)	3.67 (.58)	3.00 (1.00)	3.33 (1.15)

Note. Ratings (and standard deviations) for effectiveness, comparative effectiveness, feasibility, and appropriateness are based upon a five-point Likert scale wherein higher scores are more positive (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree).

Convergence of qualitative and quantitative findings. The quantitative and qualitative results converged in some cases. First, given frontline workers' attitudes toward Intervention A and the organizational context more generally, it is not surprising that strategies were not viewed as particularly effective. More specifically, some strategies deemed as highly ineffective in the semi-structured and focus group interviews (e.g., "mandating change", "remind clinicians," "audit and provide feedback," and "provide ongoing consultation") were also scored relatively low on the survey, and a strategy such as "make training dynamic" was perceived positively in both forums. In other cases, results did not match up or at the very least reflected the variation of stakeholders' perceptions (e.g., "organize clinician implementation team meetings," "visit other sites"). Others were difficult to compare as the strategies were not emphasized in the qualitative portion of the study (e.g., "use data experts").

Relationship Between Organizational Social Context and Implementation Phenomena

Information about Agency A's organizational social context was garnered from both qualitative analysis of semi-structured interviews and focus groups and the formal measure of organizational social context. Both of these sources of data converged and supported the notion that there are serious concerns about Agency A's social context.

Qualitative reflections of organizational social context. Qualitative analyses revealed several areas of concern related to the organizational social context, including problematic organizational expectations, leaders perceived to be too removed from "the work," a general lack of psychological safety, a sense that frontline workers don't feel heard, and a punitive environment.

Problematic organizational expectations. Case managers at Agency A expressed frustration regarding what they perceived to be inconsistent and unreasonable expectations. They were not always clear about how to do their job. For example, they were not clear about how to appropriately bill for services related to Agency A. A case manager bemoaned the fact that, "…we were taught something, they were taught something, everybody was taught something different." When they pressed their supervisors and leadership for answers, they did not necessarily obtain the clarification that they sought. One agency leader noted that expectations also shift frequently, and in the past the agency would not necessarily follow through on all of the goals, programs, and practices that were initiated. She explained, "Everyone that we see always talks about something being really important for a few months and then they kind of go their own way." Several case managers in both focus groups expressed their belief that expectations were not necessarily realistic. This includes agency expectations for the number of Intervention A cases they could carry at once. One case manager recalled, "When I was hired they said twelve clients would be the ideal caseload, but now [the medical director] is moving that up and saying, 'it can be higher, it can be higher.'" In fact, case managers reported carrying 18-20 clients at any given time. The severity of client need and (at times) family dysfunction only exacerbates the problems associated with a large caseload, and case managers expressed that they didn't believe Intervention A was a good fit for every family.

Nevertheless, leadership, "…doesn't want to hear that, and they stood up and said, 'this can be good for every case.'"

Leaders perceived to be too removed from "the work." In addition to perceptions that work expectations were not reasonable, case managers expressed feeling like agency leaders did not fully appreciate what it was like to actually deliver case management services to such a challenging population. "They push it but they don't see it," exclaimed one frontline worker, "…just the idea of really understanding how the process works would be nice." Another suggested that maybe "people at the top" should be required to get certified in the intervention so that they could "actually feel connected to the process and understand it." However, even those who were expert in Intervention A were sometimes perceived as out of touch with what it is like to deliver it in the real world. As one case manager emphasized, there are often "daily crises [such as] kids trying to blow up schools…things happen that stall our plans to run a meeting." While this frontline worker may have been a bit hyperbolic in his description of the complexities of practice, there is no doubt that difficulties abound and that case managers don't necessarily feel that leaders respond empathically.

Lack of psychological safety. Case managers shared a number of anecdotes that seem to indicate a lack of psychological safety, which can be defined as a shared belief that a team or organization is safe for interpersonal risk taking, organizational learning, or implementation processes (Edmondson, Bohmer, & Pisano, 2001; Edmondson, 1999). Participants told of experiences in which they shared something perceived to be negative about Intervention A, and they ended up being scolded or otherwise punished professionally for sharing their opinions. This led one participant to say, "There is sort of a fear mongering and there is not really a space to... you do have these team meetings, but it is not really a place where you can say, "this is not

working with [Intervention A]," or, "hey, we need extra support here." Another case manager echoed that sentiment, “It is not a place where I would feel comfortable saying anything. I personally won't say anything.”

Case managers don’t feel heard. When case managers were able to express their concerns about Intervention A, they did not feel that agency leaders heard their concerns. When asked if there were any mechanisms for them to share their concerns at team meetings or with agency leaders, one case manager responded, “I don’t think they care. I’m just saying like they know we have problems with it and it’s not realistic but it doesn’t matter.” Though the case managers reported that they did express to agency leaders that Intervention A was not always appropriate for every family, they were not clear if the message was received. “We don’t really get answers a lot of the time,” complained. Another individual expressed that talking to agency leaders was sometimes like “talking to a wall.”

Punitive environment. As indicated in the previous sections describing case managers perceptions of various implementation strategies, case managers described a relatively negative, punitive environment. “It’s never, ever like an incentive, it’s always…punishment or some sort of action,” expressed one case manager. When asked how feedback could be improved, a case manager noted, “If it was monitored for the good and bad it would be better. I feel like it is, ‘you are not doing this right, you need to do this...’” Another quickly added, “That is all aspects of the job, that is not just [Intervention A].” Indeed, it was remarkable how consistent this sentiment was across the two teams of case managers and some of the organizational leaders.

Results of organizational social context survey. Agency A’s Organizational Social Context (OSC) profile was amongst the worst when compared to norms from the national sample of children’s mental health service organizations (Glisson, Landsverk, et al., 2008).

Indeed, the composite profile score based upon the latent profile analysis was 1.00. This indicates that with respect to culture, Agency A had a low proficiency score, high rigidity score, and high resistance score. With respect to climate, Agency A had a low engagement score, low functionality score, and high stress score. Figure 5 depicts Agency A's OSC scores in relation to the national norms. Agency A's culture is amongst the worst, with their proficiency score falling one and three standard deviations below their rigidity and resistance scores. Similarly, Agency A's climate is amongst the worst, as their engagement score is approximately one and a half and three and a half standard deviations below their functionality and stress scores.

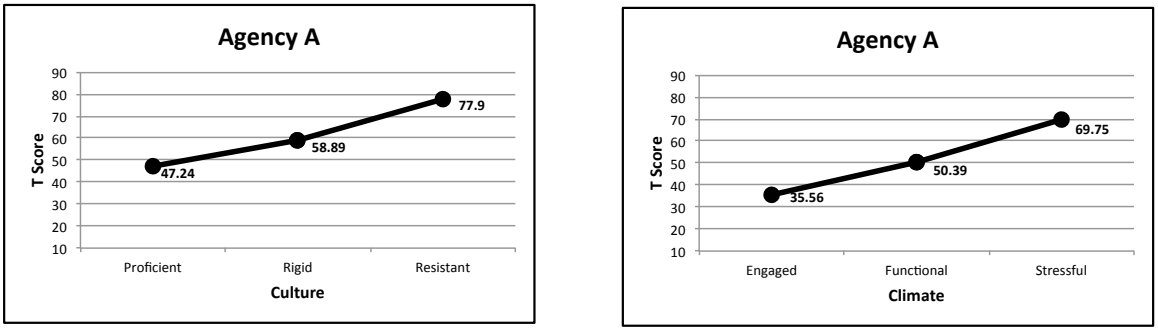

Figure 5. Agency A's organizational culture and climate profiles

Summary and relationship to implementation processes. The qualitative and quantitative findings converged and supported each other very nicely. In general, the findings suggest a climate that is highly stressful and not very functional given the lack of role clarity. Moreover, the culture does not seem to be very proficient, as case managers do not feel like the needs of their clients are necessarily prioritized, or that their pragmatic concerns about service delivery are heard or addressed proactively (Glisson et al., 2014). Participants recognized that this stressful environment contributes to high rates of turnover within the case management team.

Though some strategies that included active and supportive components were perceived

to be effective, may implementation strategies were generally perceived to be ineffective, which was particularly evident in the quantitative findings. Attitudes toward the delivery of Intervention A were obviously poor. There did not seem to be an overall implementation plan that was coherent and widely known. Whereas members of the leadership plan acknowledged an implementation plan, this was not common knowledge at the highest levels of the organization, and certainly not at the frontline worker level. The fact that strategy use was not consistently endorsed (i.e., it ranged from 25-100%) also may indicate poor communication or execution of an implementation plan. Implementation strategies may also have been used inconsistently, as training processes and fidelity monitoring seemed to occur haphazardly. In fact, one organizational leader made a sage observation about the effectiveness of implementation strategies in general. “I don't think that the strategy itself has been effective or ineffective, she stated. “I think it's the fidelity to the strategy and the commitment to communicating what's going on.” It is clear that strategies were not always used with “fidelity” or with the intensity that is deemed appropriate in the literature. In fact, it may be better to do fewer things well than to utilize a wide range of implementation strategies poorly. These qualitative and quantitative data on culture and climate also indicate that more attention should have been paid to basic inner setting (or organizational) level processes, such as developing clear communication patterns and psychological safety. Without these fundamental organizational processes in place, effective implementation becomes a challenge and perhaps an impossibility.

Agency B

General Organizational Description

Agency B is a small community mental health agency that provides outpatient psychotherapy and support group services. They treat children from about age three to older adults, and most therapists have clients across the lifespan. One leader who typified this versatility stated, "I work with kids, teens, adults, couples, families, and everything in between."

Description of Program or Practice Implemented

Agency B does not generally dictate the use of any specific evidence-base programs or practices. Thus, this case study was based largely on their general approach to practice, as well as their effort to implement a mental health educational intervention intended to increase community members' knowledge of psychopathology and common treatment options.

The general treatment approach endorsed at this Agency B is psychodynamic. One therapist who had been with the agency for almost three decades reflected on the organizations theoretical orientation, "The big sweep of things since I've been here…it was almost analytically, basically psychodynamic. We have relaxed that kind of structure. We're much more eclectic than we were from the very beginning." Despite the move toward a greater degree of eclecticism, the majority of clinicians practice from a psychodynamic orientation. In fact, the agency looks to hire individuals who have that sort of clinical training and/or theoretical bent. "That's the base. People that come in, that's the foundational language. That's the foundation, therapy modality. I think if you want to do something else, that's your own." This focus is reinforced through a program in which the organization trains individuals to be psychotherapists. The program "is clearly identified as a psychodynamic training program. The coursework is already oriented that way. The language structure is oriented that way."

Though the organization embraces a psychodynamic orientation, they promote and appreciate clinician autonomy and eclecticism. One clinician explained, "We're much more individualized. We as individual therapists implement a new treatment, rather than the agency as a whole." She went on to share that she has recently started using Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999) and mindfulness approaches (e.g., Segal, Williams, & Teasdale, 2002) in her practice. Another organizational leader admitted that the services delivered to clients tend not to be rigidly psychodynamic, "There's probably not much if any rigid cognitive behavioral work being done. This is not [local institution that focuses on CBT], but there's certainly a lot of cognitive stuff going on at all times." Moreover, he made the case that a psychodynamic approach is not always the most helpful in guiding real world practice:

> Most of the people who'd come in for services come in because they have problems, they don't come in because they really want to work through other issues and neurosis, and they're not coming in for long-term psychotherapy…I think most people come in because things aren't working in their lives, and they're hurting, they're in trouble, or their marriage is falling apart, the kids are out of control, or they think they're out of control, or they're losing their job, or they can't stop drinking, or whatever. Those are problems and the clinician then says, 'Okay, I recognize the problem and this is the way I work with it.' A strategy that generally says, 'Well, stick with us for two or three years and we should be able to help you with that.' It's not the kind of strategy that's going to enthuse people or keep them coming, particularly when they were using limited resources to pay for the services. The application of psychodynamic

> psychotherapy in that setting tends to be different than it would be if you were in a more rigidly psychoanalytic setting, I think.

He also referenced specific cases in which psychodynamic therapy was inappropriate, such as in the case when a client's intellectual ability renders them unlikely to benefit from that form of treatment. Another organizational leader underscored the agency's relative embrace of eclecticism and clinical openness:

> We all bring other things to the table besides psychodynamic. There are people who engage in other kinds of things. We meet the client where they are at. We don't pigeonhole anywhere. We don't come like 'this is the way we work and this the way you have got to fit in or no deal.' It's working with people where they are...The hiring process for clinicians here is very, it takes a while because we are looking for a certain kind, a way of working in openness and professionalism.

The agency has recently taken the lead on developing, implementing, and evaluating a novel mental health collaborative. The purpose of the collaborative is to provide support to community members so that they can better address mental health needs. The mental health collaborative was established approximately two and half years ago; however, a recent development is a specific focus on providing education and support regarding children's mental health needs. This program was developed organically, and as the leader of the collaborative emphasized, "there was no specific model…we didn't follow what somebody else had put together as in this is the way to do this. It really was organic." The mental health collaborative always involves two experts in mental health treatment who go into the community to provide training and support. Currently there are five trainers that conduct these collaborative sessions,

and soon, there will be at least seven trainers as more members of Agency B are trained to become mental health collaborative trainers.

Decision Making Processes

Treatment decision making. When asked about how they make decisions about which treatment approaches, programs, or practices to implement, organizational leaders cited a number of contributing factors that largely fell at the level of the outer setting, inner setting, and characteristics of individuals. These themes will be described below, but it is worth noting that none of these organizational leaders mentioned evidentiary status as a major contributor to treatment decision making. Rather, one of the leaders referenced that "psychodynamic is a little less evidence-based," and did not mention that fact that there actually is some evidence to support its effectiveness (e.g., Abbass, Rabung, Leichsenring, Refseth, & Midgley, 2013; Driessen et al., 2010; Fonagy, 2006; Leichsenring & Rabung, 2008; Shedler, 2010). The agency did acknowledge the growing pressure to use evidence-based programs and practices, as one leader stated reluctantly, "…that seems to be the way of the world." However, their general approach was to package their existing services differently to fit the needs of funders, rather than to adopt specific evidence-based treatments (though some clinicians were utilizing evidence-based treatments such as Trauma-Focused Cognitive Behavioral Therapy). Organizational leaders described clinical decision making being driven by outer setting factors such as client need, demands of funders, networking with other organizations, and expert consultation; inner setting factors such as direction from clinical supervisors, market niche and expertise, and organizational capacity; and factors related to the characteristics of individuals such as training and clinical experiences.

Factors related to the outer setting. Outer setting factors that influenced clinical decision making at Agency B included client need, demands of funders, networking with other organizations, and expert consultation.

Client need. Each of the agency leaders interviewed suggested that client need was a major driver of clinical services, both in general practice and in choosing to implement specific programs such as the mental health collaborative. One leader stated this emphatically, "I would say the main driving force is just need." Another agency leader, when asked about whether he seeks out research literature, paused before reflecting, "I'm a clinician. I respond to the need. It's not that I don't like to research, but I respond to the need, and then once I hear the need, I'm more apt to do some digging in the literature to see who has done research on it." This responsiveness to need was very evident with respect to the mental health collaborative, as several individuals spoke of seeing the needs of community members first-hand. "Just hearing them talk about what they are going through, their own stresses are a real indicator of some kind of need there," argued one leader. Another referenced that the mental health collaborative was a direct response to knowledge deficits of community members relative to development and psychopathology.

Dictated by funders. Though perhaps less of a "pure" motivation, leaders from Agency A affirmed the power of funding to dictate treatment objectives. One leader described multiple failed attempts to land grant funding, and noted that finally landing a grant from a local funding agency cemented the agency's focus on children's mental health. She exclaimed frankly, "funding always dictates."

Networking with other organizations. The mental health collaborative was born out of collaborative discussions with other organizational representatives at a conference,

demonstrating the importance of what Damschroder et al. (2009) call cosmopolitanism, or the extent to which organizations are networked with other organizations. A number of other organizations came together and had an idea to pilot the mental health collaborative, and they were obviously aware of Agency B's expertise. These connections appeared to be indispensible in terms of deciding what to implement (i.e., the collaborative) as well as how to implement new programs and practices (which will be seen in a subsequent section).

Expert consultation. Agency B relied heavily upon two expert consultants as they approached the development of the mental health collaborative. One consultant was a writer and advocate for mental health needs, and the other was a psychologist. Collectively, they put together the curriculum for children's mental health that they hoped would be viable to present to the collaborative members. The process of learning and interacting with the consultants has been iterative, as the leader of the collaborative emphasized, "The dialogue is going back and forth. As we field tested that curriculum, we've gone back to [our consultants] and we've said, 'This is what works and this is what doesn't, or this is what was missing.' We've really been perfecting it this year and giving each other feedback."

Factors related to the inner setting. A number of factors related to the inner setting were also critical in informing treatment decisions, including direction from clinical supervisors, market niche and expertise, and organizational capacity.

Direction from clinical supervisors and peers. One organizational leader really stressed that he had learned a great deal from "pretty competent supervisors," and the general "feel" of Agency B was one in which it was clear that there was a fairly strong sense of respect amongst colleagues. As will be discussed in a subsequent section, another clinician elevated peer supervision as one of the most helpful implementation strategies, and several clinicians

mentioned an organizational ethos of continuous learning and knowledge exchange. In some ways, it felt to this author as if the organization was much more concerned about what people felt and thought *internally* rather than externally or in the "research community." This is consistent with the high value placed on supervision and other collaborative learning approaches as means of guiding therapeutic practice.

Market niche and expertise. It was very clear that the choice to develop and implement the mental health collaborative model was driven by Agency B's market niche and expertise. In fact, when the organizational leaders were asked what factors were most important in their decision making process, most responded with some version of "this is what we do!" In this sense, this was less about the availability of funding (though that certainly played a role), and more about the excellent fit with the organization's mission and values.

Organizational capacity. Similar to the issue of fit between the agency and the mental health collaborative, agency leaders suggested the importance of organizational capacity. "It really did make sense and we had the financial stability to be able to backbone it," stated one leader. "We had the room for what we needed because we have a nice conference room in there to host." They also had the human capital to support the effort because they already had several people with the needed expertise at the agency, and so they were able to draw on their own personnel. These pragmatic concerns likely play an even bigger role in clinical (and implementation) decision making at a relatively small agency, as they don't have the luxury of having diffuse efforts that are not highly aligned with their mission and their capacities.

Factors related to the characteristics of individuals. In addition to the factors at the organizational and outer setting level, leaders mentioned training and other clinical experiences as an important factor.

Training and clinical experiences. Naturally, clinicians and organizational leaders cited their own training experiences as instrumental in guiding the choice of therapeutic interventions. What is noteworthy is the sense of continued curiosity and openness to learning that was expressed by a number of clinicians. As one clinician noted, "We do a lot of looking into things and learning about things on our own, and then we might train each other if other therapists are interested in that." Another organizational leader also identified with that: "Lots of people here also are always reading and doing research and finding out about new things and new ways to do things." Organizational leaders also relied heavily upon their own experiences, as one shared of his own efforts to "work through" difficult clinical issues and how that has informed his own views around theory and therapeutic technique. At times, a tension was evident between the leaders' and clinicians' training and clinical experiences and the direction that the agency is going in terms of systematizing some of their treatment approaches to fit with the evidence-based practice movement. As much as eclecticism was embraced, one leader shared her concern about drifting too far from the agency's psychodynamic orientation, which also happens to be her own theoretical preference: "I just don't want this psychodynamic piece to get lost in all this and I know there's a few other people who feel that way. I think it is a process and yeah we'll get there, we have to find the balance." It is clear that regardless of an agency's overarching approach, the personal convictions of individual clinicians will play a large role in dictating the choice of interventions in any environment that prizes autonomy and eclecticism.

Implementation Decision Making

Leaders from Agency B discussed a range of different factors that guide their selection of specific implementation strategies. Though the specific factors discussed in this section are

primarily related to the implementation of the mental health collaborative, it is fair to note that the organization has an obvious commitment to intensive training and supervision, which will be detailed in the next section on implementation strategies utilized. This commitment seems to indicate a strong belief in the importance of continuous training and support to facilitate the growth and professional development of their staff members. In terms of the implementation of the mental health collaborative, organizational leaders emphasized that the process was "organic" and "highly collaborative." There was not necessarily an overarching implementation plan that has guided the implementation, nor was there any formal model of implementation that the leaders relied upon. There was not a formal assessment or evaluation of need, though as emphasized above, the leaders' close relationships with community members allowed them to directly experience their need for more training and support to effectively handle mental health concerns. Implementation decision making did not appear to be informed by the implementation or quality improvement literature, as none of the leaders referenced a reliance on this growing body of research. Five main factors stood out as particularly important in guiding implementation decisions at the levels of the outer, individual, and process levels.

Outer setting factors influencing implementation decision making. At the outer setting level, organizational leaders discussed the importance of expectations outlined in grant proposals, outside consultants, and widespread collaboration in determining implementation strategies.

Expectations outlined in grants and contracts. The organizational leader that is effectively the agency's grant writer noted that implementation strategies are often dictated by what is written in grant proposals. To reiterate a previous quote, she stated "funding always dictates," and acknowledged that funding may impact the extent to which they can provide

training and other implementation strategies.

Reliance on outside consultants. Just as with treatment decision making, the implementation of the program was partly informed by the expertise of two outside consultants (as detailed above). In particular, they have guided the evaluation and efforts to systematize the processes related to the implementation of the mental health collaborative. Much of their implementation decision making has been documented by one of the outside consultants, and the consultants were universally seen as helpful in guiding the implementation of the mental health collaborative.

Widespread collaboration. The mental health collaborative involves a great deal of collaboration between Agency B, other mental health and religious organizations in the area, and funders. Thus, decisions regarding implementation were always collaborative, group decisions. One leader recalled, "We all sat around the table. Everything we make, we make a group decision. We always vote…" The director of the program also emphasized the consistent collaborative spirit of the effort:

> We got together with [multiple organizational partners], [funders], and [Agency B]. Early in the process, [large local mental health provider], Behavioral Health, and [state] Department of Mental Health were involved to help us put together a plan, a program that everyone thought would be welcome by [community members] and also would be of use to them, would be of very practical use. I think it took us, before we had our first meeting with [community members], I think we met a good six months, maybe longer.

Individual level factor influencing implementation decision making. Organizational leaders emphasized past experience as one of the major factors influencing implementation

decision making. One leader praised the experience and expertise of the leader of the mental health collaborative, stating, “He's been doing this a long time, does a lot of consultations. What does work…what doesn’t work…I would say is something that he's got that down.” This personal experience was prized as the mental health collaborative was often implemented in rural communities in which the credibility of “city folk” is tenuous. One of the leaders drew this connection, stating: “the big thing is not having the big people from the city coming down and telling you what to do.” Rather, the approach is more “What can we do for you? What do you need?” This underscores the partnered approach, in which local wisdom and expertise is valued and incorporated into implementation efforts (Alegria et al., 2012; Birkel, Hall, Lane, Cohan, & Miller, 2003; Chambers & Azrin, 2013).

Process related factors influencing implementation decision making. Finally, organizational leaders emphasized the constant processing that occurs as the mental health collaborative program is implemented. “Every month we meet and we process and we learn from each other,” stated an organizational administrator. “…and so everybody comes to the table with what their group did that month and how did it go, what materials did we present, how did it go, what are we doing next, where should we go from here?” Thus, implementation decision making is occurring constantly, including the assessment of community members’ perspectives through formal surveys. Again, the processing of the implementation effort was described as “organic,” and one leader said, “It keeps going. It has changed from that original grant, that’s for sure. On what we said it was going to do, and it sure has taken longer than we thought that it would take. Some groups haven’t taken off, fizzled. Some are doing awesome.” This iterative processing of implementation efforts and allowing it to inform the selection of implementation strategies is consistent with other accounts of implementation captured in the

literature (Aarons & Palinkas, 2007; Aarons, Green, et al., 2012; Chambers, Glasgow, & Stange, 2013; Glasgow & Chambers, 2012).

Implementation Strategy Use

Organizational leaders and clinicians from Agency B discussed the use a range of implementation and/or quality improvement strategies, most of which were at the level of the individual providers (i.e., training, supervision, and other opportunities for clinical processing). These strategies are discussed in more detail here in relation to the CFIR domains.

Strategy focusing on intervention characteristics. Agency B discussed one implementation strategy that was related to the program or practice being implemented, namely, their willingness to adapt programs as needed.

Adapting interventions. When asked if they have found a need to adapt interventions to better meet the needs of their clients, various members of Agency B's staff expressed their openness to doing that as necessary. One agency leader stated, "Yeah, I think we are very open to that. I don't know if I can be specific, but I can say in a general sense that yeah, if we know that needs change, or situations change, or a new group, there is a new concern or something, we would make the change required." More specifically, the director of the agency and the mental health collaborative explained:

> People get sick of the word, but I used the word 'this is organic.' I mean we're figuring this out as we go along and actually it's been a nice model. [Our consultant] did a great job coming up with the curriculum and one of the things we learned is that if we're too rigid with our curriculum and we try to stick with our curriculum, we got push-back from [collaborative members] because they felt like we were pushing a curriculum on them rather than listening to their

needs. We still use our curriculum but we pick and choose, and we step aside from the curriculum. And if they ask questions about material that's not in the curriculum, we'll say, 'All right, we'll find out. We'll bring it to you next time.'

Agency B did not seem to embrace the rigid application of evidence-based treatment approaches; thus, it should come as no surprise that they are comfortable with, and regularly engage in, adaptations and tweaks of programs. It is not clear if and how these adaptations are documented, which is an emerging focus of some implementation scholars (Cabassa & Baumann, 2013; Wiltsey Stirman, Miller, Toder, & Calloway, 2013; Wiltsey Stirman, Calloway, et al., 2013). Presumably, the expert consultants conducting the ongoing evaluation of the mental health collaborative are documenting adaptations related to that program.

Strategies focusing on the outer setting. Several of the strategies mentioned by Agency B personnel focused on the outer setting of implementation, including implementation strategies directed at the client-level, accessing opportunities for funding, and collaborating with other agencies to implement the mental health training collaborative.

Obtaining client feedback. Agency B employed a couple of strategies that enabled client feedback, including suggestion boxes in every waiting room that enable clients to submit anonymous feedback, and regularly administered client satisfaction surveys. Another organizational leader also emphasized that, more informally, clinicians are constantly attempting to learn from the feedback that clients give them directly within therapy or group sessions. Within the context of the mental health collaborative, feedback from members is consistently sought as well.

Carefully timing sessions. The director of the collaborative also emphasized the importance of helping members stay on task, focused, and "up to speed" by not allowing

too much time to pass between collaborative meetings. They have learned that six weeks between meetings is the maximum amount of time allowable, lest there be distractions and a flattening of the learning curve. The design of the mental health collaborative has also allowed members to hold each other accountable to address the mental health needs of their community. "It's not unusual for a [member] to turn to her or his colleague and say, 'Whatever happened to that 12-year old that you talked to us about a month ago?' That's really kind of rich to see that happening and it makes, in an informal and friendly way or collegial way, it makes for a certain accountability."

Accessing new funding. Agency B, like all agencies, relied upon grant funding to supplement their operations. They have a full-time marketing professional who also handles the "lion's share" of the grant writing. One organizational leader discussed these efforts as well as some of the unintended benefits of the grant writing process:

> [We do] a lot of writing of grants and we are trying to get more and more. In order to do that, yes, we have to formalize and articulate what we are doing here. It's not like we are not doing a lot of this stuff but it's just to get it down in the language and to really be able to document it.

The agency also conducts a number of fundraisers that are organized by the primary grant writer with the help of committee members. The mental health collaborative has been dependent in large part on the availability of grants to fund its operation. As the leader of the collaborative explained,

> I don't think it will ever be able to be totally funded by [communities] because it's important we send trainers two by two because what we found is that what one trainer misses the other one picks up. It's a pretty expensive proposition and

> each trainer is paid a $100 an hour for the actual training. You got a three hour presentation, that's 600 bucks. I don't think we will ever be able to afford that completely…Some [communities] can afford that and others will never be able to do that. I think we'll always be somewhat funding dependent on this if this program works.

Given their reliance on grant funding, they have had to be much more attuned to record keeping and research. The director admitted,

> clinicians are notoriously averse to doing that stuff because they just want to sit and work with people. That has been a significant cultural change for [Agency B], and for the collaborative. Everybody in the collaborative, we've all have to learn. We've all had to learn. We've got to document this.

When asked how he has "smoothed the path" for this transition to research and documentation, he quipped, "Easy. [the funder] said, 'We're not going to release the next check until we get this data.' It was easy." The precarious nature of funding, and Agency B's reliance on it to sustain the collaborative clearly influences their actions. This demonstrates the tremendous potential that funders have to promote more meticulous documentation of program development and implementation efforts, and ultimately, the uptake of evidence-based services (Raghavan, Bright, & Shadoin, 2008).

Collaborating with other agencies. As emphasized in the previous section on implementation decision making, Agency B has collaborated greatly with other mental health, religious, and funding organizations in implementing the mental health collaborative program. These collaborations seemed to be more than simply "on paper," as leaders repeatedly

emphasized the frequency of meetings and the continuous processing that occurs amongst partnering agencies.

Strategies focusing on the inner setting. Implementation strategies that focused on the inner setting included efforts to develop the infrastructure for implementation and quality improvement, changes to the organizational structure, and efforts to shift toward a more prevention-oriented approach.

Infrastructure development. Agency B is implementing a new electronic medical record (EMR) due to requirements set forth by the Affordable Care Act. This was done reluctantly, as the staff member in charge of information technology stated, "We're getting a new EMR because we have to and that's the only reason why we'll be doing it." She continued to describe difficulties of implementing an EMR with a clinical staff consisting of several older individuals who are not very technologically savvy. There was little acknowledgement of how this development may prove useful in enhancing the quality of service delivery at the organization.

Changes to the organizational structure. Though there were few implementation strategies that directly addressed the organizational structure and functioning of Agency B, one organizational leader referenced several recent changes that have impacted the organization's functioning. First, she referenced some unexpected changes such as the death of an organizational leader and staff turnover that impacted the culture of the organization and its relationship with its clientele. This leader also discussed more deliberate changes: "We made some changes in the administrative staff. There were some things that need to change." She was reluctant to provide details (this particular leader was reluctant to be recorded at all, and at times was rather guarded). When asked to describe the impact of those changes in the composition of the administrative staff, she said,

> Yeah, it helps the relationship climate and the administrative staff, which sort of improves functioning for the whole agency. And we did make some changes of job, we tweaked the job performances [descriptions] and some of those were changed a little bit and transferred to make, to try to make that more efficient, you know, the functioning there more efficient and functional for everybody, which also affects the functioning of the agency.

Shifting the organizational culture toward prevention. Though not necessarily a specific strategy, the director of Agency B discussed his efforts to shift his employees' focus to prevention rather than treatment given the goals and purposes of the mental health collaborative. He elaborated, "That's been a shift for our organization… they're not used to thinking in terms of larger systems. That's been a shift; and actually, I think, it's a healthy shift for the organization." Presumably, this was communicated formally and informally through meetings and informal channels; however, he was not clear on specific strategies that helped to usher in this shift.

Strategies focusing on the characteristics of individuals. Implementation strategies that focus on the development of knowledge and expertise of individual clinicians were clearly dominant for Agency B. These strategies included a variety of training opportunities, supervision, formal staff consultation, informal staff consultation, and an intensive training program.

Training. Agency B offers an extensive array of training opportunities. This includes "case conferences," which occur twice monthly for one hour and fifteen minutes. These events involve trainings focusing on a range of topics related to therapeutic work and psychotherapy. These meetings are open to individuals outside of the agency for a small fee, but are provided

free of charge to agency members and are generally expected for full-time clinicians. Continuing education units are available for those sessions. Additionally, they also offer a psychodynamically focused series of mini-courses, which can be taken individually or as a series. These courses feature a variety of topics such as an overview of specific psychodynamic theories such as drive, ego, self, and object relations (see Borden, 2009 for an overview of these theories). Each session lasts two hours, though some courses take place over the course of multiple weeks (typically over four). These courses are required for the intensive training program (described in this section), but are also open to Agency B clinicians and community members. Clinicians get 15 hours of CEU credit per year minimum; thus, they do not have to seek CEUs outside of the agency unless they desire to do so.

Supervision. All clinicians are required to have an hour of supervision twice per month. Supervision can be either individual or peer/group based. New hires are assigned supervisors for six months to a year, and that can be weekly or every other week as needed. The purpose is to "just sort of see how they work, to get them adjusted to how we work." One organizational leader and supervisor reported his struggle over getting more direct information about how his supervisees actually work in session. "I talked about process notes and I've talked about recording, but I didn't push it and it didn't happen. It seems to me that that's something that I need to address," he stated. His sense was that recording sessions was far from common practice at the agency, but he acknowledged that at least two supervisors require process notes. This is, of course, an ongoing tension in the broader field in terms of answering the question of how to monitor and improve fidelity and quality of service delivery (Schoenwald, 2011; Schoenwald et al., 2011).

Weekly staff consultations. Agency B also offers weekly staffing meetings or staff

consultation sessions. These sessions are not mandatory for all clinicians, though they are welcome and encouraged to come. These sessions provide ready access to consulting psychiatrists, allowing clinicians to receive guidance on diagnoses and pharmacological concerns. Generally, a clinician presents a case, and two senior staff members facilitate the discussion.

Informal consultation. Several leaders and clinicians also suggested the occurrence of informal consultation. "Everyone here is very open and kind and makes people feel that they can come to them," mentioned the clinical director. "It is important to me to be available for the staff… I'm in email contact and phone contact and even face-to-face contact with people on a fairly regular basis to address their needs and concerns." These informal consultations supplement more formal mechanisms of support through training and supervision.

Intensive training program. Agency B offers a formalized intensive training program for recent graduates of psychology, counseling, or social work programs that are seeking clinical licensure en route to becoming clinicians. The program is very intensive, requiring formal training and coursework as well as intensive supervision through all of the mechanisms discussed above. This program seems to benefit the agency by ensuring that there is a constant spirit of learning and growth, as well as an infrastructure to support continued training.

Strategies focusing on the process of implementation. Agency B employed three primary strategies related to the process of implementation, including outcome monitoring, meetings specifically dedicated to the assessment and evaluation of implementation processes specific to the mental health collaborative, and more generic monthly staff meetings to discuss any concerns that arise.

Outcome monitoring. Agency B reported collecting pre- and post-tests on their clients

clinical functioning; however, one clinician mentioned that they are in the process of changing that because the measures they were using were deemed inadequate. There was some discussion of how this may be integrated into the EMR system in the near future, which will enable them to more easily query outcome data. This applies to their outpatient clients, not to those involved with the mental health collaborative.

Reassessing and evaluating implementation processes. Leaders discussed several mechanisms for reassessing the implementation of the mental health collaborative. This includes meetings twice a year to evaluate the program. It also includes in-person or online meetings every four to six months that include the training team and the primary grant writer who holds the team accountable to meeting the milestones stipulated in the grant proposal. The director elaborated,

> We keep each other accountable in terms of curriculum that way, in terms of doing the research and collecting the data that we need, and in terms of the movement of the project. That's really important that we continue to meet as a training team. In a way, there's a kind of a parallel that goes on. The training team meets as often as really, about the same rate that the clusters meet.

These meetings allow the team to make any needed tweaks in terms of both the program and its implementation. The director's last point pertaining to the frequency of meetings is important to underscore, as it illustrates the utility of investing in implementation processes rather than thinking that meetings can occur sporadically while services continue without reflection or evaluation.

Monthly staff meetings. Monthly staff meetings are also held regularly, and provide a venue for the entire staff to "discuss things that are happening, to inform, to update, to tweak

and to get feedback from the staff that have concerns that they want to address. If there is something that we need more time or we need to address then we make sure we [appoint] a committee to address it that way."

Perceptions of Implementation Strategies

Qualitative results pertaining to perceptions of implementation strategies.

Qualitative data pertaining to clinicians' perceptions of implementation strategies were drawn from a focus group with clinicians as well as semi-structured interviews with three organizational leaders who also served as clinicians at the agency. It is worth noting that the focus group was cut shorter than most due to participants arriving late to the session. Perhaps not surprisingly, participants shared primarily about the provider-focused implementation strategies such as training, supervision, and consultation in addition to one process-focused strategy related to adapting programs and practices.

Perceptions of training. Clinicians generally seemed to appreciate the training opportunities provided by Agency B. They recognized the value of having training opportunities that provided continuing education units (CEUs) at their agency, and also noted the helpfulness of having speakers/trainers drawn from a variety of fields and specialties. This is consistent with findings from another study that emphasized how essential CEUs can be in motivating clinicians to attend training (Powell, McMillen, et al., 2013). One clinician wished that they "had the funds to do more training in certain areas, or even get credentialed…then those clinicians could come and train everyone else." She went on to offer the example of Acceptance and Commitment Therapy, suggesting she would love to get credentialed in that approach. Yet, she expounded,

It's so expensive to do these trainings, thousands of dollars to really get in-depth

> training. I would love to actually train. I think there are a lot of us who would love to be trainers, and to do more education. I think that would be a way to do it, rather than using the money to send everyone to these little trainings, where you get very little.

Despite the benefit of having CEUs provided internally to the agency, there are no funds to pay for additional training. Clinicians would love to have some level of funding so that they could more freely pursue their training interests. An organizational leader also confirmed that the agency could do a better job of ushering in the use of particular evidence-based programs, "There's always some interest in trying out new ideas, but there isn't a particularly formalized way of making that happen that works particularly well." Another interesting point made by a clinician in the focus group was the need for more training on topics such as "the private practice world" (despite the fact that Agency B is not in fact a group practice, but a mental health agency) and pragmatic concerns such as getting on insurance panels, having difficult conversations surrounding money, and other issues. Also, she suggested it might be helpful for those who have primarily worked in private practice to have more of an introduction to what it means to work for a non-profit. It seems that the agency is moving toward more training in some form, as the clinical director mentioned that they want to bring in (or conduct internally) even more trainings despite their already robust training infrastructure. They're "…thirsty for it. A lot of people do things on their own; they get extra trainings and things. They do other therapies and sometimes they go to another institute. I would say most of the people here are very much into training."

Perceptions of supervision. One clinician indicated that, for her, peer supervision was more helpful than case conferences. "We can talk more specifically," she stated, "It's a smaller

group, and we can talk more in depth about really tough cases. We can really get in there and talk, more than, a sketch of a case." The clinical director asserted that there is no substitute to supervision and the guidance that it can provide to clinicians of all experience levels. She offered, "I'll tell you what I think is important and what works is direct contact with a supervisor, the director, actually talking to people…"

Staff consultations. A clinician conveyed that case consultations are primarily helpful when one wants to consult with a psychiatrist; however, as stated above, other strategies such as peer supervision or one-to-one supervision may be more helpful when one desires to process cases in depth.

Adapting programs and practices or implementation strategies. Once again, the director of the mental health collaborative spoke to the importance of adaptation and, perhaps more aptly, flexibility. "Don't be a slave to the curriculum," he warned. "That's it. You can tell when you're meeting with a group of [community members]…if they begin to feel like they're being sold the program, they're gone." He noted that this was a lesson that was important for the trainers as well as the funders. He recalled,

> I know when we had the representative from [the funder] in for a our site visit, they come in once a year to annually review and talk to us, we tried to explain it to her. After a while she got it, but at first it was crazy making for her. 'But wait a minute, you have this curriculum. Aren't you testing the curriculum?' The response was, 'Yes, as a matter of fact, we are testing it and this is the feedback we're getting. Don't be a slave to the curriculum.'

Quantitative results pertaining to perceptions of implementation strategies. Six of 12 Agency B employees (50%) completed the Implementation Strategy Use and Perceptions

Survey, and the full results can be viewed in Table 7. In terms of strategy use, it is notable that a relatively narrow range of strategies were endorsed. Nine strategies were endorsed by one respondent or less, and 68% of the strategies were endorsed by at least half of the respondents. Means for the effectiveness ratings ranged from 2.00 to 4.67 (1 = least positive; 5 = most positive). Eighteen strategies received an effectiveness rating of 4.00 or higher, including 13 strategies that were endorsed as "in use" by at least half of respondents. Six strategies endorsed by at least half of respondents received scores below 3.50 (i.e., closer to neutral at best), including: "visit other sites," "use train-the-trainer strategies," "change record systems," "develop and organize quality monitoring systems," "audit and provide feedback," and "capture and share local knowledge." Thus, the quantitative survey revealed that perceptions of implementation strategies were relatively favorable, with a clear trend of positive ratings for the educational (e.g., "conduct educational meetings," "make training dynamic," "conduct ongoing training," etc.) and quality management strategies ("clinical supervision," "implementation team meetings," etc.) that the agency relies upon the most. It is also notable that some quality management strategies such as "using data experts," "developing and organizing quality monitoring systems," and "audit and provide feedback" were rated as relatively ineffective.

Convergence of qualitative and quantitative findings. In the case of Agency B, the qualitative and quantitative results converge very well. Most of the strategies rated very highly in the quantitative survey were discussed in a similar fashion in the qualitative interviews. Again, it is clear that Agency B has a bent toward educational strategies, which are viewed as effective by clinicians and leaders. It is also clear that it is not an agency that places much value on data, quality management, audit and feedback, and developing formal plans for implementation. This will be discussed further in the proceeding section on organizational

social context.

Table 7. Agency B: Implementation Strategy Use and Perceptions Survey Results (N = 6)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Planning Strategies					
Build a Coalition	83%	3.80 (.84)	3.80 (.84)	4.00 (0.00)	4.00 (0.00)
Recruit, Designate, and Train for Leadership	83%	3.80 (.45)	3.80 (.45)	3.80 (.45)	3.80 (.45)
Assess for Readiness and Identify Barriers/Facilitators	67%	3.75 (.50)	3.75 (.50)	4.00 (0.00)	4.00 (0.00)
Mandate Change	67%	3.75 (.50)	3.75 (.50)	3.50 (1.00)	3.25 (.96)
Conduct Local Consensus Discussions	67%	3.50 (1.29)	3.25 (1.26)	4.00 (.82)	4.00 (.82)
Tailor Strategies	50%	4.33 (.58)	4.33 (.58)	4.33 (.58)	4.33 (.58)
Identify and Prepare Champions	50%	4.33 (.58)	4.00 (1.00)	4.00 (1.00)	4.00 (1.00)
Stage Implementation Scale Up	50%	3.67 (1.53)	3.67 (1.53)	4.33 (.58)	4.33 (.58)
Involve Executive Boards	50%	3.67 (.58)	3.67 (.58)	4.00 (0.00)	4.00 (0.00)
Visit Other Sites	50%	3.33 (.58)	3.33 (.58)	3.33 (.58)	3.33 (.58)
Develop Academic Partnerships	33%	3.50 (.71)	3.50 (.71)	3.50 (.71)	3.50 (.71)
Conduct Local Needs Assessment	33%	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)
Develop a Formal Implementation Blueprint	17%	3.00 (undefined)	3.00 (undefined)	3.00 (undefined)	3.00 (undefined)
Obtain Formal Commitments	0%	N/A	N/A	N/A	N/A
Educational Strategies					
Conduct Ongoing Training	100%	4.33 (.52)	4.17 (.41)	4.17 (.41)	4.50 (.55)
Provide Ongoing Consultation	83%	3.80 (.84)	3.60 (.89)	4.00 (.71)	3.80 (.84)
Create a Learning Collaborative	83%	3.60 (.55)	3.60 (.55)	3.60 (.55)	3.60 (.55)
Use Train-the-Trainer Strategies	67%	3.25 (.50)	3.25 (.50)	3.25 (.50)	3.25 (.50)
Conduct Educational Outreach Visits	50%	4.67 (.58)	3.67 (.58)	4.00 (0.00)	4.00 (0.00)
Conduct Educational Meetings	50%	4.33 (.58)	3.00 (1.00)	4.00 (0.00)	4.33 (.58)
Make Training Dynamic	50%	4.33 (.58)	4.33 (.58)	4.33 (.58)	4.33 (.58)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Distribute Educational Materials	50%	4.00 (0.00)	3.67 (.58)	4.00 (0.00)	4.00 (0.00)
Develop Educational Materials	50%	3.67 (.58)	3.67 (.58)	3.67 (.58)	4.00 (1.00)
Inform Local Opinion Leaders	33%	3.00 (1.41)	3.00 (1.41)	4.00 (0.00)	4.00 (0.00)
Shadow Other Experts	17%	4.00 (undefined)	5.00 (undefined)	4.00 (undefined)	4.00 (undefined)
Develop an Implementation Glossary	0%	N/A	N/A	N/A	N/A
Increase Demand	0%	N/A	N/A	N/A	N/A
Financial Strategies					
Make Billing Easier	83%	4.20 (1.30)	4.00 (1.22)	4.20 (.45)	3.60 (1.14)
Access New Funding	83%	3.80 (.45)	3.60 (.55)	4.00 (0.00)	4.00 (0.00)
Alter Incentive/Allowance Structures	50%	3.67 (.58)	3.67 (.58)	3.33 (.58)	3.33 (.58)
Restructuring Strategies					
Change Record Systems	100%	3.33 (.82)	3.33 (.82)	3.83 (.41)	3.00 (.89)
Change Physical Structure and Equipment	83%	4.20 (.45)	3.80 (.84)	4.20 (.45)	4.00 (0.00)
Change Service Sites	67%	4.25 (.50)	4.00 (.82)	4.25 (.50)	4.25 (.50)
Create New Clinical Teams	33%	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)
Revise Professional Roles	0%	N/A	N/A	N/A	N/A
Quality Improvement Strategies					
Provide Clinical Supervision	100%	4.33 (.82)	4.17 (.75)	4.33 (.82)	4.50 (.84)
Purposefully Reexamine the Implementation	83%	4.00 (1.00)	4.00 (1.00)	4.00 (1.00)	4.00 (1.00)
Provide Local Technical Assistance	83%	3.80 (.45)	4.00 (.71)	4.20 (.45)	4.00 (.71)
Organize Clinician Implementation Team Meetings	67%	4.00 (.82)	4.00 (.82)	4.25 (.50)	4.25 (.50)
Conduct Cyclical Small Tests of Change	67%	3.75 (.96)	4.00 (1.15)	3.75 (.96)	3.75 (.96)
Remind Clinicians	67%	3.75 (.50)	3.50 (.58)	3.50 (.58)	3.25 (.50)
Develop and Organize Quality Monitoring Systems	67%	3.25 (.96)	3.00 (.82)	3.25 (.96)	3.00 (.82)
Audit and Provide Feedback	50%	3.33 (.58)	3.33 (.58)	3.67 (.58)	3.67 (.58)
Capture and Share Local Knowledge	50%	3.33 (.58)	3.33 (.58)	3.33 (.58)	3.33 (.58)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Develop Resource Sharing Agreements	33%	4.50 (.71)	4.50 (.71)	4.50 (.71)	4.50 (.71)
Use an Implementation Advisor	33%	4.00 (0.00)	3.00 (1.41)	4.00 (0.00)	3.00 (1.41)
Obtain and Use Consumer and Family Feedback	33%	3.50 (.71)	2.50 (.71)	4.00 (0.00)	2.50 (.71)
Use Advisory Boards and Workgroups	17%	4.00 (undefined)	4.00 (undefined)	4.00 (undefined)	4.00 (undefined)
Intervene with Consumers to Enhance Uptake and Adherence	17%	3.00 (undefined)	3.00 (undefined)	3.00 (undefined)	3.00 (undefined)
Use Data Experts	17%	2.00 (undefined)	2.00 (undefined)	4.00 (undefined)	4.00 (undefined)

Note. Ratings (and standard deviations) for effectiveness, comparative effectiveness, feasibility, and appropriateness are based upon a five-point Likert scale wherein higher scores are more positive (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree).

Relationship Between Organizational Social Context and Implementation Phenomena

Qualitative reflections of organizational social context. Organizational leaders and clinicians raised a number of issues related to the general organizational social context of Agency B that may be pertinent to the implementation new programs and practices. These themes include a strong commitment to a psychodynamic orientation, balance between openness and organizational identity, personal responsibility for learning and growth, tension between professional loneliness and community, and a context that has not historically been "data driven" or "research-based."

Strong commitment to a psychodynamic orientation. An inescapable feature of the context is its psychodynamic orientation. This does not seem to constrain the exploration of other approaches, but it does drive hiring processes, and undoubtedly undergirds training, supervision, and meetings in which clinical scenarios are discussed. With regard to hiring, this may severely limit the pool of applicants from which the agency can draw from, and consequently, may also limit the diversity of therapists. In fact, one organizational leader noted somewhat sheepishly that, "We have an Indian but we call that diversity…she's totally

psychodynamic-trained at Yale but we wanted to hire somebody who was African-American who was an LCSW…that's her community where she lives, and we didn't hire her because she's not psychodynamic." What is less clear is the impact of a strong psychodynamic culture on the agency's orientation toward research and the movement toward evidence-based approaches to care, though one would imagine that it has some effect given that individuals espousing a psychoanalytic/psychodynamic orientation often are less prone to embrace manualized treatments (Addis & Krasnow, 2000).

Balance between openness and organizational identity. Notwithstanding the strong psychodynamic orientation, clinicians communicated their sense that Agency B was open while still attempting to maintain a strong organizational identity. A focus group participant stated, "I think we have a pretty good balance between trying to be open and bringing in other kinds of trainings, and things like that, but also trying to maintain our own individuality." Another organizational leader affirmed this notion, "I'm given the freedom to play around, explore, and I value that."

Personal responsibility for learning and growth. Clinicians in the focus group conveyed that Agency B promotes personal responsibility for learning and growth. In addition to the internal CEU offerings, both leadership and colleagues at Agency B encourage one and other to pursue opportunities to learn new therapeutic techniques. There is an email listserv that is often used to communicate training opportunities, share articles, or query colleagues' professional advice. This spirit of initiative and responsibility for one's own professional development was typified by a clinician's comment about her colleagues, whom she described as "inherently motivated to improve themselves as clinicians."

Tension between professional loneliness and community. It would seem that Agency

B's appreciation for individual agency in terms of professional development and growth does not come without costs, as clinicians also expressed some loneliness that comes with working in an agency that has traditionally operated like a group practice of private practitioners. An administrator spoke to this shift, "The way things were organized was very private practice-oriented. It really was not agency-oriented. There's been a slow culture shift while I've been here towards that…it's been a slow shift into more agency, more as a group than as a private person doing what they want." There remain inherent pressures related to billing the expected amount of hours and carrying one's weight at the agency that can make things a bit isolating. Nevertheless, clinicians generally expressed "a real sense of community" at the agency.

Not historically data driven or research-based. Agency B has not historically been oriented towards the routine collection of data, nor have they participated in many research efforts. Though this is beginning to change, this was evident throughout the process of collecting data at the agency in both the RCT and in the current study. In fact, it became apparent that the only reason that the current study was able to occur at all was due to a single individual that "championed" the study and persuaded agency leaders to participate. Even after permission to collect data was obtained, difficulties persisted with recruitment and data collection.

Many fundamental shifts have been required to move the agency toward the ideal of an "evidence-based organization." One organizational leader recalled that when she arrived, little was defined in terms of therapeutic process or outcome. She said, "When I started it was, 'Well, what programs do you have?' 'Well, we don't have programs. We just do therapy.' 'Well, I have to be able to say we have some kind of programs.' 'We don't have programs. We just do therapy here. That's all we do.' And so I started from there and started progressing." She

reported having to systematize their programmatic offerings to meet the demands of funding agencies that wanted to serve particular populations in particular ways. However, she admitted that the Executive Director and other members of the leadership team are not entirely on board with research or evidence-based practice. One leader revealed, "He hates doing it; hates it doing outcome-based measurements," partly because he has been doing this for forty years and simply does not see a need for it. He was reported to be "coming around;" however, the primary reason for this was not a commitment to evidence-informed care, but rather, a realization that funders were going to require data and at least the appearance of an effort to strive toward evidence-based care. "It's only the funders," she remarked, "It's because to get the dollars we need it and even still he doesn't want to commit our dollars to doing it." This lack of interest in outcomes and research is particularly interesting given the obvious level of commitment that the agency takes in providing quality care to their clients, and ensuring that their therapists have the support that they need to continuously develop as professionals.

Results of organizational social context survey. Agency B's OSC profile was among the best when compared to norms from the national sample (Glisson, Landsverk, et al., 2008). The composite profile score based upon the latent profile analysis was 3.00, which indicates that with respect to culture, Agency B had a high proficiency score, low rigidity score, and low resistance score. With respect to climate, Agency B had a high engagement score, high functionality score, and low stress score. Figure 6 shows Agency B's OSC scores in relation to the national norms. Despite the high composite score, indicating that Agency B has a very strong overall organizational social context, their culture profile is not quite as strong as their climate profile. As depicted in the graph, their proficiency score is more than one standard deviation above the national norm; however, both rigidity and resistance scores are very close to

the average based on the national norms (50.00). Agency B's climate profile is clearly among the best, as their engagement and functionality scores are approximately two standard deviations above the national norms, and are almost three standard deviations above their stress score.

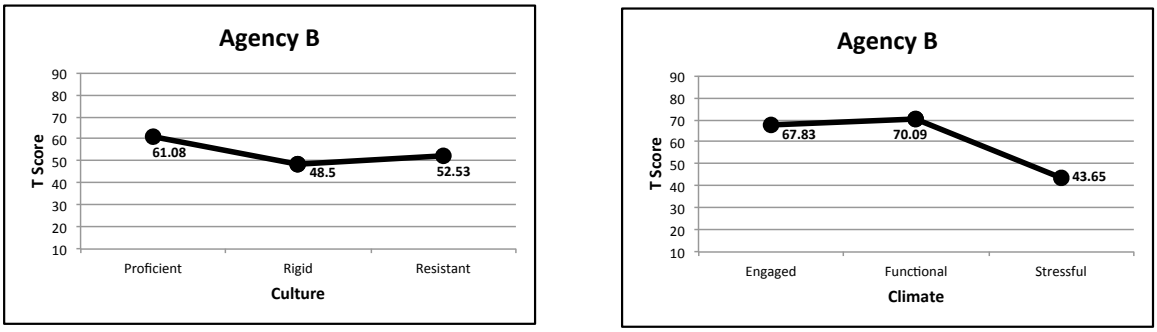

Figure 6. Agency B's organizational culture and climate profiles

Summary and relationship to implementation processes. The qualitative and quantitative assessments of organizational context converge well, as they both point to a very positive overall organizational social context. This was somewhat surprising to this author given some of the difficulties related to data collection, and indications of a general resistance to research and evidence-based treatments. However, these experiences are actually consistent with Agency B's rigidity and resistance scores, which are much closer to national averages. There also seemed to be good convergence between the other subscales of the OSC and the qualitative findings, as clinicians were generally very positive about their agency, its functioning, and the amount of support they received.

In contrast to Agency A, which had one of the worst organizational social context profiles, Agency B reported using a more restricted range of implementation strategies, though with much greater intensity. In fact, the intensity of training, supervision, and additional opportunities for clinical processing that occurred within this agency were unparalleled within

the current sample of agencies. Whereas Agency A seemed to have very poor perceptions in terms of the effectiveness of implementation strategies, Agency B rated implementation strategies more favorably and consistently. Again, this supports the notion that the effectiveness (or perceived effectiveness in this case) of implementation strategies may be moderated by organizational social context.

Agency C

General Organizational Description

Agency C is a relatively small social service agency providing services focusing solely on children, youth, and families. Though the agency delivers an impressive array of services, it is not very "top heavy" with only a few individuals in senior leadership. This case study focuses primarily upon two units within the agency: one that provides support to parents of young children, and one that provides outpatient therapy services.

Description of Program or Practice Implemented

In addition to discussing the general services offered by their agency and the implementation and quality improvement strategies used to sustain them, leaders and clinicians discussed two specific models. The first intervention (hereafter Intervention C1) is a group or home-based intervention intended to help families who have either been identified for past child abuse and neglect, or families who are at high risk for child abuse and neglect. Intervention C1 is a secondary prevention intervention designed to provide flexibility to meet the needs of children from birth to age 11. It contains a number of lessons, though the use of any individual lesson is guided through the use of program-specific assessments. Agency C generally tries to pick the "core" lessons and then use the assessment and family input to identify other areas of need. While the intervention can be used by individuals at the bachelor's through doctoral levels, Agency C has decided to ensure that it is primarily delivered by masters-level clinicians (one if home-based, two if group-based) who have a master's degree in social work (or a related field) and a minimum of three years experience working with families. Generally, families attend either group or home-based sessions lasting 90-150 minutes for approximately 15 weeks (though this varies depending upon need). Sessions include both separate experiences for

parents and children and shared family time, and involve discussion, role play, audiovisual exercises, and other didactic components (Substance Abuse and Mental Health Services Administration, 2012).

The second program or practice is a model that helps clinicians to understand the impact of trauma on development (hereafter Model C2). Model C2 was described by a clinician at Agency C, as "a way of formulating how I'm going to do therapy and how I look at a client." Another clinician explained the model further:

> [Model C2] is primarily a value-based model…understanding development and then taking that data collected and using it to make recommendations for type of therapy used or alternative therapies that you recommend to the families. It's also a really great way to help parents and families understand their child from a developmental perspective. You know a lot of times the behaviors that the kids that we see experience are very hard to understand. Why would a child be acting much younger than their chronological age? Why would abuse or neglect at a certain time in their life be causing sensory issues or other physical or developmental problems? This is a really good way to talk about it and understand how the brain develops and how that translates into symptoms and behaviors later in development.

Model C2 was also described as a unifying structure for Agency C. Given that many employees deal directly with children and adolescents that have experienced abuse, neglect, and other traumatic experiences, it provides an overarching model that can apply to everyone's work, whether that is therapy, case management, or other direct care roles. The use of Model C2 has engendered an understanding of how deprivation

and trauma can effect brain development, which has been a real shift for the agency and the parents they serve. One clinician emphasized this benefit:

> I mean it's a huge shift in the parenting to realize that there is a biological basis for why your child is acting the way they are and that the best way to parent them is really to shift your own thinking and how you are going to respond to their behaviors. I'm distilling it down to a level that they can understand and I think that's very beneficial for the families to understand that. A lot of times I say, and some cringe when I say it, 'Your kids are brain damaged.' You know and so we need to take care of that the best we can.

Intervention C1 has been implemented in the past two years (on the long side). Many of Agency C clinicians have received training and consultation in Model C2, though the agency is still deciding whether to pursue it fully. Moreover, it is not entirely clear what that would look like at the agency level given that it is more of a guiding framework. The bulk of this case study focuses on the implementation of Intervention C1, as it is qualitatively different in that it is much more of a "program of known dimensions" (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005) than Model C2 which is more "value-based."

Decision Making Processes

Treatment decision making. Agency C reported drawing information from a number of different sources as they considered interventions that would most effectively address the needs of their clients. They primarily relied upon information pertaining to intervention characteristics, the outer setting, and the inner setting.

Factors related to intervention characteristics. Organizational leaders cited several intervention characteristics that contributed to their decision to adopt Intervention C1 and Model C2, including the interventions' adaptability; compatibility with the agency, clinicians, and clients; the strength of evidentiary support; replicability; and the agency's ability to "own" the interventions.

Adaptability. The adaptability of both Intervention C1 and Model C2 was cited as a major reason why Agency C chose the interventions. Intervention C1, for instance, was adaptable in several ways. First, it was designed both for people who were at risk of abuse and neglect and had who had already committed acts of abuse and neglect. Second, it was adaptable in terms of the appropriate dosage, so that frontline workers could deliver it in increments depending upon the level of risk and/or need. Third, Agency C employs employees who have a range of educational backgrounds, including those with bachelors, masters, and doctoral degrees; thus, organizational leaders viewed the fact that all employees could use Intervention C1 as "a big deal". Collectively, these aspects of adaptability have allowed the program to be used by everyone in the agency in some capacity. Even though frontline workers in some departments (such as the education and counseling department) haven't utilized the full model, they have reportedly been able to utilize various components as appropriate.

Similarly, Model C2 was viewed as flexible in comparison to some specific manualized treatment models. One clinician lauded its adaptability and applicability regardless of one's theoretical orientation:

> The benefit of something like [Model C2] is that it is an overarching model. There is no one specific treatment method that you have to work with. It's sort of a way of understanding. In a way of formulating a diagnosis of the treatment

plan so that you can use TF-CBT or you could use a psychodynamic way of treatment depending on the needs of the child. Which is fantastic for us because we have so many different types of kids.

Compatibility with organization, personnel, and clients. Innovations are thought to be adapted more readily if they are compatible with the existing values, experiences, and needs of the potential adopters (Cook et al., 2012). Both Intervention C1 and Model C2 were perceived to be a good fit with Agency C, its employees, and the needs of clients. "We were looking for a model that had some components in it that matched our approach to parent education," explained an organizational leader, "We really tend to focus on strengths, looking at people's special needs, but in the context of how they can adjust and benefit from them, or at least cope with them more successfully…[Intervention C1] has a specific curriculum for working with children that are medically fragile." She continued:

> Again, the strength base and that approach to families meshed with our mentality here, as an agency. [Intervention C1] is based on a premise of five different pillars, I believe he calls it, of what...as far as what parents need and what kids need. Those match up really well with our mentality, but also, other areas that we use. It matched very well with resiliency issues. It matched very well with the protective factors, those kinds of things. It was a nice way to take what we already believed to work and have it be used in a model that had been proven to work…and the fact that we could implement it, fairly gracefully as far as ... it wasn't going to be a major change for clients, to say, 'We're doing this now.' We could meld it with what we were providing them and start using it without it being completely disruptive to them.

The director of the agency also said as she imagined what it would be like to deliver Intervention C1 as a clinician, it just felt right. For her, that was perhaps even more salient than the empirical evidence supporting Intervention C1.

Empirical evidence. Each of the leaders interviewed at Agency referenced the empirical evidence for Intervention C1. It was described as an evidence-based program and as having "a lot of really good scientific backing" and "some really hard evidence." Leaders expressed finding comfort in the fact that the program had been around for a while and that it had been implemented across a number of different settings. Moreover, they were one of the only agencies to seriously seek out information on some of the most prominent evidence-based clearinghouses (Soydan, Mullen, Alexandra, Rehnman, & Li, 2010): the California Evidence-Based Clearinghouse for Child Welfare and the National Repository of Evidence-Based Programs and Practices. The director recalled, "We primarily read the summaries and sort of as our first gross overview and then for the ones that we wanted to delve more into, we did a lot more reading about it." She acknowledged that she is not necessarily adept at interpreting "all the numbers and the percentages;" however, her sense that the research looked "fundamentally sound" coupled with her belief that the intervention was clinically intuitive gave her increased confidence that it was right for the agency.

Replicability. Intervention C1's replicability, partially determined by the evidence-based clearinghouses, was also cited as a primary reason for its selection:

> The ease with which it can be replicated in the community…it had a 4 out of 4 with its replicability in the community and that was important to us, because we felt like you lose a certain amount every time you train someone if it's not easily replicated and we wanted to make sure that we were delivering it with as much

fidelity as possible.

Thus, the agency was swayed by their belief that Intervention C1 was designed "for people to be able to actually use it out in the community, as opposed to more researchers, who have a different budget and a different need."

Ownership of the program. Many interventions are proprietary, which can create financial and logistical barriers to implementation (Powell, Hausmann-Stabile, et al., 2013). Agency C's director was well aware of these barriers. She stated, "Once you've got the model, what's it going to take to replicate out in the community? Do you need a lot of resources? Do you have to have tests that need to be scored somewhere else? Once you buy it, if you will, is it yours and can you use it?" Ultimately, agency leaders were satisfied that their investment would allow them to "own" the intervention, train their own employees, and benefit fully from adopting Intervention C1.

Factors related the outer setting. Treatment decision making was also driven by a number of outer setting factors such as client need, funding, and consultation with other agencies and experts.

Client need. Client need was a major contributor to treatment decision making. Client need was made clear through previous clinical experiences, routine clinical interactions, and formal focus groups with clients. One leader spoke to the latter, noting, "When you have a client sitting in front of you saying, 'This is what we need,' it pushes you a little bit to take it on. They were helpful. Those folks were really invested how it's laid out. It was nice to have a group of people that were really interested in what we were doing." Both Intervention C1 and Model C2 were perceived to be very responsive to the needs of Agency C's clients, as described in the "compatibility" section above.

Funding. The availability of funding played a role in the selection of programs in practices. As with many other agencies it was one of the first things mentioned; it remains a constant pragmatic concern in both treatment and implementation decision making, as noted by the agency director,

> The training was important. What is the expense of the training and what is its carryover to other staff, that's something we've got to look at, length of time training. Financially, it's a big deal. Time commitment for staff is a big deal. It would affect their efficiency rating in terms of how many clients they see, which affects some of our other clients…The reality is funding is important.

Especially important in their decision to adopt Intervention C1 was the ability to have the treatment developer come to train everyone at the agency rather than having them travel elsewhere, and the fact that they would "own" the program for the most part after they became certified in its use as an agency.

Learning from other organizations and consultants. Agency C seized the opportunity to talk to other individuals and organizations that had used both Intervention C1 and Model C2. They did this so that they could obtain "on the ground" information about what it was like to deliver the models, how difficult it was, and whether or not it was different than what has been portrayed in the literature. Leaders from the agency were particularly proactive in seeking contacts outside the agency through national conferences and other venues. They also reached out to local experts, one of whom initially consulted with the agency and later became their clinical supervisor. She helped the agency to, "know what the clinical issues were and what we needed to be training the staff on and what we needed to be looking for as far as personality, characteristics, level of training, level of degree, all those kinds of things, in our staff."

Factors related to the inner setting. Though not necessarily novel, Agency C was one of the only agencies to discuss being driven strongly by their strategic plan and by input from their board of directors.

Strategic plans and board input. Agency leaders acknowledged the importance of their strategic plan as well as input from their board in influencing the decision to implement Intervention C1 and Model C2. "Our strategic plan is...pretty significant," stated one leader. "These are our major goals, and then definitely direct those types of decisions." The strategic plan does not necessarily suggest specific programs or practices that will be implemented, but rather it frames the overall efforts of the agency and ensures that any new effort fits the mission of the agency. Members of the agency's board also work to hold leadership accountable to stick to the agency's mission; thus, the director immediately brought the board chair into the discussion when they began to consider implementing Intervention C1. She remembered,

> We also called our board chair in, just to say this is where we want to go, this is what we want to tie our name to, this is why we think that.' And our board chair at the time was not a clinician, but the board is still charged with governance of the agency, so we pulled him into the process too. And as we walked down that path, we just made sure the board knew what we were doing because all of a sudden saying, we're licensed as such and such and they didn't know anything about it – [that] usually isn't a good thing.

Implementation decision making. Given the level of thought dedicated to treatment decision making, leaders from Agency C were relatively less able to articulate processes pertaining to implementation decision making. There were no reported evaluations of the organization's performance prior to and after implementation. The agency reported no formal

implementation plan, and a model did not guide implementation or any guiding principles outside of those articulated in their strategic plan. The leaders did not report being informed by the implementation or quality improvement literature or any empirical data on implementation processes. It seems that treatment developers dictated many of the implementation processes described by Agency C leaders, and in fact, this author recorded a field note stating that it was "difficult at times to draw much else out of her regarding implementation decision making and implementation strategies." The sole guidance for implementation decision making for Agency C was at the level of the outer setting in the form of guidance from treatment developers. Though leaders mentioned a host of other considerations, most of them pertained primarily to reevaluating processes during the course of the implementation effort, and will be discussed in more detail in the "implementation strategy use" section below.

Guidance from treatment developers. When asked about the types of information or evidence that they sought to inform implementation processes, one leader quickly responded, "I think we definitely followed the guidelines set by the actual program. [Intervention C1] has specific requirements or expectations for training for implementation and supervision. That is all detailed out in that model. We definitely looked at that and followed that as closely as we could." She maintained that the model and the implementation processes specified therein were the most important form of guidance for implementation, though she couldn't recall exactly where this information was spelled out (either the website or the implementation manual they produce). She explained, "I know there's a whole manual, as far as, do this, do that, 30 days before your first class, all that kind of implementation stuff. I know we have it but I couldn't tell you where. Maybe in our library downstairs." The agency did not present this author with an implementation guide, and it was not freely available online. One wonders whether a manual

that could not immediately be located is actually serving to guide implementation processes much at all. An examination of the guide's table of contents seemed to reveal that the guide focuses heavily upon Intervention C1 and less on implementation issues that might arise at the individual, team, organization, or outer setting levels. The agency also contacted Intervention C1 developers directly to determine what was involved in training and to make sure that they were "setting up the right training." There are different levels of training that can be obtained; thus, conversations with treatment developers allowed them to determine the training modules that best meet their needs.

Implementation Strategy Use

Agency C used a range of implementation strategies at the intervention, outer setting, inner setting, individual, and process levels. Again, it appears that organizational leaders gave relatively less attention to implementation strategies and processes as compared to decision making surrounding the interventions themselves. This is evidenced in some cases where details about implementation processes were more difficult to obtain, and also in cases in which there were some discrepancies between leaders' and frontline workers' reports of strategy use.

Characteristics of the intervention. Agency C leaders primarily touted the flexibility of Intervention C1 and Model C2; however, they did report using two strategies that focused on adapting Intervention C1 and the associated assessment tools.

Adapting the intervention delivery. Intervention C1 can be delivered in either a group or individual format. However, the agency has been combining the two approaches in cases in which the group format is insufficient in addressing the individual needs of some clients. To the director's knowledge, this represents an adaptation that she has not necessarily seen elsewhere.

Adapting assessment tools. Organizational leaders from Agency C discussed the need to adapt one of the assessment tools for Intervention C1. There are two different assessment tools, she explained, one attitude-based and one knowledge-based. The agency likes portions of both assessments, but doesn't like either wholly. The leader described one of the assessments as too "theoretical" or "academic," whereas the other gave false results. She gave an example of a question, "How many times a week do you feed your child a nutritious meal?" and described how it can be problematic:

> If you haven't developed rapport with someone, they're defensive. They know the right answer. They're going to say, 'most of the time.' After the pre-assessment early, you can't do it five weeks in. You don't have the rapport; you don't have trust yet. Then you do the post and they say 'most of the time' but on the pre, they said 'all the time.' So, it looks like we're making people worse.

The agency was in discussions with the treatment developer to eliminate some questions and perhaps add others to the assessment. This seems to be positive in two ways. First, it demonstrates a willingness to change tools and processes that are not working. Second, it demonstrates that they don't make adaptations erratically, but rather, in a planned manner in consultation with the treatment developer.

Strategies directed at the outer setting. Several strategies were utilized at the level of the outer setting, including accessing new funding, obtaining client feedback, developing educational materials for families, and collaborating with other agencies.

Accessing new funding. Agency C applied for and received funding for Intervention C1 through a local fund that draws its revenue from a one-quarter cent quarter sales tax. The grant is a purchase of service grant, which allows them to bill X dollars per unit of service. The

director of Agency C attributes their use of an established evidence-based program as one of the reasons they were able to obtain funding, and she noted the benefit of a funding source that has an inherent level of sustainability. “In theory, as long as we continue to perform well and continue to apply, it shouldn’t necessarily end,” she explained. “So it isn’t time limited like a traditional grant…but their goal was to build a network of services in the community and so, to build it up and tear it down every year doesn’t make a lot of sense.”

Developing marketing materials. Agency C leaders mentioned their efforts to develop marketing materials aimed at both clients and professionals from other community agencies. This was somewhat difficult according to one leader who mentioned, “It was not something that was within any of our areas of expertise, so I know that for me that was a challenge…Our first brochures were quite pathetic. They were in-house…and they were fairly pathetic.” Yet they were eventually able to develop materials that targeted clients and professionals separately. This was essential because “no client wants to see, ‘in order to interrupt the cycle of abuse or neglect, come join us.’” Thus, parenting materials were much more about “satisfaction and parenting, happy memories with children, reducing stress to make room for fun and those kinds of things,” whereas professional marketing materials focused on “interrupting cycles of abuse or neglect and enhancing families.”

Obtaining client feedback. Agency C garners client feedback through surveys that are completed regularly after every educational session in which the agency will “ask them if it met their needs, if they think it will help with their parenting, if they were treated well and respectfully…if it was comfortable.” The agency also receives client feedback through annual satisfaction surveys.

Educational materials for families. The agency regularly puts money aside for

educational materials for professionals, which is also used for resources for parents if and when potentially helpful materials are identified.

Collaborating with other agencies. Agency C collaborated with two other agencies when they were applying for funding for Intervention C1. Though the partnerships did not facilitate implementation per se, it did increase the reach of program and allow for more clients to be served. Moreover, having two other agencies delivering the same types of services provided some support, and an opportunity to share lessons learned and identify ways of addressing identified barriers. These opportunities for shared learning seemed to take place solely at the leadership level, as the directors of the three partnering agencies occasionally scheduled meetings to check-in about the program's implementation.

Strategies directed at the inner setting. Agency C's implementation efforts also involved strategies targeting the inner setting, including the pursuit of accreditation in Intervention C1, spreading the word about Intervention C1, and shifting the organization's philosophy away from their focus on providing for concrete physical needs of clients.

Pursuing accreditation. Agency C made a "strategic decision" to become an accredited provider of Intervention C1. As one leader stated, this was done to "prepare us for anything we wanted to take on in the future using this model," and to allow the agency to continue to provide training to their own staff members and other area agencies. This was critical in allowing them to "own" the intervention.

Spreading the word about Intervention C1. One leader talked about how Agency C has been around a long time and that many of the individuals on the management team have been with the agency for many years. Though this presents many benefits related to continuity and expertise, she suggested that it also makes innovation difficult. Thus, she stressed the

importance of taking every opportunity to raise the visibility of the innovation and the implementation effort by presenting the information to the board and the community via the website and other channels as appropriate.

Effort to shift toward empowerment philosophy. One organizational leader spoke passionately about how the agency needed to shift away from a treatment philosophy that was based upon constantly meeting the concrete physical needs of their clients, and move toward an approach that empowered clients by teaching them new skills. She reasoned,

> When we first started, we had thought we needed to attend to people's concrete needs first. The old 'if they're hungry and they're being evicted, they can't listen to the lesson.' I found that we were being eaten alive. We were just one more place delivering goods and services and bringing goods to people and they were really never able to really begin making those changes. My big philosophical epiphany was one day I thought, wait a minute, they've been without diapers for years. They've been without adequate food for years. They've been evicted before. They've never had a car before. These are things that are chronic and unseen. Chronic is more uncomfortable to me and my staff than it is to them. I started looking at who is the most uncomfortable. It was really the staff who were really uncomfortable with chronic, probably. So, I flipped it and I said, 'You know what, we are no longer the deliverer of things that make the day-to-day life easier. We are the deliverers of things that will make life down the road easier. We are going to talk with parents about freeing up energy that they're currently wasting on ineffective parenting.' Strengthen their self-worth and confidence so they'll have more energy. They'll have more self-belief and they'll

attend to those other issues in time.

This is not to say that they began to ignore physical needs entirely. Rather, they shifted to addressing only the most acute of physical needs, and they focused the bulk of their attention on parent training and reducing the stress of parenting. The strategy in this case seems to be the vision and will of a single leader who communicates this clearly to the team. She made it clear that one staff member could not "get onboard" with this new approach to services, and had to leave the agency, and also described how they assess individuals' comfort with chronic poverty and associated needs through the interview process.

This cultural shift is akin to others described in this study, such as Agency A's shift from a focus on services to a focus on need, and Agency B's shift from thinking solely about treatment to thinking more about prevention. It is also consistent with efforts in community mental health to move toward more of an empowerment and recovery orientation rather than one in which clients are infantilized by practitioners who address needs that the clients could be taking care of themselves (Powell, Hausmann-Stabile, et al., 2013).

Strategies directed at the characteristics of individuals. Not surprisingly, a number of implementation strategies focused on the characteristics of individuals, including hiring with implementation in mind, training, educational materials, informal refresher training, live observation of sessions, case presentations, consultation with experts and other agencies, supervision, and record review/chart audits.

Hiring with implementation in mind. Two agency leaders emphasized the importance of hiring new staff members that are a good fit with Intervention C1. One stated, "while we're interviewing, [we assess] their attitudes and beliefs around what we know are tenets of the program." She elaborated,

> With this particular model…I think it's really being able to join clients where they are. Most people don't have a child with the intention of being unsuccessful as a parent, but what they're utilizing in their parenting strategies, they are not successful…so kind of joining with them and starting and bringing them along as opposed to somebody who is more judgmental.

Training. Agency C was trained directly by the treatment developer of Intervention C1 over a three-day period. They were deliberate about getting every eligible clinician associated with the organization trained, even though not all of them would immediately have the opportunity to implement it. After the initial three day training, the agency developed some supplementary training activities to "make sure we were upon it, we understood it, talked about it, implemented it." These training activities were developed as an effort to problem solve prior to implementing the model formally. Since the agency pursued accreditation in the model, they are now able to train their own staff. This has led to a much more ongoing, fluid process, involving a combination of theoretical readings about the program, watching training DVDs, talking with other clinicians, and observing them in the field. New clinicians are also brought into the program by helping to co-facilitate group sessions. Overall, one leader reiterated, they "do a lot of teaching by watching." Another leader repeated this point, saying that the agency's Intervention C1 expert will model lessons rather than just talking about the theory behind it, "just so they can see it because when they're in a crisis and they've got the client, they tend to fall back on something they've seen."

More generally, a leader discussed a requirement that all staff have 40 hours of training per year if they are full-time. This requirement is built into their annual evaluations, and sometimes this involves specific areas that they will focus on. Though organizational leaders

did not explicitly address this, it seems apparent that some of these hours of training are the responsibility of the individual clinician, while some are provided internally at the agency.

Educational materials. Educational materials (e.g., DVDs, manuals, etc.) for both training and intervention purposes were purchased through the Intervention C1 developers. Educational materials also have had a prominent role in the organizations' exploration of Model C2, as they engaged in a distance training/consultation model that gave them access to PowerPoint presentations, articles, and other educational materials that clinicians have used both internally and to share with parents as deemed appropriate.

Informal refresher training. One leader described the agency's efforts to conduct refresher trainings on Intervention C1 to ensure that clinicians "keep their skills up." She said that peers will "co-train" each other so that "if there is a little stray, we can pull people back." They did this more frequently when they initially rehearsed prior to implementing the model, and tend to do it more frequently when new staff is trained.

Live observation of sessions. The organizational leader most familiar with Intervention C1 occasionally observes clinicians' sessions directly to ensure that it is delivered with fidelity.

Case presentations. For Model C2 specifically, clinicians participating in the training/consultation sessions had the opportunity to present a case. They were able to describe a child and go through a Model C2-specific evaluation matrix while talking about some possible recommendations for intervention. Case presentations also seemed to be a strategy used during monthly staffing meetings, though this seems to be less formal and the regularity of these meetings was not particularly clear as discussed in the "supervision" section.

Consultation with experts and other agencies. For Intervention C1, Agency C benefited from opportunities to consult with the developer. They also benefitted from an online

community that provided a platform to ask questions and address common concerns. In the case of Model C2, clinicians were offered the opportunity to receive group-based telephone consultation from the developer. They were also given the opportunity to hear from and speak with trainers from across the country and even internationally.

Supervision. Agency leaders and clinicians presented mixed messages about the level of supervision that they deliver and receive (i.e., there were inconsistencies in their accounts). One leader suggested that both individual and group supervision regularly occurred, with individual supervision being conducted weekly and group supervision being conducted monthly. Group supervision was reported to be particularly important for "working out the kinks" and integrating the services provided by multiple service providers. Part-time staff, she acknowledged, receive less consistent supervision and most of that contact comes via telephone or email. This was deemed appropriate because most of the part-time staff are actually more experienced and thus require less oversight. Another leader interestingly revealed, "I'm not quite sure. I think we have formal supervision." This was prior to explaining that supervision happens "daily," as she is constantly working with her staff members to address immediate needs and concerns that arise. She stressed that when clinicians first begin using Intervention C1, supervision is daily for a couple of hours per day. Then it progresses to weekly, then it is monthly, but she also described "an open door, accessible philosophy" in which she is regularly available to discuss concerns with her staff members. Another leader stated that supervision was usually weekly, but that it depends upon how experienced a clinician is. She also described supervision as "individualized." In terms of the content of supervision, one leader identified one essential component as the monitoring of fidelity (in a qualitative sense). She stated, "the program has a lot of flexibility; where we need to stick with the model to meet the fidelity, we

really feel like we need to do that." When clinicians were asked about supervision, they acknowledged group supervision on a monthly basis and also the "open door" policy of their supervisors, but they also said that they do not regularly get weekly or even biweekly supervision at the individual level. One clinician explained that individual supervision is something that they have really fought for at the agency. He was fortunate to have supervision regularly because he was going through the licensure process; however, he admitted that supervision wasn't "something that was extended or provided to every clinician…unless they really ask for or feel they really need it." He continued, "We would have occasional, weekly kind of group staff meetings, case discussions, but even those certain times have been once a month. I think there are a lot of us who have wanted those and need more opportunities to talk about cases and talk about treatment." The clinicians acknowledged a major barrier to supervision: the billable hour. The inconsistencies in accounts of supervision are somewhat alarming. For the agency, it clearly raises the concern of whether or not frontline workers know what to expect regarding the support that they receive to do their work well. From a research perspective, it raises concerns about the viability of studying implementation solely from the perspectives of organizational leaders, who might tend to exaggerate the use of implementation strategies or rate the organizational social context more favorably than frontline clinicians (Patterson, Dulmus, Maguin, Keesler, & Powell, 2014).

Record review/chart audits. Agency supervisors reportedly conduct regular record reviews/chart audits to ensure that clients are "moving" forward and progressing toward their goals. This seems somewhat compliance driven, with a focus on efforts to "make sure everything is in the file at the right time." It did not appear that there was any sort of formal fidelity monitoring occurring. In fact, when asked about fidelity, one clinician remarked, "We

don't really have any interest in fidelity. Fidelity is doing your job, that's about it. Are you still doing therapy?" When this author asked how anyone would know whether or not that particular clinician was "doing therapy," another clinician chimed in, "He turns the do not disturb sign on his door." Clearly, this is not a "high bar" for clinical accountability.

Strategies directed at the process of implementation. Many of the strategies used by Agency C were at the level of implementation process; however there were several aspects of process that appeared to be absent. When asked if there were regular meetings amongst agency staff to discuss implementation process and make adjustments, one leader admitted, "No, definitely no. It should probably be a definite yes, but it's a definite no." Outcome monitoring was also reportedly completed only "sporadically" and therapists seemed to have a relatively lax standard when it came to their therapeutic process. One therapist stated (somewhat jokingly) that if parents are not calling to complain that they want a new therapist, then we know that they're doing okay. Nevertheless, there were several strategies at the level of process that were utilized, including the engagement of champions and opinion leaders, the sequential role-out of Intervention C1, and opportunities to revisit implementation when completing annual funding progress reports.

Engaging champions and opinion leaders. The agency director highlighted her efforts to engage champions and opinion leaders. Her intention is to determine the individuals who might become early adopters who will be "singing the praises" of the innovation and, ultimately, make their colleagues at the organization "professionally jealous" so that that they want to implement the innovation as well. "It helps because if I've got one group of people doing something and other people kind of think it's cool, then they want it," she said. "If I come to work tomorrow and I say, 'hey guys, here's what we're doing tomorrow,' then everybody's

got their heels dug in. I go with my early adopters and make everybody else want it." She gave a practical example of using electronic medical records in a very small department that she knew could be successful, and now the other departments are "clamoring for it." This also goes hand-in-hand with the agency's sequential role-out of new programs and practices described in this section.

Sequential role-out. The role out of the Intervention C1 was intentionally sequential. The agency started by introducing only one component of Intervention C1 (for children with special needs and health challenges). This gave the agency the chance to "grow into it" before adding another Intervention C1 program. These programs formed a solid foundation and allowed the agency to leverage an opportunity for grant funding that later expanded their services to additional geographic areas. The director emphasized, "it's definitely been kind of one piece at a time, not 'hey everyone, we're all doing this starting tomorrow.'"

Funder's reporting requirements. The reporting requirements from funding agencies provided another opportunity for organizational leaders to examine implementation processes. "If the grant comes up each year, we certainly have a process of looking at what would be done differently during the next year," stated an agency leader.

Perceptions of Implementation Strategies

Qualitative results pertaining to perceptions of implementation strategies. One focus group consisting of 10 frontline workers (clinicians and case managers) at Agency C was conducted. The qualitative reflections in this section are drawn from that session as well as the semi-structured interviews with agency leaders. Perceptions of strategies were related to the pursuit of grant funding, implementing innovations sequentially, training, shadowing and other

opportunities for live observation, video demonstrations, and supervision. While supervision is presented last in this section, it was clearly the most pressing concern for clinicians.

Perceptions of grant funding, and focusing on needs vs. funding. Though perhaps a blend of philosophy and strategy, one organizational leader made an interesting point about not attempting to follow available funding too aggressively. Rather, she suggested that Agency C's "overriding strategy" was to focus on the needs of their clients. It may seem very "pie in the sky," she acknowledged, but if you focus on "what needs to happen" and "what works" then the funding will naturally follow. "The times where we've really tried to force another system in place are the times that we've faltered the most," she recalled. Certainly, leaders from other agencies (for instance, Agency F) affirmed this belief that "chasing the money" can be devastating to an agency.

Perceptions of sequential implementation. As stated before, the director of Agency C is a proponent of implementing new programs and practices sequentially. "That was really important for us," she argued. "It's more manageable and when you have a bump, it's a bump that one clinician had…it's not seven people going, 'oh my God, this is a disaster,' because then it's overwhelming and that's frustrating. I would do something in small batches if I had the luxury of doing something like that." This approach to implementation has been advocated elsewhere (e.g., Stetler et al., 2008), and is identified as a strategy, "stage implementation scale-up," in a recently published compilation of strategies (Powell et al., 2012).

Perceptions of training. Clinicians in the focus group did not discuss training much given their focus on supervision and other implementation supports. However, they largely expressed positive views about the training that they received, especially the training and consultation focusing on Model C2. Similarly, an organizational leader expressed her

satisfaction with the way that the Intervention C1 trainings have evolved, stating, “What we've done so far seems to work really well. Could that be different with the next social worker we hire that needs to learn differently? Absolutely, but so far doing it this way has been really effective. I don't have any plans to change it at this point.” In fact, the agency’s ability to train its own staff members has been critical, as the agency director noted the downside of having the treatment developer conduct and intensive training and having to take everyone “offline” for three days.

Perceptions of shadowing and other opportunities for live observation. More active implementation strategies that occurred in the course of on-the-job training were perceived by organizational leaders to be very effective. “The modeling, the going out, the experiencing…I think that is much more effective than just sitting and watching [the treatment developer] for 28 hours,” declared one leader.

Perceptions of video demonstrations. Conversely, passive strategies such as video demonstrations were viewed as less effective, even if they were often used as adjunctive implementation strategies. One leader acknowledged that clinicians “want to be in the field. They don’t want to be sitting at their desk doing a bunch of dry training.”

***Perceptions of supervision*.** The overwhelming consensus during the focus group with clinicians was that they rarely received supervision, and that they would feel much more supported if they received individual supervision or small group supervision on a regular basis. One case manager revealed,

> We are part of the clinical staff, but we don't get any clinical supervision…I always feel like I'm on the outside of the clinical staff, and then I can't have meaningful contributions to the conversation because we don't get that, that

> intimate clinical feedback about how we're doing and what we can be doing better. I feel like an outsider and that seems like I don't have the intelligence they have. Because they get to talk about the stuff on a meaningful level every week when I'm scrambling to document what I did every fifteen minutes.

The latter part of her comment refers again to the challenge of managing supervision when billable hours are such a concern, and documenting service in 15-minute increments (sometimes to three different funders) represents another barrier. However, staff were so hungry for more accountability that they expressed their willingness to come to work early if it would allow them to receive that type of support. In contrast to monthly staff meetings, another clinician expressed, "I would rather have real time feedback so that I can process that and adjust rather than 'shoot I have been doing this for eight months the wrong way' kind thing…I would like more accountability…It's like I just don't feel like I'm growing professionally."

In addition to wanting more individual supervision, staff members also voiced their desire for more opportunities to process clinical concerns in teams or small groups. "I learn the most from the conversations we have as a group," stated a clinician. "I mean, I learn more from that than anything you will hand me to watch for myself." Another clinician agreed, "It's great we share resources and say "hey watch this' you know…but I would like to have a conversation about how it applies and what we can do with it." Both of these clinicians were referring in part to the relatively passive approach of having clinicians attend 40 hours of training per year, and then share readings, videos, and other materials that they acquire. Though these can be helpful, the more active forms of discussion and processing were prized far more.

Quantitative results pertaining to perceptions of implementation strategies. Five of 10 Agency C employees (50%) completed the Implementation Strategy Use and Perceptions

Survey. The full results can be seen in Table 8 below. Fewer than half of the strategies (n = 24) were endorsed by more than two respondents. Mean effectiveness ratings ranged from 2.75 to 4.67 (1 = least positive; 5 = most positive). Half (n = 25) of the strategies received effectiveness ratings of 4.00 or above, including 16 strategies that were endorsed as "in use" by at least half of respondents. Only three strategies received effectiveness ratings under 3.50 (i.e., closer to neutral at best), one of which ("use an implementation advisor") was endorsed as "in use" by at least half of respondents. Thus, the quantitative findings seem to indicate that Agency C utilized fewer strategies, but that that those they used were rated very positively, with multiple strategies rated over 4.00 in each of the five strategy categories (i.e., planning, educational, financial, restructuring, and quality improvement).

Convergence of qualitative and quantitative findings. The results from the quantitative survey complement the qualitative findings well. For instance, active strategies such as "make training dynamic," "clinician implementation team meetings," "capturing and sharing local knowledge," and "providing clinical supervision" were viewed as the most effective. Many of the other strategies mentioned as positive in the qualitative interviews and focus group also received positive ratings in the survey, such as the "development of educational materials," "involving executive boards," and "identifying champions." In fact, the overall sense that most implementation strategies were regarded positively was evident in both qualitative interviews and these quantitative findings. "Audit and provide feedback" was rated positively, but was endorsed by only one individual. This is consistent by the general finding that clinicians did not feel that they regularly received feedback on their clinical work. Moreover, examining qualitative and quantitative findings regarding perceptions and (more importantly here) strategy use raises an important warning. It would appear from the

quantitative findings (limited sample size not withstanding) that supervision is both highly endorsed and effective, and in the absence of the qualitative findings, one would not realize that it was actually being provided inconsistently.

Table 8. Agency C: Implementation Strategy Use and Perceptions Survey Results (N = 5)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Planning Strategies					
Build a Coalition	100%	4.00 (0.00)	3.60 (.55)	4.00 (0.00)	3.80 (.45)
Assess for Readiness and Identify Barriers/Facilitators	80%	4.25 (.50)	4.00 (.82)	4.25 (.50)	4.25 (.50)
Identify and Prepare Champions	80%	4.00 (.82)	4.00 (.82)	3.75 (.50)	3.50 (1.00)
Involve Executive Boards	80%	3.75 (.96)	3.00 (.82)	3.75 (.50)	3.75 (.50)
Conduct Local Consensus Discussions	60%	3.67 (1.53)	3.33 (1.15)	3.00 (1.00)	3.33 (1.15)
Recruit, Designate, and Train for Leadership	60%	3.67 (.58)	3.67 (.58)	3.67 (.58)	3.67 (.58)
Mandate Change	60%	3.67 (.58)	3.33 (.58)	3.33 (.58)	3.00 (0.00)
Stage Implementation Scale Up	40%	4.00 (1.41)	4.00 (1.41)	4.00 (1.41)	4.00 (1.41)
Develop Resource Sharing Agreements	40%	3.50 (.71)	3.50 (.71)	4.00 (0.00)	3.50 (.71)
Conduct Local Needs Assessment	40%	3.50 (.71)	3.00 (0.00)	2.50 (.71)	3.00 (0.00)
Develop a Formal Implementation Blueprint	40%	3.50 (.71)	3.50 (.71)	3.50 (.71)	3.50 (.71)
Develop Academic Partnerships	0%	N/A	N/A	N/A	N/A
Obtain Formal Commitments	0%	N/A	N/A	N/A	N/A
Tailor Strategies	0%	N/A	N/A	N/A	N/A
Visit Other Sites	0%	N/A	N/A	N/A	N/A
Educational Strategies					
Conduct Educational Meetings	100%	4.40 (.55)	4.20 (.84)	4.40 (.55)	4.20 (.84)
Conduct Ongoing Training	80%	4.25 (.50)	3.75 (.50)	4.25 (.50)	4.25 (.50)
Inform Local Opinion Leaders	80%	3.50 (.58)	3.00 (.82)	3.50 (.58)	3.00 (.82)
Make Training Dynamic	60%	4.67 (.58)	4.33 (1.15)	4.00 (1.00)	4.00 (1.00)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Use Train-the-Trainer Strategies	60%	4.00 (1.00)	3.67 (.58)	4.00 (1.00)	4.00 (1.00)
Conduct Educational Outreach Visits	40%	4.00 (0.00)	3.50 (.71)	4.00 (0.00)	4.00 (0.00)
Distribute Educational Materials	40%	3.50 (2.12)	3.50 (2.12)	3.50 (2.12)	3.50 (2.12)
Increase Demand	40%	3.50 (.71)	3.50 (.71)	3.50 (.71)	4.00 (0.00)
Provide Ongoing Consultation	40%	3.50 (.71)	3.00 (1.41)	3.50 (.71)	3.00 (1.41)
Develop Educational Materials	20%	4.00 (undefined)	4.00 (undefined)	4.00 (undefined)	4.00 (undefined)
Create a Learning Collaborative	20%	3.00 (undefined)	3.00 (undefined)	3.00 (undefined)	3.00 (undefined)
Develop an Implementation Glossary	0%	N/A	N/A	N/A	N/A
Shadow Other Experts	0%	N/A	N/A	N/A	N/A
Financial Strategies					
Access New Funding	100%	4.00 (1.22)	3.60 (1.34)	4.20 (.84)	4.40 (.55)
Make Billing Easier	80%	4.50 (.58)	4.50 (.58)	4.50 (.58)	4.50 (.58)
Alter Incentive/Allowance Structures	20%	4.00 (undefined)	3.00 (undefined)	3.00 (undefined)	2.00 (undefined)
Restructuring Strategies					
Create New Clinical Teams	100%	4.60 (.55)	4.20 (.84)	4.00 (.71)	3.80 (.84)
Change Physical Structure and Equipment	80%	4.25 (.50)	4.25 (.50)	3.75 (.50)	3.50 (.58)
Revise Professional Roles	80%	4.25 (.50)	4.00 (.82)	3.75 (1.26)	3.75 (.96)
Change Service Sites	60%	4.33 (.58)	4.33 (.58)	4.00 (0.00)	4.00 (0.00)
Change Record Systems	60%	3.67 (1.53)	4.00 (1.00)	3.67 (1.53)	3.67 (1.53)
Quality Improvement Strategies					
Organize Clinician Implementation Team Meetings	100%	4.60 (.55)	4.20 (.84)	4.20 (.84)	4.00 (1.22)
Provide Clinical Supervision	80%	4.50 (.58)	4.50 (.58)	4.50 (.58)	4.75 (.50)
Use an Implementation Advisor	80%	2.75 (.96)	2.75 (.96)	3.00 (.82)	2.75 (.50)
Develop and Organize Quality Monitoring Systems	60%	4.00 (0.00)	3.33 (.58)	3.00 (1.00)	3.67 (.58)
Use Advisory Boards and Workgroups	60%	3.67 (1.15)	3.67 (1.15)	3.33 (.58)	3.33 (.58)
Capture and Share Local Knowledge	40%	4.50 (.71)	4.50 (.71)	4.00 (0.00)	4.00 (0.00)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Intervene with Patients to Enhance Uptake and Adherence	40%	4.00 (1.41)	4.00 (1.41)	4.00 (1.41)	4.00 (1.41)
Obtain and Use Consumer and Family Feedback	40%	3.50 (2.12)	3.50 (2.12)	3.50 (2.12)	3.50 (2.12)
Provide Local Technical Assistance	40%	3.50 (.71)	4.00 (0.00)	3.50 (.71)	3.50 (.71)
Purposefully Reexamine the Implementation	40%	3.50 (.71)	3.50 (.71)	3.50 (.71)	3.50 (.71)
Remind Clinicians	40%	3.00 (1.41)	3.00 (1.41)	3.00 (1.41)	3.00 (1.41)
Audit and Provide Feedback	20%	4.00 (undefined)	4.00 (undefined)	3.00 (undefined)	2.00 (undefined)
Conduct Cyclical Small Tests of Change	20%	4.00 (undefined)	4.00 (undefined)	4.00 (undefined)	4.00 (undefined)
Use Data Experts	20%	4.00 (undefined)	4.00 (undefined)	4.00 (undefined)	3.00 (undefined)

Note. Ratings (and standard deviations) for effectiveness, comparative effectiveness, feasibility, and appropriateness are based upon a five-point Likert scale wherein higher scores are more positive (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree).

Relationship Between Organizational Social Context and Implementation Phenomena

Qualitative reflections of organizational social context. Leaders and frontline workers conveyed an overarching positivity about the social context of Agency C, which is not to say that they did not raise some concerns. Major themes relative to the context that were very apparent included an orientation toward improvement and growth, collegiality and respect, autonomy and trust, and a propensity toward innovation without follow-through.

Oriented toward improvement and growth. It was clear from talking to both leaders and frontline workers that Agency C was oriented toward innovation, improvement, and growth. "We are continuously involved in some type of process improvement project, capacity building project for the agency," stated the director. "It is my goal that we have built in a formal way that we're always doing something besides exactly who we are…Learning or capacity building, it's not all the improvement piece, but it's just growth. And not numeric growth, but just fabric growth." This deliberate effort to avoid stagnation is apparent in the agency's pursuit of

Intervention C1 and Model C2, as well as their examination of other opportunities that may allow them to improve as an organization.

Collegiality and respect. One thing that stood out about Agency C was that even in discussing problematic aspects regarding the structure and functioning of the organization, leaders and clinicians alike were respectful of their colleagues. This is in contrast to some of the other agencies in this study that often exhibited expressions of animosity and disdain. This foundation of mutuality and respect surely serves Agency C well, though one wonders if the frontline workers regularly have the opportunity to voice their concerns to leadership or whether the culture of respect becomes one in which nobody wants to rock the proverbial boat.

Autonomy and trust. The context of Agency C is certainly one marked by autonomy and trust. As noted by some of the clinicians, this trust, while appreciated, is sometimes at an extreme that is unhelpful. They yearned for more accountability and support. Yet, the autonomy and trust seemed to contribute to the aforementioned spirit of innovation and growth. One leader reported being given a lot of freedom to pursue potential new innovations such as Model C2, and noted that she received "a tremendous amount of support from and reinforcement her [the director]." This freedom is also offered to clinicians. One clinician reiterated that "each of us are afforded a lot of freedom in terms of how we individually do our jobs…we are not a micro management kind of organization. Which again from my prior experience is fantastic." Again, this autonomy and trust undoubtedly can drive growth and a search for better ways to do things, as one leader emphasized, "It's very much expected practice for us to continually look to see what information is out there." But the trust afforded to leadership and frontline workers can be problematic, as will be seen below.

Vision and innovation over follow through. In the focus group, it was acknowledged that the leadership of Agency C has somewhat of a reputation for having big ideas, but not being very detail oriented. Thus, the follow through on certain initiatives might not always be adequate. "She is not detail oriented, she's like 'here is what you need to do. Do it however you want to do,'" described one clinician. "And I think there are people who do feel like they would want a little bit more direction or scaffolding as you put it. She is the first to say she is not detail oriented. She's the big idea gal and she's off and running onto the next project." Indeed, the vision of the leadership can lead to rapid growth, but without the proper supports, the impact of innovation is not always what it could be. One clinician presented an apt analogy:

> This department has this ambition to grow and has been growing in leaps and bounds, and they seem to do it in like little spurts. You know and when a spurt comes it is kind of overwhelming to people who are already in supervisor positions…I think what everybody is saying is that we are excited about the growth but when growth occurs, if we lose this piece of it [opportunities for supervision and other implementation supports], that's not doing the thing. I think it's about the agency as a whole learning to manage those growth spurts you know. We are now children running around in pants that are too short because we didn't plan ahead for that.

This fits well with this author's experience of asking about implementation strategies and other supports at the agency level, in that much more thought seemed to go into the actual interventions that might be used as compared to how the organization could support clinicians in their efforts to implement the new programs and practices well. Clearly, far more attention to implementation processes is warranted.

Results of organizational social context survey. Agency C's OSC profile was close to the average based upon the norms from the national sample (Glisson, Landsverk, et al., 2008). The composite profile score based upon the latent profile analysis was 1.99, again, indicating that culture and climate subscales are much closer to the national averages. Figure 7 shows Agency C's OSC scores in relation to the national norms. Positively, the agency's proficiency score is a full standard deviation above the national average; however, the rigidity score is very close to the national average and the resistance score is almost one and a half standard deviations higher than the national average. In terms of climate, all three subscales (engagement, functionality, and stress) were slightly above the national average.

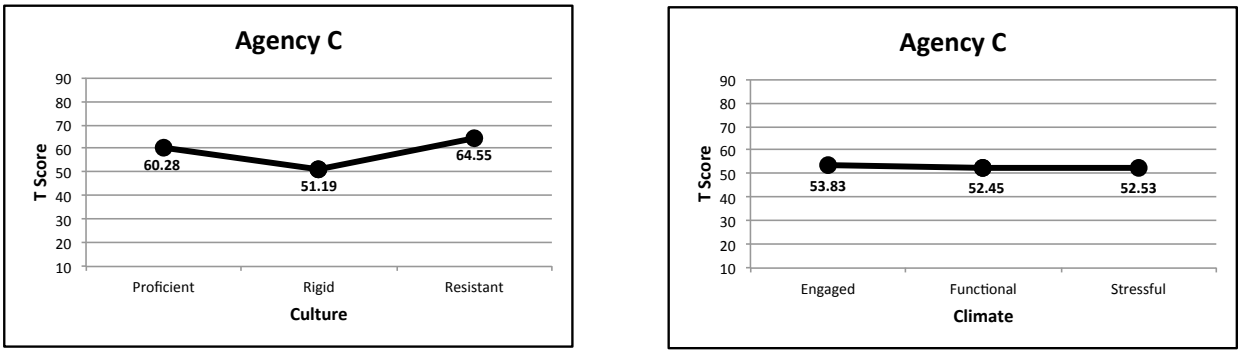

Figure 7. Agency C's organizational culture and climate profiles

Summary and relationship to implementation processes. Admittedly, it is more difficult to interpret the OSC findings when they are closer to the national average as compared to when the profiles are at the positive and negative extremes. There does not appear to be any qualitative evidence that contradicts the quantitative findings. In fact, it is not surprising that Agency C's OSC results indicate that it is more proficient than the average organization from the national sample given the organization's culture of trust and the expectation that clinicians seek and utilize the best available evidence to guide services. It is also clear that the organization's social context is not one that focuses on the details of implementation and the

"little things" that need to be done to support innovation and change. This is evident in the absence of careful implementation planning, as well as in the lack of detail in some of the leaders' responses to questions about implementation strategies. It is also suggested by the relatively low number of strategies that were endorsed by more than two individuals, and perhaps more importantly, by the lack of frequency and intensity of some strategies such as supervision. In this case, the average social context did not seem to moderate perceptions of effectiveness, as staff members appeared to be very positive about any implementation support that they received.

Agency D

General Organizational Description

Agency D is a large community mental health agency that has recently expanded to become a Federally Qualified Health Center (FQHC). The multi-site agency provides services to adults and children. As one agency leader exclaimed, "the breadth of what [Agency D] serves is incredible," including a wide range of mental health, substance abuse, and child welfare services for children and adults. The agency also offers an array of non-traditional services such as art therapy, play therapy, and animal-assisted therapies (canine and equine).

Description of Program or Practice Implemented

The current study focused on the children's services delivered at Agency D through two main programs: 1) a community psychiatric rehabilitation program and 2) substance abuse treatment services. Additionally, several of the organizational leaders associated with these programs provide outpatient therapy to children, youth, and families in addition to their administrative roles.

The community psychiatric rehabilitation program provides children and youth with a psychiatric diagnosis in-home and community support from a trained bachelor's or master's level staff member. These community support specialists serve as liaisons between the child and family and the education, juvenile justice, and child welfare systems. Though these staff members are not supposed to be doing therapy with the children and families, they inevitably must utilize a range of therapeutic skills. For example, they may use techniques such as behavior charts or parent-training techniques. There are two levels of community psychiatric rehabilitation. The first of which requires a bachelor's degree and involves home visits at least every other week though weekly visits are ideal. The second more intensive level requires a

master's degree, and involves home visits at least two times per week for approximately two hours each time. Though these individuals are not delivering therapy per se, it would seem that there may be opportunities to integrate components of evidence-based programs and practices into this work though common elements models (Barth & Liggett-Creel, 2014; Barth et al., 2012). Nevertheless, Agency D is not implementing any specific EBTs with this group.

The youth substance abuse treatment teams included in this study provide outpatient services to youth. This program often provides linkages to mental health services at the agency as many individuals suffer from comorbid disorders. In fact, leaders and clinicians emphasized that there has been a push through the state's department of mental health for the integration of mental health and substance abuse services, though the agency is not currently using an explicitly integrated treatment model such as Integrated Dual Disorder Treatment (Brunette et al., 2008). Clinicians reported that they have not often used two of the practices that the agency outwardly claims to have adopted. The first of which is a program philosophy or guiding structure for youth services based upon a popular book (it remains unnamed to protect the confidentiality of the agency). The agency's website promotes the use of the program philosophy and states that it has achieved international acclaim for the program, and even hangs posters throughout the agency that prominently display the principles of the approach. Yet clinicians at the agency say that they rarely if ever use it in their programming. The second example is collaborative documentation, a process in which clients and clinicians complete session notes together at the end of a session. A focus group participant elaborated further,

> You and your clients sit together and you collaboratively talk about the session. What were our goals for the session, what do we talk about in the session, what do we learn from the session. You complete your documentation with the client

> present in the room. In an effort to cut back on seeing your client and then also needing to take 10 or 15 minutes to do the note afterwards. They are thinking that that's going to alleviate you; give you more time to do direct patient work versus taking the time to do the documentation summary.

Perhaps even more important than alleviating paperwork burdens, collaborative documentation is "an effort to include the client more in their own therapy process." Yet again, collaborative documentation was reported to be a practice that did not seem to be widely used by clinicians (though admittedly some clinicians really bought into the approach). It was actually difficult to ascertain the extent to which collaborative documentation was even expected of clinicians; respondents seemed to have different answers for the question, "Is [Agency D] implementing collaborative documentation?" Clinicians have definitely been trained in the approach, but they do not do it all of the time and the agency leaders don't seem to hold them accountable in this regard.

The fact that Agency D was not currently implementing any EBTs is somewhat puzzling given the fact that "best practices" are listed on their webpage as an agency value. All of the leaders and clinicians characterized the agency as very flexible and open in terms of the expected therapeutic approaches and techniques. Ways of working at the agency were described as "very independent," with another clinician stating, "we all have our own way of working with our own clients." One frontline worker conveyed,

> There's not a push as far the therapeutic piece of it to like follow a certain type or modality…we don't have to use like CBT or you don't have to use solution focused therapy. You don't have to use, they don't push that on us. It's basically your own style; however you work the best with your client; which I can

> appreciate that. Because I think that someone coming in and telling you how to work with your client is frustrating. That's not what you believe is going to work with your clients.

Rather than pushing any particular form of treatment, the agency seems to value flexibility and creativity. "There is a support to really think outside of the box," said one clinician. "Really be creative in terms of delivering services and then really supporting that." Each client was described as, "really different in terms of how you want to approach and work with them." Thus, the agency as a whole seemed to embrace a philosophy that therapy was more art than science. One of the most senior organizational leaders doubted the potential utility of evidence-based programs and practices:

> Obviously, I guess I'm a little conflicted about evidence-based ... not from the perspective of, let's just go out and do anything whether it works or not. Obviously I want us to provide quality services that make a difference for our clientele. Evidence base sometimes can be so prescriptive. You have to follow it a particular way. It can be very expensive to do so. That's where the conflict comes in. Whereas if I can do something ... I can remember a couple of workshops I went to at [a local university], that was talking about ... I can't remember how they were titled. Evidence base was in it. Basically what they were doing is, they were teaching us as field instructors how they work with their students. [She was referring to the process model of evidence-based practice (Gibbs, 2003; Gray, Joy, Plath, & Webb, 2013; McCracken & Marsh, 2008; Rubin & Parrish, 2010) in which practitioners or other interested parties formulate a practice or policy based question, locate available evidence, assess

> the quality of that evidence, integrate it into their practice, and review or evaluate the results]. "If I can approach it from that perspective as opposed to SAMHSA's recommended evidence based or promising practices, then that may be more practical for us at an agency like this, where we have the turnover that we have and couldn't necessarily keep someone who's complete ... for long periods of time. Who could then be that "expert" that could guide ... That's how I would like to approach it more.

Given the agency's focus, questions about implementation and quality improvement were necessarily broadened to focus on more general implementation and quality improvement processes.

Decision Making Processes

Treatment decision making. Agency leaders discussed a variety of contributors to treatment or clinical decision making, citing client need, opportunity, collaborations with other agencies, chances to confer with colleagues, CEU offerings and training materials, and national trends as among the most prominent.

Client need. Like many of the other agencies in this study, leaders from Agency D placed great emphasis on client need as a motivator for clinical decision making. For this agency, this was emphasized both at the level of deciding what types of programs and practices to offer, as well as the more micro-level decisions regarding the use of therapeutic techniques (i.e., tailoring therapeutic techniques to meet the needs of each individual client). One underscored this fundamental drive, "I'm not going to offer a basket weaving course if nobody [in the county] wants basket weaving." Part of this assessment of client need is also determining whether or not other area agencies are providing those services. When faced with the prospect

of adopting Dialectical Behavior Therapy (DBT; Linehan, 1993), one agency leader voiced that she might prefer to refer youth to neighboring programs rather than have her agency invest the time and money to develop their own DBT teams.

Opportunity. Another pragmatic contributor to clinical decision making is opportunity. Returning to the case of DBT, an agency leader told of the state's Department of Mental Health offering free trainings for organizations that want to develop DBT programs. Opportunities like that obviously influence clinical decision making by removing a major obstacle to EBT adoption: lack of funding for training. She reiterated the importance of opportunity, stating, "I may really want to [adopt a program] or a staff member may bring a great idea of something that he or she thinks would be a great program to do. Because of what it would require to do the program, we may not have the resources, at least at this time. Again, opportunity plays a part."

Collaborating with other agencies. Agency D leaders emphasized positive working relationships with many neighboring organizations and systems, and revealed their tendency to trust local knowledge about what works. One leader explained, "If there's something going on that we have a question about in our substance abuse program here, we might contact one of those sister agencies to say, 'Hey what are you doing, how do you approach this?'" This type of knowledge was valued even more than evidence from places like SAMHSA, because these organizations are "actually doing what we do. If they found something that works, that's going to mean more to me than if SAMHSA says this could work."

Conferring with colleagues. In addition to the local knowledge gleaned from collaborations external to the agency, leaders also stressed the benefits of conferring with colleagues about potential treatment options at the micro level. A leader remarked, "Over the years, just meetings to talk about what should we do in this situation. 'Yeah, that happened

before,' everyone jumps in. 'Why don't you try this? Did you try calling this organization?' We all just jump in and help each other."

CEU opportunities and the passive receipt of "research findings." When asked about how leaders make decisions about what programs, practices, and clinical techniques to implement, leaders did bring up research evidence. They did so in a very narrow sense, and it quickly became clear that they were not relying heavily upon rigorous research studies but rather the materials that they had accumulated through CEU trainings in the community. "Basically, the research, it's already been done," one leader said while pointing to shelves full of binders containing materials from CEU trainings. "The information, you already have…that's what I use because that's what we're paying to go to." When this author challenged the leader to articulate the process by which she chooses between the numerous CEU offerings, many of which are undoubtedly not based upon the best available evidence, she admitted, "I definitely look at the brochure and the credentials, the name and what I'm interested in and what I feel like would fit my clientele." Ultimately, she did not necessarily seek out trainings in EBTs, and she described a very eclectic approach in which she drew from the range of materials that she had as she saw fit. Another leader described being influenced by research findings that were presented by an external consultant, though she admitted that she did not look at the research herself in any way.

National trends. Agency D also reported being influenced by national trends. One leader illustrated this using the integrated treatment example, "integrated treatment, it is becoming the norm across the nation. I believe that our funding sources, the department of mental health, and Medicaid all that, are going in a direction so then we try to get ahead of it before it became a, 'you have to do it like it'…kind of thing."

Implementation decision making. It was admittedly difficult to discuss implementation decision making in the absence of specific examples of implementing a program or practice with known dimensions (Fixsen, Naoom, et al., 2005). Further contributing to this difficulty was the sense that Agency D rarely seemed to institute firm expectations that clinicians engage in practices that have been adopted (e.g., collaborative documentation). Nevertheless, agency leaders were able to suggest some basic processes that are typical of their implementation efforts. The agency did not seem to regularly document implementation plans in a formal sense (with the exception of generating memorandums of understanding to guide partnerships), nor do they guide implementation efforts using any sort of formal model. Leaders did not report conducting formal evaluations of organizational performance prior to and after implementation efforts. Rather, one disappointedly noted, "we don't really keep statistics, which is embarrassing in a way." There were not any reports of relying upon literature or research focusing on implementation or quality improvement. Implementation decision making seemed to be driven largely by partnership and consultation between agency leaders, managers, and staff members.

Direction from the highest levels of leadership. A number of leaders described Agency D as a top heavy organization; thus, it is not necessarily surprising that they cited direction from the CEO and other senior leaders as informing implementation decision making. A leader noted the CEO in particular as someone who can be very helpful in terms of both treatment and implementation decision making. "[He] is very much a visionary himself. Even though he trusts all of us to take things and run, he also, because he has to look at things more broadly, he's also very good as far as the input and seeing the vision. Being able to help you figure out what's getting you stuck and getting you past that." Naturally, his blessing is needed before the agency can take on any new endeavor.

Conferring with managers. Agency D leaders pointed to conversations at the management level as guiding implementation choices. "I'll probably collaborate with the managers. I won't 'probably', I definitely will collaborate with the managers within those specific programs that are affected," explained one leader. She continued:

> What are the things that need to happen, like you said? Is there going to need to be staff training? If so, who can do it? How quickly? How long will it take and all that kind of stuff. If there is a training that they need to attend, how do we get that implemented and how do we do it? How do we look at the staffing? Are we going to do this as a pilot first? Do a smaller sample therefore it takes less staff, or are we going to try it and then broaden it or are we going to broaden it all together?

This approach highlights the importance of engaging middle managers in implementation efforts (Birken, Lee, Weiner, Chin, & Schaefer, 2013).

Conferring with staff members. Conversations with frontline workers ideally round out initial discussions between with upper and middle management. "I'm going to talk with staff. Like I said, I don't know everything," declared one leader. "I have very good capable and creative staff. They're going to be able to think of things that I don't. How can we put all those good ideas and how can we make it work?" Obtaining the input of frontline workers was perceived to be essential to building buy-in and contributing to successful implementation. This will be discussed further in proceeding sections.

Implementation Strategy Use

Though not implementing a specific manualized program or practice, Agency D leaders and clinicians reported the use of strategies that facilitated the delivery and improvement of the

services that they routinely provided, including those at the level of the intervention, outer setting, inner setting, individual, and process level.

Strategies related to intervention characteristics. At the level of the intervention, Agency D discussed the adaptation of interventions.

Adapting interventions. Although Agency D did not report adopting any manualized treatments that would demand strict adherence, organizational leaders did express their willingness to adapt interventions as needed. In fact, one leader described how in past years they adapted a substance abuse treatment model (Rawson et al., 1995) that was designed for adults to use with their adolescent clients. The adaptations that she described included minor changes, such as tweaking adult-focused scenarios involving work and family considerations so that they are more appropriate to youth. She also discussed selecting certain elements of the model rather than utilizing the full model as originally intended (Wiltsey Stirman, Miller, et al., 2013). Again, any adaptations are not surprising given the agency's eclectic and individualized approach to treatment.

Strategies related to the outer setting. Several outer setting strategies were routinely utilized by Agency D, including accessing new funding, obtaining client/consumer feedback, direct marketing to clients/consumers, active outreach to clients, providing incentives for clients, informing clients of existing services through information sheets, and collaborating with other agencies and systems.

Accessing new funding. Organizational leaders acknowledged that the search for grant funding was "constant." Given the fact that Agency D is not currently implementing any evidence-based program or practice within the children's services department, they were not able to state specific examples of how this facilitates implementation.

Obtaining client/consumer feedback. Agency D regularly administers client-satisfaction surveys as a means of obtaining feedback. These occur either quarterly or every six months (the leaders could not recall). One leader said that she regularly tries to ask clients directly what they appreciate about the services they receive and what can be done better. Additionally, the agency is able to solicit feedback from individuals on their board of directors, half of which are consumers.

Direct marketing to clients/consumers. One leader discussed how they send notices to clients to make them aware of available services. In addition they attempt to target clients who are having difficulty obtaining services by sending marketing materials to the child welfare, juvenile justice, and education systems.

Outreach to clients. Some clients who have chronic conditions and are involved in Agency D's health care home program are regularly followed by nurses. These nurses actually go into the community and attempt to insure that they are receiving appropriate medical services.

Providing incentives for clients. Agency D occasionally gives adolescent clients incentives for doing well in treatment, because "that keeps them coming back." Though they don't have much money in the budget for that, they often solicit local businesses for coupons and gift certificates amounting to a very modest amount of money.

Waiting room notices. Interestingly, one leader told of information sheets that were hung in the waiting room walls. These sheets described the agency's commitment to integrated care for mental health and substance abuse services. These advertisements could potentially prompt clients to ask questions about getting connected to additional services; however, the organizational leader was not sure what (if any) impact these information sheets have had.

Collaborating with other agencies. Agency D regularly collaborates with other organizations and systems to accomplish their programmatic goals. The vast majority of these collaborations seem to afford the opportunity to expand the reach of services. For example, Agency D is beginning to provide mental health and health services within the school system, and has been given space within the schools to do so. Organizational leaders did not share any cases in which they have collaborated with other organizations or systems to implement specific programs or practices.

Strategies related to the inner setting. Implementation and quality improvement strategies at the level of the organization (or inner setting) were noticeably absent for Agency D, though they did identify their efforts to increase staff salaries and support staff appreciation efforts as means of improving staff morale.

Increasing staff salaries. One of Agency D's goals is to ensure that staff salaries are "over market" by the year 2018. This was one of two agencies to mention staff salary increases as a way of ensuring that they can hire and retain quality personnel.

Staff appreciation committee. When asked about organizationally focused implementation and quality improvement strategies, several leaders and clinicians mentioned a staff appreciation committee that organizes events designed to boost worker morale. Though obviously not intervention specific, some of the clinicians spoke of this in a positive light.

Strategies related to the characteristics of individuals. Provider level strategies were certainly dominant for Agency D. They routinely provide staff members with funds and paid time off for training, in-house training opportunities, E-learning training modules, opportunities to shadow other workers, clinical supervision, weekly staffing meetings, informal peer support, monitoring of progress notes and other documentation of services, and annual evaluations.

Funds and paid time off for training. Every staff member is allotted a modest training allowance and paid time off to attend trainings. The agency occasionally hosts required trainings for learning that they deem essential for all of the clinicians (e.g., DSM-5, ethics, etc.); however, staff members do not have to use their hours or training dollars on those trainings unless for some reason they were not required to attend.

In-house training opportunities. In-house training opportunities are provided periodically (usually 2-4 times per year). Examples of training include a session on the DSM-5, an ethics training that involved a dancing/theatrical performance to make the topic a bit more engaging, and a session focusing on play therapy techniques.

E-learning modules. Agency D maintains a system to deliver E-learning modules, several of which allow the user to print certificates of completion that are accepted by licensing boards for CEU requirements. When the agency initially offered this option, it seemed as if there were set expectations that clinicians complete certain modules; however, the clinicians interviewed reported that they rarely use the E-learning resource due to lack of time.

Shadowing. While not a strategy identified by the majority of respondents, one focus group member suggested that shadowing is regularly used by Agency D. "When you're a new person coming in, you basically shadow everybody once or twice. So you kind of get an idea about how everybody works and does everything different," she said.

Supervision. Leaders and clinicians reported somewhat different accounts about supervision. With regards to frequency, some reported that supervision was weekly, while others made comments such as "I haven't had supervision in weeks" and "I really don't regularly have supervision." This discrepancy is similar to that reported by clinicians at Agency C. One clinician justified this by stating, "I think in the beginning they tried to be a little bit

more stringent on having the hour of supervision, but I think as you become more seasoned and you know what you're doing, you know how to handle things kind of on your own, I think it becomes a little bit lax on supervision." That clinician did not see a problem with this, particularly because of the fact that nearly everyone interviewed acknowledged that supervisors try to maintain an open door policy and are regularly available for more informal consultation. Still others maintained that weekly supervision would be helpful and expressed their desire for that to be the norm.

The content of supervision clearly seemed to vary depending upon the supervisor. One supervisor emphasized his respect for clinicians' autonomy and inherent strengths, taking a relatively laissez faire approach to supervision:

> [I] try to flow with what their strengths are, what they want to pursue, and try not to impose anything on them. A lot of times, in supervision, it's more of exploring what they want to do and where they want to go, and how they feel they can get to that point. I'm certainly not an expert on a number of different theories or approaches, that's just not who I am. I rely on their understanding. I can help them explore or what have you, what they're trying to get their answers for.

His response, while clearly supportive, is consistent with the agency's general ethos of eclecticism and lack of expectation for specific theoretical or technical expertise when it comes to therapeutic and/or case management services. Other supervisors reported being no more directive theoretically or technically, but shared a more active approach to supervision in that they regularly offered career guidance to their supervisees and encouraged consistent growth in that regard. Additional elements of supervision will be discussed in the context of participants' perceptions of supervision.

Weekly staffing meetings. Staffing meetings that occur weekly provide an opportunity for clinicians to check-in and obtain support for their clinical work. It might be a time to say, "I'm really struggling with this. Does anybody have any suggestions? Has anybody worked with a client that's had similar issues with clients, can anybody give me any kind of guidance?" Team members regularly "weigh in" with approaches that they have found particularly helpful or unhelpful.

Informal peer support. A number of staff members spoke about how indispensible their peers were in providing support and supervision-like functions. One worker shared with great emotion, "I probably walk into her [a coworker's] office about 500 times. I'm a little bit in culture shock as far as working with juveniles and she's been wonderful with just teaching me everything. There's the open door policy as far as helping and teaching." Others complimented the team's ability to communicate well and provide mutual support, noting that communication amongst the team is constant as things come up on a daily basis. The mutual support is enhanced by each team members' knowledge of the children and youth served though the program. One clinician exemplified the utility of this, saying, "I feel I have a pretty good grasp on every kid on our program, not just my own caseload…I think about the whole group…I love that about our team." Surely this collective knowledge of each other's caseloads facilitates their ability to provide both technical and emotional support.

Monitoring notes/production. Though no form of fidelity monitoring was noted given that Agency D was not implementing a specific program or practice, leaders communicated that they regularly monitor clinicians' progress notes and that they receive monthly reports on their production. The notes are reviewed for content and structure in order to ensure that they meet all of the requirements. This focuses far less on the clinical content of the notes. One leader

admitted that she mainly looks to ensure that " there is enough 'meat' in it for like, say your note does get subpoenaed or something like that, there is enough, but not too much…Enough to cover the funding requirements and the funding sources, but not too much." This focus on compliance and funding requirements over clinical content seems to be pervasive across agencies.

Annual staff evaluations. Several participants identified annual staff evaluations as a quality improvement strategy, though most acknowledged that they can become "routine" and that they do not necessarily identify areas for improvement in the clinical domain as much as they focus on administrative concerns such as focusing on completing documentation responsibilities in a timely manner.

Strategies related to the process of implementation. Finally, strategies pertaining to the process of implementing services included assessing barriers and facilitators, outcome monitoring, program review meetings, and seeking anonymous feedback from staff members.

***Assessing barriers and facilitators*.** An organizational leader spoke of routinely assessing barriers and facilitators when the organization takes on new initiatives. "I want to see what the stumbling blocks are going to be so I can troubleshoot around those," she stated. "You can have a great plan but if there's a lot of obstacles on the way, it's going to take you a while to get to it." When asked the method that she uses to assess barriers, she mentioned that she primarily queries staff members, sharing her ideas for a particular effort and asking them to brainstorm any potential barriers. At times she relies upon supervisors to do this, because she recognizes that staff members may not always be comfortable sharing that information with her. While this is a relatively unsystematic method of collecting information about potential barriers and facilitators, it has been used in studies focusing on tailoring implementation strategies to

address barriers to change (Wensing et al., 2011). The process of selecting strategies to overcome identified barriers was not well articulated, and seemed to rely upon the judgment of leadership and staff through a similar process of soliciting feedback.

Outcome monitoring. Agency D has adopted the Shortform Assessment for Children (Glisson, Hemmelgarn, & Post, 2002) that was offered through the ARC RCT (Glisson & Proctor, 2009). The agency also uses the state mandated Daily Living Activities (DLA-20©) Youth Version (Presmanes & Scott, 2002; R. L. Scott & Presmanes, 2001). Though these assessments were viewed as a way to "assess our efficacy," leaders and clinicians reported that they do not always use these assessments. Moreover, it seemed as if little was actually done with the measures if/when they were completed. While one leader stated, "I always share the reports…because I think that's good for staff to know," other leaders and clinicians that were interviewed did not seem to acknowledge that they regularly received that feedback. If they did receive the feedback, it was always at the aggregate (rather than the individual clinician) level, and thus was not viewed as a means of improving their individual practice.

Program review meetings. The adolescent substance abuse treatment program conducts quarterly program review meetings. "We're actually addressing and taking a look at the program itself in terms of what services we deliver, how we operate," explained a clinician. "We're reviewing that in terms of…are there other things that we can be offering or doing to make treatment more engaging."

Seeking anonymous feedback from staff. On an annual basis, Agency D provides an opportunity for staff members to give the CEO anonymous feedback. This is conducted as a part of strategic planning and budgeting for the upcoming year. Of course, they are able to identify themselves if they want to, but they do not have to and there is no way for the CEO to identify

who is giving the feedback. The solicitation of anonymous feedback is a strategy that is incorporated in other implementation and quality improvement strategies that have been outlined in the business literature (e.g., Nickerson, 2010).

Perceptions of Implementation Strategies

Qualitative results pertaining to perceptions of implementation strategies. The qualitative reflections represented in this section are drawn from two focus groups consisting of 16 frontline workers (clinicians and community support specialists) as well as five semi-structured interviews with agency leaders. Themes related to strategy perceptions in Agency D include perceptions of financial support for training, in-house trainings, E-learning, outcome monitoring, annual reviews, supervision, weekly meetings and peer review, staff driven initiatives, and management training.

Perceptions of financial support for training. Agency D employees were almost universally appreciative of the yearly allowance and paid time off for training. With the exception of Agency B's robust training infrastructure, this allowance was very generous compared to the other agencies in the current study. Although the amount of time and money available is not likely to allow clinicians to become certified in most manualized EBTs, it is indeed generous, and exceeds the amount that most clinicians would be willing to pay for training independent of that support (Powell, McMillen, et al., 2013).

Perceptions of in-house trainings. Agency leaders and clinicians alike expressed a desire for more in-house trainings, particularly given the logistical concerns of attending outside trainings. "…You have to take a day. You use your time, you usually travel to a hotel somewhere and you sit in the conference room and you do the training…It would be more just purely convenient and probably make people go to them more often if [Agency D] were able to

bring trainings here." Several individuals expressed their disdain for didactic lectures that essentially amount to "one of us reading from a piece of paper or watching a slideshow." Rather, one clinician recommended that the agency conduct more active training sessions in which trainers present case examples and then facilitate conversations about working with clients in particular scenarios. This is of course consistent with research that suggests the importance of more active and dynamic training (Beidas & Kendall, 2010; Davis & Davis, 2009).

Perceptions of E-learning. While clinicians acknowledged that E-learning is encouraged, they also asserted that "nobody does it" because they simply don't have time. One participant estimated that it would probably take 60 hours to get caught up on all of the things that he is required to take. Thus, when staff members are required to take courses, they generally click through the modules as quickly as possible in order to take the final quizzes, knowing that if they fail they can simply take the test again. Needless to say, the general sentiment was that this is not an effective method of learning.

Perceptions of outcome monitoring. As previously indicated, clinicians did not report finding outcome monitoring valuable either for assessing their level of effectiveness or for driving improvement efforts. This may be due to the fact that these measures were not routinely fed back to them, were not individualized, and were not directly tied to performance evaluations.

Perceptions of annual reviews. Performance reviews were not perceived to contribute to the improvement of clinical practice. "I feel like there wasn't much feedback given to me," stated one frontline worker. "A lot of times we're not told if we're doing well or not. We only hear about, 'you need to get this paperwork in.'" Theoretically, this could be a valuable

opportunity to comment on each of the workers' clinical strengths and identify potential areas of improvement; however, it did not appear that Agency D used it as such. This may also be due to the fact that supervisors are not acutely aware of their supervisees' clinical work as described in the "perceptions of supervision section" below.

Perceptions of supervision. Clinicians voiced a variety of opinions about the effectiveness of clinical supervision. Some clinicians reported that it is very helpful and praised their supervisors for their availability. Others articulated a distance between them and their supervisors. "They really don't know about how we're actually doing with our clients," said one participant. "They can look in the charts and, I mean, what's there and what's not there and what needs to be filled out better, but other than that, they don't really know." Another clinician agreed, "Our supervisors have a very kind of vague idea of our, you know, of our work and our clientele and most of what we talk about... we do talk about our clients, but it seems like the emphasis is on making sure we get our paperwork in on time." This is not necessarily a knock on the supervisors. Most of them carry the burden of both clinical and administrative duties. One clinician wondered "how they don't feel compassion fatigue because they're seeing their own list of clients and then they have another, you know, six or so people that they have to come and try to empathize with us." Another clinician asserted, "My supervisor's not out in these homes and doesn't know these people…[he] can't be expected to, you know, know the best thing to do in this situation with this client." There is also the reality that supervision is a two-way street; clinicians must be actively involved. In fact, one clinician said that she was "getting the best supervision" at this point in her career, speculating that it is due in par to that fact that she has grown and now knows "more of the things to ask." But despite the reasons for the erratic receipt of supervision and (in some cases) the disconnect between supervisors and

supervisees, some clinicians simply don't feel like they get that much help in their "actual work." One suggestion they had for making supervision more valuable was the integration of more positive praise and encouragement, ideally arriving in greater proportions than requests to meet billing requirements or work harder.

Perceptions of weekly meetings and program review. In reference to the weekly meetings and program review sessions, one clinician stated "If you're going to be delivering services and have a program of value and a quality program, I think definitely the weekly staffing meetings and the program review definitely have to be a part of it." His colleagues quickly expressed their agreement that these meetings were indispensible in promoting dialogue about what is working and what might need to be tweaked to improve service delivery. One leader dubbed these meetings among "the most beneficial" strategies.

Perceptions of staff-driven initiatives. Several leaders noted the importance of involving clinicians at the 'ground level' of any change effort. "When there's input from the staff, when the staff are providing the ideas and suggestions, it's always been successful," exclaimed one leader. "It appears that they accept it a little bit easier sometimes than coming down from an administrative standpoint. The more input, feedback I get, the more committed they are to it."

Perceived need for more management training and support. Interestingly, one leader identified a need for the agency to provide more training and support for managers and supervisors. Apparently the agency does hold manager meetings periodically, but they do not occur very often and when they do, they primarily focus on developments pertaining to the broader landscape of mental health services. In her estimation, the organization would benefit from dedicated opportunities to receive instruction and support related to supervision and

management. This emphasis is well taken and timely given recent efforts to develop implementation leadership capacity (Aarons, Ehrhart, & Farahnak, 2014; Aarons & Sommerfeld, 2012; Aarons, 2009).

Quantitative results pertaining to perceptions of implementation strategies. Sixteen of 23 Agency D employees (70%) completed the Implementation Strategy Use and Perceptions Survey, the full results of which can be seen in Table 9 below. All 50 strategies were endorsed by at least one Agency D employee, with 86% of the strategies being endorsed by at least half of participants. There was a relatively restricted range of responses, with means ranging from 3.13 to 4.30 (1 = least positive; 5 = most positive). Only eight strategies endorsed as "in use" by at least half of respondents were rated a 4.00 or higher, whereas three strategies endorsed as "in use" by at least half of respondents were rated under a 3.50 (i.e., closer to neutral at best) including: "mandate change," "change record systems," and "use data experts." Quantitative findings suggest that a wide range of implementation and quality improvement strategies are in use at Agency D, but that strategies were not generally perceived to be very effective, with the majority of mean effectiveness scores ranging from 3.50 to 3.92. There did not appear to be a clear preference for any given category of implementation strategy.

Convergence of qualitative and quantitative findings. The qualitative and quantitative findings were consistent for several strategies. For example, "supervision" was rated relatively poorly (3.63), not surprising given clinicians' strong opinions expressed in the qualitative interviews. While "audit and provide feedback" was not discussed as a formal strategy in the qualitative interviews, the fact that it was rated relatively poorly is consistent with clinicians' expressions that feedback was often negative and unwelcome. Conversely, some strategies such as "conduct local consensus discussions" and "capture and share local knowledge" were not

rated highly despite qualitative support for any opportunities to share lessons learned with leadership and colleagues. The range of implementation strategies endorsed in the quantitative survey does not necessarily match the narrower range of strategies endorsed in the qualitative interviews, which may indicate that respondents over-endorsed implementation strategies. The agency's diverse service offerings and lack of focus on a specific EBT could have also led respondents to endorse a wider range of implementation strategies.

Table 9. Agency D: Implementation Strategy Use and Perceptions Survey Results (N = 16)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Planning Strategies					
Mandate Change	81%	3.38 (.96)	3.15 (.80)	3.61 (.77)	3.54 (.88)
Build a Coalition	75%	3.83 (.94)	3.67 (.89)	3.75 (.62)	3.75 (.62)
Involve Executive Boards	75%	3.83 (.72)	3.33 (.78)	3.83 (.72)	3.75 (.75)
Assess for Readiness and Identify Barriers/Facilitators	69%	3.91 (.54)	3.55 (.69)	3.82 (.60)	3.82 (.60)
Develop Resource Sharing Agreements	63%	3.90 (.74)	3.70 (.82)	4.00 (.82)	3.90 (.74)
Tailor Strategies	63%	3.70 (.67)	3.80 (.79)	3.80 (.63)	3.70 (.67)
Develop a Formal Implementation Blueprint	63%	3.60 (.97)	3.50 (.97)	3.60 (.97)	3.50 (.97)
Recruit, Designate, and Train for Leadership	63%	3.50 (1.08)	3.70 (.95)	4.00 (.82)	3.80 (.92)
Conduct Local Needs Assessment	56%	4.00 (.71)	3.56 (1.01)	3.89 (.78)	3.89 (.78)
Develop Academic Partnerships	56%	3.67 (.87)	3.33 (.50)	3.89 (.33)	3.67 (.50)
Conduct Local Consensus Discussions	56%	3.56 (.88)	3.33 (.71)	3.56 (.73)	3.56 (.73)
Identify and Prepare Champions	50%	3.75 (.89)	3.60 (.74)	3.75 (.89)	3.75 (.89)
Stage Implementation Scale Up	44%	3.86 (.90)	4.00 (.58)	4.00 (.58)	3.86 (.69)
Obtain Formal Commitments	44%	3.86 (.69)	3.57 (.53)	3.86 (.69)	3.86 (.69)
Visit Other Sites	38%	3.83 (.75)	3.83 (.75)	3.83 (.75)	3.67 (.82)
Educational Strategies					
Conduct Ongoing Training	88%	3.57 (1.22)	3.29 (1.14)	4.07 (.62)	3.86 (.77)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Use Train-the-Trainer Strategies	75%	3.92 (.51)	3.50 (.67)	3.92 (.67)	4.00 (.60)
Create a Learning Collaborative	75%	3.83 (1.11)	3.42 (1.08)	4.00 (.74)	4.00 (.74)
Conduct Educational Outreach Visits	69%	3.82 (.75)	3.45 (.82)	3.73 (.79)	3.73 (.79)
Provide Ongoing Consultation	69%	3.73 (.65)	3.64 (.67)	3.73 (.65)	3.73 (.65)
Distribute Educational Materials	63%	4.10 (.74)	3.50 (.85)	3.80 (.92)	4.00 (.82)
Shadow Other Experts	63%	3.70 (.67)	3.60 (.70)	3.60 (.70)	3.60 (.70)
Conduct Educational Meetings	56%	4.11 (.60)	3.67 (.71)	4.11 (.60)	4.00 (.71)
Develop Educational Materials	56%	3.67 (.71)	3.56 (.73)	3.67 (.71)	3.89 (.60)
Inform Local Opinion Leaders	44%	3.57 (.98)	3.43 (.98)	3.71 (.76)	3.71 (.76)
Make Training Dynamic	31%	4.00 (.71)	3.80 (.84)	4.00 (.71)	4.00 (.71)
Develop an Implementation Glossary	13%	3.50 (.71)	3.00 (1.41)	4.00 (0.00)	4.00 (0.00)
Increase Demand	6%	4.00 (undefined)	4.00 (undefined)	4.00 (undefined)	4.00 (undefined)
Financial Strategies					
Access New Funding	63%	4.10 (.88)	3.50 (.71)	3.80 (1.03)	3.90 (.88)
Make Billing Easier	44%	4.14 (.38)	4.00 (.58)	4.14 (.38)	4.14 (.38)
Alter Incentive/Allowance Structures	31%	3.40 (.55)	3.80 (.84)	3.20 (.84)	3.00 (1.00)
Restructuring Strategies					
Change Service Sites	81%	4.15 (.69)	3.54 (.97)	4.00 (.82)	4.15 (.69)
Change Physical Structure and Equipment	63%	4.30 (.48)	3.70 (.82)	4.10 (.57)	4.20 (.42)
Create New Clinical Teams	56%	4.00 (.87)	3.56 (.73)	3.89 (.60)	3.78 (.97)
Revise Professional Roles	56%	3.89 (.78)	3.56 (.73)	3.89 (.78)	3.78 (.67)
Change Record Systems	56%	3.33 (1.12)	3.00 (1.32)	3.56 (1.01)	3.44 (1.13)
Quality Improvement Strategies					
Provide Clinical Supervision	100%	3.63 (1.02)	3.38 (1.02)	3.81 (.91)	3.69 (.95)
Develop and Organize Quality Monitoring Systems	88%	3.71 (.83)	3.57 (.76)	3.71 (.83)	3.71 (.83)
Audit and Provide Feedback	81%	3.54 (.97)	3.31 (.85)	3.77 (.60)	3.69 (.63)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Organize Clinician Implementation Team Meetings	75%	3.83 (.83)	3.50 (.90)	3.92 (.67)	3.92 (.67)
Use Advisory Boards and Workgroups	69%	3.91 (.54)	3.73 (.79)	3.91 (.70)	3.82 (.60)
Intervene with Consumers to Enhance Uptake and Adherence	69%	3.64 (.67)	3.27 (.65)	3.55 (.69)	3.55 (.69)
Obtain and Use Consumers and Family Feedback	63%	3.80 (.63)	3.60 (.70)	3.80 (.63)	3.60 (.84)
Provide Local Technical Assistance	56%	4.00 (.71)	3.78 (.97)	4.00 (.71)	4.00 (.71)
Purposefully Reexamine the Implementation	56%	3.78 (.67)	3.67 (.71)	3.78 (.67)	3.78 (.67)
Capture and Share Local Knowledge	56%	3.56 (.73)	3.22 (.44)	3.56 (.53)	3.56 (.73)
Use an Implementation Advisor	50%	3.63 (.52)	3.50 (.53)	3.75 (.46)	3.63 (.52)
Use Data Experts	50%	3.13 (.83)	3.00 (.76)	3.00 (.76)	3.00 (.76)
Conduct Cyclical Small Tests of Change	44%	3.71 (.76)	3.57 (.79)	3.71 (.76)	3.71 (.76)
Remind Clinicians	25%	4.25 (.50)	4.25 (.50)	4.25 (.50)	4.25 (.50)

Note. Ratings (and standard deviations) for effectiveness, comparative effectiveness, feasibility, and appropriateness are based upon a five-point Likert scale wherein higher scores are more positive (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree).

Relationship Between Organizational Social Context and Implementation Phenomena

Qualitative reflections of organizational social context. The interviews and focus groups with leaders and clinicians yielded several salient contextual themes that warrant discussion. Positively, Agency D's teams seemed to be marked by a strong sense of collegiality and positive communication patterns. Several other themes were more concerning, including evidence that the organization was top heavy and characterized by some disconnect between leaders and frontline workers, a punitive culture, the emphasis of documentation compliance over quality, and elevating new growth over current program excellence.

Collegiality and strong communication within teams. The teams interviewed for this

study generally acknowledged that there were positive and cohesive relationships within their own teams. It is worth mentioning that this is not necessarily indicative of the organization as a whole, as each team may have its own distinct culture. Nevertheless, respondents believed that their teams worked extremely well together. One clinician painted a positive picture of her team:

> I think that everybody kind of gets along well and I think that that helps with cohesion and it helps with being able to knock on someone's door and walk in and ask them a question about something. In terms of our team I feel like that. It's kind of a personality issue too that everybody wants to work together and everybody is really open to suggestions and nobody is really stuck on working in one way with the client. Everybody's openness to accept something different is a reason that makes our team work well.

These strong bonds between coworkers may be forged in the fire of very difficult work, as acknowledged by one clinician. "I think there's openness about our work being hard. I mean, adolescents…they are the toughest group of kids to work with and they're still on substance abuse on top of that; that's difficult… I think that's part of what makes a team so strong." Participants described a culture that allowed for a lot of informal contact through shared lunches, hallway conversations, texts, and phone calls, all of which were perceived as contributing mightily to their ability to do good clinical work.

Top-heavy organization prone to disconnects between administrative layers. Agency D was described as "top-heavy," which at times creates tension as one clinician articulated. "We have a lot of managers, a lot of people in higher positions that do not have to do any productivity. There's a lot of us 'little people' running around, we're working our feet off to

deliver services. I don't understand such a top heavy organization like that." Tangibly, this leads to feelings of disconnect between frontline workers and upper management. Even managers were quick to identify communication caps, with one stating that "they don't necessarily inform me all the time either, why things happen the way they do." Another leader agreed that communication isn't what it could be: "The door of communications needs to be open all the time from top, middle, down. It seems like it's not always open as much as it could be because everyone is so busy doing other things at the top level that they just assume and rely on the lower managers to take care of it." She proceeded to describe scenarios in which she is constantly directed toward her direct supervisor rather than having ready access to the ears of upper management. This concern is far from a 'touchy feely' cultural issue; it has real importance in terms of the delivery of clinical services. A leader hammered this point home by saying that immediate needs related to clinical care sometimes go unaddressed due to poor access to upper management. She said in frustration, "by the time you might actually address the issue, it could be a month to two months down the path and it's like, 'Okay, well, that's not effective.'" The solution, according to one leader, would be for upper management to check-in with staff members to see if there are ways in which they could make their jobs easier. She thought this needed to happen individually, as staff members may not feel very safe to raise suggestions and concerns within the context of large group meetings.

Punitive culture. Several individuals raised concerns that Agency D's culture can be punitive at times. Contributing to this overarching sense is a lack of positivity and praise from supervisors and upper management for a job well done. Staff expressed a desire for a "a simple acknowledgment of what we're doing." More seriously, some staff shared stories of being punished professionally or psychologically for completing paperwork "wrong" despite

inconsistent/inadequate training, or saying the "wrong thing" to the wrong person (the details of these stories are omitted to protect confidentiality).

Documentation compliance over quality. Many of the clinicians shared the concern that requirements of funders related to the documentation of services often seem to trump efforts to deliver quality services. To be fair, this was a concern shared by virtually every agency in the study; however, it is noted here given the pervasiveness of the concern. One clinician reflected, "Our job is basically, well, it feels this way sometimes, is our job is to please the auditors and not to, as opposed to the clients."

Elevating new growth over current program excellence. Several individuals, both clinicians and leaders, mentioned that the agency sometimes elevates new endeavors over investing the quality of existing programs. One leader warned that the agency should really be more deliberate about pursuing new programs. "Slow it down," she directed. "Don't try to develop all these millions of programs, you know, but focus on the ones you have to improve them, instead of spreading everyone even thinner to develop new programs." She wondered if the agency is getting too big too fast, with quality suffering as a result. This concern may be well founded given the breadth of the agency's offerings. It is likely difficult to prioritize any one area as a target for improvement, and it is easy to see how staff members might feel like they get lost in the fray.

Results of organizational social context survey. Agency D's OSC profile was close to the average based upon the norms from the national sample (Glisson, Landsverk, et al., 2008). The composite profile score based upon the latent profile analysis was 1.97, again, indicating that culture and climate subscales are much closer to the national averages. Figure 8 depicts Agency D's OSC scores in relation to the national norms. In this case, the graphs are more

informative than the agency's LPA score, which is very close to that of Agency C. In actuality, Agency D's culture and climate were rated more negatively. Agency D's culture profile shows that its rigidity and resistance scores are approximately one standard deviation above its proficiency score, which is only slightly above the average. In terms of climate, results show that employees are less engaged than the average from the national norms. More positively, the functionality of the climate was ranked over one standard deviation higher than the average from the national norms. Finally, the employees rated the climate as more stressful than the average from the national norms.

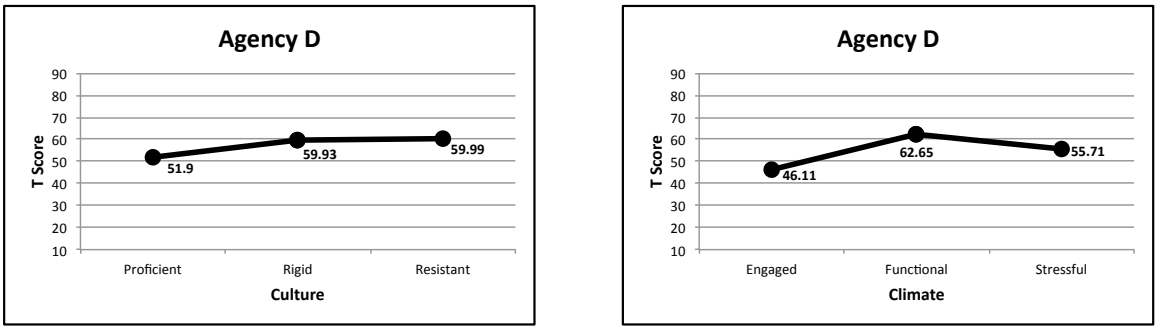

Figure 8. Agency D's organizational culture and climate profiles

Summary and relationship to implementation processes. The qualitative and quantitative findings regarding organizational social context did not contradict each other. The hierarchical nature of Agency D may contribute to increased rigidity, as staff members must rely upon multiple layers of leadership to make certain decisions regarding program delivery. Despite being characterized as a flexible and open culture in terms of clinical approach, the qualitative results definitely reflect that there is often little consensus regarding the importance of given change efforts. This is consistent to the higher than average resistance score.

The qualitative data definitely point to a context that is so overwhelmed by multiple efforts (not EBTs, but different clinical programs) that it has little time or energy left over to focus in on the details that are necessary to implement new programs and practices well. This is

evident in agency leaders' difficulty in identifying clear implementation processes and strategies. It may also be evident in the wide range of strategies endorsed, as Agency D is another agency that employed a lot of implementation strategies with very little intensity. The experience of interviewing individuals from Agency D was an interesting one. Nearly all of the interviews felt scattered and unfocused despite the use of a structured interview guide. Many of the respondents' answers regarding implementation processes were "thin," lacking much depth and nuance. This may be expected given that we were unable to focus on a specific program or practice; however, it may also be indicative of an environment that is somewhat hectic and unfocused given the burden so many different service goals and populations. In any case, the overarching social context was not facilitative of implementation processes that would be consistent with best practices.

Agency E

General Organizational Description

Agency E is a large behavioral health organization that focuses primarily upon the needs of children and families with a history of abuse or neglect and children with developmental disorders. While this multi-site agency provides a wide rage of services throughout the state, this case study focuses on a subset of the children's services delivered out of one location by approximately 60 employees. Specifically, this case study focuses on an evidence-based home visiting program intended to promote child well-being, and the administration of two programs designed to prevent child abuse and neglect.

Description of Program or Practice Implemented

Within the past year the agency has adopted an evidence-based home visiting program (hereafter Intervention E1). Agency E is "slowly starting to implement all of their rules and regulations on how to run a good program." The program is a free and voluntary home visiting program that is funded by the state's Department of Social Services. The goal is to provide new parents the opportunity to receive the education and support that they need in order to promote healthy child development and bonding, positive parent-child interactions, access to medical services and immunizations, developmental screenings, goal setting and planning for the future, and linkage to community resources.

This case study also focuses on the administration of two additional programs (hereafter Interventions E2 and E3). Intervention E2 is designed to prevent child abuse and neglect by providing crisis intervention services for families as they work through difficult times. These services last from four to six weeks, but services are very intensive, generally about 8-10 hours per week. The families also have access to support 24 hours a day via an on-call staff member.

Frontline workers provide training and education pertaining to parenting, child development, housekeeping skills, budgeting and home management, problem solving and negotiation, family roles and boundaries, stress and coping, communication, and utilizing formal and informal resources. Intervention E3 involves a similar array of intensive services to families who are being reunited with their children who have previously been placed in the foster care system. These services include training and education related to parenting, money management, conflict resolution, and communication. While the majority of this case study examines the implementation processes surrounding Intervention E1, parts will also discuss strategies and processes related to the ongoing implementation and improvement of Interventions E2 and E3.

Decision Making Processes

Treatment decision making. Agency E considered a range of potential home visiting programs, but ultimately, factors related to the characteristics of the program, outer setting, and inner setting proved influential in leading to the selection of Intervention E1.

Factors related to the characteristics of the intervention. Two characteristics of the intervention itself motivated Agency E to adopt it: its status as an evidence-based program and the sense that it was adaptable.

Evidence strength and quality. Every agency leader interviewed cited the fact that Intervention E1 was an evidence-based program. None of them shared specifics about how they assessed the evidence, nor did they reference evidence-based clearinghouses or other sources of information about evidence-based programs and practices. Nevertheless, it was very clear that the fact that the intervention is evidence-based was essential for them, either due to their personal commitment or, perhaps more likely, the fact that the request for proposals suggested that the proposed intervention must be an evidence-based program or a "promising" program.

Adaptability. Intervention E1 was also perceived by some to be very adaptable or flexible in that it offered the agency the opportunity to select their own curriculum as long as it was "evidence-based" and they provided a rationale for it. Though they appreciated this flexibility, leaders expressed ambivalence about the curriculum that they ended up choosing, noting that they could likely have spent more time and energy scrutinizing the pros and cons of various curricular options.

Factors related to the outer setting. Both client need and the opportunity to obtain funding were cited as important outer setting factors influencing the choice of Intervention E1.

Client need. One leader pointed out that there was an identified need for services directed toward pregnant and parenting teens in the community. She noted, "a lot of the research coming out of, especially like [parts of the county] which indicated that there was a need for this type of service." As will be seen below, the agency felt confident that they could address this need.

Availability of funding. Leaders universally pointed to the state's request for proposals as a major reason why they chose to pursue a home visiting model. They originally bid on it in three of their locations, but were only awarded a contract for one site.

Factors related to the inner setting. Two factors related to the inner setting were among the most important (if not *the* most important) influences on intervention decision making. The first, is the organization's perceived need to fill a gap in preventive services at their agency, or to put it another way, a strong implementation climate (S. R. Jacobs, Weiner, & Bunger, 2014; Weiner, Belden, Bergmire, & Johnston, 2011) in terms of having a strong tension for change, compatibility, and relative priority (Damschroder et al., 2009). The second is the agency's expertise and capacity to deliver the intervention.

Gap in preventive services. Agency E leaders articulated a gap within their organization in terms of preventive services. As they surveyed their programs, they realized that they are very strong when it comes to child welfare services that are delivered after there are indications of abuse and neglect (or at least high risk of abuse and neglect), but they had little to offer when it came to prevention. "What's missing now really is the prevention piece," said a leader. "We want to get in there and we want to define parenting before they have created bad parenting habits." Expanding their services into the prevention realm was also timely given the agency's recent merger with another social service organization, as one leader stated, "we started thinking about the idea of how we wanted to be across the age spectrum." Though they have not expanded their services to adults at this point, this move toward prevention with the youngest children did fill a substantial gap in their programmatic offerings. Moreover, leaders informed this author that the decision to adopt Intervention E1 was strategic as it "gets their foot in the door for prevention" and that it will allow them to qualify for additional funding in the coming years.

Existing expertise and capacity. Perhaps the strongest motivator to adopt and implement Intervention E1 is that the agency had a leader with previous experience with the model, and they also had experience delivering similar services in other locations. The leader with previous experience with the model had been a key player in implementing the model in another state. She explained:

> I think it was basically because of my experience. As I've said I've already supervised it. I knew the program. It's evidence-based and we definitely need to pick something evidence-based. It was one of the models that we could choose from and I think it would just make natural sense because then I was going to be

> spearheading. Even if it went sort of out, I could help people implement it because I already knew the program. That made sense.

Multiple leaders affirmed that this was one of the primary drivers of their decision to choose Intervention E1 rather than potential alternatives. Her experience was also recognized as invaluable as she was the primary writer of the proposal submitted for funding.

In addition to this individual's expertise, the agency also had a history of delivering community-based services, and more specifically, parent training programs. A leader described how they were able to leverage that expertise:

> We were building on what they already do, and added in the component of the [Intervention E1]. We have experience of doing home visitation programs, just in a different region. The regions had kind of partnered and piggybacked off of each other and [this region] is where we received the award.

Another leader concluded, "I think that was a natural fit, so it was convergence of previous experiences of each programs, what information we had on board and what we wanted to do."

Implementation decision making. When asked about how they made decisions regarding implementation strategies and processes, agency leaders were quick to convey the frenzy of activity that happens after a grant is awarded:

> "You did all this time, effort to put this together and you have no idea if you're going to get them or not and that's the problem. That's really the thing I don't like about program implementations; you never know…I don't have the leisure of pontificating on, 'How would I implement this program if I got it?'

The timing and uncertainty of funding for implementation complicate planning. In Agency E's case, the funder ended up funding far fewer staff members than they had originally hoped,

which forced them to go back to the drawing board in terms of their approach to implementation. Organizational leaders acknowledged that they did not rely upon any formal or informal models to guide implementation, though one leader recognized that an implementation model might have been very helpful. They also reported that they did not develop a formal implementation plan. At first, many leaders noted that they did have an implementation plan, but upon closer inspection and consideration, they realized that it was really more of a plan to demonstrate that they could meet the clinical requirements of Intervention E1. "I don't know if we're ... I don't think we're very good at formal planning," stated one leader. She continued to note that they are excellent at strategic planning and at having a very good overall big picture of where they want to go; however, she said, "as far as program implementation, I feel like I'm on my own to figure it out." When asked whether she thought it would have been helpful to have a formal plan that could be updated periodically as adjustments were needed, she responded,

> It probably would be good to have had revisited that and make it more formal but honestly, I don't have the time to do that. You know how long it will take me if I to sit down and actually formalize it? For me, it's actually more like just get it done and so I think honestly making it more formal wouldn't have helped me. What I'm saying, it's not just all in my head. There are things I've written down. I have a whole page of things that we need to make sure we're following up on, that we were doing. I guess it's sort of formalized but not like, "This is our plan." It's more like, "Okay, where are we at on this? Where are we at on that? Where are we at on this based on what the big vision was at the beginning?

Leaders talked about basing implementation decisions upon the following: requirements of the intervention developer, expectations of funders, financial constraints, guidance from fellow

organizational leaders, guidance from frontline workers, consultations with other agencies across the nation, and web-based information about Intervention E1. Most of these factors apply primarily to the Intervention E1 implementation effort, while only guidance from fellow organizational leaders and frontline workers apply to Intervention E2 and E3.

Dictated by intervention developer. Agency E leaders acknowledged that many implementation decisions were dictated by the developers of Intervention E1, as "they have a very prescribed training that your staff have to go through." One staff elaborated on how Intervention E1 guides the process:

> [Intervention E1 developer] is really, really great, in that once you become affiliated they have ... I feel like they sent us an email that had like 17 different documents going, 'For this data to be captured, we need to know all of these things and all of these things that you're doing ... this, and how your clients are doing over here.' They have a very specific way to chart all these sorts of things about your program, to guide you towards what they call 'accreditation.' So you get affiliated and you're able to put their logo and their brand on everything, but you're not actually a fully accredited member until you demonstrate that you are, that you have fidelity to their model. They give you a two-year window to make your implementation plan, to actually implement everything in that plan, and then you're accredited if they find that you're meeting that. Those spreadsheets are what they use to track how you're doing, so that at the two-year mark they can say, 'Yes, you've been doing it' or 'No, you haven't.'

While reliance upon intervention developers for implementation guidance is by no means unique to Agency E, it is possible that too much confidence is placed in it. Case in point, one

leader expressed her hesitance about looking into implementation models or research to guide implementation. She stated, “I don't know if I would look into them or not, just because Intervention E1 is so specific on how they want you to do things. I don't know how beneficial it would be to look into or research what that's like.” This is unfortunate because many intervention developers may not have fully determined how to implement their interventions effectively in real world contexts, and a potential overreliance on that source may preclude the search for models and strategies that may be more effective.

Expectations of funders. In addition to the requirements from the intervention developer, leaders maintained that many implementation strategies and processes are delineated in the request for proposals or in what they write into their proposals. “Really, contracts dictate a lot of that,” a leader said. “They tell you these are the kind of staff you have to have, this is the kind of supervision you have to have, this is the kind of training you have to have…so a lot of that is already spelled out…so by the time we are awarded this contract, our road map is developed, essentially.”

Financial constraints. One leader underscored the role of finances in dictating implementation strategies and processes. “The biggest thing that we have to think about is the money piece,” she voiced. “How does this look budget wise? Because before we agree in signing off on them we have to ask, ‘Can we do this with the money that we said we could do based on what they gave us?’” The reality that this is a primary driver of implementation decision making coupled with the fact that there are limited data on the costs of implementation strategies (Vale, Thomas, MacLennan, & Grimshaw, 2007) is problematic. This highlights the importance of incorporating economic evaluations in implementation studies (Raghavan, 2012; Saldana, Chamberlain, Bradford, Campbell, & Landsverk, 2013).

Guidance from fellow organizational leaders. As with intervention decision making, Agency E's implementation decisions were influenced by their previous experience. This includes the experiences of the leader who previously implemented Intervention E1 in another state, as they "worked a lot with their site and different forms that they have used and their policy manual and things like that." While undoubtedly helpful, the agency also realized that some of her previous experiences "didn't necessarily match the critical element rationale" – i.e., they weren't necessarily implementing the model with fidelity. Thus, she noted, "we had to adjust different elements of the program to fit what [Intervention E1 developers] wanted and not necessarily what her experience communicated." Nevertheless, another leader deemed "her experience doing the model…probably the most invaluable piece we have." Leaders emphasized their colleagues in the other site that had also delivered home visiting services as critical as well.

A leader of the Intervention E2 and E3 programs also depended upon advice from colleagues over other forms of evidence regarding implementation. She said,

> I think a lot of times when things come up, my first reaction is to call somebody who has been in this position rather than find the literature because it's not always easy to find the literature as quick as you need it, and as reliable. I think, well when we were in school and having access to some of those databases that you could get evidence-based stuff and clear use of, you don't always have that in a professional environment. I think a lot of us count on our counterparts and our colleagues to kind of bounce things off of and really interact and communicate and discuss implementation rather than finding the literature… very rarely do I go

start reading articles. I might do that about certain things but I don't think implementation is one of them.

Guidance from frontline workers. Referencing Intervention E2 and E3 services, a leader impressed the importance of garnering feedback from frontline workers. She described formal question and answer sessions that allowed frontline workers to specify "what they need in order to be successful." Along with the aforementioned consultation with peers, she placed this amongst the most important types of information guiding implementation.

Consultation with other agencies. A key leader in the Intervention E1 initiative reported a very active effort to reach out to other agencies around the country that had implemented the model. She gathered email addresses from the Intervention E1 website and from her own Google searches, and reached out to as many organizations as she could. She asked questions such as "What forms do you use? What practices do you use? Can I read your manuals that you have on how to run a program?" Rather than adopting the approaches of other agencies whole cloth, she described "taking little bits from here and there that we liked in order to build our own unique program."

Web-based information. Agency E benefited from web-based information about how other programs were implementing the program. As one leader noted,

> I read everything that there was on the [Intervention E1] website. They post a ton of stuff. I read through all sorts of different Intervention E1 program websites to see how they were doing it and different ones had really good suggestions on, as far as how they were going about implementing a program that we adapted or didn't adapt based on what fit our needs best.

Implementation Strategy Use

Agency E reported the use of a number of strategies related to the implementation and improvement of Intervention E1, E2, and E3. These strategies were at the level of the outer, inner, individual, and process levels. The agency did not report intervention-level strategies, perhaps due to the flexibility that they had in designing programs that were a good fit for their organization. This is discussed further in the perceptions of implementation strategies section.

Strategies related to the outer setting. Strategies at the outer setting included accessing new funding, collaborating with other agencies, marketing to clients, client engagement, and mechanisms for client feedback.

Accessing new funding. Agency E obviously has dealt with accessing new funding in order to provide Intervention E1. This has largely occurred through the state contract discussed above, though leaders discussed other possible funding sources that might allow them to expand their services. Leaders also discussed funding challenges, or at least complications, related to collaborating with other organizations. For instance, in drafting the contract they had to think about "who's paying for the computer" and other details. Leaders even mentioned an oversight that forced them to pay a greater percentage to the partnering agency than they would have liked or been obligated to pay.

Collaborating with other organizations. Agency E partnered with another organization to implement Intervention E1. This was a strategic decision. The state's RFP process gives special consideration ("extra points") to proposals that involve partnerships with women or minority-owned businesses, so they partnered with an area organization that is a woman-owned business. A leader informed this author that prior to partnering with this organization, there was a woman-owned business that would just "clean our clocks;" thus, this [partnering with a

woman or minority owned business] is just the "way that it looks on the landscape" now. The organization also partners with Agency E with respect to Intervention E2 and E3, and leaders noted that the collaboration was not solely strategic. "I think anytime you are partnering with another organization, bringing together different perspectives only makes you stronger," emphasized one leader. "What the other organization maybe brings to the table…is helpful to make both of us even better." Another leader agrees, stating,

> You are just getting different approaches in widening your connection base, because people are attracted to different things in the community…they definitely help bring in more referrals because they are talking to a different base than we usually talk to, so it has brought a lot of people to the table. That's been a big advantage.

Of course, there are also challenges with these types of partnerships, one of which is the fact that the contracting agency ends up supervising people who are not their employees. Issues of authority and who has the ultimate say over program delivery can be complicated. An Agency E leader collaborating with the other agency through Intervention E2 and E3 programs echoed this challenge, stating,

> I think a challenge definitely is they have their own agency protocols, they have their own agency rules and discipline and so that is something we might see as a huge issue and I'll want to act on it, and they don't do that there and that is something I have to learn; how both agencies run.

As emphasized in the intervention and implementation decision making sections, they have reached out to other agencies that have implemented this program, and they have benefited from the lessons that those agencies have learned along the way. Additionally, the agency is

partnering with medical facilities, mental health facilities, and other organizations that would be potential referral sources. One leader lamented that these collaborations are somewhat slow in coming, as she has essentially had to develop all of these relationships from the ground up. Ideally, these relationships would be reciprocal, with Agency E receiving referrals for their program and also referring to partnering agencies for additional services related to maternal and infant health. In some cases, other organizations that administer similar home visiting programs have flat out refused to refer clients to Agency E because they perceive them to be competition. While the leader from Agency E disagreed, believing their services to be complementary, this situation is consistent with empirical evidence suggesting that in the absence of trust, competition is negatively associated with coordination between agencies (Bunger, 2012).

Marketing to clients. One strategy that Agency E has used that is both at the client-level and the inter-organizational level is reaching out to potential sources of referrals to ensure that as many clients as possible receive information about Intervention E1. The office of one of the leaders has an oversized whiteboard with the names of every agency that could possibly offer referrals to their program. At the time of that interview, she hadn't made contact with every agency, but the effort was ongoing and very active.

Client engagement. Per the Intervention E1 model, once Agency E will engage with potential clients for 12 weeks until they either formally refuse services or accept services. This can be via phone, letter, or any other ways that frontline workers may be able to connect and engage the client. If a client misses more than two visits after they are formally signed up for services, the agency will resort to what they call the "creative outreach level," which is essentially the same 12-week system of trying to reengage the client. Thus, for those three

months the client would receive at least two weekly contacts to let them know that they are still cared for and that they are welcome to reengage in services.

Mechanisms for client feedback. Agency E plans to adjust standardized client satisfaction surveys that are used across the agency for the purposes of receiving feedback on the delivery of Intervention E1. The same surveys are routinely used in the Intervention E2 and E3 programs.

Strategies related to the inner setting. Implementation and quality improvement strategies related to the inner setting include structural changes involving personnel, the pursuit of credentialing and accreditation, and peer review of files.

Structural changes. Agency E made several structural changes at the organizational level, namely adding staff to implement Intervention E1 and changing supervisory structures to ensure adequate oversight. Again, leaders brought up the structural challenges of collaborating with another organization, with one leader stating, "I mean there are supervisors who have to do multiple programs. That happens but I think the little twist to it is that, now you're supervising somebody from another agency. It gets somewhat challenging really." The agency also made some structural changes as the Intervention E2 and E3 programs expanded. Previously, there was simply a supervisor and a set of frontline workers, but there is now a coordinator, two supervisors and 16 frontline workers dedicated to those programs.

Credentialing and accreditation. Agency E used credentialing and accreditation as a means of improving and demonstrating quality in both the Intervention E1 model and, for the Intervention E2 and E3 programs through the Family Development Credential Program (National Family Development Credential Program, 2014). The accreditation process for Intervention E1 is described elsewhere. The Family Development Credential program involves

90 hours of classes, the completion of a portfolio documenting their ability to apply certain concepts and skills, and a standardized exam. Agency E employees reported taking courses once a month for nine months. Focus group participants described it as "social work 101" and "busy work," but acknowledged that it was written into their contract funding Intervention E2 and E3 so the agency works to ensure that each staff member in those programs is credentialed.

Peer review of files for Intervention E2 and E3. Agency E engages in a quarterly peer review in which individuals from other agencies who do similar work review their files. This process is intended to ensure that their files are all in good shape before state auditing processes. Interestingly, staff members reported that they generally don't receive feedback that could potentially be used to drive the improvement of their documentation and service delivery performance. They maintained that their old supervisor used to provide a general overview of the peer review results, but that they have not been receiving similar feedback during recent review cycles.

Strategies related to the characteristics of individuals. Provider-level implementation and quality improvement strategies were dominant, and included hiring with implementation in mind, a training requirement, training allowance, training (in a variety of forms), supervision, supervising the supervisors, fidelity monitoring, auditing documentation compliance, and informal peer support.

Hiring with implementation in mind. Agency E was very deliberate about hiring carefully for Intervention E1. A leader tasked with hiring explained:

> I went higher in terms of the education, in terms of ... I wanted a person that could be creative. I wanted a person who could react to ... like we may get up there and find that the program needs to change in different ways that we didn't originally

> conceive. I wanted a person who would be able to give me that information. A person that would can articulate those concerns, who'd come in and talk about how we could make the program adjust. I really needed somebody who could be a partner in this situation. I think we went for the higher level of education and for somebody who could really bump our working relationship.

If the program had already been in place for a year, they may have been able to hire someone different; however, since the program was new, they were acutely aware that they needed "maximum adaptability and capability." The person they hired, who was also interviewed for this study, was someone who was already known by the organization due to previous work experience at Agency E. She was viewed as a "go-getter" and a "natural fit" for the position. This author's interactions with her confirmed these characterizations, as she seemed to be very competent and demonstrated a willingness to essentially spearhead the implementation of this program even though she was hired as a frontline worker (i.e., parent educator). This is a clear example of an obvious point, quality implementation and organizational improvement depends in large part on hiring the right people (Waldron, 2014).

Training requirement. Agency E requires that all of its employees receive 40 hours per year of training. Annual refresher training in areas such as child development, suicide prevention, safety in the community, and some of the other training opportunities listed in this section generally meet about 20 hours of that requirement. Employees are expected to seek the remaining hours outside of the agency, and are permitted to use their training funds to do so.

Training allowance. Agency E allots a small training allowance for employees to pursue training opportunities of their choice.

Intervention E1 training. Intervention E1 developers require intensive training for

organizations that wish to use their model and obtain a formal affiliation. This includes a core training consisting of four full days of training plus an additional fifth day for supervisors and program managers that focuses on identifying overburdened families, interview skills, conducting risk assessments, paperwork and documentation, family-centered support services, and communication skills. There is also an additional week of training focusing more specifically on skills related to home visitation including the home visitor's role within the model and includes topics such as establishing and maintaining trust with families, goal setting, paperwork and documentation, communication skills, and intervention strategies. Additional training and support services are offered on the website, though the aforementioned trainings were the only ones identified by Agency E participants. At the time of the interviews, Agency E personnel had not yet attended this training (it is required within the first six months), but their understanding was that training was a mix of didactic instruction and hands on experience with assessment tools and intervention components.

State training for staff providing Intervention E2 and E3. When individuals are hired to work in the Intervention E2 and E3 programs, they are required to become approved by the state (based upon résumé and education). This approval process also requires that individuals shadow a specialist for a "full intervention" which generally lasts about six weeks. That same specialist then shadows that worker for another six weeks or so. Interestingly, only a few of the personnel had the opportunity to shadow an experienced worker for six weeks. In fact, when this was mentioned as a strategy in the focus group, several participants seemed to be unaware of this opportunity; thus, it may be a strategy that is newly offered by the state or one that is not offered consistently.

Approval also requires a three-day training conducted by the state. Topics of that

training, as reported by focus group participants, include the strengths-based perspective, conducting family service plans, safety plans, and strategies to engage families and build rapport. One participant stated his disappointment that the training was "geared to the least common denominator" and that the material seems like material from the first semester of college. Another participant nodded in agreement, mentioning that the training covered "common sense stuff."

Training through receipt of Federal Development Credential. This training is described briefly in the preceding section on credentialing and accreditation, but is listed here as well given its pertinence to individual-level training and staff development.

Weekly in-service trainings. When she took charge of the Intervention E2 and E3 programs, one leader conducted weekly trainings to provide additional support on some of the technical aspects of the work. Training topics included paperwork, expectations, requirements of the contract, how to write goals, and how to use our database.

Monthly brown bag sessions. Agency E offers monthly "brown bag" or in-service sessions, which participants described as training opportunities on a range of topics. These sessions are led both by individuals internal and external to the agency.

Online training modules. Intervention E1 also requires that clinicians complete online training modules. There are 35 additional training hours that are divided into ten or twelve modules. Affiliated organizations are expected to complete all of the modules, though the deadlines for doing so are spread out over the course of a year.

Additionally, Agency E develops a number of online training modules covering topics such as HIPAA, safety, child development, suicide prevention, defensive driving, and other topics pertinent to work at the agency. These online modules often include videos, question and

answer sections, and quizzes that must be completed prior to advancing to the next section or module.

Supervision. The Intervention E1 developers require that each home visitor receive an hour and a half of supervision. This supervision is termed "reflective supervision," which is intentionally longer than a typical supervision session to give frontline workers space to reflect on their cases. Given the early stage of implementation, the program supervisor characterized the sessions thus far as "pretty broad in general."

Intervention E2 and E3 frontline workers reported receiving weekly individual supervision, which seems to focus a lot on monitoring paperwork compliance and addressing other issues regarding staff members' professional performance. For every session, there is a supervision log completed that details the topics covered and any follow-up actions that are necessary.

Providing feedback to the supervisors. One of the leaders in charge of the Intervention E2 and E3 programs mentioned that she regularly provides feedback to supervisors and ensures that they are staying vigilant in monitoring their staff member's performance. Supervisors are required to email her all of their supervisor logs on Friday nights, which she then reviews. She then meets with each supervisor weekly. When asked what comes up in those meetings, she noted that they discuss things like "staff morale, people being late to meetings or not being attentive during meetings, paperwork issues." The focus on "non clinical" issues in these sessions is notable given some of the focus group members concerns about supervision being more about monitoring their compliance than helping them do better clinical work. On the other hand, the fact that being late to meetings or attentiveness at meetings needs to be addressed may also speak volumes about staff members' professionalism and/or the utility of meetings.

Fidelity monitoring. The funding that Agency E received for Intervention E1 is contingent upon regular site audits from the state. The state is primarily concerned with two outcomes: fidelity and the number of clients served. Intervention E1 developers will also provide oversight of fidelity through the process of accreditation. Though both of those levels of fidelity audits will eventually be in place, one of the leaders affiliated with the Intervention E1 implementation initiative informed this author that the "actual audit process or peer review process" is not yet set up internally at the agency. She speculated that they might end up conducting peer audits of each other's files to ensure they are delivering the model with fidelity. None of the leaders interviewed shared a fidelity measure or suggested any sort of life fidelity monitoring.

Auditing documentation compliance. Agency E's Intervention E2 and E3 programs regularly conduct audits of documentation compliance, a process made easier by an electronic records system that allows an individual to query open cases to determine whether any notes are missing or if anything else is not in its proper place.

Informal peer support. Agency E employees regularly looked to their peers for clinical support and advice, and staff members generally seemed to express a willingness to help each other as much as possible. One frontline worker said, "We can kind of go back and forth and I get a lot of my needs met that way, especially if it's heavy on my heart right then and there and I don't want to wait until staffing."

Strategies related to the process of implementation. Two process strategies were reported: weekly staff meetings and informal meetings.

Weekly staff meetings. The Intervention E2 and E3 teams have weekly meetings that provide opportunities for regular communication about the implementation of the program.

"They process with their team every time they get a new case and every time they close a case and then their team will give them feedback of, 'hey, it looks like that family was struggling with this, maybe you could've utilized A, B, and C.'"

Informal meetings. Agency E leaders did not report having formal meetings to check in regarding the implementation of Intervention E1. However, the small size of the program as it is currently constituted allows the key personnel to be in touch quite regularly about how things are going. In fact, reevaluation was described as "ongoing" and "constant." One of the leaders described her style as very "hands on;" thus, she maintains regular contact with the other three individuals who are primarily responsible for implementing the program.

Perceptions of Implementation Strategies

Qualitative results pertaining to perceptions of implementation strategies. Qualitative reflections pertaining to implementation strategies were primarily gathered through one focus group with nine members of the Intervention E2 and E3 teams, but are also supplemented by the five semi-structured interviews conducted with organizational leaders (including those central to the implementation of Intervention E1). In general, focus group participants were not positive about the implementation strategies that they discussed, with a few exceptions. Participants discussed their views of the following strategies and processes:

Perceptions pertaining to the selection of interventions. Given how intervention characteristics are thought to influence implementation efforts (Grol et al., 2007; Rogers, 2003), it is not surprising that leaders discussed the importance of choosing interventions carefully. "I think a lot of research up front on why you're choosing whatever program it is you're choosing to do is really helpful," communicated one leader. "Then making sure that you can wholeheartedly commit to it, once you've chosen it." She and another leader both confessed that

they have had second thoughts about the model that they have adopted, and have speculated that the agency may have been too hasty in its decision to start this program.

Perceptions of research and planning. Research and planning were elevated as important implementation strategies. "I think the things that are more impactful in my experience is whether you really take the time to sit down at the beginning and map out what are the phases of the implementation and who needs to do what along the way," suggested one leader. She warned, however, that constraints related to funders' timelines often limit planning and propel implementation at a pace that is beyond the agency's control. Nevertheless, to the extent possible, another leader advocated for "reading, talking to other people that are doing it, getting a really good feel for what it's supposed to look like" prior to implementing a new program.

Perceptions of flexibility in program development and implementation. The ability to have some level of autonomy in shaping Intervention E1 and its implementation was particularly important to one leader. She stated:

> Having flexibility in the leadership above you as you're developing a program is really wonderful. I think if I had had somebody come in say, 'You're doing it this, this, and this way,' and then not give me any guidance on how to do that or what it looks like would have been really hard. It was really good to create and take it back to them and say, 'What do we think?' and then adapt and then actually implement the program we have.

Perceptions of training. Agency E employees expressed a range of opinions about training in its various forms. Focus group participants characterized agency-based trainings as rarely "productive" or "clinically supportive," and as "common sense" and "the biggest waste of

time." One of the major issues they had was the basic nature of much of the training, a barrier also identified in a survey of mental health clinicians (Powell, McMillen, et al., 2013). "I feel like it's all pointless except supervision," one worker said of the various implementation and quality improvement strategies discussed, "…I learned it first day of high school." Another worker extended this point:

> It's too common. We need to go deeper. Stuff that just could be more useful, because part of our job is to try to explain certain diagnosis to families and sometimes I don't feel like I'm equipped with that information because I'm not being trained on Schizophrenia [and other psychiatric diagnoses].

In addition to a greater focus on advanced clinical training, participants called for leaders to avoid too much repetitiveness in training topics. One of the organizational leader acknowledged that, "training implementation is one of the things that I think is more challenging for us because we don't have internal trainers." In her view, that is one of the benefits of sending people to external trainings such as the Intervention E1 training. Even when Agency E does have the ability to use trainers internal to the organization, it proves to be problematic: "It is challenging for people who already have full-time jobs that now have to spend two days a month training everybody else throughout the organization. I think that it is a good strategy but within our organization I think it is a challenge."

Perceptions of online training. Frontline workers were not particularly enamored with the online training opportunities developed by the agency, largely because trainings were compliance focused and were not challenging. Some mentioned that they cheated and completed all of the required modules very quickly. "We have to do the same trainings every year, so there's no difficult material remaining after the first time," said one frontline worker.

An organizational leader also believed that online trainings were not as effective as in-person and more interactive training. This is especially true in this type of work where "every case is so different [and] you have to be very able to adapt to what your case needs…you have to be able to adapt very quickly depending on which house you're pulling up to." Nevertheless, she did acknowledge that online training is "the way things are going."

Perceptions of weekly staffing. Agency E personnel gave mixed reviews of weekly staffing. One leader stated it that staffing "can be very effective because it's not just your supervisor telling you, it's your team who is also out in the field doing the same thing you're doing. I think that's very effective." This view certainly fits with frontline workers' appreciation for the support of their colleagues. However, one specialist voiced a desire for more clinical content in staffing sessions. He had worked at another agency in a different state that required teams to be led by supervisors who held clinical licenses and also required psychiatrists to sit over all staffing meetings. This upped the level of the clinical discourse in meetings and gave greater support to masters-level staff working toward licensure. "I know that we're probably never going to get that here," he admitted, "I feel like we just sort of treat symptoms as they come up as opposed to saying, 'Here's the mental health, the terms that are being dealt with. Here's all the different aspects on how to treat them." His colleagues seemed to agree, with one mentioning that it is difficult to link clients to certified specialists (therapists, psychiatrists, etc.) when "we don't know what we're even dealing with." Clearly, infusing these meetings with a greater level of clinical expertise would be a welcome change.

Perceptions of supervision. Focus group participants from the Intervention E2 and E3 programs did not express positive views of supervision, though this seemed as much about their perceptions of their current supervisor as it was about the strategy more generally. Many of the

frontline workers had positive things to say about their previous supervisor, who was described as "great clinically" even if he was not very detail oriented. One worker praised his ability as a supervisor:

> Clinically he was amazing and he would point out our flaws too. He said, 'Well did you think about this, maybe you're doing that wrong?' I never took it as criticism, I took it as, 'Oh my God, he's gonna make me a better counselor.' When you're going to supervision with someone that doesn't have the years of experience that you do and doesn't really have the clinical base, supervision is kind of pointless.

Conversely, their current supervisor was described as more detail and task oriented, but with fewer clinical experiences and credentials. Some staff members seemed to be unwilling or unable to benefit from supervision. "It's not effective for me and it's not like, it's not a process," said one participant. "I think we're used to someone that clinically had a lot more experience than we did. When I had an issue he was ... and I told him exactly what I did, he always had an answer." Another staff member was disappointed that the agency did not hire someone with a clinical license who could provide supervision leading to clinical licensure. Not surprisingly, their supervisor did not agree with their assessment of supervision, calling it "really huge" in "addressing any concerns we have and also advocating for the client."

Another individual in Intervention E1 program shared concerns about supervision that mirrored the experience of the frontline workers in the other program. Specifically, she reported that supervision has focused on topics such as the number of clients on her caseload rather than "professional development type stuff that usually is pretty helpful from supervision." Though she has a positive relationship with her supervisor, he was described as "reluctant" and as

someone who "doesn't necessarily love the idea of the program." The experiences of workers in both programs indicate the importance of identifying supervisors with the appropriate clinical background and expertise for the specific programs that they will oversee. Their experiences also point to the need for well-rounded supervisors who possess clinical skills and skills related to organization and management.

Perceptions of shadowing. The frontline workers delivering Intervention E2 and E3 that were able to shadow other workers found it to be a very effective strategy. "We had lots of training," acknowledged one frontline worker, "just none of it is really very pertinent to what we do." Shadowing on the other hand was described as "the best way to learn," and in some cases, as filling in perceived inadequacies of training. One specialist recalled, "I came in, no one trained me whatsoever, except I latched on to somebody, basically told me she was going to train me, another worker and she did. None of the higher ups trained me at all, which I think actually happened to several people." Whether formal or informal, this form of on the job learning was deemed essential to learning the nuts and bolts of the job as well as some of the more nuanced clinical skills necessary to perform it well.

Perceptions of informal consultation. One leader emphasized the importance of informal peer-to-peer consultation can be very useful because "it gives you that more one-on-one time to talk to somebody." Frontline workers generally agreed that this was very helpful, and that sharing offices provided the opportunity for this to occur constantly.

Perceptions of monitoring paperwork compliance. Frontline workers did not appreciate having their paperwork audited for compliance, particularly because they did not believe that they had been trained adequately or consistently. "We're tired of having complete accountability for your files when you don't have complete training for it," complained one

frontline worker. Her colleagues responded with a chorus of similar comments that all conveyed the same sentiment: they have not received clear instruction and thus do not feel that they can be "a hundred percent accountable." Since none of them feel that they have been properly trained, they also believe they continue to pass on practices to their peers that may not be completely correct. They suggested that improvement would require leadership meeting them halfway.

Perceptions of peer review. Consistent with front line workers' perception that they don't receive adequate training on documentation, they also noted that they do not benefit from the agency's participation in a file peer review process. Though these peer reviews are regularly conducted, they reported not receiving direct feedback as to how they can improve either individually or collectively. Of course, it may be that the agency benefits from this strategy by ensuring that they maintain compliance at the organizational level (which is where this strategy was classified in the previous section), but it does not seem to be a driver of improvement at the individual worker level.

Perceptions of consulting with other agencies. Consulting with other agencies was thought to be helpful at times; however, one leader conveyed doubts in this regard. He stated, "I think they [other organizations] don't really care about what happens to us. It is a good idea. It is good to check in with people because you never know." Another worker has seen some good come out of these connections, but noted that there is not "a really great formula" for how to approach other organizations. She has learned that cold calling is "about 30% effective" and that it is critical to network through existing relationships in order to forge useful connections with organizations who have implemented the model elsewhere.

Perceptions of partnering with other agencies. While consulting with other agencies

may have been variably effective, one leader emphasized that developing community partnerships has been one of the most sustainable and important implementation strategies. She elaborated:

> As far as, getting referrals and finding clients that fit the criteria for our actual implementation plan providing services, I've had much better results from the providers that I have relationships with. With the providers that I don't have relationships with, I'm finding that it's harder to rotate clients. It's harder to get responses. It's harder to get information about if this is effective for them. So I have found that interesting over the last few months, because you can really tell there is a community need, but you can't always tell how people are going to react ... so it's interesting once you give them the information about our program and what you're doing and how you're going about doing it. They seem really excited, and then they just kind of forget or they refer and then don't care to ever follow-up on how this kid is doing. So again, just networking with people you actually know has been hugely important to getting this off the ground.

Again, the importance of community partners in implementation research and practice has been repeatedly emphasized by leaders in the field (Alegria et al., 2012; Berwick, 2008; Chambers & Azrin, 2013).

Quantitative results pertaining to perceptions of implementation strategies. Eight of 15 Agency E employees (53%) completed the Implementation Strategy Use and Perceptions Survey, the full results of which can be seen in Table 10 below. Each of the 50 strategies were endorsed by at least two Agency E staff members, with 86% of the strategies endorsed by at least half of the participants. Means for effectiveness ranged from 2.60 to 4.25 (1 = least

positive; 5 = most positive), and 11 strategies endorsed by at least half of participants were rated a four or higher. Conversely, nine strategies endorsed as "in use" by at least half of respondents received effectiveness scores of less than 3.50 (i.e., closer to neutral at best). Educational strategies were viewed most positively; however, it is interesting to point out that more active educational strategies such as "make training dynamic" and "shadow other experts" were rated rather poorly in comparison to some of the more passive strategies. "Develop educational materials," for instance, was rated most favorably in terms of effectiveness. Some of the lowest rated implementation strategies were related to planning, such as "developing a formal implementation plan" and "assessing for readiness and identifying barriers and facilitators." A number of quality management strategies were rated quite poorly despite their potential role in ensuring implementation success, including "using data experts," "audit and provide feedback," "using an implementation advisor or facilitator," and "organizing implementation team meetings." Supervision received an effectiveness and comparative effectiveness score below 4.00; however, it received feasibility and appropriateness scores of 4.13 (.35). The quantitative data suggests that while Agency E reports using a wide range of strategies, stakeholders' perceptions of those strategies were highly variable.

Convergence of qualitative and quantitative findings. Qualitative and quantitative findings differed in some respects. Most notably, the quantitative results were surprisingly positive, as practitioners rated educational strategies very high despite qualitative appraisals of training that were poor. This may be due to the difference between what training could be versus what it actually is within their agency, or may be due to response bias. In other cases, the results did converge. The relatively low rating for the effectiveness of supervision, and the higher rating for feasibility and appropriateness of that strategy, for instance, is consistent with

the qualitative findings that supervision is a useful strategy that is perceived to be mishandled at the agency. Qualitative results suggested that formal planning of the implementation process was not a strength of the agency, nor was thoughtfully appraising potential barriers and facilitators. Thus, it is not surprising that these strategies were generally deemed to be ineffective. Finally, the fact that some of the strategies pertaining to data and quality management were rated poorly was consistent with qualitative findings that the agency does not necessarily place a high value on those strategies.

Table 10. Agency E: Implementation Strategy Use and Perceptions Survey Results (N = 8)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Planning Strategies					
Involve Executive Boards	100%	3.25 (1.04)	3.25 (1.04)	3.38 (.92)	3.25 (1.04)
Build a Coalition	88%	3.57 (.79)	3.57 (.79)	3.43 (.79)	3.57 (.79)
Conduct Local Consensus Discussions	88%	3.29 (.95)	3.14 (.90)	3.29 (.95)	3.29 (.95)
Develop Resource Sharing Agreements	75%	4.00 (0.00)	3.83 (.41)	4.00 (0.00)	4.00 (0.00)
Conduct Local Needs Assessment	75%	3.67 (.82)	3.50 (.84)	3.50 (.84)	3.67 (.82)
Mandate Change	75%	3.17 (.75)	3.33 (.82)	3.50 (.84)	3.83 (.41)
Visit Other Sites	63%	3.80 (.45)	3.80 (.45)	3.80 (.45)	3.60 (.55)
Recruit, Designate, and Train for Leadership	63%	3.40 (.55)	3.40 (.55)	3.60 (.55)	3.60 (.55)
Develop a Formal Implementation Blueprint	63%	2.60 (.89)	3.20 (.84)	3.60 (.55)	3.20 (.84)
Tailor Strategies	50%	4.00 (0.00)	3.75 (.50)	4.00 (0.00)	3.50 (1.00)
Develop Academic Partnerships	50%	3.50 (1.00)	3.75 (.50)	3.50 (.58)	3.75 (.50)
Stage Implementation Scale Up	50%	3.50 (.58)	3.50 (.58)	3.50 (.58)	3.50 (.58)
Identify and Prepare Champions	50%	3.50 (.58)	3.50 (.58)	3.50 (.58)	3.50 (.58)
Assess for Readiness & Identify Barriers and Facilitators	50%	3.25 (.96)	3.25 (.96)	3.00 (0.00)	3.50 (.58)
Obtain Formal Commitments	38%	4.00 (0.00)	3.67 (.58)	4.00 (0.00)	4.00 (0.00)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Educational Strategies					
Provide Ongoing Consultation	100%	3.63 (.74)	3.63 (.74)	4.00 (0.00)	4.00 (0.00)
Conduct Ongoing Training	88%	4.14 (.38)	4.14 (.38)	4.14 (.38)	4.14 (.38)
Conduct Educational Meetings	88%	4.00 (0.00)	3.71 (.49)	3.86 (.38)	4.00 (0.00)
Create a Learning Collaborative	88%	3.57 (.79)	3.57 (.79)	3.57 (.79)	3.57 (.79)
Distribute Educational Materials	75%	4.00 (0.00)	3.83 (.41)	4.00 (0.00)	4.00 (0.00)
Make Training Dynamic	75%	3.67 (.52)	3.67 (.52)	3.83 (.41)	3.67 (.52)
Conduct Educational Outreach Visits	63%	4.00 (0.00)	3.60 (.89)	4.00 (0.00)	3.60 (.89)
Use Train-the-Trainer Strategies	63%	3.60 (.55)	3.60 (.55)	3.60 (.55)	3.60 (.55)
Shadow Other Experts	63%	3.40 (.89)	3.60 (.55)	3.60 (.55)	3.60 (.55)
Develop Educational Materials	50%	4.25 (.50)	4.00 (.82)	3.75 (1.26)	4.25 (.50)
Develop an Implementation Glossary	38%	4.00 (0.00)	3.67 (.58)	4.00 (0.00)	4.00 (0.00)
Increase Demand	25%	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)
Inform Local Opinion Leaders	25%	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)
Financial Strategies					
Make Billing Easier	75%	3.67 (.82)	3.50 (.84)	3.50 (.84)	3.50 (.84)
Access New Funding	63%	3.80 (.45)	3.40 (.55)	3.40 (.89)	3.80 (.45)
Alter Incentive/Allowance Structures	38%	3.33 (1.15)	3.33 (1.15)	3.33 (1.15)	4.00 (0.00)
Restructuring Strategies					
Change Record Systems	75%	4.00 (0.00)	3.83 (.41)	4.00 (0.00)	4.00 (0.00)
Change Physical Structure and Equipment	63%	4.00 (0.00)	4.00 (.71)	4.00 (0.00)	4.00 (0.00)
Create New Clinical Teams	63%	3.60 (.89)	3.60 (.89)	3.60 (.89)	3.60 (.89)
Change Service Sites	63%	3.60 (.55)	3.60 (.55)	3.60 (.55)	3.60 (.55)
Revise Professional Roles	63%	3.60 (.55)	3.80 (.84)	3.60 (.55)	3.60 (.55)
Quality Improvement Strategies					
Provide Clinical Supervision	100%	3.88 (.83)	3.88 (.83)	4.13 (.35)	4.13 (.35)
Intervene with Consumers to	100%	3.63 (.74)	3.50 (.76)	3.50 (.76)	3.63 (.74)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Enhance Uptake and Adherence					
Audit and Provide Feedback	100%	3.38 (.92)	3.25 (.71)	3.63 (.52)	3.38 (.74)
Obtain and Use Consumer and Family Feedback	88%	4.00 (0.00)	3.86 (.38)	4.00 (0.00)	4.00 (0.00)
Develop and Organize Quality Monitoring Systems	88%	3.86 (.69)	3.86 (.69)	4.00 (.58)	4.00 (.58)
Organize Clinician Implementation Team Meetings	88%	3.57 (.53)	3.57 (.53)	3.71 (.49)	3.71 (.49)
Use Advisory Boards and Workgroups	88%	3.57 (.53)	3.57 (.53)	3.57 (.53)	3.57 (.53)
Provide Local Technical Assistance	88%	3.50 (.84)	3.50 (.84)	3.50 (.84)	3.50 (.84)
Capture and Share Local Knowledge	75%	3.67 (.52)	3.83 (.75)	3.67 (.52)	3.67 (.52)
Use an Implementation Advisor	75%	3.50 (.84)	3.67 (.52)	3.67 (.52)	3.67 (.52)
Use Data Experts	75%	3.33 (.52)	3.17 (.41)	3.33 (.52)	3.17 (.41)
Purposefully Reexamine the Implementation	63%	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)
Conduct Cyclical Small Tests of Change	38%	3.67 (.58)	3.67 (.58)	3.67 (.58)	4.00 (0.00)
Remind Clinicians	38%	3.67 (.58)	3.67 (.58)	3.67 (.58)	3.67 (.58)

Note. Ratings (and standard deviations) for effectiveness, comparative effectiveness, feasibility, and appropriateness are based upon a five-point Likert scale wherein higher scores are more positive (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree).

Relationship Between Organizational Social Context and Implementation Phenomena

Qualitative reflections of organizational social context. Four themes related to the social context of Agency E were evident from the qualitative interviews: a tendency to engage in "hasty" decision making, a disconnect between leaders and frontline workers, a lack of role clarity, and a shift toward greater rigidity.

Hasty decision making. A number of organizational leaders alluded to the agency's tendency to make hasty decisions about new programs and practices. "I think you should pay the price upfront and get it over with instead of making a bunch of hasty decisions," advised one leader. "We kind of do that here, kind of make some hasty decisions." One of these decisions

was adopting [Intervention E1] in the first place. Though it may end up being very positive, the narrow range of clientele that are permitted to enroll in the program makes recruitment a challenge. It is possible that other home visiting interventions may have been a better fit – perhaps not. At the very least, it was expressed that the agency would have been wise to take it a bit slower and seriously consider a wider range of interventions.

Disconnect between organizational leaders and frontline staff. A general disconnect between organizational leaders and frontline staff was apparent throughout many of the interviews. This was very similar to Agency A in the sense that there was a real sense of animosity that was expressed by frontline workers toward management. In fact, a frontline worker used that word in describing the inter-agency relationships: "I think there's animosity there. I personally don't feel comfortable going and expressing any of my frustrations or concerns because I don't think anything is going to be done about them." It was very evident that more could be done to facilitate positive relationships between layers of leadership at the agency.

Lack of role clarity. In at least two cases, leaders and frontline workers criticized what they found to be an unclear definition of roles. This was manifested in a variety of ways, but generally pertained to supervisors that were impotent. One example was of a supervisor who was unable to make decisions or provide direction to supervisees without first consulting another supervisor. The other involved a frontline worker who was essentially the de facto supervisor of one program, creating confusion for other frontline workers.

Shift from relaxed to more rigid culture. Focus group and semi-structured interviews both suggested that the agency had recently made a shift from a looser, more flexible culture to a much more rigid one. It is difficult and perhaps premature to determine whether this will

ultimately have a positive impact on the agency. This ambivalence is reflected by a frontline worker participating in the focus group, who stated, "See, we're under new management, so…they're bringing in their own style, and I don't know if they're giving better direction or if they're just coming up with this, I mean I still don't know." At the supervisory level, it seems that past leadership was more relaxed and perhaps more relational than the newer cohort of supervisors and directors. While some focus group participants didn't know whether to chalk that up to personality or new agency expectations that were real and concrete, a recently hired frontline worker seemed to capture the situation well. She suggested:

> I think by me being a new staff and also having done [Intervention E2] years ago, I can see when I came in everything was relaxed and I think when new management came in it's been a culture shift to you guys who have been here a long time, because you're not used to people saying, 'this is what we have to do, this is the requirement.'

Others were not so measured in their responses to this cultural shift: "It's streaming into like micromanaging a little bit and that's really irritating when you have been given a lot of freedom and flexibility and now it's like…they're just constantly on you. I don't like it." Another frontline worker wished there was an opportunity to be "eased into it."

Results of organizational social context survey. Agency E's OSC profile was close to the average based upon the norms from the national sample (Glisson, Landsverk, et al., 2008). The composite profile score based upon the latent profile analysis was 1.99, indicating that culture and climate subscales are much closer to the national averages. Agency E's OSC scores in relation to the national norms are shown in Figure 9. Agency E's culture profile indicates that it is more proficient than the average organization in the national sample, but also more rigid

and resistant, the latter being over a full standard deviation above the national average. In terms of climate, Agency E scored just above the national average on all three subscales.

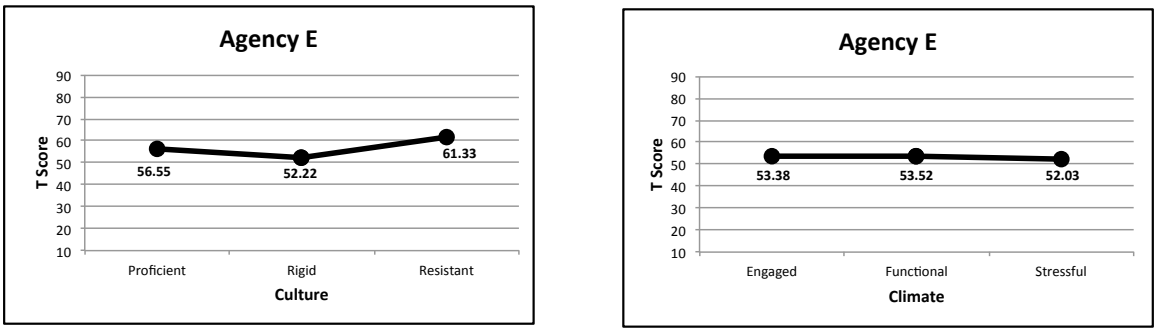

Figure 9. Agency E's organizational culture and climate profiles

Summary and relationship to implementation processes

Qualitative and quantitative findings regarding the organizational social context both point to a culture that is resistant to change (or perhaps reeling from a sudden shift toward greater accountability). The qualitative themes likely work in concert to make implementation and quality improvement more difficult. The tendency toward hasty decision making obviously complicates implementation in multiple ways. In this case, it may have precluded the exploration of potentially appropriate interventions. It also created an implementation timeline that made careful implementation planning difficult, something that is evident in both qualitative and quantitative assessments of strategy use. Obviously, the perceived disconnect between frontline staff and their leaders and the lack of role clarity creates a context that is not conductive to successful implementation. Frontline staff members' negative qualitative reports of implementation and quality improvement strategies may indicate that the organizational context moderates their effectiveness. To be fair, Agency E is clearly in a time of transition, and the implementation of Intervention E1 is just beginning. It may be that perceptions of rigidity and micromanagement will merely prove to be growing pains as the organization continues to

develop and improve. Indeed, it can take 2 to 4 years to fully implement a new program or practice (Fixsen, Blase, Naoom, & Wallace, 2009).

Agency F

General Organizational Description

Agency F is a mid-sized social service agency providing counseling, crisis intervention, and community outreach services. The counseling department provides outpatient therapy to children and adults in multiple locations throughout the metropolitan area. Counseling services does not have a child and youth-specific component; thus, most of the clinicians serve a mix of clientele including children, youth, and adults. The counseling department also operates a separate group treatment program, including addictions treatment, domestic violence prevention, and sexual offender treatment. The addictions treatment program will soon be phased out in the near future. The community outreach division serves children in after school outreach and preventive services at a number of urban elementary schools. These programs include activities such as tutoring, mentoring, and a range of recreational activities. The outreach division also provides counseling and case management services to older adults in the community. The crisis intervention division provides suicide prevention and crisis intervention services 24 hours per day, 365 days per year. One leader described how these three divisions fit together: "They're kind of diverse. They all have a mental health component to them, because we are a mental health agency. I came here a little over three years ago and when I came…they operated very much as three separate entities." Yet within the past year, the agency is making a concerted effort to promote internal collaboration given that there is a lot of overlap between the three units. This was described as a "slow wheel to turn" but was also called "a really positive change" with increasing levels of buy-in at the agency-level. The primary focus of this case study will be the counseling services provided to children, youth, and families; however, for the purposes of gaining a fuller understanding of this agency, interviews were also conducted with

individuals in leadership roles in the other two primary service areas (crisis intervention and community outreach). At times, these interviews are used to supplement the perspectives of leaders and frontline staff who primarily work in the counseling division.

Agency F was described as an organization very much in flux. During the recent recession (2007-2009), "there was what is known as the Mass Exodus, where they lost a lot of employees." Another leader sketched a vivid picture of that time period at the agency, and its lingering effects:

> My predecessor described it as in 2008/2009, a bomb went off at [the agency] and everybody sort of wandered around in shock for a year or two. And then just now when I came on, like picking things up and then you're going, 'Look at that. Do we need that?' There was lots of knowledge that walked out the door, there was no, when someone left, there was no one identified to be taking over what they were doing and so huge chunks of necessary infrastructure were just not in place. Really since I've been here I've been trying to put necessary infrastructure back in place.

In many ways, Agency F is still attempting to fortify itself. There have been a number of major administrative and personnel changes in recent years, three of which are worth noting here. First, at the executive level, the organization recently hired a new executive director. At the time this author was conducting interviews, the agency was under the direction of an interim executive director. Second, there is a layer of senior management between the clinical director and the executive director that is no longer with the agency. A leader explained, "the mentality is we're getting rid of expensive overhead, which a lot of these positions were, then taking that money that we're saving to put it into direct services staff." This leads directly to the third

change – to work toward a greater balance between full and part-time staff on the clinical team. This change follows "an experiment" conducted in recent years that involved hiring a lot of part-time staff members. At this point, that has been deemed a failed experiment, as it did not allow the agency to generate sufficient revenue.

Description of Program or Practice Implemented

The recent changes at Agency F have led them to focus most heavily on getting the infrastructure to a place that will allow them to begin implementing new programs and practices. Thus, there are no current systematic implementation efforts within the counseling department. They have made an effort to expose their clinicians to Trauma-Focused Cognitive-Behavioral Therapy (Cohen, Mannarino, & Deblinger, 2006) and play therapy. Trauma-Focused Cognitive Behavioral Therapy is introduced to every new-hire in the counseling department via the free online training (Medical University of South Carlolina, 2005), though there is no formal expectations that clinicians will implement it. Most clinicians interviewed in the focus groups reported either not using the treatment or utilizing some components of it, though one clinician said that she has used it "from start to finish." All clinical staff also recently received training in play therapy, though again, it is not necessarily expected that they utilize that modality on a regular basis. Rather, it was viewed as an effort to equip therapists with new clinical tools that would be pertinent to children's mental health.

Clinical treatment at Agency F was characterized as "very eclectic" with "methodology and intervention" varying depending upon the issue at hand, the client's developmental level, and "so many other various factors." This seemed to be a context in which therapy is viewed as more art than science. "I think what makes a good therapist, which I feel like – I feel like I'm a very good therapist," conveyed one clinician. "I feel like I'm successful, but I feel like it's not

because of my education, not that that hindered it because I'm sure it didn't. But it's about my personality. You can't learn to be empathic." It was clear, at all levels of the organization, that there was not a firm push to adopt any EBTs.

Decision Making Processes

Treatment decision making. Since Agency F was not currently implementing any EBTs (or other programs and practices) treatment decision making was discussed in a broader sense. Participants were asked how the agency generally makes decisions about adopting new programs and practices, and how they inform treatment decisions on a more micro-level. Participants identified contributors to treatment decision making at the intervention, outer, inner, individual, and process levels.

Factor related to the characteristics of the intervention. One agency leader reported that she often looks for guidance about potential programs and practices from national organizations. Organizations such as SAMSHA, the National Council for Behavioral Healthcare, National Treatment of Mental Health, and other federal guideline and funding sources have proved to be a valuable source of information for the clinical director. She reported that she often looks to them for guidance about what types of programs and practices to pursue, though she was not able to give an example of how that has led to a specific treatment choice at Agency F.

Factors related to the outer setting. Like many of the other organizations in this study, client need and the availability of funding were raised as critical factors in treatment decision making.

Client need. Client need was consistently mentioned as one of the biggest factors driving programmatic choices and clinical treatment. Client need was ascertained from client

interactions, as well as through what appear to be more formal assessments of need. For example, one leader mentioned that the agency's director of development often obtains statistics related to client need. Another leader talked about how the agency's receipt of training for play therapy was in direct response to the agency's need to improve its ability to meet the needs of their child clients.

Funding. Funding was mentioned as perhaps the most important driver of treatment decision making. In fact, one leader revealed that the agency had sometimes allowed funding to dictate programmatic decision making too much:

> Historically, what we've done, I feel we've done a little bit of chasing the money…You see an RFP [request for proposals] come out and we say, 'Oh, it's a $100,000, we've got to apply for it.' The question is, do we have the staff to do it? Do we have an interest? Does it meet our mission? I feel we've been a little bit flip-flopped. Having said that, that's historically in my three-year history, how we've done it is we have chased the money. If there's funding, I feel we have taken this path.

She underscored her philosophy of ensuring that funding opportunities are appropriate for the agency, and that they are increasingly ensuring that they are clear about whether or not they can meet the terms of the grant or contract.

Factors related to the inner setting. The agency's mission and input from organizational leaders and frontline staff were also cited as important factors in treatment decision making.

Agency's mission. The agency is now attempting to be very careful about only pursuing opportunities that fit their mission. One leader provided an example of their effort to do so:

> We go back to our mission statement. Does this fit our mission, and really trying to focus on who are we, what do we do. And that's actually part of the reason why we made the decision to end the addictions program, because I felt like we weren't providing a high quality of intervention there and I really want to focus on what we do well, build that and then reevaluate possibly at the end of next year.

Input from organizational leaders. Agency leaders communicated that they generally make decisions about what grants to pursue as a management team. That team includes the vice president of finance, the clinical director, and the executive director. The clinical director also emphasized consultation with one of her colleagues who is the quality assurance professional at the agency.

Input from frontline workers. Clinicians did not appear to be regularly queried to discuss potential programs and practices; however, the clinical director acknowledged, "I will hear from them when there is a need." She then provided an example of pursuing training in autism spectrum disorders because she kept hearing rom staff, 'I keep getting these referrals and I'm really not sure that what I'm doing is effective or appropriate.'

Factor related to characteristics of individuals. Clinicians discussed their previous training and experiences as influencing their treatment decisions. One clinician stated:

> I use the cognitive therapy a lot more because I was more thoroughly trained in that before I came here at a hospital, I did more in-depth training. And art therapy is something that I was trained in before and I use that more. And I'm really old school with family systems and use the diagram of family and trying to understand the dynamics in the family.

Other clinicians seemed to downgrade formal training, stating that they learned little in

their graduate programs. “In all my six years of training maybe there were six classes that were helpful,” said one clinician. Again, some of the clinicians elevated life experiences and personality as more important than training or clinical experience.

Factor related to the process of implementation. Finally, the clinical director maintained that the biggest influence on clinical decision making at the therapist-level is the opportunity that they have to process their cases through individual or group supervision. She gave an example of how this can be particularly helpful:

> One of my favorite ones was the clinician had actually been working with this client for a few years and came in and said, ‘You know, when you get to know somebody really well, you kind of end up with blinders on…this is where I'm at and I'm feeling stuck.’ And then at the table we're able to give her four or five different ideas or ways to address that and she's like, ‘Oh my God! I know all that but,’ you know, it's like you just get in your groove with the client and sometimes you need that sort of outside, that fresh pair of eyes to look at stuff and help you go, ‘Oh yes! Oh yes!’

Implementation decision making. When asked about how they make decisions about how to implement programs and practices, Agency F leaders responses mostly pointed to processes that were “ad hoc.” They have not formally assessed their organization’s performance prior to or after any implementation effort. In fact, when asked that question, a leader stated bluntly, “No, that requires a level of organization that [our agency] has not had the staff or the ability to do.” There has been no formal implementation planning other than what is written into grant proposals, and not surprisingly, they have not utilized any guiding implementation or quality improvement model. They did not report relying upon any literature or outside

information from peer organizations that might inform quality improvement and/or implementation. It seemed that the majority of the opportunities to reflect and evaluate implementation processes has come through meetings that are primarily focused upon compliance to funder expectations. These meetings sometimes happen twice – once before implementation and once at the end of a grant cycle, though one leader mentioned that the agency really needs to move toward quarterly meetings to give more opportunities to ensure that they are on track and adjust implementation efforts as needed. While implementation should never be an afterthought, it is clear that the relatively recent tumult at the agency makes implementation, and in particular, careful thinking about things like implementation and quality improvement strategies a rarity.

Implementation Strategy Use

Though not implementing a specific program or practice, leaders and clinicians from Agency F discussed the use of several implementation and quality improvement strategies at the outer, inner, individual, and process levels.

Strategies related to the outer setting. Agency has used several strategies that target the outer setting, including accessing new funding, administering client satisfaction surveys, and client engagement strategies.

Accessing new funding. As previously mentioned, the agency was able to obtain grant funding for play therapy training and equipment. There is a full-time director of resource development that dedicates her time to identifying and pursuing opportunities for funding, and leaders acknowledged that the entire agency is free to bring opportunities to her attention.

Client satisfaction surveys. Agency F leaders reported the use of client satisfaction surveys; however, one admitted that they were not used for "a long time" and were only

recently beginning to be used again. “Who knows what’s going to happen with that,” she said (not inspiring much confidence), “but it’s something that’s supposed to happen quarterly now.”

Client engagement. One leader discussed client engagement strategies such as phone calls and letters for clients who have not been attending appointments. “No show” rates have been particularly high at some offices. When it is a new client that cancels an intake or first appointment, there is one case manager for the entire counseling department that will follow up to determine if there are any barriers to attending services. After a client is already enrolled in services, the therapists generally handle the follow-up. After 60 days of no contact, clients are considered inactive, so every effort is made to contact them if they haven’t been in touch for a while. These calls are made by therapists to ensure that it is perceived as a personal attempt to make contact. The agency has considered an incentive program, such as giving a $10 gift card if they attend four sessions in a row, but they expressed uncertainty as to whether that is something that they should be doing.

Strategies related to the inner setting. Strategies targeting the inner setting included the agency’s strategic planning process, efforts to develop infrastructure, all staff meetings, a competitive analysis of salaries, and adapting agency policies.

Strategic planning. Every leader interviewed mentioned that they are in the middle of a strategic planning process, which consequently is their 3rd strategic planning process in the past 10 years, indicating how much change the agency has undergone. A large part of this process has targeted the improvement of inter-agency communication processes and basic infrastructure development. One leader confessed that, “although lip service was given in the past to breaking down the silos [between departments], nothing was ever done on the policy and procedure side to really make that happen.” She described their focus on communication, collaboration, and

infrastructure development, saying,

> If we really want to have the ability for a client to come in through any door whether it's life crisis, counseling, after school services and get access to whatever services they need, we need to have good policies in place for how we work intra-departmentally and sort of whose role and responsibility it is for that connection.

Infrastructure development. Though not a specific strategy, it is worth reiterating the Agency F's belief that they need to get a stronger infrastructure in place before they can think about implementing a range of new programs and practices. One leader stated:

> I would love to be working towards things like trauma informed care, we're just, we had so much to get our house in order that we had a lot of work to do before we can even reach that level…You have to have your house in order, you have to have your structure in place, your normal policies and procedures have to be functioning well…Trying to implement something at the level you're talking about. You can't do it unless you have that infrastructure in place already.

A quality improvement professional at the agency agreed entirely, "A lot of our focus has been cleaning up the mess…we have to clean up before we can move forward with better trainings." Another leader's response to this author's question about what programs and practices have been implemented in the past year or so is telling in this regard. She began to detail the new visitor's policy that the agency had recently adopted (i.e., a policy to ensure that visitors signed and were given proper identification). A worthy effort indeed, but also illustrative of the fact that implementing EBTs is unlikely to be on the agency's "front burner" in the immediate future.

All staff meetings. Getting all of the staff together "sounds like a simple thing to do but it's really not," an Agency F leader explained. There are a number of barriers because "time is money" and these meetings eat up a lot of billable hours. Yet, the agency has recently started to hold all staff meeting to communicate to everyone at once, to foster collaboration between different disciplines and departments within the agency, and to strengthen ties between staff members and the board of directors (members of which are often invited to attend). An agency leader attributed these meetings as addressing a longstanding problem at the agency: "I think there has not been a culture of respect for colleagues here for a long time."

Competitive salary analysis. Clinicians in the focus group reported that the agency is conducting an analysis of their employees' salaries to ensure that they are competitive. They expressed their hope that the agency would act accordingly by adjusting salaries once that analysis is complete. Obviously, this could potentially have some bearing on the quality of care provided at the agency by enhancing their ability to recruit and retain good employees.

Adapting policies. A leader mentioned that although the agency is blessed to have an excellent crisis services unit and thus, a "really strong suicide intervention policy." Yet, since the policy is written from the perspective of the crisis intervention unit, it was very confusing to clinicians on the counseling side of the agency. During the past year, the agency has worked to adapt those policies and processes to ensure that it is a better fit for the counseling department.

Strategies related to the characteristics of individuals. Strategies targeting the characteristics of individuals included training, educational materials, individual supervision, staffing meetings, auditing files, and informal consultation.

Training. Training at Agency F is primarily the responsibility of individual clinicians, as they obviously must obtain a certain number of CEUs to maintain their license. Historically, the

agency did not pay for those trainings, nor did they pay for the clinicians' time off. Recently they have started to pay their clinicians for their time, though they still do not provide any training allowance. The clinical director has asked for more robust training funds in the 2014 budget in order to offer agency-wide (or at least counseling program-wide) trainings on things like DSM-5. Unfortunately, the department has had no line item for training in recent years, which means that any in-house training is provided by agency staff or other who will provide training pro bono. As previously mentioned, the agency has been able to obtain grant funding for specific training efforts (e.g., play therapy training); however, most of the training burden still falls primarily upon the individual clinicians.

Educational materials. Agency F employees identified the availability of some educational materials, even if all clinicians weren't aware of them. "You have a binder for like intervention tools up there, like with intervention ideas and stuff in the office that ... I've only looked at that once or twice," one clinician mentioned. Another added that the software that they use to complete their therapy notes has a homework function that allows clinicians to print homework and other handouts for clients, but he also conceded, "nobody really knows how to access that too well."

Individual supervision. Clinicians at Agency F are supposed to receive one hour of clinical supervision every month, though some clinicians cast doubt as to whether that happens regularly or not. If there has been inconsistency in terms of how much supervision clinicians receive, it may be due to recently restructuring. Sometime in the past year, the agency went from having just one or two supervisors for the entire agency, which employs approximately 35 therapists, to having six site supervisors. One agency leader recalled that when she first started, there was "a six-month hiatus from having a supervisor over people." Now that there are site-

level supervisors it is possible for clinicians to receive supervision more regularly, and for supervisors to take more of a "hands on" approach to addressing issues that arise at local sites. While the content of supervision was reported to be largely left to the discretion of the supervisor, some clinicians complained that supervision too often focused on compliance issues or that it was dominated by their supervisor's idiosyncratic thoughts and opinions. This will be discussed in more detail in the proceeding section on perceptions of implementation strategies.

Staffing. Twice a month clinicians get together for staffing meetings, which given them the opportunity to seek guidance from their supervisor and their peers about difficult cases or any other matters of concern. Like individual supervision, some clinicians voiced their view that these meetings are too dominated by paperwork compliance issues, and don't offer adequate time to be spent on clinical matters.

Auditing files. Agency F leaders regularly audit client files to ensure that all necessary paperwork is in place. These audits are conducted by the director of quality improvement, and focus on whether or not progress notes, assessments, treatment plans, and other important documents are in the file and are accurately completed. It does not necessarily focus at all on clinical appropriateness or on assessing the clinical techniques used; however, the agency has asked clinicians to strive for increasing levels of sophistication in documenting the services they provide (i.e., naming specific treatments and techniques that they are using). These audits occur randomly, as the agency does not have the person power to audit every file, and their electronic record systems are not yet sophisticated enough to facilitate quicker audits. Each file that is audited receives a compliance score that is fed back to clinicians along with any necessary corrective actions. Though these audits may seem basic, they are no small adjustment for the agency, and one leader discussed how higher expectations for documentation will translate well

in an era that demands more transparency in service delivery and accountability for outcomes. She said,

> This is a big mental shift for the majority of my clinicians because like even when I was in school the first time 20 years ago, you never wrote about what you were doing in the session. The note was always about the client. Medicaid wants to know…what did you do? How do you prove that you did something that was beneficial? This is really a general mind switch that I don't think would be possible if we hadn't started holding people accountable for their documentation long before this.

Informal consultation. Though not an active strategy, clinicians reported benefiting greatly from informal consultation with peers. "I have access to most of the people I work with if I do have questions," a clinician assured.

Strategies related to the process of implementation. Agency F reported the use of outcome monitoring. Specifically, leaders and clinicians reported collecting symptom checklists routinely, specifically, the Pediatric Symptom Checklist ("Pediatric Symptom Checklist," n.d.). They collect these data on a monthly basis, and it is mandated and audited by leadership ("…you have to have that or you're going to hear it"). There were discrepant reports about how the Pediatric Symptom Checklist was used. One leader claimed that these data are fed back to clinicians in aggregate form. However, the majority of participants reported that the results of the Pediatric Symptom Checklist were used primarily on a biannual basis in reports to funders, not as a mechanism by which to examine clinical improvement at the client, clinician, or agency level. "I don't look at it," a clinician admitted. "I mean right now the focus is on getting it done and so I don't really keep track."

Perceptions of Implementation Strategies

Qualitative results pertaining to perceptions of implementation strategies.

Qualitative reflections pertaining to implementation strategies were primarily gathered through two focus groups with a total of nine members of the counseling department, as well as six interviews conducted with organizational leaders. Participants discussed their perceptions of training, supervision, staffing meetings, routine collection of symptom checklists, and audit and feedback.

Perceptions of training. Leaders and clinicians universally recognized the sparse training resources at Agency F as problematic, and called for more and better training opportunities. They expressed a desire for more in-house training, but also recognized the role of seeking training outside the agency to ensure that trainings are fresh and that logistical barriers related to scheduling can be avoided. At the same time, they recognized the limits of passive didactic training, with one clinician providing the example of attending a training session on Friday and becoming excited about the potential utility of the content only to have the information "gone" by Monday. One suggestion to minimize knowledge loss after trainings was to have more time carved out to discuss them and to share ideas as a clinical staff. "You need to share it, take it apart, dissect it. That's how I learn," said a clinician. Another clinician thought the agency should offer more opportunities to shadow her peers, both as new staff members and even as more experienced clinicians, "just to see what other therapists, what tricks are up their sleeves." A good first step for the agency might be to provide some financial support for training. Surprisingly to this author, clinicians were very pleased simply to be provided paid time off to attend training, feeling that the agency had met them halfway to a certain extent. "You're hearing us," a clinician exclaimed hopefully. Even "the gesture" of

offering $150 per therapist for training would be meaningful to them, which goes to show that these clinicians are far from unreasonable in their requests for a bit more support.

Perceptions of supervision. Supervision was generally viewed as an essential strategy. The agency's renewed commitment to supervision was lauded by organizational leaders, one of whom said:

> People get away with what they're allowed to get away with. It's not in a bad way, but if no one's molding you to do something better, you don't know to do something better so, having eyes on what you're doing or having your supervisor looking at your assessment to be able to know who your clients are and say, 'Oh, you should try this with them,' or 'Oh, I like what you recommended for them, versus just feeling like they're working independently.'

A frontline clinician also highlighted the value of supervision:

> I would never give up supervision, even if the person that I'm working with has less experience than me, just because it makes me accountable to another person. And seriously, because I have a person that I can talk to about what's going on in the session, and I can get their response. I mean it's just like therapy.

Other clinicians raised concerns about the quality of supervision. Some pertained to their supervisor's style. "Our supervisor is very directive…It feels kind of punitive and it's kind of like, 'this is the way to do it.' It's not negotiating or learning or problem solving or talking about it…it's kind of like a classroom here where we're the students and she's the teacher." Others described their supervisor as "adversarial" and expressed feeling like they had to "walk on eggshells" for fear that their work will be unfairly scrutinized. According to these clinicians, the supervisor was not pushing a particular EBT or set of therapeutic techniques, but rather a

subjective opinion of what clients should work on. “I just don't find it helpful,” one participant vented. “You know…it's more like what do you want me to do? Tell me, I'll do it to make you happy. It's not really useful for me.” In other cases, clinicians raised concerns about their supervisor’s level of training and expertise, leading them to seek guidance elsewhere. Finally, some clinicians believed supervision was too focused on compliance to documentation standards rather than delivering quality treatment, though others conceded that there is usually time to focus on clinical concerns as well. In terms of the frequency of supervision, clinicians seemed to suggest that monthly individual supervision coupled with monthly staffing meetings is sufficient.

Perceptions of staffing meetings. Staffing meetings were critiqued due to their lack of time to discuss clinical content, and it seems as if the meetings have not been managed efficiently. “There should be more clinical content in those team meetings,” argued one clinician. “That was the intent to begin with. That was how they were originally intended.” However, these meetings have reportedly devolved to discussions of documentation and other logistical concerns prior to asking if anyone has any clinical cases to discuss with “five minutes at the end” of the meeting. It would seem that these meetings would be a good opportunity to create space for clinicians to share their knowledge and expertise with one and other.

Perceptions of symptom checklists. Clinicians did not particularly appreciate the use of symptom checklists and did not believe they were important in terms of improving their services as clinicians. One clinician said, “It doesn’t mean that much to me." Another maintained that the checklist “doesn’t encapsulate how much your client has grown.” Many shared the concern that these checklists did not adequately reflect a client’s functioning. “They might be doing leaps and bounds better than they were, but they had a bad day, so they had

these really high scores on something," argued one clinician. Another reasoned, "going to a therapist's office, it's their place to unload, so they might come in already thinking about all their depression symptoms, and this is just where they're going to spew everything." There was also concern that using these tools simply takes too much time. No clinician talked about regularly using this information to guide their clinical practice or to evaluate their own clinical effectiveness.

Perceptions of documentation audit and feedback. Perceptions of audit and feedback pertaining to documentation were mixed. Agency leaders have found it to be effective and worthwhile, and clinicians largely seemed to dislike or at best tolerate the process. "People perform at the level of expectation you set for them," maintained one leader, "so actually setting a level of expectation and then holding them accountable for it" [has been very important to the agency]. She continued to describe situations in which "performance improvement plans" needed to be put in place, and even a case in which one employee needed to be "let go" because they were not performing well professionally. The audit process allows them to have concrete data that supports those decisions, and thus, in her opinion, improves the quality of care delivered at Agency F. Interestingly, as she touted the effectiveness of the auditing process, she introduced the challenge of getting her superiors to understand that the quality improvement professional that performs the audits fills a necessary position even though it is a non-revenue generating position. Clinicians' responses to audit and feedback seemed to vary, and one leader described three categories of responses: "I have my type A clinicians who have a meltdown because they missed one thing and then I have my, we'll call them type B clinicians who are like, 'Oh, okay.' Then I sort of have the hardest people who have…never been held accountable before." An important point was made by the quality improvement professional who spearheads

the audits:

> What works better is if we really translate the feedback to them…I'm taking the time to explain, 'Here's what I need from you'…Sometimes you have to spell things out and they're more than willing to fix what they need to fix and team up on it. It's about really communicating well about it, which is extra work on my part, but at least it gets done.

This underscores a point that should be apparent with all of these implementation and quality improvement strategies – it is not always what strategy one uses, but how they use it that determines its effectiveness.

Quantitative results pertaining to perceptions of implementation strategies. Nine of 12 Agency F staff members (75%) completed the Implementation Strategy Use and Perceptions Survey. Table 11 depicts the full results. All but one of the 50 strategies was endorsed by at least one Agency F participant; however, only 56% of strategies were endorsed by at least half of participants. Means for effectiveness ratings ranged from 3.00 to 4.50 (1 = least positive; 5 = most positive), with 11 strategies endorsed as "in use" by at least half of participants rated a 4.00 or higher and six strategies endorsed as "in use" by at least half of respondents rated below 3.50 (i.e., closer to neutral at best). Overall, the quantitative results suggest that Agency F stakeholders may not have a clear sense of the implementation and quality improvement processes occurring at the agency, as indicated by the low number of strategies that were endorsed by more than half of respondents as "in use" in comparison to the overall number of strategies endorsed by at least one respondent. They also suggest an organizational preference for educational strategies, as well as several quality management strategies, including "audit and provide feedback," "supervision," and "organize clinician implementation team meetings."

Table 11. Agency F: Implementation Strategy Use and Perceptions Survey Results (N = 9)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
		Planning Strategies			
Develop a Formal Implementation Blueprint	89%	4.00 (.76)	4.00 (.76)	4.00 (.76)	4.13 (.83)
Tailor Strategies	78%	3.86 (.69)	3.71 (.76)	4.14 (.69)	3.86 (.69)
Mandate Change	67%	3.83 (1.17)	3.50 (1.05)	3.67 (1.03)	3.83 (1.17)
Build a Coalition	67%	3.83 (.41)	3.33 (.82)	4.00 (0.00)	4.00 (0.00)
Involve Executive Boards	67%	3.50 (1.38)	3.33 (1.37)	3.83 (.98)	3.50 (1.05)
Assess for Readiness and Identify Barriers/Facilitators	56%	3.80 (.45)	3.40 (.55)	3.80 (.45)	3.40 (.89)
Develop Resource Sharing Agreements	56%	3.40 (.89)	3.60 (.55)	3.60 (.55)	4.60 (.55)
Visit Other Sites	44%	4.25 (.50)	3.75 (.50)	4.00 (0.00)	4.00 (0.00)
Obtain Formal Commitments	44%	4.00 (.82)	4.00 (.82)	3.75 (.50)	3.75 (.50)
Develop Academic Partnerships	44%	3.75 (.96)	3.50 (.58)	3.50 (.58)	3.75 (.96)
Recruit, Designate, and Train for Leadership	44%	3.75 (.96)	3.75 (.96)	3.75 (.96)	3.75 (.96)
Conduct Local Needs Assessment	44%	3.25 (.96)	3.00 (.82)	3.25 (.96)	3.25 (.96)
Stage Implementation Scale Up	33%	4.00 (0.00)	4.00 (0.00)	4.33 (.58)	4.33 (.58)
Identify and Prepare Champions	33%	3.67 (.58)	3.67 (.58)	4.00 (0.00)	4.00 (0.00)
Conduct Local Consensus Discussions	33%	3.33 (.58)	3.33 (.58)	3.33 (.58)	3.33 (.58)
		Educational Strategies			
Conduct Ongoing Training	89%	4.00 (.53)	3.88 (.64)	4.00 (0.00)	4.13 (.35)
Use Train-the-Trainer Strategies	78%	4.14 (.69)	3.86 (.69)	4.14 (.69)	4.14 (.69)
Develop Educational Materials	78%	4.00 (.58)	3.71 (.76)	4.00 (.58)	3.86 (.69)
Distribute Educational Materials	78%	3.71 (.95)	3.43 (.79)	4.14 (.38)	3.86 (.90)
Conduct Educational Outreach Visits	56%	4.00 (.71)	4.00 (.71)	3.80 (.84)	3.60 (1.14)
Conduct Educational Meetings	44%	3.50 (1.00)	3.50 (1.00)	3.75 (.50)	3.75 (.50)
Create a Learning Collaborative	33%	3.67 (.58)	3.67 (.58)	3.33 (.58)	3.00 (1.00)
Make Training Dynamic	22%	4.50 (.71)	4.00 (1.41)	4.50 (.71)	4.50 (.71)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Provide Ongoing Consultation	22%	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)
Inform Local Opinion Leaders	22%	3.50 (.71)	3.50 (.71)	3.50 (.71)	3.50 (.71)
Increase Demand	22%	3.50 (.71)	3.00 (1.41)	3.50 (2.12)	3.00 (1.41)
Shadow Other Experts	11%	4.00 (undefined)	3.00 (undefined)	4.00 (undefined)	4.00 (undefined)
Develop an Implementation Glossary	0%	N/A	N/A	N/A	N/A
		Financial Strategies			
Access New Funding	67%	4.17 (.41)	3.67 (.82)	4.00 (0.00)	4.17 (.41)
Make Billing Easier	67%	3.17 (1.33)	2.83 (.98)	3.67 (.52)	3.17 (.98)
Alter Incentive/Allowance Structures	11%	4.00 (undefined)	4.00 (undefined)	4.00 (undefined)	4.00 (undefined)
		Restructuring Strategies			
Revise Professional Roles	67%	3.83 (.75)	3.67 (.52)	3.67 (.52)	4.00 (.63)
Change Record Systems	67%	3.33 (1.21)	2.83 (1.17)	3.33 (.82)	3.33 (.82)
Change Service Sites	67%	3.33 (1.21)	3.33 (1.21)	3.33 (1.21)	3.33 (1.21)
Change Physical Structure and Equipment	56%	3.80 (.45)	3.80 (.84)	3.60 (.55)	3.80 (.84)
Create New Clinical Teams	33%	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)
		Quality Improvement Strategies			
Develop and Organize Quality Monitoring Systems	100%	4.33 (.50)	4.00 (.71)	4.33 (.50)	3.89 (1.05)
Audit and Provide Feedback	100%	4.00 (.87)	4.00 (.87)	4.22 (.97)	3.78 (1.09)
Use Advisory Boards and Workgroups	89%	3.88 (.83)	3.63 (.92)	3.50 (.93)	3.63 (.74)
Capture and Share Local Knowledge	89%	3.38 (.74)	3.25 (.71)	3.25 (.71)	3.25 (.71)
Provide Clinical Supervision	78%	4.29 (1.11)	4.14 (1.07)	4.29 (.49)	4.29 (.76)
Use an Implementation Advisor	78%	4.00 (.82)	3.86 (.69)	3.86 (.69)	3.57 (.98)
Obtain and Use Consumer and Family Feedback	78%	3.29 (1.11)	3.29 (1.11)	3.86 (.90)	3.57 (.98)
Organize Clinician Implementation Team Meetings	67%	4.17 (.41)	4.17 (.41)	4.00 (0.00)	4.17 (.41)
Purposefully Reexamine the Implementation	67%	3.50 (1.05)	3.50 (.55)	4.00 (.63)	3.83 (.41)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Intervene with Consumers to Enhance Uptake and Adherence	67%	3.50 (.55)	3.33 (.52)	3.67 (.52)	3.33 (.82)
Remind Clinicians	33%	4.00 (1.00)	3.33 (.58)	3.67 (.58)	3.83 (.75)
Use Data Experts	33%	3.33 (.58)	3.33 (.58)	3.67 (.58)	3.67 (.58)
Conduct Cyclical Small Tests of Change	22%	3.50 (.71)	3.00 (0.00)	3.50 (.71)	3.50 (.71)
Provide Local Technical Assistance	22%	3.00 (1.41)	3.50 (.71)	3.00 (1.41)	3.50 (.71)

Note. Ratings (and standard deviations) for effectiveness, comparative effectiveness, feasibility, and appropriateness are based upon a five-point Likert scale wherein higher scores are more positive (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree).

Convergence of qualitative and quantitative findings. When considering the qualitative and quantitative data side-by-side, the first area of convergence is that many strategies were not endorsed by the majority of participants, consistent with the qualitative reports of a relatively restricted range of strategy use. Of course, there are notable exceptions. For instance, it is somewhat puzzling that a majority of participants endorsed strategies such as "develop a formal implementation blueprint," "conduct ongoing training," and "use an implementation advisor" despite the fact that these strategies weren't mentioned in the qualitative interviews. Participants' quantitative ratings of "audit and feedback" were more positive than anticipated based upon qualitative reports. That said, the results of both inquiries seemed to converge in important areas. Participants' desire for more training and educational opportunities is reflected in the high ratings of educational strategies, the perceived effectiveness of accessing new funding is fitting with an agency that has had fiscal struggles, and the positive ratings of supervision are consistent with qualitative reports that it is valued even if it is sometimes underutilized.

Relationship Between Organizational Social Context and Implementation Phenomena

Qualitative reflections of organizational social context. The semi-structured interviews and focus groups shed light on a number of contextual themes that are pertinent to their ability to deliver quality social services. These themes include a lack of clinical and administrative oversight, an underdeveloped infrastructure, poor inter-organizational communication, and a failure to embrace a "learning organization" perspective. To be fair, the agency is moving away from many of these patterns that seem to have been contextual hallmarks in recent years, and indeed, some of the present tension that occurs between staff and management may be a direct result of that change.

A lack of clinical and administrative oversight. Agency F's recent efforts to provide more accountability and oversight are a direct response to an environment that had become very lax in the past ten years. A clinician pointed out that 13 years ago or so, there was much more clinical oversight:

> There was more funding and there was a lot more emphasis on training…and what they would do, they would actually use therapy rooms with a mirror, a double-sided window…and they would give a lot more feedback too. Since then, since I've been here, nobody's actually observed my actual therapy process, which used to be one of those fancy training techniques.

For the past ten years or so, it seems as if any audits of professional performance had no teeth. "There were audits, but there were no consequences," stated one participant. Another agreed, saying that any audits that did occur "were very loose and very infrequent." One leader emphasized the extent of this lack of oversight by mentioning, "If someone had been working here for years, no one was looking to make sure that their progress notes were done so, you

could be as behind as you wanted to be or be caught up but no one's going to know."

Oversight at the agency has obviously been ramped up considerably in recent years, and while this is likely a positive change, it creates discomfort among those who have become accustomed to the freedom, autonomy, and lack of accountability that they were previously afforded. Thus, the new methods of oversight have been perceived as micromanagement by a number of clinicians. "To come from that and then feel that I'm being micromanaged is frustrating," conveyed a clinician. "It's definitely frustrating and I'm just trying to work to kind of figure out how to work the system the best I can." An agency leader predicted that some individuals will need to leave the agency, as they won't be willing or able to adapt to the way the agency is moving. "Not everybody is on board with a systematic approach," she said. "Some people liked to just fly by the seat of [their] pants…and doing what fits at that moment, which we're moving away from."

Underdeveloped infrastructure. Despite some of the clinicians' complaints about organizational leadership, they were quick to admit that much of the infrastructure for clinical practice simply hasn't been there. For example, they noted that the new clinical leadership team needed to develop orientation manuals and even basic forms. "We didn't even have consent to treat forms," a clinician exclaimed in disbelief. A leader in charge of quality improvement processes affirmed that reality, "With the quality analysis stuff, I can't believe they didn't have it in the first place. There is a lot of cleaning up to do. There were a lot of big issues without going into detail, but it was ridiculous." Concerns about the organization's infrastructure extend to its financial management ("I think that as an organization, they do need help with the financials"), information technology systems, and its training and quality monitoring systems. Positively, there was consensus that these things needed to be bolstered – a tension for change

was evident.

Poor inter-organizational communication. Concerns about effective communication were evident at all levels of the organization. "There's a lot of disorganization in the organization," quipped one participant. This disorganization seems to be due in no small part to communication concerns. Concerns about communication arose in three different ways. First, both leaders and clinicians expressed that there were communication problems associated with a lack of role clarity among some leaders. Basic expectations about who had the authority to provide guidance and make decisions in certain situations were not clearly delineated, leading to frustration at all levels of the organization. That problem is directly related to another communication failure: inconsistent communication to clinicians during staffing meetings. Clinicians offered specific examples about how two leaders in particular often contradicted each other, and when contradictions became apparent, they would not acknowledge or reconcile the differences. Finally, participants in the focus group expressed that they felt disconnected from management and that the environment was not necessarily psychologically safe (Edmondson et al., 2001; Edmondson, 1999). "You can't make mistakes, can't be wrong, can't ask questions," shared a clinician. When asked directly if the organization felt like a safe place to share thoughts and concerns, clinicians generally acknowledged that they felt safe with their colleagues, but not with administration and management.

Failure to embrace the perspective of a "learning organization." Agency F has been in business so long that it is unfair to say that it has not been innovative over the years; it has to have grown and adapted over the years in order to remain in operation. However, participants described an organization that has become stagnant over the past ten years or so. As explained by an agency leader, "for a long time before 'the great explosion,' [Agency F] was sort of the

800 pound gorilla in the area," and they exuded an attitude of "we're all that." But it has been a tough decade for the agency, and there hasn't been leadership in place to cast a strong and innovative vision. The overarching perspective was "really like that little social services model" instead of conceptualizing mental health within the larger context of healthcare services. "When you're in survival mode," said a leader, "you're not looking to be innovative, you're looking to survive." Agency F's insularity was deepened by an executive director who "never left his office." A leader described the effects of the director's inaction:

> If you have an executive director that nobody knows, and doesn't network and doesn't go to community events, you're not going to get money from corporations. People don't think of you when they think, 'Oh, you should collaborate with [this agency],' because nobody knows who you are.

This trend of insularity was seemingly passed down from the highest level, as Agency F was perhaps the least collaborative and "cosmopolitan" (Damschroder et al., 2009) of the agencies in this study. They did not talk about learning from other organizations or gaining the perspectives of others through external networking.

Results of organizational social context survey. Agency F's OSC profile was close to the average based upon the norms from the national sample (Glisson, Landsverk, et al., 2008). The composite profile score based upon the latent profile analysis was 1.92, indicating that culture and climate subscales are somewhat close to the national averages. Agency F's OSC scores in relation to the national norms are shown in Figure 10. Agency F's culture profile reveals that rigidity and resistance scores are one and one and a half standard deviations above its proficiency score (which is essentially at the national average). Agency F's climate profile demonstrates that it is just above the national averages for engagement and stress, and just over

a standard deviation more functional than the national average. Both the LPA score and the OSC subscale scores make it clear that Agency F places above only Agency A in terms of its organizational social context (i.e., it has the second worst OSC in the sample).

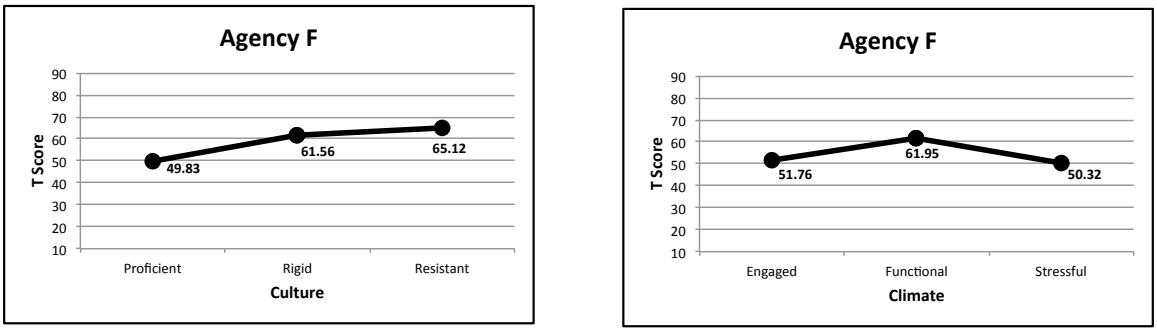

Figure 10. Agency F's organizational culture and climate profiles

Summary and relationship to implementation processes. In summary, both qualitative and quantitative assessments of Agency F's social context point to serious concerns that need to be addressed before drastic improvements in quality of mental health care are likely. Once again, the positive sign here seems to be that agency leaders and clinicians, while they have their disagreements and communication problems, seem to largely agree about what many of the problems and needs are. With some other agencies (e.g., Agency A and Agency D come to mind) there are serious discrepancies between the perspectives of leaders and clinicians; here everyone was relatively clear: the agency needs to improve in a myriad of ways.

It is abundantly clear that the organization's social context influenced implementation processes. The agency was not yet in a place where they could even attempt to adopt a new program or practice, as they were consumed with much more fundamental concerns related to the delivery of services (e.g., documentation, visitor policies, etc.). The current state of the agency precludes the careful selection of new programs and practices, thoughtful implementation planning, and the use of implementation strategies in a systematic and thoughtful manner. The agency applied relatively few implementation and quality improvement

strategies, most of which were reportedly used in a cursory manner. There was no use of intensive training, it was not entirely clear how often supervision *actually* occurred (and several people were unclear about how often it was *supposed* to occur). Ultimately, contextual influences seemed to stop implementation before it could even begin.

Cross-Case Analysis

A cross-case analysis was conducted to examine key similarities, differences, and omissions related to the key study aims (Stake, 2005; Yin, 2009). A table comparing the main findings from each aim was created in order to facilitate comparisons across cases (Miles & Huberman, 1994). This table can be seen in Appendix D, and a summary of the cross-case findings is presented aim-by-aim below.

Decision Making Processes

Treatment decision making. A number of commonalities related to the selection of interventions and treatment approaches emerged across cases. Several of these can be categorized using the five major domains of the CFIR (Damschroder et al., 2009).

Factors related to the characteristics of the intervention. The three organizations that adopted EBTs were greatly influenced by the characteristics of the interventions that they adopted. This is consistent with implementation related theories and conceptual models that underscore the importance of intervention characteristics in either promoting or inhibiting the uptake of innovations (Damschroder et al., 2009; Grol et al., 2007; Rogers, 2003). For example, all three agencies cited the fact that the interventions were evidence-based and/or mentioned that they were supported by empirical research. Their assessments of the research evidence were usually derived from some 3rd party source such as an evidence-based clearinghouse and/or an intervention developer (e.g., Substance Abuse and Mental Health Services Administration, 2012; The California Evidence-Based Clearinghouse for Child Welfare, 2014); thus, there were no detailed discussions of agency stakeholders assessing the evidence first-hand. In addition to relying upon evidence-based clearinghouses, many organizations seemed to place a great amount of trust in endorsements from outside experts. The agencies that had not adopted an

EBT did not reference the assessment of evidence for different treatment approaches with any depth. While some mentioned it briefly, there was no information provided to suggest that the agencies' treatment decision making was driven by the empirical evidence.

Two of the three agencies implementing EBTs discussed being drawn to the adaptability or flexibility of the interventions. They eschewed interventions that they perceived as rigid, and preferred interventions that they believed would be applicable to a wide range of their clients. This is consistent with empirical findings suggesting that therapists are not necessarily averse to evidence-based practices, but that they have concerns about the rigidity of manualized treatments (Borntrager, Chorpita, Higa-McMillan, & Weisz, 2009). It is also fitting with survey findings that clinicians desire to receive training in practices that are widely applicable to their caseloads (Powell, McMillen, et al., 2013). At least two organizations mentioned other intervention characteristics as important, such as the interventions' compatibility with their personnel and clients, the replicability of the intervention (as rated by NREPP), and the fact that they would "own" the intervention and not be forever beholden to the intervention developers after they became accredited to deliver the intervention. Being too tightly tethered to treatment developers has been cited as a concern by stakeholders in another qualitative study (Powell, Hausmann-Stabile, et al., 2013).

Factors related to the outer setting. Client need and the availability of funding were far and away the biggest drivers of treatment decision making. Formal assessments of client need were rarely if ever conducted, as participants were far more likely to discuss their first-hand clinical experiences of felt need. Though it is perhaps unfair to state that the availability of funding was the primary motivator for implementing EBTs, a lack of funding would have certainly curtailed all of the efforts described in this study. One Agency B leader was more

blunt in her assessment of the role of funding in implementation efforts, stating, "funding always dictates." Indeed, there were no agencies that did not underscore the importance of both client need and funding in guiding their decisions. The central role of funding in facilitating implementation efforts has been highlighted in a number of key publications (e.g., Isett et al., 2007; Magnabosco, 2006; Rieckmann, Kovas, Cassidy, & McCarty, 2011), and should be considered as a key change lever at the outer setting-level. Client need and client values, of course, are one of three main considerations (along with best available evidence and practitioner expertise) in the original definition of evidence-based practice (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). It is heartening that so many stakeholders spoke eloquently about their commitment to addressing client need.

At least four of the six agencies relied upon collaborations with other agencies to guide treatment decision making. This included two of the three agencies implementing EBTs and three of the four agencies that discussed implementing a novel program or practice. This is consistent with empirical evidence documenting widespread collaboration in this service sector (Bunger, 2012), and points to the role of "cosmopolitanism" or the extent to which organizations are connected with external organizations in driving innovation (Damschroder et al., 2009). Connections with other organizations provide opportunities to learn about novel interventions. Recognition of this has made social network approaches to implementation an important line of inquiry (Palinkas et al., 2013; Palinkas, Holloway, et al., 2011; Valente, 2012). In at least one case (Agency B), these collaborations predated the organization's interest in the novel program. Collaborations with neighboring institutions helped Agency B to develop and deploy the mental health collaborative program, and continue to be important as they examine its implementation. In other cases, these collaborations were actually born out of agencies'

interests in particular EBTs. For instance, both Agency A and Agency C reached out to other organizations who had implemented Intervention A and Intervention C in order to obtain their feedback on the interventions and learn from their experiences. One of the agencies (Agency F) that did not cite collaborations with other agencies as a driver of treatment decision making was characterized as very insular, isolated from other agencies in the surrounding community. Another agency (Agency E) appeared to be highly connected, though they did not discuss how that led them to select specific programs or practices.

Agency D was the lone agency that cited CEU opportunities as a major influencing factor on treatment decision making. Though this was a top-three motivator for clinicians to attend training in practice-based research network survey (Powell, McMillen, et al., 2013), this is a particularly passive approach to guiding treatment decision making, especially since they did not necessarily seek CEU opportunities that focused on EBTs. Indeed, there did not appear to be a systematic or thoughtful approach to selecting CEU opportunities other than personal interest. The potential to leverage the continuing education industry as a means of increasing the delivery of EBTs has been identified by Raghavan and colleagues (2008) and will be discussed further in the next chapter.

Agency A was the only agency to cite cost-savings for the community as a guiding factor in treatment decision making. They felt that the introduction of Intervention A services would result in a reduction in costly treatment options (inpatient stays, residential placements, etc.). This may indicate a missed opportunity for other agencies to consider the potential cost savings to their communities, which could aid in their efforts to receive funding to implement new programs and practice. Yet, it also highlights a major impediment to EBT implementation:

the paucity of economic data specifying the costs of EBTs themselves as well as the implementation-related costs (Powell et al., 2014; Raghavan, 2012; Vale et al., 2007).

Factors related to the inner setting. Five of the six agencies maintained that their agencies' missions and their existing capacities were essential in guiding their selection of programs and practices. They expressed strongly that they did not want to drift too far from their agencies' niches. Interestingly, Agency D, the only agency that did not mention their mission or existing capacity as a driver of treatment decision making, had a much more diffuse focus (i.e., a wider range of programs). The agency was also criticized for constantly pursuing new service areas rather than investing in the quality of current programs and practices.

Three of the six organizations mentioned consultation with stakeholders internal to their organizations as important in the process of treatment decision making. These opportunities for input from organizational stakeholders were largely described as informal, and input from organizational leaders seemed to supersede input from frontline workers, who more often than not seemed removed from treatment decision making at the organizational level. This is problematic as the involvement of frontline workers is an important element of effective implementation (Grol & Wensing, 2005). Some agencies acknowledged as much, stating that getting frontline worker buy-in early in change processes was important; however, in many cases they did not have formal mechanisms for ensuring frontline worker involvement.

Factor related to the characteristics of individuals. Two agencies (Agency B and Agency F) mentioned their clinicians' previous training and expertise as influential in treatment decision making. Those two agencies both placed a high level of value on the expertise and discretion of individual therapists (McCracken & Marsh, 2008), and did not express positive attitudes toward evidence-based practices in the semi-structured and focus group interviews

(Aarons, Cafri, Lugo, & Sawitzky, 2012; Aarons, 2004). They thought of treatment decision making as occurring at the level of individual clinicians, and thus, being influenced largely by the previous training and knowledge of clinicians. Treatment in their view must be tailored to the unique needs of every client, which clinicians conceptualized as too complex to be addressed by specific EBTs.

Factor related to the process of implementation. Agency F was the one agency that mentioned individual and group supervision as an influence on treatment decision making. Again, much like the previous section emphasized, this agency viewed treatment decision making at the individual-level with treatment being tailored to the specific needs of each individual client.

Omissions and critiques. Several opportunities to improve treatment decision making seem to have been missed. First, it is apparent that with some exceptions, using empirical evidence to guide the selection of treatments is not very common. Those that were eager to find interventions that were evidence-based relied upon 3rd party sources and did not seem to engage with the primary literature in any meaningful way.

Second, agencies generally did not take the opportunity to involve frontline workers and clients in decisions about what treatments should be implemented.

Third, some decisions to implement new programs and practices were hastily made, often due to opportunities to seek new funding for services. This was reported as problematic once an agency received funding and was actually "stuck" with implementing an intervention that not everyone believes in. Taking more time to thoughtfully consider different options, and engaging a wide range of stakeholders in the intervention decision making process would have gone a long way toward ensuring a better decision.

Finally, there may have been too much reliance on the notion of "therapy as art." Clients are indeed unique and many of them have comorbid conditions; however, the notion that standardized interventions are incapable of addressing these complex needs is not necessarily well founded (Kazdin & Whitley, 2006; Weisz et al., 2012). It seemed to this author that some of the practitioners who expressed the view that EBTs are too rigid and not well suited to address the complex needs of their clients may have simply been averse to a high level of clinical oversight and accountability for their work.

Implementation decision making. Participants from each agency in this study struggled somewhat to articulate how they actually made decisions about how to implementation new programs and practices. While the quantitative survey results may suggest otherwise, none of the agencies reported documenting a formal implementation plan that details the implementation strategies that they would employ and describes implementation processes in any detail. The importance of implementation planning should not be overlooked (Boaden, Harvey, Moxham, & Proudlove, 2008; Graham et al., 2006; Grol & Wensing, 2005); thus, this presents a significant missed opportunity.

None of the agencies used any sort of implementation or quality improvement model. While this may seem too formal or even scientific for agencies in practice, it seems unfortunate that with such a proliferation of models and frameworks (Tabak, Khoong, Chambers, & Brownson, 2012) none of them have had any traction in community practice. Even more practically than many of those research-based conceptual models, there are emerging models that could have potentially guided the organizations as they attempted complex service changes (e.g., Chinman, Imm, & Wandersman, 2004; Grol & Wensing, 2005; Meyers et al., 2012; Pipkin, Sterrett, Antle, & Christensen, 2013). Further research will be necessary to determine

how feasibly these models can be used in community settings, but it would seem that they would represent a profound improvement upon current processes that could be described as rudderless.

Agencies did not report formally conducting assessments of need or organizational performance prior to and after implementation. Most implementation models conceptualize this as an essential process that is cyclical and relatively constant (e.g., Graham et al., 2006; Grol & Wensing, 2005). The absence of such evaluations makes it more difficult to determine if and when adaptations to the implementation processes and/or clinical interventions are necessary.

Finally, there were only minimal references to the implementation or quality improvement literatures, and there was no evidence that these emerging sciences played any substantial role in any of the implementation efforts described in these case studies. It would be a sad irony if findings from the very science intended to bridge the research-practice gap failed be properly disseminated and implemented in real world settings. While there is admittedly a long way to go in building the empirical base for specific implementation actions, there is a substantial body of literature that can inform implementation now (Cochrane Collaboration, n.d.; Grimshaw, Eccles, Lavis, Hill, & Squires, 2012; Novins, Green, Legha, & Aarons, 2013; Powell et al., 2014).

Agency participants mentioned four primary influences on implementation decision making. First, at least half of the agencies alluded to grant or contract expectations as guidance for the types of implementation strategies and processes they would employ. For example, they referred to the training and supervision requirements or requirements to more carefully document services as influencing implementation actions.

Second, the agencies implementing EBTs relied heavily upon the treatment developers for guidance as to how they should implement the programs. In many cases, these developers have requirements for things like training, supervision, and other elements of agency infrastructure that need to be in place to implement their programs. Organizational leaders seemed to place a lot of faith in these developers, assuming that they have all of the implementation issues figured out. Yet as is abundantly clear from each of the case studies, there are a myriad of factors that prove to be important to implementing new programs and improving the quality of services that are likely outside of the purview of intervention developers. Thus, it would seem that leaders might have placed too much confidence in this source of information in guiding their implementation decisions.

Third, agencies again relied upon collaborations with other agencies to learn what implementation strategies had been successful for them. This included reaching out to other agencies to obtain their "lessons learned" about implementation, and in some cases (e.g., Agency A) even scheduling site visits that allowed for the exchange of ideas.

Finally, the majority of agencies relied upon internal communication with organizational leaders and staff about how to effectively implement new programs and practices. Again, while frontline workers were involved in some cases, this level of communication almost always seemed to take place between organizational leaders. This suggests a missed opportunity to build buy-in from frontline workers and to ensure that implementation is informed by the needs and constraints of the individuals that will actually be delivering the services. There also seems to be a missed opportunity to involve clients in discussions about potentially relevant programs and practices and any relevant implementation concerns.

Implementation Strategy Use

Qualitative reports of strategy use. Implementation strategies at the individual provider-level were clearly dominant in this study; however, across agencies there were a number of similarities and differences between strategies used at the intervention, outer setting, inner setting, individual, and provider levels.

***Strategies related to the characteristics of intervention*.** Participants across agencies mentioned only one strategy related to the interventions themselves, which was to adapt the intervention and/or corresponding assessment tools to their local needs. This was mentioned by at least three of the agencies, though others also addressed the issue of adaptation either by mentioning the inherent flexibility or adaptability of the interventions that they adopted or maintaining a stance toward clinical treatment that elevates individualized service delivery over more standardized treatments. Participants from some agencies were unable to provide very specific examples, whereas others, such as participants from Agency C described adaptations such as combining group and individual treatments. Again, it is less clear if these adaptations were carefully documented, and whether or not there was any sort of framework guiding the adaptation process both of which are the focus of recent work in this area (Cabassa & Baumann, 2013; Wiltsey Stirman, Miller, et al., 2013; Wiltsey Stirman, Calloway, et al., 2013).

***Strategies related to the outer setting*.** Several strategies related to the outer setting were common across agencies. First, all six agencies relied upon accessing new funding to implement their programs and practices. The extent to which they had supports in place do access funding varied, as not all agencies had staff dedicated to development and grant writing. Second, all of the agencies reported soliciting client feedback as a means of improving the quality of services that they offer. It is important to note, however, that this generally involved generic satisfaction

surveys and not mechanisms for clients to provide feedback on specific programs and services. Four of the six agencies reported client engagement strategies such as phone calls, community visits, and incentives that were used to ensure that clients remain in treatment. Three of the six agencies discussed their efforts to design and deploy marketing and/or educational materials that targeted clients in the community with the intent of making them aware of the services available to them. Finally, five of the six agencies reported collaborating with other organizations to implement new programs or improve the quality of their services. These collaborations varied widely. In some cases they could be characterized as "marriages of convenience" in which relationships were established in order to submit stronger grant applications. In others, collaborative relationships were a way to extend the reach of services into new geographic areas. Still others, such as Agency B, appeared to be truly engaging in collaborative relationships with other agencies that were marked by mutuality, the free exchange of ideas, and shared responsibility for implementation. It is also important to note that the one organization that did not mention any major collaborative efforts was perhaps the least innovative agency in the study, with one of its leaders making the case that previous leaders had not made it a priority to venture out into the community to develop those types of relationships. It was certainly encouraging to see the extent of the collaboration between agencies; however, there seem to be opportunities to be more strategic and thoughtful about how organizations might collaborate to implement specific EBTs. Models such as the recently developed Interagency Collaborative Team model may prove useful in considering the possibilities in this regard (Hurlburt et al., 2013).

Strategies related to the inner setting. Strategies directed at the inner setting were relatively minimal across agencies despite many indications of need. Two of the six agencies

discussed structural changes, such as hiring and firing staff members or changing organizational/supervisory charts to accommodate new programs. At least half of the agencies discussed efforts to develop a stronger infrastructure for services, specifically through developing more robust documentation processes and/or instituting electronic medical records. Three of the agencies mentioned efforts to shift the organizational philosophy in some way. For example, Agency B desired to shift toward a more preventive framework and Agency E shared a need to shift toward more of an empowerment-based perspective. This may sound "soft," and admittedly, it is not well defined as a strategy. Leaders did not provide much detail as to how these shifts were made, but reported regularly communicating these shifts whenever the opportunity arose. All three of the agencies that were implementing EBTs were pursuing accreditation or credentialing through the intervention developers that would bolster their organizational capacity to deliver the interventions. In some cases, such as Agency C, it also afforded the opportunity for the agency to train other clinicians and agencies in the community, extending the reach of the intervention locally. Three agencies attempted to improve intra-organizational communication in a general sense and/or in relation to a specific EBT. Largely these efforts were underspecified, but in one case, this took the form of all staff meetings intended to improve communication across agency departments at Agency F. Several strategies were mentioned only by single agencies. For example, Agency D discussed efforts to build morale through a staff appreciation committee that would institute agency-wide events (e.g., barbeques, etc.). Agency F discussed their strategic planning process as a way to break down agency silos and promote greater integration of services. Finally, an Agency A participant described the use of quality improvement processes across the organization, though this did not apply specifically to the implementation of Intervention A. As has been seen through the

individual case descriptions, there are serious concerns with many of the organizational contexts of these agencies; thus, it is unfortunate that relatively few implementation and quality improvement strategies have been directed at the organizational level. Many of these organizations could have benefited from ARC (Glisson et al., 2010, 2012, 2013) or other targeted organizational improvement interventions, which will be discussed in more detail in the next chapter.

Strategies related to characteristics of individuals. Perhaps not surprisingly, implementation strategies at the individual level were dominant across agencies. There was substantial variation, however, in terms of the frequency and intensity of a number of commonly used strategies. Training is an excellent example. Though it was central to each agency's implementation and quality improvement efforts, the training supports offered by the agencies varied widely. Two extremes can be found in Agency B and Agency F. Agency B provides a robust training infrastructure, including an array of opportunities for clinicians to receive both training and CEUs in-house, whereas Agency F provides no funding allowance and have not had a budget to provide any training sessions in-house. Two agencies (Agency D and E) provided modest training allowances. The components of training also varied across agencies. All agencies used some form of didactic training and many incorporated relatively passive strategies such as workbooks, video demonstrations, and E-learning modules. Given the evidence suggesting that passive strategies are less effective (Beidas et al., 2009; Beidas, Edmunds, Marcus, & Kendall, 2012; Beidas & Kendall, 2010; Davis & Davis, 2009; Davis et al., 1999; Davis, Thomson, Oxman, & Haynes, 1995; Herschell et al., 2009, 2010), it would behoove community agencies to move toward some of the more active approaches.

Encouragingly, many agencies also incorporated role-play, live observation and feedback, shadowing, and other more active strategies.

Like training, supervision was used by every agency, but had a similar range in terms of its frequency and intensity. The frequency of supervision officially varied from once per week to once per month (typically for an hour). But some participants expressed that they rarely receive supervision, demonstrating that what is deemed "official policy" by leaders does not always occur in practice. Moreover, the content of supervision varied, with some organizations focusing much more on clinical concerns (e.g., Agency B), and others using supervision to address administrative concerns such as paperwork compliance (e.g., Agency A, Agency E, Agency D). One organization reported a concerted effort to provide direct feedback to supervisors so that they could improve the quality of supervision that they provide. The range of supervisory practices was surprising given the rich traditions of supervision within counseling, psychology, and social work. Indeed, one of the administrative competencies specified by the Network for Social Work Management is to ensure "that the organization offers competent and regular supervision to staff at all levels of the organization" (Hassan, Waldman, & Wimpfhiemer, 2013, p. 7). That not all agencies in this study met this basic competency is cause for concern. Hopefully ongoing empirical work will support organizations by helping to determine the specific components of supervision that are most valuable and essential. One recent study of supervision found that supervision involving active components such as modeling and role-play predicted EBT use in the next session (Bearman et al., 2013). Another ongoing trial within the field of mental health should shed more light on the extent to which supervision will impact implementation and clinical outcomes (Dorsey et al., 2013).

Five of six organizations reported the use of some type of audit and feedback process. These largely focused on documentation compliance. In some cases was viewed as a sort of proxy to fidelity to some EBTs, though participants did not support the monitoring of fidelity as an implementation strategy. This will be discussed in more detail in the proceeding section on stakeholders' perceptions of implementation strategies.

Frontline workers from five of the six organizations reported informal peer support as regularly occurring. This consultation took place in shared offices, open door policies, phone calls, and text messages. The general sentiment of participants at each of these agencies was that peers were generally willing and able to provide support pertaining to both clinical and logistical concerns such as difficulties with paper work or information technology systems. This type of support was reported to the most readily available.

A more formal avenue for peer support and access to supervisors occurred through weekly staffing or team meetings that occurred at the majority of agencies. Similar to supervision, the content of these meetings varied widely, with some focusing much more heavily on clinical concerns and others focusing more on administrative concerns. It may be beneficial to leverage these meetings as implementation team meetings in which team members can discuss challenges and successes related to the implementation of a particular EBT. These meetings have been deemed helpful in studies documenting implementation efforts (Dickinson, Edmundson, & Tomlin, 2006; Powell, Hausmann-Stabile, et al., 2013; Rapp et al., 2008).

Four of the agencies reported their effort to thoughtfully hire new employees in ways that fit a specific innovation (e.g., Agency A, Agency C, Agency E) or a specific theoretical orientation (e.g., Agency B). To these agencies a large part of implementation success was "getting the right people on the bus" (Collins, 2001), and they seemed to recognize that hiring

thoughtfully can actually be a smoother path to EBT implementation than attempting to alter the habits and attitudes of current staff members (Waldron, 2014).

Finally, three agencies discussed the dissemination of educational materials such as workbooks, PowerPoint presentations, etc. While some clinicians reported the value of such materials, there were other cases in which clinicians referred to binders or folders that are clearly "languishing on the shelf."

Strategies related to the process of implementation. Agencies reported a variety of strategies related to the process of implementation and quality improvement. Monitoring some form of clinical outcome was common for the majority of agencies, but none of the agencies reported using outcome data to inform implementation or quality improvement efforts. In fact, the vast majority of frontline workers reported that they do not regularly review the results of outcome measurements, nor is the information fed back to them at the individual, team, or agency level. Opportunities to improve this state of affairs en route to the ideal of measurement-based care (K. Scott & Lewis, 2014) are discussed in the next chapter.

Two agencies discussed assessing barriers and facilitators to implementation. This primarily involved brainstorming and informal consultation with staff members and organizational leaders, and did not involve a formal, structured process as has been recommended by implementation researchers (Flottorp et al., 2013; Wensing et al., 2011, 2009). Though the most effective ways of identifying barriers and tailoring strategies to effectively address them have yet to be determined, there seem to be opportunities to both increase the use of this strategy and increase the level of sophistication by which barriers are identified and strategies are selected.

The majority of agencies reported regular meetings that provided opportunities to evaluate and reassess implementation and quality improvement processes. Two agencies had regular meetings that were dedicated to a specific implementation effort, while other simply used existing meetings to check-in about implementation. Still others reported much more informal ways of reflecting on implementation processes. Given the complexity of some of the changes discussed in the case studies, it is surprising regular meetings dedicated to the specific efforts were not the norm. Again, this has been identified as particularly helpful in other efforts (Dickinson et al., 2006; Powell, Hausmann-Stabile, et al., 2013; Rapp et al., 2008).

Unique implementation strategies (not used by more than one agency) at the process level included engaging champions and opinion leaders (Carpenter & Sherbino, 2010; Soo, Berta, & Baker, 2009), rolling out the innovation in a sequential fashion, seeking anonymous feedback from staff, and adapting implementation strategies as necessary.

Quantitative reports of strategy use. The number of implementation strategies endorsed by at least 50% of participants ranged from 24 to 43, indicating substantial variability by agency. The quantitative results will be discussed further in relation the fourth aim pertaining to the impact of organizational social context on implementation processes. The aggregate findings of the Strategy Use and Perceptions Survey can be viewed in Table 12.

Perceptions of Implementation Strategies

Qualitative reports of stakeholders' perceptions. Stakeholders' perceptions of implementation strategies were remarkably similar across agencies. Frontline workers and leaders alike focused primarily upon their perceptions of provider-focused implementation strategies – not surprising given that type of strategy's dominance at all six organizations. One theme that held across agencies was a preference for more active implementation strategies such

as dynamic training, role-playing, shadowing, and live observation and feedback. Conversely, passive strategies such as didactic lectures, video demonstrations, online learning or E-learning modules, and workbooks were viewed as ineffective. This is consistent with empirical literature documenting the effectiveness of provider-focused strategies (Beidas et al., 2009, 2012; Beidas & Kendall, 2010; Davis & Davis, 2009; Davis et al., 1999, 1995; Herschell et al., 2009, 2010).

In addition to wanting more dynamic, active approaches to training, many stakeholders voiced a preference for more clinical depth in training, believing that many of their trainings were far too basic and did not foster their clinical growth. In fact, this was a cross-cutting concern across agencies and implementation strategies such as training, supervision, team meetings, etc., with frontline workers and leaders suggesting that more in-depth clinical training would be beneficial. Many frontline workers complained that training, supervision, and team meetings end up being dominated by administrative concerns, precluding the in-depth exploration of their clinical concerns and ultimately stunting their professional growth. The desire for more clinical depth is consistent with findings from a broader survey of clinicians' training preferences (Powell, McMillen, et al., 2013).

Frontline workers from the two agencies that provided training allowances (Agencies D and E) expressed great appreciation. Employees from Agency F, who had recently been granted paid time off to attend training (but no training allowance) also expressed great appreciation for that gesture. The need for training funds was underscored at agencies where allowances were not yet available. It would seem that these relatively modest gestures go a long way in ensuring that frontline workers feel supported. That said, some frontline workers at Agency D expressed not knowing how to most effectively utilize their training dollars, which suggests that agencies and professional organizations might do a better job of identifying the most promising training

opportunities and more closely orient CEU opportunities around evidence-based programs and practices (Raghavan et al., 2008).

Frontline workers and leaders also expressed a desire for more in-house trainings, providing that the level of clinical content and rigor is appropriately elevated. The rationale for this preference is that there are many barriers to the receipt of training external to the agency, as the combined costs of training, lodging, and other travel-related expenses are often too steep for most frontline workers to cover (Powell, McMillen, et al., 2013; Stewart & Chambless, 2010).

Frontline workers almost universally desired to receive supervision, but it was not always perceived as helpful in its current form. First, workers from a number of agencies admitted that they do not receive supervision as often as they are supposed to. This is problematic in at least two ways: 1) it represents a breach of clinical oversight, and 2) it communicates a lack of support to frontline workers. Second, when supervision does occur, some frontline workers felt that supervision was not clinically focused enough, and that their concerns were crowded out by efforts to monitor documentation compliance or ensure that they had enough clients on their caseload. Third, some frontline workers did not feel that their supervisors had the clinical training and/or experience to truly provide them with adequate supervision. Finally, participants wanted to receive more empathy and respect from their supervisors. They did not always feel like their supervisors understood how difficult their job is, nor did they feel that they were given the proper due when they performed well.

Stakeholders' perceptions of audit and feedback were very interesting; clinicians almost universally despised the practice, while agency leaders often felt that it served their purposes well. For clinicians, the approach was marred by what they perceived to be a negative and punitive bent. Indeed, the literature on audit and feedback suggests that punitive approaches are

not effective (Hysong, Best, & Pugh, 2006; Ivers et al., 2014; Kluger & Van Dijk, 2010). Their performance was never monitored "for the good;" thus, they experienced audits as continual nagging. Moreover, many frontline workers believed that the content of the audits actually constituted a very small part of their job. This led them to believe that supervisors were in a sense making mountains out of molehills when they criticized them for their performance through the auditing process. Conversely, organizational leaders at multiple agencies found value in auditing workers' because they truly believed that it motivated workers, and it gave them the leverage they needed to make personnel moves when workers' performances were particularly poor.

The majority of frontline workers and organizational leaders did not seem to value the routine collection of clinical outcome data (or any other data on the processes and outcomes of implementation and/or clinical care). While many organizations routinely collected this information, it seemed to primarily serve the function of satisfying the reporting requirements of the state or other funders. Ultimately, these measures seemed to be relegated to binders somewhere, and results were not routinely utilized by clinicians or even made available to them. Not surprisingly then, they found little value in collecting these data.

As previously mentioned, formal and informal peer support was identified as a very important implementation and quality improvement strategy. Many frontline workers seemed to be quicker to rely upon their peers than their supervisors.

Another cross-agency theme was the appreciation for opportunities to adapt interventions, and or to adopt interventions that were inherently flexible. This was perceived as a means of ensuring that the breadth of their client-base could be adequately served by the interventions. It was also promoted as a way of ensuring that the needs of clients, rather than the

providers, are prioritized. An example can be seen in Agency B's adaptation of the mental health collaborative curriculum when community members express unique needs and requests. Rigidly sticking to the curriculum, in the directors view, would be a tremendous disservice to the members of the collaborative who would likely perceive the clinicians as "pushing a curriculum on them rather than listing to their needs."

Organizational leaders expressed mixed opinions about the value of collaborations in promoting implementation and quality improvement. These differences largely reflect the different types of collaborations previously described. In some cases, the collaborations seem to be mere formalities that are pragmatic or strategic in nature. In other cases, collaborations were more essential to implementing a program or practice (as in the case of Agency B).

Some agencies mentioned annual reviews as one of their quality improvement strategies. This was not mentioned by all agencies, though this author's assumption is that all agencies have some form of annual reviews in places. Nevertheless, none of the stakeholders found much value in the annual reviews as a means of improving quality, believing them to be too generic to be very helpful.

Several stakeholders shared their opinions about strategies that were unique to a given agency, or about implementation strategies that they believe are needed but not yet in place at their agencies. Some of these suggestions are listed in the table in Appendix D, though a few will be mentioned here given their salience. First, as described in Agency C's case study, one leader was a big proponent for sequential implementation efforts. This way, agencies can make relatively small investments in select groups that have a high probability of success before attempting to spread innovations more widely. Agency C is the only organization to report doing this deliberately, though it is a well-established approach in implementation and quality

improvement (Berwick, 1996; Stetler et al., 2008). Second, leaders at Agency D consistently reiterated the importance of staff-driven change initiatives, as ideas generated by staff members are more likely to be accepted and acted upon than top-down initiatives that often struggle to achieve widespread buy-in. Interestingly, this approach did not seem to be very prevalent at Agency D, or at any other agency for that matter. Finally, one agency leader expressed the need for more management training to provide leaders the opportunity to develop their supervisory and management skills. This has received more attention lately as the idea of implementation leadership has gained traction (Aarons et al., 2014; Aarons, 2009), but opportunities to develop further capacity in this area are discussed briefly in the next chapter.

Quantitative reports of stakeholders' perceptions of implementation strategies. The results of the Implementation Strategy Use and Perceptions Survey can be seen in Table 12. There are relatively few strategies that were rated very highly, though it is important to note that the standard deviations are relatively high indicating substantial variability in respondents' ratings. The qualitative and quantitative findings largely converge and complement each other, and the extent of convergence is documented within Table 12 (see the note below for explanations of the superscripts preceding each strategy). Several strategies are worth highlighting. First, educational strategies such as making training dynamic, conducting educational meetings and outreach visits, and conducting ongoing training were rated as effective. This is consistent with qualitative findings that training is effective, particularly when it is dynamic as opposed to simply lecture-based. Supervision was rated relatively highly despite frontline workers' concerns about the quality of supervision that they receive; thus, it is indicated as mixed in terms of the extent to which qualitative and quantitative results converged. Similarly, strategies that focus on peer support such as forming clinician

implementation meetings were rated as relatively effective. Audit and feedback was rated relatively poorly, consistent with qualitative reports. Some strategies are rated rather low despite qualitative data suggesting they might be rated more highly. These strategies include shadowing other experts and providing ongoing consultation. Nevertheless, both of these strategies were still rated above a 3.50 and thus were generally consistent with qualitative reports. Some strategies reported in the survey were simply not discussed much (if at all) in the interviews; thus, it is impossible to denote convergence or divergence. The quantitative findings will be discussed again in relation to the impact of organizational context on implementation processes.

Table 12. Cross-case findings: Implementation Strategy Use and Perceptions Survey (N = 52)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
Planning Strategies					
[C]Build a Coalition	79%	3.78 (.69)	3.59 (.74)	3.78 (.52)	3.80 (.56)
[M]Involve Executive Boards	75%	3.46 (1.05)	3.21 (1.00)	3.67 (.87)	3.56 (.91)
[C]Mandate Change	75%	3.33 (1.06)	3.18 (.94)	3.56 (.88)	3.56 (.94)
[C]Assess for Readiness and Identify Barriers/Facilitators	65%	3.76 (.70)	3.44 (.75)	3.79 (.54)	3.76 (.70)
[C]Recruit, Designate, and Train for Leadership	62%	3.59 (.76)	3.69 (.69)	3.81 (.64)	3.78 (.66)
[C]Develop a Formal Implementation Blueprint	62%	3.41 (.95)	3.41 (.95)	3.63 (.75)	3.56 (.91)
[D]Conduct Local Consensus Discussions	58%	3.43 (.94)	3.27 (.83)	3.50 (.78)	3.53 (.78)
[C]Tailor Strategies	56%	3.83 (.66)	3.79 (.73)	3.90 (.67)	3.76 (.74)
[C]Develop Resource Sharing Agreements	54%	3.89 (.69)	3.82 (.67)	3.96 (.64)	3.89 (.63)
[C]Identify and Prepare Champions	54%	3.68 (.86)	3.61 (.83)	3.71 (.71)	3.82 (.77)
[N]Conduct Local Needs Assessment	52%	3.74 (.76)	3.48 (.85)	3.56 (.85)	3.70 (.82)
[C]Stage Implementation Scale Up	50%	3.81 (.80)	3.88 (.77)	3.92 (.63)	3.92 (.63)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
[N]Develop Academic Partnerships	44%	3.61 (.78)	3.52 (.51)	3.70 (.47)	3.70 (.56)
[C]Visit Other Sites	40%	3.71 (.72)	3.62 (.67)	3.62 (.74)	3.52 (.75)
[N]Obtain Formal Commitments	31%	4.00 (.63)	3.81 (.66)	3.94 (.57)	3.94 (.57)
Educational Strategies					
[C]Conduct Ongoing Training	88%	3.91 (.84)	3.74 (.83)	4.02 (.54)	4.02 (.68)
[N]Use Train-the-Trainer Strategies	73%	3.79 (.70)	3.44 (.65)	3.76 (.71)	3.82 (.73)
[C]Provide Ongoing Consultation	69%	3.64 (.83)	3.50 (.91)	3.75 (.77)	3.67 (.83)
[C]Distribute Educational Materials	67%	3.86 (.81)	3.51 (.85)	3.89 (.68)	3.89 (.80)
[N]Create a Learning Collaborative	65%	3.71 (.87)	3.53 (.83)	3.71 (.68)	3.74 (.79)
[M]Conduct Educational Meetings	63%	4.00 (.61)	3.64 (.74)	3.97 (.53)	4.00 (.61)
[C]Conduct Educational Outreach Visits	62%	3.97 (.65)	3.66 (.75)	3.88 (.61)	3.78 (.75)
[C]Develop Educational Materials	60%	3.84 (.78)	3.61 (.84)	3.84 (.69)	3.94 (.68)
[C]Make Training Dynamic	48%	4.12 (.67)	3.92 (.86)	4.04 (.61)	4.04 (.68)
[C]Shadow Other Experts	48%	3.60 (.71)	3.56 (.71)	3.64 (.57)	3.76 (.72)
[C]Inform Local Opinion Leaders	40%	3.52 (.75)	3.33 (.86)	3.71 (.56)	3.62 (.67)
[N]Increase Demand	17%	3.67 (.50)	3.56 (.73)	3.78 (.83)	3.62 (.67)
[N]Develop an Implementation Glossary	13%	3.71 (.49)	3.43 (.79)	4.00 (0.00)	4.00 (0.00)
Financial Strategies					
[C]Make Billing Easier	58%	3.90 (.96)	3.73 (.94)	3.90 (.71)	3.73 (.87)
[C]Access New Funding	73%	3.89 (.76)	3.55 (.76)	3.87 (.74)	3.97 (.59)
[C]Alter Incentive Structures	29%	3.67 (.72)	3.67 (.72)	3.40 (.74)	3.40 (.83)
Restructuring Strategies					
[C]Change Record Systems	71%	3.41 (1.01)	3.24 (1.06)	3.59 (.80)	3.35 (.98)

Strategy	% Use	Effect.	Comp. Effect.	Feasibility	Approp.
[N]Change Service Sites	69%	3.89 (.82)	3.61 (.87)	3.81 (.79)	3.86 (.76)
[N]Change Physical Structure and Equipment	63%	4.06 (.50)	3.79 (.74)	3.91 (.52)	3.91 (.52)
[N]Create New Clinical Teams	54%	4.00 (.72)	3.75 (.70)	3.82 (.61)	3.75 (.75)
[N]Revise Professional Roles	54%	3.82 (.67)	3.68 (.70)	3.71 (.71)	3.79 (.63)
Quality Improvement Strategies					
[M]Provide Clinical Supervision	92%	3.94 (.93)	3.79 (.97)	4.08 (.71)	4.06 (.81)
[M]Develop and Organize Quality Monitoring Systems	85%	3.82 (.81)	3.61 (.78)	3.77 (.83)	3.73 (.87)
[C]Audit and Provide Feedback	79%	3.56 (.98)	3.39 (.89)	3.73 (.74)	3.54 (.87)
[C]Organize Clinician Implementation Team Meetings	77%	3.93 (.76)	3.78 (.80)	3.95 (.60)	3.90 (.74)
[C]Use Advisory Boards and Workgroups	69%	3.78 (.68)	3.67 (.76)	3.64 (.68)	3.67 (.63)
[N]Intervene with Consumers to Enhance Uptake and Adherence	69%	3.58 (.73)	3.36 (.76)	3.58 (.65)	3.56 (.77)
[N]Obtain and Use Consumers and Family Feedback	63%	3.70 (.81)	3.55 (.87)	3.89 (.70)	3.67 (.85)
[N]Use an Implementation Advisor	63%	3.58 (.75)	3.42 (.79)	3.64 (.65)	3.45 (.75)
[N]Capture and Share Local Knowledge	63%	3.55 (.71)	3.42 (.71)	3.52 (.57)	3.52 (.62)
[C]Purposefully Reexamine the Implementation	60%	3.77 (.80)	3.77 (.67)	3.94 (.63)	3.90 (.60)
[C]Provide Local Technical Assistance	56%	3.66 (.77)	3.69 (.81)	3.72 (.80)	3.76 (.69)
[C]Remind Clinicians	42%	3.68 (.78)	3.55 (.74)	3.68 (.72)	3.64 (.79)
[N]Use Data Experts	42%	3.32 (.72)	3.18 (.66)	3.27 (.70)	3.23 (.69)
[N]Conduct Cyclical Small Tests of Change	40%	3.71 (.64)	3.67 (.80)	3.71 (.64)	3.76 (.62)

Note. Ratings (and standard deviations) for effectiveness, comparative effectiveness, feasibility, and appropriateness are based upon a five-point Likert scale wherein higher scores are more positive (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree). [C] = quantitative and qualitative results largely converged, [D] = quantitative and qualitative findings diverged in some way, [M] = mixed findings, [N] = not addressed thoroughly in qualitative results.

Relationship Between Organizational Social Context and Implementation Phenomena

Qualitative reflections of organizational social context. There are several points of commonality between the qualitative reports pertaining to the organizational social context of each agency (see Appendix D). First, participants from the majority of agencies (all but Agency B) reported concerns about the quality and openness of communication between frontline workers and agency leaders. For some agencies, relationships between frontline workers and agency leaders were marked by animosity; in others there simply weren't open lines of communication established. This undoubtedly has a detrimental effect on implementation and quality improvement given the importance of clear communication within organizations (Damschroder et al., 2009). More specifically, obstructed lines of communication mean that frontline workers cannot clearly communicate the need for organizational leaders to remove barriers to implementation that only they have the power to remove.

A second concern related to problems in communication is the lack of role clarity that was identified in at least two organizations. The absence of clearly delineated roles and responsibilities related to implementation efforts leads to confusion amongst staff members who do not know who to turn to for various forms of support.

A third concern is related to the general infrastructure for services (Alexander, Weiner, Shortell, Baker, & Becker, 2006; Schoenwald et al., 2008). Participants from all six agencies discussed problems related to information technology, documentation problems, and the availability of basic supports needed to excel in their work. These concerns are well documented in each individual case study, and all of them have clear implications for implementation and quality improvement efforts. The importance of infrastructure is perhaps

best illustrated through Agency F's experiences, and their acknowledgement that they need to "get their house in order" before they can begin thinking about implementing EBTs.

At least half of the agencies in this study had organizational contexts that were characterized as punitive or as lacking a basic sense of psychological safety. Clinicians in these environments are scared to make mistakes, they "walk on egg shells," and they are unable to fully process their successes and failures because they fear some sort of reprisal if they express their concerns honestly. Clearly, this does not foster learning at the team or organizational levels (Carmeli & Gittell, 2009; Edmondson, 1999), and it likely stymies implementation and quality improvement efforts.

Three of the agencies (Agencies A, E, and F) were transitioning from more lax organizational contexts to more rigid contexts that valued more structure and systematic practices. While these transitions may ultimately be very positive, and in fact, may be absolutely necessary to facilitate the implementation of EBTs, the organizations were dealing with the growing pains that accompany such shifts. Inevitably some staff members will need to "move on" as they will not be able to accommodate the agencies' new approaches to practice. Others will need to adjust their ways of working, accommodating increasing levels of oversight and service documentation.

Participants from two agencies (Agency D and E) reported that their agencies tended to make hasty decisions about new programs and practices, and participants from another agency (Agency C) reported struggling with innovation without much follow through. While other agencies did not necessarily express the same sentiments, this tendency seems to represent a common trap given the pressures inherent to running a non-profit social service organization. Yet each of these cases demonstrates the need to think very carefully about implementing new

programs and practices, as well as the need to ensure that implementation-related issues are not an afterthought.

Frontline workers from five of the six organizations were vehement regarding what they perceived to be the overemphasis of documentation compliance at the expense of quality service delivery. Again, many of these workers felt that training, supervision, and team meeting time has been taken up by lesser concerns such as the documentation of services. Of course, one could argue that, like in the case of Agency F, basic concerns over documentation need to be dealt with prior to attempting to improve the quality of service delivery. But this issue was so wide-spread, making it seem likely that organizations' implementation and quality improvement efforts might also suffer due to "losing the forest for the trees." That is, there may be some wisdom in placing increasing emphasis on clinical support, and in investing in efforts to cut down on the duplication of documentation requirements.

More positively, two organizations (Agencies B and C) expressed a commitment to fostering continual growth. Agency C discussed this at the organizational level, with the director making the point that she always wants the agency to be pushing itself to be better by being actively engaged in some type of improvement project. Agency B discussed this at the level of the clinician, with participants noting that there is a real culture of responsibility for personal growth and development. The agency provides commensurate support for clinicians through an array of training and supervision opportunities.

In summary, many of these cross-cutting contextual themes negatively influenced these agencies' implementation and quality improvement efforts. Unfortunately, many of these contextual challenges appear to be "par for the course." But despite the fact that they are

commonplace, it is likely that they will need to be addressed in order to obtain high levels of implementation effectiveness.

Results of organizational social context survey. The OSC profiles for each agency can be viewed in the table in Appendix D, which orders the agencies according to their profiles (from best to worst). Agency B is the only agency that qualified as the "best" according to national norms, four of the agencies (Agencies C, D, E, and F) fell in the "average" category, and one agency (Agency A) fell in the "worst" category. The latent profile analysis scores ranged from 1.00 (worst) to 3.00 (best). The ranges of the subdomains for organizational culture were as follows: proficiency (47.24 to 61.08), rigidity (48.50 to 61.08), and resistance (52.53 to 77.90). The ranges of the subdomains for organizational climate were as follows: engagement (35.56 to 67.83), functionality (50.39 to 70.09), and stress (43.65 to 69.75). Again, a score of 50 represents the means from the national sample, and every ten-point jump represents a single standard deviation. Comparing and contrasting each agencies' implementation-related processes in light of these OSC profiles provides some interesting insights; however, it is important to remember that this small sample makes it difficult to come to firm conclusions regarding the potential impact of organizational social context on implementation processes. Thus, these results should be considered accordingly.

First, the agencies with the three best OSC profiles in the current sample were more likely to be implementing novel programs (three of three were implementing a new program or practice) than those with the worst three OSC profiles (in which only one of three was implementing a novel program). This might suggest that organizations with more positive OSCs are more likely to implement novel practices.

Agencies D and F, both of which are in the bottom half of agencies according to their OSC profiles, definitely had the most difficulty articulating their agencies' approach to implementation and quality improvement. However, this was not the case for the agency with the worst OSC profile (Agency A). They were able to clearly articulate a range of implementation strategies and a coherent plan for improvement despite the fact that contextual weaknesses seemed to largely derail their efforts. In comparison, agencies with the best OSC profiles had a far easier time articulating implementation and quality improvement processes.

Interestingly, agencies with the three best OSC profiles had far narrower organizational foci than the agencies with the worst three OSC profiles in the sample. The best three were organizations that focused on a relatively well-defined population and/or type of services, whereas agencies with the worst three OSC profiles tended to have more diffuse foci. This might suggest that it is advantageous (at least in some ways) for organizations to do a smaller range of things really well than to have diverse offerings that they are unable to manage appropriately.

Agencies with the best three OSC profiles actually used fewer implementation strategies ($M = 33.67$) than agencies with the worst three OSC profiles ($M = 36.33$). However, agencies with the best three profiles also rated strategies more positively than those with the three worst profiles. Of those strategies endorsed by at least 50% or respondents, agencies with the best three OSC profiles had a mean percentage of 43% or strategies a "4" or higher, on the effectiveness scale, whereas agencies with the worst three OSC ratings rated only 21% a "4" or higher. This finding largely held in the qualitative reports as well, most noticeably at the extremes of the OSC ratings. Indeed, Agency B was the most positive about the implementation and quality improvement strategies offered by their agency, and Agency A was perhaps least

positive about the strategies that their agency had employed. This suggests that organizational social context may moderate the effect of implementation and quality improvement strategies. In short, the same exact implementation strategy may be perceived very differently depending upon the social context in which it is deployed.

In summary, it appears that in the present sample, agencies with more positive OSC profiles were more likely to implement a program or practice with known dimensions, were more likely to have a narrow focus, and were more likely to have positive views of the implementation strategies employed by their agency. Organizations with poorer organizational social contexts as determined by both qualitative and quantitative reports faced a myriad of barriers to implementation and quality improvement, many of which may need to be addressed before implementation effectiveness is possible.

Chapter 6: Implications and Future Directions

The purpose of this study was to characterize "implementation as usual" in social service organizations serving children, youth, and families in order to identify the extent to which these processes reflect emerging "best practices" documented in the implementation and quality improvement literatures. Each agency in this study demonstrated a host of unique strengths and some approached what might be considered "best practices" in some areas; however, this investigation documents that implementation as usual generally falls short of established principles in the implementation and quality improvement literatures. Just as we have not done an adequate job of disseminating and implementing the products of clinical research (Balas & Boren, 2000), we have a long way to go to ensure that the findings of implementation and quality improvement research actually impact real world practice. This discussion focuses on the implications for practice, policy, and research that can be derived from this study as well as some of the limitations of this study.

Implications for Practice

Focus on the fundamentals and nurture organizational contexts. One of the lessons of the current study is that implementation and quality improvement efforts are not always about EBTs and other "sexy" changes. Agencies discussed a number other changes such as implementing a visitation policy, managing administrative assistants and receptionists, and getting documentation standards in place. This reality was recently reflected by McMillen (2014) who was in the midst of teaching a course on quality improvement methods. He recognized that students were facing very practical problems:

> Many of our agencies struggle with basic things like making social service clients feel welcome, respecting privacy, giving people a comfortable and respectful

> environment in which to receive services, getting people to come back, getting basic paperwork done (including the most vital stuff like client informed consent)… But these students realized that agencies needed to get some basics right before they could expect to move mountains.

Organizational leaders and other stakeholders involved in improvement efforts should not overlook these fundamental concerns; this work may necessarily precede more intensive efforts to shift practice patterns.

A related concern is the lack of attention to the organizational social contexts of services. Practical steps such as ensuring open lines of communication, instituting some level of participatory decision making and inclusion between organizational leaders and frontline workers, and creating safe spaces to discuss disagreements are unquestionably necessary. It was evident to this author that virtually all of the agencies in this study would benefit from ARC (Glisson et al., 2010, 2012, 2013) or an ARC-like intervention; however, there also seemed to be many "fixes" that would seem relatively easy. For example, ensuring that frontline workers feel heard and have an opportunity to provide feedback to the highest levels of the organization are strategies that are feasible and low-cost. It was striking how many frontline workers identified issues related to the organizational social contexts of their organizations, while organizational leaders (with some exceptions) were not always quick to acknowledge these concerns. Organizational leaders and clinicians alike need to take responsibility for improving the contexts in which services are offered.

Couple stories with empirical data. Many of the organizational leaders expressed the value of learning from other agencies and clinicians who had previously implemented the EBT that they were exploring. In some ways, they valued these anecdotal lessons even more than

reports of the empirical evidence that are available on the evidence-based clearinghouses. This is consistent with research demonstrating that stakeholders are much more influenced to attend trainings in EBTs when they are presented with narrative summaries describing the EBT than when they are presented with an information sheet listing the results of randomized controlled trials (Stewart & Chambless, 2010). Thus, treatment developers, researchers, organizational leaders, and others attempting to influence others to embrace a particular EBT would do well to "integrate case studies, video vignettes, role-plays, and other anecdotal case information" into marketing and educational materials (Powell, Hausmann-Stabile, et al., 2013, p. 405).

Consider adopting common elements and/or modular-based approaches to intervention. Participants from nearly every agency conveyed their desire to implement interventions that were flexible or adaptable, so that they would be maximally beneficial to their diverse clientele. Participants did not convey any knowledge or interest in common elements (Barth et al., 2012; Barth, Kolivoski, Lindsey, Lee, & Collins, 2013; Chorpita, Becker, & Daleiden, 2007) or modular approaches (Chorpita et al., 2013; Weisz et al., 2012) to intervention. However, these approaches would be particularly well suited to many of these settings given their relevance to a wide range of clinical diagnoses and their ability to appropriately address a range clinical presentations. Moreover, these approaches mitigate clinicians' concerns about the rigidity of EBTs (Borntrager et al., 2009), perhaps smoothing the path to implementation. This study has provided further evidence that the characteristics of interventions can play a large role in adoption decisions. It will not be surprising if common elements, modular approaches, or other transdiagnostic approaches (McHugh, Murray, & Barlow, 2009) gain traction among community agencies as they are increasingly aware of the features of these interventions.

Involve stakeholders in decision making. Stakeholder involvement in the implementation and quality improvement processes across the agencies in the current study was highly variable. While most agencies incorporated the perspectives of frontline workers in some way, it appeared as if most agencies relied most heavily upon the input and direction of senior leaders to guide implementation processes. This is clearly a mistake, as evidenced by many of the frontline workers' strong reactions against some of the EBTs and other agency practices. Every effort should be made to involve frontline workers, clients, and other potential partners (such as academic partners) in the planning and execution of implementation efforts (Birkel et al., 2003; Chambers & Azrin, 2013; Grol & Wensing, 2005).

Assess barriers and facilitators. Only two out of six agencies in the current study reported assessing potential barriers and facilitators to implementation and quality improvement, and those that did reported relatively nominal approaches. It would seem that all of the agencies would have greatly benefited from the systematic assessment of barriers and facilitators. Engaging in this process would simultaneously serve to help the agencies anticipate (or become aware of current) problems and as a means of generating buy-in and participation from any stakeholders that are involved in the assessment process. Potential barriers and facilitators can be assessed through a number of methods, including literature review (e.g., Gravel, Légaré, & Graham, 2006), informal consultation with stakeholders (e.g., Grimshaw, 2012), qualitative interviews and focus groups (e.g., Forsner et al., 2010; Manuel, Mullen, Fang, Bellamy, & Bledsoe, 2009; Rapp et al., 2010), surveys (e.g., Chenot et al., 2008; J. A. Jacobs, Dodson, Baker, Deshpande, & Brownson, 2010), or mixed-methods approaches (e.g., Woltmann et al., 2008). Several (relatively) generic scales for measuring barriers to implementation have also been developed (Funk, Champagne, Wiese, & Tornquist, 1991;

Larson, 2004; Wensing & Grol, 2005). Wensing and Grol (2005) offer additional approaches that can aid in the identification of implementation problems, such as utilizing direct observation, the self-registration of behavior (e.g., completing a form directly after contact with a patient), medical records, and other routinely collected data that can be used to document variations in care. Mixed-methods approaches may be especially useful for capturing both nuanced descriptions of barriers and facilitators *and* evaluating their impact on implementation outcomes (Aarons, Fettes, et al., 2012; Palinkas, Aarons, et al., 2011). It may be very helpful if assessments of barriers and facilitators are guided by theoretical frameworks, and a recently developed framework would be very useful in identifying the potential domains in which barriers and facilitators might arise (Flottorp et al., 2013).

Develop an implementation plan. The organizations in the current study did not develop and document implementation plans. The absence of implementation plans clearly impacted their ability to communicate about implementation processes (e.g., leaders and clinicians sometimes struggled to recall basic details about training and supervision), and more importantly, limited their ability to systematically execute implementation processes. Respondents did not rate the strategy "develop a formal implementation blueprint" very positively, giving it a mean score of 3.41 (*SD* = .95). Nevertheless, the development of an implementation plan is undoubtedly important, particularly given the complexity of most change efforts. Studies have shown that it may be more important for an organization to have a standard road map to conduct improvement projects rather than to have any specific framework (Boaden et al., 2008). It would be even more ideal if implementation plans built upon some the conceptual and/or empirical work in the implementation and quality improvement fields.

Several resources would be particularly useful in this regard (Graham, Tetroe, & KT Theories Group, 2009; Grol & Wensing, 2005; Meyers et al., 2012; Tabak et al., 2012).

Consider evidence for implementation strategies. While empirical evidence was discussed as an important factor in intervention decision making, organizational leaders did not report benefiting from the literature informing implementation and quality improvement practice. This is unfortunate, as some of the strategies that they employed are not likely to be very effective. For example, passive approaches such as training workshops that lack experiential elements and ongoing supervision and consultation and disseminating educational materials have been found to be largely ineffective in promoting the skillful use of EBTs (Beidas & Kendall, 2010; Herschell et al., 2010). Moreover, the way in which they used some of the strategies is out of sync with best practices. Many frontline workers, for instance, complained about the punitive approaches to audit and feedback, supervision, and fidelity monitoring. Yet the literature suggests that audit and feedback and fidelity monitoring is much more effective if it is delivered in a non-punitive manner (Hysong et al., 2006; Ivers et al., 2014; Kluger & Van Dijk, 2010). In fact, fidelity monitoring that is presented as supportive consultation has been shown to increase staff retention (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009). Agencies in the current study also focused primarily upon the provider level despite clear evidence that there was a need for facilitative changes at the organizational level. The literature suggests that this approach is not likely to be effective (Flanagan, Ramanujam, & Doebbeling, 2009; Glisson, 2007; Weiner et al., 2011), and while this study did not assess implementation and clinical outcomes, it appears that many of the agencies' efforts are failing partly due to this costly omission. While the evidence for the effectiveness of specific implementation strategies is admittedly imperfect, implementation stakeholders would do well

not to perpetuate approaches to implementation that have been deemed ineffective. The evidence to support the use of specific implementation strategies continues to advance (Grimshaw et al., 2012; Novins et al., 2013; Powell et al., 2014), and journals such as *Implementation Science* provide a wealth of information that is freely available. Efforts should be made to communicate this to providers in the community who may benefit from these resources.

Learn from frontline workers. This study highlighted a number of salient themes regarding stakeholders' perceptions of implementation strategies. Two of the primary lessons are 1) to integrate as much clinical depth into training, supervision, and team meetings as possible; and 2) to avoid the negative and punitive approaches that were prevalent in the majority of agencies in this study. Additionally, clinicians reported preferring active implementation strategies, which is heartening given that active approaches have been shown to be more effective that passive strategies. Integrating these principles into routine practice to the extent possible would be advantageous.

Stage implementation. As the director of Agency C argued, it may be wise to consider a staged approach to implementation. Not only is this more fiscally prudent, it also may serve as a way of identifying barriers and facilitators and refining implementation strategies before attempting to spread the EBT more widely. It also provides time for a "buzz" to develop around the intervention. As Agency C's director stated, this ideally leaves clinicians clamoring to implement the new intervention, ensuring that a critical group of dedicated frontline workers is amassed by the time the intervention is spread throughout the organization, which can be essential in ensuring that the intervention sticks (Powell, Hausmann-Stabile, et al., 2013).

Create opportunities for reflection and revision. With some exceptions, agencies in the current study had few opportunities to regularly reflect upon and revise implementation processes, and they were clearly worse off because of it. It would be more prudent to prepare all of the involved individuals for an iterative rather than a linear process of implementation (Aarons & Palinkas, 2007; Straus et al., 2009a). In fact, the implementation plan itself (assuming one exists) may need to be adapted throughout the process. Setting high expectations for the implementation effort has been noted to be vital to successful implementation (Rapp et al., 2008), but acknowledging that barriers and setbacks will be encountered and using them as opportunities to learn is also important. Building in opportunities to reflect on the implementation process as an explicit part of the implementation plan (e.g., Grol & Wensing, 2005), and facilitating open communication about successes and frustrations related to EBT implementation through regular team meetings is one way to facilitate this process (Powell, Hausmann-Stabile, et al., 2013; Rapp et al., 2008). This was well illustrated in the current study by Agency B's implementation of the mental health collaborative. As the director of the collaborative consistently reiterated, the process was "organic" and it involved a lot of meetings in which clinical and implementation concerns were processed.

Address emotional aspects of implementation processes. The salience of emotion in implementation processes could not possibly be overlooked in this study. Numerous agencies revealed concerns about a lack of psychological safety (Edmondson et al., 2001; Edmondson, 1999) and other emotional concerns such as a perceived lack of empathy from agency leaders. Emotion is a key domain in one of the most widely used frameworks in implementation, the Theoretical Domains Framework (Cane et al., 2012; Michie et al., 2005), and it is imperative that leaders are cognizant of the emotional tenor of the tenor of their organizations. This will

ensure that frontline workers have the opportunity to speak to their feelings about the innovation and implementation process directly, addressing concerns and smoothing the path to implementation and sustainability. Kotter and Cohen (2002) provide this important reminder, "…the core of the matter is always about changing the behavior of people, and behavior change happens in highly successful situations mostly by speaking to people's feelings."

Evaluate clinical and implementation processes. Though the majority of agencies in this study routinely collected clinical outcome data in some form, most were not serious about letting the results guide their efforts toward clinical improvement. This is an unfortunate missed opportunity. Though the costs of clinical assessments may have been a legitimate concern for some agencies, a recent review has identified 29 adult and 20 youth measures that can be used as a part of an evidence-based assessment toolkit for a heterogeneous group of clients (Beidas et al., 2014). Hopefully, the field of mental health care will increasingly move toward measurement-based care, in which clinical care is based upon data collection throughout the treatment process (K. Scott & Lewis, 2014). Adopting a measurement-based care approach would breath life into the measurement process, which has become perfunctory for the agencies in this study.

This study also demonstrates a need for implementation processes to be more carefully evaluated in community settings. Agencies in this study primarily reported informal ways of evaluating implementation and quality improvement efforts. Of course, there were some exceptions such as Agency B's mental health collaborative which was launched as a pilot study. However, agencies would do well to collect basic data on the process of implementation. The ultimate goal of implementing new programs and practices is of course to improve client outcomes, and these should be routinely measured as outlined above. But evaluating a wide

range of implementation outcomes (Proctor, Silmere, et al., 2011) may allow organizations to expand (and systematize) the "practice based evidence" that they generate regarding what works and how/why it works. Different outcomes may be more or less salient depending upon the stage of implementation that the organization is in. For instance, assessing feasibility, acceptability, and appropriateness may be more important early on, whereas outcomes such as sustainability are obviously more pertinent in the long-term (Proctor et al., 2011). In addition to promoting a more nuanced understanding of the implementation process, assessing outcomes such as fidelity have been shown to generate positive results for organizations (e.g., Aarons, Sommerfeld, Hecht, et al., 2009). Though measurement in implementation science is at an early stage of development (Proctor, Powell, & Feely, 2014), the availability of outcome measures that can be used routinely in organizations is likely to expand given recent attention to measurement in implementation (Cancer Research Network Cancer Communication Research Center & National Cancer Institute, 2012; Seattle Implementation Research Conference, 2011). Moreover, this study indicates that many agencies would benefit from creating opportunities to reflect upon implementation (as discussed above), and or providing the opportunity for staff to provide anonymous feedback on the implementation process (Nickerson, 2010).

Implications for Policy

Leverage opportunities to promote high quality implementation through funders. Naturally, every organization in this study was heavily influenced by funding opportunities as well as the regulations and requirements of different funders. This is well illustrated by the director of Agency B who attributed the shift toward increasing levels of documentation and accountability at his agency to a simple cause: the funders unwillingness to send the check if the agency did not comply.

This suggests tremendous opportunity for funders to positively influence social service agencies. First, as many agencies demonstrated, it is helpful for funders to provide financial support for agencies to deliver evidence-based programs and practices. Many of the agencies implementing EBTs admitted that they would be unable to do so without the support of special funding dedicated to supporting evidence-based services.

Second, and more pertinent to this study, there is an untapped opportunity for funders to promote high quality implementation by advancing requirements that agencies submit detailed implementation plans. Funders could also require that the implementation plans have a strong rationale for the implementation strategies that they will use, pushing agencies to draw upon implementation and quality improvement science rather than relying upon the status quo. This would accelerate thinking on implementation issues and ensure that implementation was not an afterthought, only to be considered in the small window of time between a notice of award and the provision of clinical services.

Finally, this study adds to a robust body of literature suggesting that organizational social context is critical to the delivery of effective services. Specifically, this study demonstrated that concerns at the level of the organizational social context can preclude the level of organization and foresight required to implement new programs and practices, and can also negatively influence frontline workers perceptions of implementation and quality improvement strategies if adoption does occur. Perhaps it is time for funding agencies to seriously consider lending support to organizational improvement strategies such as the ARC organizational implementation strategy (Glisson et al., 2010, 2012, 2013). Without serious improvement in organizational social context, benefits from the implementation of EBTs will likely not be accrued.

Rethink continuing education units. Many of the leaders and frontline workers in this study reported relying upon continuing education units (CEUs) as their primary source of information to guide clinical decisions. This is concerning for two reasons. First, the quality of CEU opportunities undoubtedly varies widely, and there is little assurance that they will be based upon the best available evidence. Second, the format of even the most intensive CEU offerings does not meet minimum standards for effective implementation strategies They are typically didactic lectures without much of an interactive component, and they do not include ongoing supervision and consultation which have been found to be important in promoting clinician behavior change (Beidas et al., 2012; Beidas & Kendall, 2010; Herschell et al., 2010; Nadeem, Gleacher, & Beidas, 2013). There is an opportunity to recast CEU opportunities so that they are more closely aligned with evidence-based clinical and implementation practices. This opportunity was identified by Raghavan and colleagues (2008) who stated:

> Regulations surrounding mandated continuing education units (CEUs) offer policymakers the ability to shape professional practice toward EBPs. State licensing board regulators, or their interagency partners, can assume all costs of, or subsidize, certain CEUs, provide direct technical assistance in developing courses and programs, or disallow certain courses for licensing credit. However, in order to promote an EBP environment, licensing boards will need to reconsider the structure of the CEU. Because single-shot training and didactic approaches are usually ineffective in shaping provider behavior, licensing boards will need to support quality improvement approaches that are rooted in the literature on provider behavioral change (p. 4).

Though not necessarily at the policy level, the ARC trial (Glisson & Proctor, 2009) provides a

nice example of how academics can work with university field education offices and local community agencies to design a series of continuing education workshops that more closely approximate evidence-based approaches to implementation. The trial has sponsored several training opportunities in evidence-based treatments such as MATCH ADTC (Weisz et al., 2012) and the Coping Power program (Lochman et al., 2009), and often trainings involved multiple days and a host of active strategies such as behavioral rehearsal. Encouraging state mental health departments and other funders to invest in and reimagine CEU offerings will be essential to developing evidence-based systems of care.

Implications for Research

Develop and test a wider range of implementation strategies. The use of the Consolidated Framework for Implementation Research (Damschroder et al., 2009) to organize the implementation strategies used by the agencies in this study afforded the opportunity to identify areas in which further strategy development is necessary. While agencies used implementation strategies at each of the five domains, provider-level strategies were clearly dominant and strategies at the inner and outer context levels generally lacked much depth (e.g., staff appreciation committees at the inner setting and client satisfaction surveys at the outer setting). This finding is consistent with a review of the implementation literature that also classified implementation strategies using the CFIR (Powell et al., 2014). This suggests a need to develop a wider range of strategies. At the inner setting level, strategies such as ARC (Glisson et al., 2010, 2012, 2013) should be developed and tested. There is also a need to develop policy-level interventions and to evaluate the impact of existing policies. We know that policy decisions are not handed down from "upon high" and implemented exactly as intended (Pressman & Wildavsky, 1984). Rather, "street level bureaucrats" transform these policies as

they apply them in the real world (Lipsky, 1980). One current example of an effort to evaluate the real world impact of a policy change is an examination of mental health transformation in Philadelphia (Beidas et al., 2013). Similar efforts will be essential to advancing the field.

Identify and develop practical tools to guide implementation. The proliferation of implementation science is a wonderful thing, and it holds great promise for improving real-world practice. But there is also a need for practical tools that aid in translating implementation and quality improvement research findings into real world systems. One example of such a tool is the Quality Implementation Tool (Meyers et al., 2012), which evaluates a number of steps corresponding to six main components: 1) develop an implementation team, 2) foster supportive organizational/communitywide climate and conditions, 3) develop an implementation plan, 4) receive training and technical assistance, 4) practitioner-developer collaboration in implementation, and 6) evaluate the effectiveness of the implementation. These types of tools that provide concrete guidance to implementers are sorely needed, and efforts should be made to test existing tools and develop new ones as necessary. While individuals in the current study did not express a need for this type of tool, it is difficult to imagine that it would not be useful to them.

Provide leadership training in implementation and quality improvement practice. One leader from Agency D raised the idea of management training for organizational leaders that would focus on supervisory issues and other administrative competencies. Her point is well taken. There is a void in the social services in basic management training, and there is also a need to provide specific training in quality improvement and implementation research. Quality improvement trainings are available through national organizations such as ASQ, but these organizations are unlikely to be an option for social service employees given prohibitive costs

(McMillen, 2013). One promising opportunity for training in leadership and quality improvement is available through the Institute for Health Care Improvement's Open School, which provides online courses for a nominal cost (Institute for Healthcare Improvement, 2014). The National Institute of Mental Health has also recently invested in the development of an implementation-specific leadership program (Aarons, 2009). Determining the most effective and efficient way of providing management and leadership support to social service leaders is an important area for further research.

Specify key components of implementation strategies. The findings of this study lend further support for the need to better specify the components or "active ingredients" of implementation strategies. As participating agencies demonstrated, there are many ways in which training, supervision, audit and feedback, and other strategies can be deployed. These variations in delivery impact effectiveness, as was seen in the way that audit and feedback was deployed in several agencies in the present study. Yet more needs to be understood about the elements of implementation strategies that contribute to their effectiveness.

One way of working toward that end is through improved reporting of the implementation strategies and how they are used in both implementation research and practice. Several resources exist that may help stakeholders think about the specific components of implementation strategies that they are using in research and practice (Albrecht, Archibald, Arseneau, & Scott, 2013; Davidoff, Batalden, Stevens, Ogrinc, & Mooney, 2008; Davidoff & Batalden, 2005; Michie, Fixsen, Grimshaw, & Eccles, 2009; Proctor et al., 2013). While intended as a guide for research reporting, the guidelines set forth by Proctor et al. (2013) may also be a useful tool for community stakeholders who are developing implementation plans.

Another critical way of developing a better understanding of which elements of implementation strategies are the most critical for their effectiveness is through ongoing research that focuses on the specific components that need to be included in strategies such as audit and feedback, supervision, and learning collaboratives (e.g., Dorsey et al., 2013; Ivers et al., 2014; Nadeem, Olin, Hoagwood, & Horwitz, 2013).

Both of the aforementioned improvements would allow us to better understand variations in effectiveness that cannot be accounted for by contextual variation. Assessing the frequency, intensity, and fidelity at which implementation strategies are delivered may also be an important next step as we struggle to understand variations in effectiveness (Powell et al., 2012). Just as with clinical treatments, the appropriate balance between fidelity and flexibility will also need to be scrutinized. Ultimately, the field may be better off developing and testing protocols for adapting strategies or elevating generalizable processes that facilitate the selection of discrete implementation strategies (e.g., Aarons, Green, et al., 2012; Glisson et al., 2013; Hurlburt et al., 2013; Meyers et al., 2012; Pipkin et al., 2013). These processes could be translated into practical tools that organizational leaders could use to guide their implementation efforts.

Use multiple informants in implementation research. This study highlights the importance of using multiple informants in implementation research, and in organizational research more generally. Each of the respondents in this study provided a unique perspective. While the perspectives offered at a given organization most often converged, it is undeniable that limiting the interviews to the CEOs and directors of programs would have yielded a skewed picture of implementation and quality improvement processes. Similarly, limiting the scope of inquiry to frontline workers would also have been a mistake, as many of them had limited

knowledge about the higher level strategic planning taking place at the agency. Scholars have previously emphasized the importance of having multiple respondents in management research (e.g., Bowman & Ambrosini, 1997), and this raises important questions about whether research focusing solely upon the perspectives of organizational leaders is likely to be accurate.

Use mixed methods approaches to studying implementation. In addition to the benefits derived from using multiple respondents, this study also demonstrates substantial benefit from using mixed methods approaches to studying implementation phenomena. Leading scholars have advocated for the use of qualitative and mixed methods approaches to implementation and quality improvement have advocated for the use of qualitative and mixed methods studies for good reason (e.g., Berwick, 2008; Institute of Medicine, 2007; Palinkas, Horwitz, et al., 2011). In the present study, qualitative methods provided rich descriptions of organizational contexts and implementation processes, which were complemented nicely by quantitative reports of implementation strategies. As measurement in implementation science advances, it may be possible to provide more accurate depictions of implementation strategy use quantitatively; however, this study would suggest that qualitative reflections of implementation processes are indispensable. This study also benefited tremendously from the use of a "gold standard" measure of organizational social context that has established national norms (Glisson et al., 2014; Glisson, Landsverk, et al., 2008). This enhanced the generalizability of the present inquiry by establishing where the agencies fell in relation to other organizations nationwide.

Limitations

There were a number of limitations related to the sample, the cross-sectional nature of these data, and measurement, each of which will be considered below.

Sample. There is some concern that the organizations in the sample were not comparable since they were not implementing the same programs and practices. One could argue that this renders the dependent variables in the study (strategy use, implementation decision making, and perceptions of implementation strategies) uninterpretable – a comparison of "apples to oranges." While this is a valid concern, there were several protections against this danger.

First, while there is evidence to suggest that specific programs and practices will require unique implementation strategies (see for instance, Isett et al., 2007), implementation strategies can also be viewed as more general components of an organization's infrastructure (Schoenwald et al., 2008). In fact, this view of implementation strategies may become more salient as we begin to shift the focus away from implementing solitary practices and toward fostering evidence-based systems and learning organizations capable of implementing a number of EBTs well (Chambers, 2012). Most organizations serve a wide range of individuals and families with complex and comorbid clinical conditions (Weisz et al., 2012), and thus need to implement not one, but a number of new treatments and programs in order to meet the clinical needs of their clientele. Since the evidence does not stop accumulating, it also means that organizations will have to "exnovate," or get rid of treatments that are obsolete or no longer effective (Glied, 2012). Creating learning organizations that are up to this task will likely necessitate a better understanding of the types of strategies that need to be institutionalized within organizations and systems. Thus, it will be important to determine the types of training and supervision structures, quality monitoring systems, and support systems are that are needed. Obtaining descriptive data about the types of implementation strategies that organizations are currently

using was a first step toward determining which strategies may need to be routinized in organizations and systems of care.

Second, the organizations in this sample had much in common in terms of client need, service provision, funding requirements, and other external or "outer setting" factors (Damschroder et al., 2009). Thus, while they may not have been implementing all of the same programs and practices, they were comparable in many other respects.

Finally, this study was primarily exploratory and developmental in nature. Its primary aims were to describe: 1) the range of strategies being used in usual care, 2) how organizational leaders make decisions about what to implement and how to implement it/them, 3) stakeholders' perceptions of implementation strategies, and 4) the impact of organizational culture and climate on the aforementioned aims. These aims were relevant for organizations that were implementing new practices as well as those that were not. Organizational variation in innovativeness was actually a good thing, as it afforded the opportunity to examine strategy use, implementation decision making, and perceptions of strategies in messy, real world settings. Ultimately, variation in strategy use is unlikely to be based upon the programs and practices alone, and the depth of understanding of each organization that this multiple case study afforded allowed other factors that contribute to variation to emerge.

Cross-sectional data. The cross-sectional nature of these data did not reveal how implementation processes change over time. Additionally, recall bias may have limited the accuracy of participants' memories of implementation processes. However, the use of multiple informants and the use of triangulation increased the validity of findings and minimized the threat of this bias (Wensing et al., 2005; Yin, 2009).

Measurement. Another challenge was the lack of existing surveys that could assess stakeholder perceptions of strategies; however, the web-based survey was informed by theories related to the intervention characteristics associated with increased adoption (Damschroder et al., 2009; Grol et al., 2007; Rogers, 2003), related surveys (Rabin et al., 2012), a taxonomy of implementation outcomes (Proctor et al., 2011), and other emerging measurement models (e.g., Cook et al., 2012). Lastly, while this study assessed the perceived effectiveness of strategies based upon stakeholders' self-reports, it did not assess the impact of strategies on the adoption of EBTs, fidelity, or clinical outcomes, as its primary purpose was to elucidate the *processes* of implementation in usual care. This study will inform future efforts to develop and test the effectiveness of implementation strategies that are responsive to stakeholder preferences *and* the capacities of service systems, which will involve assessing a wide range of implementation, service system, and clinical outcomes (Proctor et al., 2009, 2011).

Conclusion

This study makes a significant contribution to the implementation, mental health, and children's social service literatures by describing "implementation as usual" in children's social service organizations. While documenting a great deal of variation between organizations, this study demonstrated that implementation processes often fell short of best practices represented in the implementation and quality improvement literatures. Targeted investments at the practice, policy, and research levels could potentially strengthen the foundation for implementation in community based settings, propelling them toward the ideal of evidence-based systems of care.

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Appendix A: Recruitment Materials

Recruitment materials include: 1) a recruitment email addressed to agency directors, 2) a script that will be used when recruiting directors by phone, 3) a letter that administrators will sign to indicate that their employees' involvement in the study is strictly voluntary, 4) a recruitment email addressed to organizational leaders who will participate in the semi-structured interviews, 5) a script that will be used in recruiting leaders by phone, and 6) a recruitment email addressed to clinicians and direct care staff who will take part in the focus groups. All of these materials have been approved by Washington University in St. Louis' Institutional Review Board (IRB ID# 201204042).

Agency Director Recruitment Email

Dear (INSERT NAME),

We hope this letter finds you well. We are writing to invite you and members of your organization to participate in a research study that will be conducted within the context of the control group of the ARC project. The study is being conducted by Byron Powell, a PhD student at the Brown School, under the direction of Enola Proctor (Brown School) and Charles Glisson (University of Tennessee).

Though your organization is not receiving the ARC intervention, we know that your agency is not "standing still," and we would very much like to learn about how your organization is attempting to implement new programs and/or improve the quality of services that you provide. Accordingly, this study will examine: 1) the specific strategies that your organization has employed to implement new programs or to improve the quality of services that you offer, 2) your organization's approach to making decisions about the programs that will be adopted and how they will be implemented, 3) the implementation and quality improvement strategies that your organization has found to be particularly useful, and 4) how your organization's culture and climate (as measured for the ARC RCT) influences these processes and experiences. We believe that this study will contribute to a better understanding of the types of implementation and quality improvement strategies that organizations find to be effective, acceptable, and feasible in the "real world." We also hope that the study will shed light on the types of support that organizations may need to implement new programs and practices in order to improve the quality of their services.

Members of your agency could be involved in a range of study activities. For instance, 3 to 5 of your organizational leaders who are involved in implementation and quality improvement efforts may be asked to participate in a semi-structured interview that would last approximately 60-90 minutes, which would focus on the specific strategies that your agency has employed as well as your approaches to implementation decision making. Second, 6-8 clinicians and direct-care staff from your organization may be asked to participate in focus groups that explore their experiences and perceptions of a range of implementation or quality improvement strategies. Individuals who participate in semi-structured interviews or focus groups will receive $30.00 for their time. Additionally, all organizational leadership and clinical staff will also be invited to complete a survey that would capture their perceptions and experiences with specific implementation strategies. As a token of appreciation for their participation, they will receive a $5.00 Amazon.com gift card after completing the survey. Finally, your organization may have documents such as meeting notes, quality improvement plans, implementation manuals, and other sources that may provide the details of specific efforts to implement a new program or practice or to improve your organization in some way. With your permission, these documents will also be analyzed as a way of supplementing the knowledge that we gain from the interviews, focus groups, and survey methods. The informed consent document that describes the study as well as any potential risks and protections is attached for your review.

We believe that this study offers us a tremendous opportunity to learn more from you and to help you build "practice-based evidence" regarding your approaches to organizational

improvement. However, we want to emphasize that your participation is (of course) voluntary, and that it will in no way affect your standing as a participant in the ARC project. If you are willing to allow us to recruit participants from your agency, we will need two things from you. First, we ask that you sign a letter emphasizing the voluntary nature of participation for your employees. The text of the letter is attached to this email, and we would appreciate it if you would send us a signed copy of this letter on agency letterhead via email. Second, we would appreciate it if you could supply us with a contact list (emails and phone numbers) of agency practitioners so that we can contact them directly.

If you have any questions or would like to set up a time to talk about this study in more detail, please contact Byron Powell at (630) 730-1703 or bjpowell@wustl.edu. Thank you in advance for your consideration and for your ongoing support and participation in the ARC project. We will look forward to hearing from you.

Best Regards,

Byron Powell, AM Enola K. Proctor, PhD Charles Glisson, PhD

Agency Director Phone Script

My name is Byron Powell and I am a PhD student at the Brown School of Social Work at Washington University. I am calling to invite you to participate in a research study I am conducting under the direction of Dr. Enola Proctor and Dr. Charles Glisson. The study will take place within the context of the ARC study that your organization is currently participating in. Do you have a few minutes to talk? *(If yes, continue. If no, then leave contact information so that they can reach me at a more convenient time).*

Though your organization is not receiving the ARC intervention, we know that your agency is not "standing still," and we would very much like to learn about how your organization is attempting to implement new programs and/or improve the quality of services that you provide. Accordingly, this study will examine: 1) the specific strategies that your organization has employed to implement new programs or to improve the quality of services that you offer, 2) your organization's approach to making decisions about the programs that will be adopted and how they will be implemented, 3) the implementation and quality improvement strategies that your organization has found to be particularly useful, and 4) how your organization's culture and climate (as measured for the ARC RCT) influences these processes and experiences. We believe that this study will contribute to a better understanding of the types of implementation and quality improvement strategies that organizations find to be effective, acceptable, and feasible in the "real world." We also hope that the study will shed light on the types of support that organizations may need to implement new programs and practices in order to improve the quality of their services.

Members of your agency could be involved in a range of study activities. For instance, 3 to 5 of your organizational leaders who are involved in implementation and quality improvement efforts may be asked to participate in a semi-structured interview that would last approximately 60-90 minutes, which would focus on the specific strategies that your agency has employed as well as your approaches to implementation decision making. Second, 6-8 clinicians and direct-care staff from your organization may be asked to participate in focus groups that explore their experiences and perceptions of a range of implementation or quality improvement strategies. Individuals who participate in semi-structured interviews or focus groups will receive $30.00 for their time. Additionally, all organizational leadership and clinical staff will also be invited to complete a survey that would capture their perceptions and experiences with specific implementation strategies. As a token of appreciation for their participation, they will receive a $5.00 Amazon.com gift card after completing the survey. Finally, your organization may have documents such as meeting notes, quality improvement plans, implementation manuals, and other sources that may provide the details of specific efforts to implement a new program or practice or to improve your organization in some way. With your permission, these documents will also be analyzed as a way of supplementing the knowledge that we gain from the interviews, focus groups, and survey methods. The informed consent document that describes the study as well as any potential risks and protections is attached for your review.

We believe that this study offers us a tremendous opportunity to learn more from you and to help you build "practice-based evidence" regarding your approaches to organizational improvement. However, we want to emphasize that your participation is (of course) voluntary,

and that it will in no way affect your standing as a participant in the ARC project. If you are willing to allow us to recruit participants from your agency, we will need two things from you. First, we ask that you sign a letter emphasizing the voluntary nature of participation for your employees. The text of the letter is attached to this email, and we would appreciate it if you would send us a signed copy of this letter on agency letterhead via email. Second, we would appreciate it if you could supply us with a contact list (emails and phone numbers) of agency practitioners so that we can contact them directly.

If you have any questions or would like to set up a time to talk about this study in more detail, please contact me at (630) 730-1703 or bjpowell@wustl.edu. Thank you in advance for your consideration and for your ongoing support and participation in the ARC project. We will look forward to hearing from you.

Administrator Letter to Employees

Date

Dear Colleagues,

Our agency has agreed to participate with Washington University in a research project that involves semi-structured interviews, focus groups, and an online survey that will explore our experiences with implementing new programs and improving the quality of our organization. Byron Powell, a doctoral student at the Brown School of Social Work, is conducting the study under the direction of his faculty mentors Dr. Enola Proctor and Dr. Charles Glisson.

The study is affiliated with the ARC study that our organization has participated in since 2009; however, participation in this study is not a requirement of our participation in that trial. While I believe in the importance of this research and have given Mr. Powell permission to recruit employees from our organization, I want to emphasize the voluntary nature of your participation. Indeed, the choice to participate is yours entirely. There will be no consequence if you decide to decline to participate in the study, nor will there be any advantages given to employees who choose to participate. If a supervisor or other administrator has stated or implied you that you must participate in this study as part of your duties as an employee, please let me know so we can correct any misinformation that may exist about employees' participation in research efforts.

Thank You,

Name
Title

Organizational Leader Recruitment Email

Dear (INSERT NAME),

My name is Byron Powell and I am a PhD student at the Brown School of Social Work at Washington University. I am writing to invite you to participate in a research study that I am conducting under the direction of Dr. Enola Proctor and Dr. Charles Glisson. The purpose of the study is to learn more about how organizations attempt to implement new practices and to determine the types of implementation and quality improvement strategies that are most effective, acceptable, feasible, and appropriate in the "real world."

As a participant, you will be asked to complete a semi-structured interview lasting approximately 60-90 minutes. The interview will focus on the specific strategies that your organization has used to implement new practices and/or improve services. You will also be asked questions about how you make decisions about what programs and practices you implement and how you choose to implement them. You will be paid $30.00 for your time.

Attached you will find a letter from the director of your agency that emphasizes the voluntary nature of your participation. Additionally, you will find a copy of an informed consent form, which provides more information about the study and details your rights as a research participant as well as the risks and benefits of participation. If you have any questions about this study or would like to express your desire to participate, please contact me by email at bjpowell@wustl.edu or by phone at (630) 730-1703. Thank you in advance for your consideration.

Best,
Byron Powell

Byron J. Powell, AM, LCSW
Brown School of Social Work
Washington University
Campus Box 1196
One Brookings Drive
St. Louis, Missouri 63130

Organizational Leader Phone Script

My name is Byron Powell and I am a PhD student at the Brown School of Social Work at Washington University. I am calling to invite you to participate in a research study that I am conducting under the direction of Dr. Enola Proctor and Dr. Charles Glisson. Do you have a few minutes to talk? *(If yes, continue. If no, then leave contact information so that they can reach me at a more convenient time).*

The purpose of the study is to learn more about how organizations attempt to implement new practices and to determine the types of implementation and quality improvement strategies that are most effective, acceptable, feasible, and appropriate in the "real world." If you agree to participate, you will be asked to complete a semi-structured interview lasting approximately 60-90 minutes. The interview will focus on the specific strategies that your organization has used to implement new practices and/or improve services. You will also be asked questions about how you make decisions about what programs and practices you implement and how you choose to implement them. You will be paid $30.00 for your time.

The director of your agency is aware of this research; however, your participation in this research is entirely voluntary, and it will not impact your employment status positively or negatively. Actually, you will receive a signed letter from your agency director assuring you of the voluntary nature of your participation. You may have already received an email containing the letter from your agency director as well as a copy of an informed consent form, which details your rights as a research participant and the risks and benefits of participation. If you did not receive this email, I will gladly send you an email or hard copy of these documents.

Do you have any questions or concerns at this point? If this sounds like something you would like to participate in, you may let me know now and we can schedule a time to meet, or you may take some time to think about it and contact me at your earliest convenience. You may contact me at (630) 730-1703 or bjpowell@wustl.edu. Thank you so much for your time and consideration.

Focus Group Recruitment Email

Dear (INSERT NAME),

My name is Byron Powell and I am a PhD student at the Brown School of Social Work at Washington University. I am writing to invite you to participate in a research study that I am conducting under the direction of Dr. Enola Proctor and Dr. Charles Glisson. The purpose of the study is to learn more about how organizations attempt to implement new practices and to determine the types of implementation and quality improvement strategies that are most effective, acceptable, feasible, and appropriate in the "real world."

If you agree to participate, you will be asked to participate in a focus group with 6-8 peers from your organization. The focus group session will last approximately 60-90 minutes. During the session, you and your peers will be asked to reflect on some of the specific strategies that your organization has used to implement new practices and/or improve services. The overall purpose of the focus group is to obtain more information about the types of strategies that you and your peers have found to be most helpful and practical in your setting. You will be paid $30.00 for your time.

Attached you will find a letter from the director of your agency that emphasizes the voluntary nature of your participation. Additionally, you will find a copy of an informed consent form, which provides more information about the study and details your rights as a research participant as well as the risks and benefits of participation. If you have any questions about this study or would like to express your desire to participate, please contact me by email at bjpowell@wustl.edu or by phone at (630) 730-1703. Thank you in advance for your consideration.

Best,
Byron Powell

Byron J. Powell, AM, LCSW
Brown School of Social Work
Washington University
Campus Box 1196
One Brookings Drive
St. Louis, Missouri 63130

Appendix B: Consent Forms

The following informed consent form has been approved by Washington University in St. Louis' Institutional Review Board (IRB ID# 201204042). The reader will note that no information about the quantitative survey (as described in Aim 3) is included in the consent. Once the survey is formally developed, this author will request a waiver of written consent from the Institutional Review Board. Ultimately, informed consent language will precede the online survey, and the respondents' will indicate their consent by continuing to complete the online survey.

Consent Form

Project Title:	A Mixed Methods Multiple Case Study of Implementation as Usual in Children's Social Service Organizations
Principal Investigator:	Byron Powell
Research Team Contact:	Byron Powell Brown School of Social Work Washington University in St. Louis bjpowell@wustl.edu (630) 730-1703

You are invited to participate in a research study led by doctoral student Byron Powell under the direction of his faculty mentors, Dr. Enola Proctor (Washington University) and Dr. Charles Glisson. This consent form describes the research study and helps you decide if you want to participate. It provides important information about what you will be asked to do during the study, about the risks and benefits of the study, and about your rights as a research participant. If you have any questions about anything in this form, you should ask the research team for more information. You may also wish to talk to your family or friends about your participation in this study.

WHAT IS THE PURPOSE OF THIS STUDY?

We invite you to participate in this research study because your organization is participating in a National Institute of Mental Health funded study (led by Charles Glisson and Enola Proctor) that is testing an organizational implementation/quality improvement strategy called the Availability, Responsiveness, and Continuity (ARC) intervention. While your organization is not currently receiving the ARC intervention, we also know that your organization is not "standing still," and that we have much to learn from your organization's efforts to implement new practices and approaches to quality improvement.

The purpose of the study is to learn more about how children's social service organizations attempt to improve the quality of their services. The study will examine: 1) the specific strategies that your organization has employed to implement new programs or to improve the quality of services that you offer, 2) your organization's approach to making decisions about the programs that will be adopted and how they will be implemented, 3) the implementation and quality improvement strategies that your organization has found to be particularly useful, and 4) how your organization's culture and climate influences these processes and experiences. We believe that this study will contribute to a better understanding of the types of implementation and quality improvement strategies that organizations find to be effective, acceptable, and feasible in the "real world." We also hope that the study will shed light on the types of support that organizations may need to implement new programs and practices in order to improve the quality of their services.

WHAT WILL HAPPEN DURING THIS STUDY?

You may be asked to participate in an interview, a focus group, or an online survey depending upon your role in the organization. Additionally, this study will involve a review of documents (e.g., quality improvement plans, manuals of interventions or implementation strategies, implementation plans, etc.) that your organization deems pertinent to its implementation or quality improvement efforts.

Organizational Leaders

If you are an organizational leader (e.g., CEO/Director, Clinical Director, Quality Improvement Specialist, Clinical Supervisor, etc.) you may be asked to participate in a semi-structured interview in which you will be asked about how your organization makes decisions about what new programs or quality improvement initiatives to pursue as well as the specific strategies used to accomplish these initiatives. The interview will last approximately 60-90 minutes, and will take place in a private setting that is convenient to you (at your organization or Washington University). Though the questions you are asked will not be personal in nature, you are free to skip any question you do not wish to answer or to stop the interview at any time.

Clinicians and Direct-Care Staff

If you are a clinician or direct-care staff you may be asked to participate in a focus group with 6-8 peers from your organization. The purpose of the focus group is to explore your experiences and thoughts regarding specific implementation and quality improvement strategies. It will last approximately 60-90 minutes and will take place in a private conference room (at your organization or Washington University). You will be free to skip any questions that you do not wish to answer or leave the focus group at any time.

Audio/Video Recording or Photographs

One aspect of this study involves making audio recordings of the semi-structured and focus group interviews. These recordings will be made to ensure the accuracy of transcription, and no one outside of the study team will have access to them. They will be destroyed after this study is completed and all scholarly presentations and publications have been disseminated.

I give you permission to make audio recordings of me during this study.

_____ Yes **_____ No**
Initials **Initials**

HOW LONG WILL I BE IN THIS STUDY?

If you agree to take part in this study, your involvement will include a maximum of two contacts over a time period of about 16 months. The first contact may be your participation in *either* a semi-structured interview or a focus group, which will take 60-90 minutes to complete. The second contact would be the online survey, which will take approximately 15-25 minutes to complete. Thus, the total time investment in this study will be less than two hours *maximum* over the course of 16 months.

WHAT ARE THE RISKS OF THIS STUDY?

The risks of participating in this study are related to confidentiality and coercion, and we will

use several strategies to keep these risks very small. We will protect your confidentiality by holding interviews in private spaces and ensuring that both organizational leaders and clinicians/direct care staff have separate opportunities to share their experiences and perceptions. Furthermore, data from interviews will be immediately de-identified and stored on a secure network at Washington University.

To minimize the risk of coercion to participate, your organization's chief executive officer has provided a written agreement which states an unqualified commitment to your voluntary participation and emphasizes that there will be no repercussions should you choose not to participate. We are also seeking your consent to participate without management present.

WHAT ARE THE BENEFITS OF THIS STUDY?

There are no immediate tangible benefits to participating in this study, although we hope that you will find it helpful to reflect upon your experiences implementing new programs and improving the quality of your services through other means. Ultimately, we hope that this study will help to improve services and outcomes for the children, youth, and families served by your organization and others like it.

WILL I BE PAID FOR PARTICIPATING?

You will be paid for being in this research study. If you participate in either the semi-structured interview or focus group, you will receive a check for $30.00. If you participate in the online survey, you will receive a $5.00 Amazon.com gift card. You may need to provide your social security number (SSN) in order for us to pay you. You may choose to participate without being paid if you do not wish to provide your social security number (SSN) for this purpose. You may also need to provide your address if a check will be mailed to you. Please allow 3-6 weeks for delivery. Your social security number is obtained for payment purposes only, and will not be retained for research purposes.

HOW WILL YOU KEEP MY INFORMATION CONFIDENTIAL?

We will do everything we can to protect your privacy, and neither you nor your organization will be identified in any publication that may result from this study. In rare instances, a researcher's study must undergo an audit or program evaluation by Washington University or an external oversight agency (such as the Office for Human Research Protection). This may result in the disclosure of your data as well as any other information collected by the researcher. If this were to occur, such information would only be used to determine whether the research conducted this study properly and adequately protected your rights as a human participant. Importantly, any and all audits would maintain the confidentiality of any information reviewed by their office(s).

IS BEING IN THIS STUDY VOLUNTARY?

Taking part in this research study is completely voluntary. You may choose not to take part at all. If you decide to be in this study, you may stop participating at any time. If you decide not to be in this study, or if you stop participating at any time, you won't be penalized or lose any benefits for which you otherwise qualify.

WHAT IF I HAVE QUESTIONS?

We encourage you to ask questions. If you have any questions about the research study itself, or if you feel that you have been harmed in any way by your participation in this research, please contact Byron Powell at (630) 730-1703 or bjpowell@wustl.edu. You may also contact Mr. Powell's faculty mentor, Dr. Enola Proctor at (314) 935-6660 or Dr. Charles Glisson at (865) 974-0840.

If you have questions, concerns, or complaints about your rights as a research participant please contact the Human Research Protection Office, 660 South Euclid Avenue, Campus Box 8089, St. Louis, MO 63110, (314) 633-7400, or 1-(800)-438-0445 or email hrpo@wusm.wustl.edu.

I have read this consent form and have been given a chance to ask questions. I agree to participate in the research study described above, but understand that this form is not a contract and that I may choose not to participate at any time. I will receive a copy of this form for my records.

Do not sign this form if today's date is after

_____ _____

(Signature of Participant) (Date)

_____

(Participant's name – printed)

Statement of Person Who Obtained Consent

The information in this document has been discussed with the participant or, where appropriate, with the participant's legally authorized representative. The participant has indicated that he or she understands the risks, benefits, and procedures involved with participation in this research study.

_____ _____

(Signature of Person who Obtained Consent) (Date)

_____

(Name of Person who Obtained Consent - printed)

Appendix C: Data Collection Tools

This section includes a number of data collection tools, including: 1) the demographic survey, 2) the semi-structured interview guide, 3) the focus group interview guide, 4) the document review data collection guide and form, 5) the project-specific Implementation Strategy Use and Perceptions Survey, and 6) the Organizational Social Context (OSC) measure. The Washington University in St. Louis Institutional Review Board has approved all of the data collection tools (IRB ID# 201204042) with the exception of the document review data collection guide and form and the quantitative survey that will be informed by the interviews and focus groups.

Demographic Survey

Thank you for being a part of this research study. We would like to find out a little about the participants by having you answer the following questions. Please choose only one answer for each question. Circle the number which goes with each answer you choose. For instance, for question 2 if you are male circle "1" and if you are female circle "2".

1. How old are you right now?

_____
YEARS

2. What is your gender?

Male	1
Female	2

3. What is the highest level of education you have finished?

Bachelor's	1
Master's degree	2
Doctoral degree (please provide details, e.g.: PhD, PsyD, etc.)	3
_____	
Other (please provide details)	4
_____	

4. What was your field of study?

_____
FIELD OF STUDY

5. How do you usually describe yourself?

Alaska Native/Eskimo/Aleut	1
American Indian	2
Asian or Asian-American	3
Black	
African American	4
Caribbean or West Indian	5
Other: _____	6
Middle Eastern	7
Pacific Islander	8
White, Caucasian	9

		Biracial or Multiracial:_____	10
		Other:_____	11
6.	Are you of Hispanic or Latino origin?	No	0
		Yes	1
7.	How many years of paid experience do you have in the field of children's social services?	_____ YEARS	
8.	How long have you been employed at your agency?	_____ MONTHS	
		_____ YEARS	
9.	What is your current job title?		
10.	Is this a full-time or part-time position?	Full-time	0
		Part-time	1

Semi-Structured Interview Guide

Thank you for taking the time to meet with me. As you are aware, this study focuses on implementation and quality improvement in mental health. I am going to ask you a series of questions regarding your organization's efforts to improve care by implementing new programs. I'm interested in how your organization makes decisions about *what* programs and practices to implement and *how* they should be implemented (i.e., the deliberate processes that should be used to integrate a particular program or practice). Thus, I will ask you a series of questions about your decision making processes as well as the specific implementation strategies that your organization has used over the course of the last year or so. I will ask you to be as specific as possible regarding the content of the implementation strategies that you used. For instance, though it would be helpful to know that your organization trains clinicians in a new program, it would be more helpful to know the basic components of that training and details about its frequency, duration, and intensity. I will also remind you throughout the interview to be explicit about the programs and practices you are referring to (if there are more than one), as well as the different stages or phases of implementation that you are referring to (e.g., pre-implementation vs. sustainability monitoring). It is expected that there will be details that you are not aware of or can't recall, and it also may be the case that another organizational leader or employee is better equipped to provide this information. Thus, after the interview, I will ask you if there are other people within your organization that I should also interview if given the opportunity. We are thrilled to be able to learn from your experiences, and we hope that this study contributes to future research developing implementation strategies that will be more effective and helpful to organizational leaders like yourself. Thus, as you reflect upon your experiences implementing new programs and practices, please be as frank as possible about what works, what doesn't, and the pragmatic constraints that you face as a leader in children's mental health.

Question	**Possible Prompts**
Program(s) or Practice(s) Implemented	
-Can you tell me about a new practice or set of practices that your organization has implemented in the past year or so? If your organization has implemented a wide range of practices, I will ask you to focus on the implementation of a single practice or 2-3 practices with similar characteristics.	
Implementation Decision Making (EBT or Practice Related)	
-How did your organization decide to implement the practice(s) or program(s)?	
-What types of information or "evidence" did you seek to inform your decisions?	
-Which types of information or "evidence" were most important to your decision making process?	
Implementation Decision Making (Processes and Strategies)	
-After you decided to implement the practice or program, what factors were considered when you thought about how to implement it	-How did you plan for implementation? -Who was involved in this process? -Was there a formal evaluation of

within your organization?	organizational performance prior to and after implementation? -Did your organization rely upon any formal models of implementation or quality improvement? -Was there a formal plan developed and documented? -If not, what were the guiding principles that informed your implementation processes? -Were there any plans for assessing or reevaluating the implementation process?
-What types of information or "evidence" did you seek to inform your decision about how to approach implementation? -Where did you seek this information?	
-Which types of information were most important in guiding your decisions about how to approach implementation?	
Implementation Strategies	
-How did the organization implement the new program(s) (i.e., what implementation strategies did you use)? -Has your organization used any additional strategies to implement programs and practices that we have not discussed today? -Did you find that different practices required the use of unique implementation strategies?	*Probe for specifics of implementation strategies/processes:* Could provide specific examples from Powell and colleagues' compilation of implementation strategies to sensitize participants to the notion of implementation strategies. Could ask if they used strategies that addressed any of the following: -The intervention itself (e.g., selecting or adapting interventions to maximize fit with your organization) -The policy or inter-organizational level (e.g., policies and incentives, leveraging peer-pressure to implement the intervention?) -Your organizations' structure and functioning (e.g., culture, climate, networks and communication, organizational incentives and awards) -Involved individuals such as clinicians and clients (e.g., knowledge, self-efficacy, individual stage of change) -Process elements (e.g., planning, engaging, executing, reflecting and

	evaluating)
The Perceived Effectiveness of Implementation Strategies (i.e., "Practice-Based Evidence")	
-In your experience, have some implementation strategies been more or less effective than others? If so, which strategies have been particularly effective? Ineffective?	
-Have you found certain implementation strategies to be more acceptable, feasible, and sustainable than others?	
Wrap-Up (Other)	
-What advice would you give to others who might lead their organizations in the implementation process?	
-Is there anything else that you would like to share related to your experiences with implementation or anything else that we have discussed today?	

Focus Group Interview Guide

Thank you so much for taking the time to participate today. As you are aware, this research project focuses on efforts to improve the quality of children's mental health care by implementing evidence-based programs and practices. We are interested in your experiences with implementation process. The majority of this focus group will focus on implementation strategies, or the deliberate processes by which your organization has attempted to integrate a particular program or practice. Thus, a series of questions will be posed to give us a common reference by which to discuss your experiences and perceptions relative to specific implementation strategies. Your "practice-based evidence" will inform future research focused on the development of implementation strategies that will hopefully make implementation and service delivery more effective. This will be a free-flowing discussion, so please feel free to share your thoughts, questions, and concerns throughout the process.

Question	**Possible Prompts and Other Instructions**
Program(s) or Practice(s) Implemented	
-Could you please talk about something that [insert organization] has tried to implement in the past year or so?	Facilitator could mention specific programs or practices that were discussed as being implemented in earlier phases of this research (i.e. in semi-structured interviews).
Implementation Strategies	
-How did your organization attempt to implement this program or practice (i.e., what specific strategies were used)?	*Probe for specifics of implementation strategies/processes.* Have group discuss a range of implementation strategies, writing them down so that they are visible to the entire group. Could provide specific examples from Powell and colleagues' compilation of implementation strategies and/or a list of strategies that were identified by organizational leaders in that agency in order to sensitize participants to the notion of implementation strategies.
Relative Importance (Effectiveness) of Implementation Specific Implementation Strategies	
-Of the strategies you listed, could you talk about those that have been most critical to the successful implementation of a program or practice? -Were some strategies more or less useful depending upon the stage of implementation (e.g., early vs. late, planning vs. sustaining)? -Why were they so important?	
-Conversely, have some of the strategies listed been ineffectual or simply less helpful to you? -Why was this the case?	

Acceptability	
-Are any of the strategies listed simply more agreeable, palatable, or satisfactory to you?	
Feasibility	
-Did any of the strategies listed sound good *in theory*, but prove to not as helpful *in practice*?	
Appropriateness	
-Do some of the strategies listed simply fit your organization better than others?	
Wrap-Up	
-Are there other things that you would like to share with me related to your experience of implementation and implementation strategies?	

Document Review Data Collection Guide and Form

- Ask the agency director to identify individuals who have access to documents related to implementation.
- Ask if it would be possible to set up times to discuss the documents and tell the site liaison and others in advance that you would like to have copies of some key documents, if possible, as long is there is no client identifying information.
- Ask how and when the documents were developed.
- Take detailed notes regarding the purpose and use of the documents.

Agency: _____ Date: _____

Participant ID: _____

Document reviewed: _____

Purpose and use of the document(s): Results from document:

The Organizational Social Context (OSC) Measure

Organizational Social Context (OSC) Measurement System

The University of Tennessee Children's Mental Health Services Research Center

		Not at all	A slight extent	A moderate extent	A great extent	A very great extent
1	How often do your coworkers show signs of stress	O	O	O	O	O
2	I have to ask a supervisor or coordinator before I do almost anything	O	O	O	O	O
3	I really care about the fate of this organization	O	O	O	O	O
4	I can easily create a relaxed atmosphere with the clients I serve	O	O	O	O	O
5	Members of my organizational unit are expected to have up-to-date knowledge	O	O	O	O	O
6	How often does your job interfere with your family life	O	O	O	O	O
7	I understand how my performance will be evaluated	O	O	O	O	O
8	How satisfied are you with the chance to do something that makes use of your abilities	O	O	O	O	O
9	Members of my organizational unit are expected to avoid being different	O	O	O	O	O
10	I feel like I'm at the end of my rope	O	O	O	O	O
11	I am willing to put in a great deal of effort in order to help this organization be successful	O	O	O	O	O
12	I feel exhilarated after working closely with the clients I serve	O	O	O	O	O
13	Members of my organizational unit are expected to be critical	O	O	O	O	O
14	The same procedures are to be followed in most situations	O	O	O	O	O
15	A person can make his or her own decisions without checking with anyone else	O	O	O	O	O
16	I feel I treat some of the clients I serve as impersonal objects	O	O	O	O	O
17	Members of my organizational unit are expected to improve the well-being of each client	O	O	O	O	O
18	I have accomplished many worthwhile things in this job	O	O	O	O	O
19	How satisfied are you with the chances for advancement	O	O	O	O	O
20	Once I start an assignment, I am not given enough time to complete it	O	O	O	O	O
21	Members of my organizational unit are expected to evaluate how much we benefit clients	O	O	O	O	O
22	To what extent are the objectives and goals of your position clearly defined	O	O	O	O	O
23	This agency provides numerous opportunities to advance if you work for it	O	O	O	O	O
24	We usually work under the same circumstances day to day	O	O	O	O	O
25	Members of my organizational unit are expected to stay uninvolved	O	O	O	O	O
26	I deal very effectively with the problems of the clients I serve	O	O	O	O	O
27	My job responsibilities are clearly defined	O	O	O	O	O
28	I am proud to tell others that I am part of this organization	O	O	O	O	O
29	Members of my organizational unit are expected to criticize mistakes	O	O	O	O	O
30	How satisfied are you with the freedom to use your own judgment	O	O	O	O	O
31	This agency emphasizes growth and development	O	O	O	O	O
32	When I face a difficult task, the people in my agency help me out	O	O	O	O	O
33	Members of my organizational unit are expected to place the well-being of clients first	O	O	O	O	O
34	I find that my values and the organization's values are very similar	O	O	O	O	O
35	People here always get their orders from higher up	O	O	O	O	O
36	No matter how much I do, there is always more to be done	O	O	O	O	O
37	Members of my organizational unit are expected to find ways to serve clients more effectively	O	O	O	O	O
38	I know what the people in my agency expect of me	O	O	O	O	O
39	I feel fatigued when I get up in the morning and have to face another day on the job	O	O	O	O	O
40	To what extent do your coworkers trust each other	O	O	O	O	O
41	Members of my organizational unit are expected to avoid problems	O	O	O	O	O
42	How satisfied are you with the feeling of accomplishment you get from your job	O	O	O	O	O
43	There is only one way to do the job - the boss's way	O	O	O	O	O
44	This agency rewards experience, dedication and hard work	O	O	O	O	O
45	Members of my organizational unit are expected to be stern and unyielding	O	O	O	O	O
46	We are to follow strict operating procedures at all times	O	O	O	O	O
47	I feel used up at the end of the workday	O	O	O	O	O
48	I feel I'm positively influencing other people's lives through my work	O	O	O	O	O
49	Members of my organizational unit are expected to act in the best interest of each client	O	O	O	O	O
50	People here do the same job in the same way everyday	O	O	O	O	O
51	Members of my organizational unit are expected to become more effective in serving clients	O	O	O	O	O
52	I talk up this organization to my friends as a great organization to work for	O	O	O	O	O

		Not at all	A slight extent	A moderate extent	A great extent	A very great extent
53	In my work, I am calm in dealing with the emotional problems of others	O	O	O	O	O
54	Members of my organizational unit are expected to be competitive with coworkers	O	O	O	O	O
55	How satisfied are you with the prestige your job has within the community	O	O	O	O	O
56	Whenever we have a problem, we are supposed to go to the same person for an answer	O	O	O	O	O
57	There can be little action until a supervisor or coordinator approves the decision	O	O	O	O	O
58	Members of my organizational unit are expected to go along with group decisions	O	O	O	O	O
59	I feel burned out from my work	O	O	O	O	O
60	I have become more callous towards people since I took this job	O	O	O	O	O
61	Any decision I make has to have a supervisor's or coordinator's approval	O	O	O	O	O
62	Members of my organizational unit are expected to strive for excellence	O	O	O	O	O
63	Rules and regulations often get in the way of getting things done	O	O	O	O	O
64	How satisfied are you with being able to do things the right way	O	O	O	O	O
65	Interests of the clients are often replaced by bureaucratic concerns (e.g., paperwork)	O	O	O	O	O
66	Members of my organizational unit are expected to interact positively with others	O	O	O	O	O
67	There is a feeling of cooperation among my coworkers	O	O	O	O	O
68	To what extent is it possible to get accurate information on policies and administrative procedures	O	O	O	O	O
69	How satisfied are you with the chance to try your own approaches to working with clients	O	O	O	O	O
70	Members of my organizational unit are expected to learn new tasks	O	O	O	O	O
71	How well are you kept informed about things that you need to know	O	O	O	O	O
72	How often is there friction among your coworkers	O	O	O	O	O
73	To what extent are you constantly under heavy pressure on your job	O	O	O	O	O
74	Members of my organizational unit are expected to follow rather than lead	O	O	O	O	O
75	How satisfied are you with the chance to do things for clients	O	O	O	O	O
76	This organization really inspires the very best in me in the way of job performance	O	O	O	O	O
77	I have to do things on my job that are against my better judgment	O	O	O	O	O
78	Members of my organizational unit are expected to be dominant and assertive	O	O	O	O	O
79	There are not enough people in my agency to get the work done	O	O	O	O	O
80	There are more opportunities to advance in this agency than in other jobs in general	O	O	O	O	O
81	How often do you end up doing things that should be done differently	O	O	O	O	O
82	Members of my organizational unit are expected to be available to each client we serve	O	O	O	O	O
83	The amount of work I have to do keeps me from doing a good job	O	O	O	O	O
84	I am extremely glad that I chose to work for this organization	O	O	O	O	O
85	How things are done around here is left pretty much up to the person doing the work	O	O	O	O	O
86	Members of my organizational unit are expected to pay attention to details	O	O	O	O	O
87	I feel emotionally drained from my work	O	O	O	O	O
88	It's hard to feel close to the clients I serve	O	O	O	O	O
89	How satisfied are you with the recognition you get for doing a good job	O	O	O	O	O
90	Members of my organizational unit are expected to not make waves	O	O	O	O	O
91	The same steps must be followed in processing every piece of work	O	O	O	O	O
92	How often do you have to bend a rule in order to carry out an assignment	O	O	O	O	O
93	I worry that this job is hardening me emotionally	O	O	O	O	O
94	Members of my organizational unit are expected to be number one	O	O	O	O	O
95	I feel I'm working too hard on my job	O	O	O	O	O
96	How often do you feel unable to satisfy the conflicting demands of your supervisors	O	O	O	O	O
97	For me this is the best of all possible organizations to work for	O	O	O	O	O
98	Members of my organizational unit are expected to plan for success	O	O	O	O	O
99	I feel that I am my own boss in most matters	O	O	O	O	O
100	Members of my organizational unit are expected to be thoughtful and considerate	O	O	O	O	O
101	Opportunities for advancement in my position are much higher compared to those in other positions	O	O	O	O	O
102	Members of my organizational unit are expected to defeat the competition	O	O	O	O	O
103	At times, I find myself not really caring about what happens to some of the clients	O	O	O	O	O
104	Inconsistencies exist among the rules and regulations that I am required to follow	O	O	O	O	O
105	Members of my organizational unit are expected to be responsive to the needs of each client	O	O	O	O	O

Implementation Strategy Use and Perceptions Survey

Introduction

You are invited to participate in a research study led by doctoral candidate Byron Powell under the direction of his faculty mentors, Dr. Enola Proctor and Dr. Charles Glisson. The purpose of the study is to learn more about how children's social service organizations attempt to improve the quality of their services. We believe that this study will contribute to a better understanding of the types of implementation and quality improvement strategies that organizations find to be effective, acceptable, and feasible in the "real world." We also hope that the study will shed light on the types of support that organizations may need to implement new programs and practices in order to improve the quality of their services.

We are inviting you to participate because you are an organizational leader or direct service provider at a participating organization, and we are eager to learn more about your perceptions of implementation and quality improvement strategies. We obtained your name and address through your previous participation in this study or from an organizational leader at your organization. Approximately 100-125 people will be invited to complete this portion of the study.

If you agree to participate, we would like you to complete the following online survey. The survey focuses on the types of implementation and quality improvement strategies that have been used by your organization in the past 1-2 years, as well as on your perceptions about those strategies. It should take you approximately 20 minutes to complete. Your name and email will be linked to your responses for the purposes of data management and to enable the processing of incentives. However, any data that is shared with your organization will be in aggregate form (i.e., it will include all of the responses from individuals within your organization or across the entire study); thus, your individual responses will not be identifiable. If you choose not to participate, you may simply select "no" and then the "next" button. Selecting "yes" will allow you to access the survey questions. If you do not complete the survey and do not opt out by selecting "no", you will receive three reminders, which will be sent one week, two weeks, and three weeks after the initial invitation.

There are no known risks from being in this study, and no immediate personal benefits. However we hope that others may benefit in the future from what we learn as a result of this study. Taking part in this research study is completely voluntary. If you decide not to complete this survey study, you won't be penalized or lose any benefits for which you otherwise qualify. As a small token of our appreciation for completing this survey, a $10.00 Amazon gift card will be emailed to you.

Should you have any questions, you may contact Byron Powell at bjpowell@wustl.edu or 630-730-1703. If you have questions about the rights of research participants or want to speak with someone other than the research staff, please contact the Human Research Protection Office, 660 S. Euclid Ave., Campus Box 8089, St. Louis, MO 63110, (314) 633-7400, or 1-(800)-438-0445 or email hrpo@wusm.wustl.edu. Thank you very much for your consideration!

Consent to Participate

Would you like to participate in this survey?

- o Yes
- o No

Demographic Questions

D1) How old are you right now (years)?

D2) What is your gender identity?

D3) What is the highest level of education that you have completed?
- Bachelor's Degree
- Master's Degree
- Doctoral Degree
- Other _____

D4) What was the field of study for your highest degree?

D5) How do you usually describe yourself?
- Alaska Native/Eskimo/Aleut
- American Indian
- Asian or Asian-American
- Black or African American
- Middle Eastern
- Pacific Islander
- White
- Multiracial
- Other _____

D6) Are you of Hispanic or Latino origin?
- Yes
- No

D7) How many years of paid experience do you have in the social services field (years and months)?

D8) How long have you been employed at your agency (years and months)?

D9) What is your current job title?

D10) Are you currently employed part or full-time?
- Part-time
- Full-time

Implementation Strategy Use Questions

You will now be asked a series of questions about the strategies your organization has used to implement new programs and practices and/or improve the quality of your services within the last year or so. Before you answer these questions, please list the program(s) and practice(s) that you have been involved in implementing (e.g., trauma-focused CBT, case management services, outpatient therapy, etc.).

S1) Access New Funding - Access new or existing money to facilitate the implementation.

We have used this strategy at our organization
We have not used this strategy at our organization

S2) Alter Incentive/Allowance Structures - Work to financially incentivize the adoption and implementation of the clinical innovation

We have used this strategy at our organization
We have not used this strategy at our organization

S3) Assess for Readiness and Identify Barriers and Facilitators - Assess various aspects of an organization to determine its degree of readiness to implement, barriers that may impede implementation, and strengths that can be used in the implementation effort.

We have used this strategy at our organization
We have not used this strategy at our organization

S4) Audit and Provide Feedback - Collect and summarize clinical performance data over a specified period and give it to clinicians and administrators to monitor, evaluate, and modify provider behavior.

We have used this strategy at our organization
We have not used this strategy at our organization

S5) Build a Coalition - Recruit and cultivate relationships with partners in the implementation effort.

We have used this strategy at our organization
We have not used this strategy at our organization

S6) Capture and Share Local Knowledge - Capture local knowledge from implementation sites on how implementers and clinicians made something work in their setting and then share it with other sites.

We have used this strategy at our organization
We have not used this strategy at our organization

S7) Change Physical Structure and Equipment - Evaluate current configurations and adapt, as needed, the physical structure and/or equipment (e.g., changing the layout of a room, adding equipment) to best accommodate the targeted innovation.

We have used this strategy at our organization
We have not used this strategy at our organization

S8) Change Record Systems - Change records systems to allow better assessment of implementation or of outcomes of the implementation.

We have used this strategy at our organization
We have not used this strategy at our organization

S9) Change Service Sites - Change the location of clinical service sites to increase access.

We have used this strategy at our organization
We have not used this strategy at our organization

S10) Conduct Cyclical Small Tests of Change - Implement changes in a cyclical fashion using small tests of change before taking changes system wide. Results of the tests of change are studied for insights on how to do better. This process continues serially over time and refinement is added with each cycle.

We have used this strategy at our organization
We have not used this strategy at our organization

S11) Conduct Educational Meetings - Hold meetings targeted toward different stakeholder groups (e.g., providers, administrators, other organizational stakeholders, and community, patient/consumer, and family stakeholders) to teach them about the clinical innovation.

We have used this strategy at our organization
We have not used this strategy at our organization

S12) Conduct Educational Outreach Visits - Have a trained person meet with providers in their practice settings to educate providers about the clinical innovation with the intent of changing the providers' practice.

We have used this strategy at our organization
We have not used this strategy at our organization

S13) Conduct Local Consensus Discussions - Include local providers and other stakeholders in discussions that address whether the chosen problem is important and whether the clinical innovation to address it is appropriate.

We have used this strategy at our organization
We have not used this strategy at our organization

S14) Conduct Local Needs Assessment - Collect and analyze data related to the need for the innovation.

We have used this strategy at our organization
We have not used this strategy at our organization

S15) Conduct Ongoing Training - Plan for and conduct training in the clinical innovation in an ongoing way.

We have used this strategy at our organization
We have not used this strategy at our organization

S16) Create a Learning Collaborative - Facilitate the formation of groups of providers or provider organizations and foster a collaborative learning environment to improve implementation of the clinical innovation.

We have used this strategy at our organization
We have not used this strategy at our organization

S17) Create New Clinical Teams - Change who serves on the clinical team, adding different disciplines and different skills to make it more likely that the clinical innovation is delivered or more successful.

We have used this strategy at our organization
We have not used this strategy at our organization

S18) Develop a Formal Implementation Blueprint - Develop a formal implementation blueprint that includes all goals and strategies. The blueprint should include: 1) aim/purpose of the implementation; 2) scope of the change (e.g., what organizational units are affected); 3) timeframe and milestones; and 4) appropriate performance/progress measures. Use and update this plan to guide the implementation over time.

We have used this strategy at our organization
We have not used this strategy at our organization

S19) Develop Academic Partnerships - Partner with a university or academic unit for the purposes of shared training and bringing research skills to an implementation project.

We have used this strategy at our organization
We have not used this strategy at our organization

S20) Develop an Implementation Glossary - Develop and distribute a list of terms describing the innovation, implementation, and the stakeholders in the organizational change.

We have used this strategy at our organization
We have not used this strategy at our organization

S21) Develop and Organize Quality Monitoring Systems - Develop and organize systems and procedures that monitor clinical processes and/or outcomes for the purpose of quality assurance and improvement.

We have used this strategy at our organization
We have not used this strategy at our organization

S22) Develop Educational Materials - Develop and format manuals, toolkits, and other supporting materials in ways that make it easier for stakeholders to learn about the innovation and for clinicians to learn how to deliver the clinical innovation.

We have used this strategy at our organization
We have not used this strategy at our organization

S23) Develop Resource Sharing Agreements - Develop partnerships with organizations that have resources needed to implement the innovation.

We have used this strategy at our organization
We have not used this strategy at our organization

S24) Distribute Educational Materials - Distribute educational materials (including guidelines, manuals, and toolkits) in person, by mail, and/or electronically.

We have used this strategy at our organization

We have not used this strategy at our organization

S25) Identify and Prepare Champions - Identify and prepare individuals who dedicate themselves to supporting, marketing, and driving through an implementation, overcoming indifference or resistance that the intervention may provoke in an organization.

We have used this strategy at our organization

We have not used this strategy at our organization

S26) Increase Demand - Attempt to influence the market for the clinical innovation to increase competition intensity and to increase the maturity of the market for the clinical innovation.

We have used this strategy at our organization

We have not used this strategy at our organization

S27) Inform Local Opinion Leaders - Inform providers identified by colleagues as opinion leaders or "educationally influential" about the clinical innovation in the hopes that they will influence colleagues to adopt it.

We have used this strategy at our organization

We have not used this strategy at our organization

S28) Intervene with Patients/Consumers to Enhance Uptake and Adherence - Develop strategies with patients to encourage and problem solve around adherence.

We have used this strategy at our organization

We have not used this strategy at our organization

S29) Involve Executive Boards - Involve existing governance structures (e.g., boards of directors, medical staff boards of governance) in the implementation effort, including the review of data on implementation processes.

We have used this strategy at our organization

We have not used this strategy at our organization

S30) Make Billing Easier - Make it easier to bill for the clinical innovation. This might involve requiring less documentation, "block" funding for delivering the innovation, and creating new billing codes for the innovation.

We have used this strategy at our organization

We have not used this strategy at our organization

S31) Make Training Dynamic - Vary the information delivery methods to cater to different learning styles and work contexts, and shape the training in the innovation to be interactive.

We have used this strategy at our organization

We have not used this strategy at our organization

S32) Mandate Change - Have leadership declare the priority of the innovation and determination to have it implemented.

We have used this strategy at our organization
We have not used this strategy at our organization

S33) Obtain and Use Patients/Consumers and Family Feedback - Develop strategies to increase patient/consumer and family feedback on the implementation effort.

We have used this strategy at our organization
We have not used this strategy at our organization

S34) Obtain Formal Commitments - Obtain written commitments from key partners that state what they will do to implement the innovation.

We have used this strategy at our organization
We have not used this strategy at our organization

S35) Organize Clinician Implementation Team Meetings - Develop and support teams of clinicians who are implementing the innovation and give them protected time to reflect on the implementation effort, share lessons learned, and support one another's learning.

We have used this strategy at our organization
We have not used this strategy at our organization

S36) Provide Clinical Supervision - Provide clinicians with ongoing supervision focusing on the innovation. Provide training for clinical supervisors who will supervise clinicians who provide the innovation.

We have used this strategy at our organization
We have not used this strategy at our organization

S37) Provide Local Technical Assistance - Develop and use a system to deliver technical assistance focused on implementation issues using local personnel.

We have used this strategy at our organization
We have not used this strategy at our organization

S38) Provide ongoing consultation – Provide ongoing consultation with one or more experts in the strategies used to support implementing the innovation.

We have used this strategy at our organization
We have not used this strategy at our organization

S39) Purposefully Reexamine the Implementation - Monitor progress and adjust clinical practices and implementation strategies to continuously improve the quality of care.

We have used this strategy at our organization
We have not used this strategy at our organization

S40) Recruit, Designate, and Train for Leadership - Recruit, designate, and train leaders for the change effort.

We have used this strategy at our organization
We have not used this strategy at our organization

S41) Remind Clinicians - Develop reminder systems designed to help clinicians to recall information and/or prompt them to use the clinical innovation.

We have used this strategy at our organization
We have not used this strategy at our organization

S42) Revise Professional Roles - Reassess and revise roles among professionals who provide care and redesign job characteristics. This includes the expansion of roles to cover provision of the clinical innovation and the elimination of service barriers to care, including personnel policies.

We have used this strategy at our organization
We have not used this strategy at our organization

S43) Shadow Other Experts - Provide ways for key individuals to directly observe experienced people engage with or use the targeted practice change/innovation.

We have used this strategy at our organization
We have not used this strategy at our organization

S44) Stage Implementation Scale Up - Phase implementation efforts by starting with small pilots or demonstration projects and gradually moving to system wide rollout.

We have used this strategy at our organization
We have not used this strategy at our organization

S45) Tailor Strategies - Tailor the implementation strategies to address barriers and leverage facilitators that were identified through earlier data collection.

We have used this strategy at our organization
We have not used this strategy at our organization

S46) Use Advisory Boards and Workgroups - Create and engage a formal group of multiple kinds of stakeholders to provide input and advice on implementation efforts and to elicit recommendations for improvements.

We have used this strategy at our organization
We have not used this strategy at our organization

S47) Use an Implementation Advisor - Seek guidance from experts in implementation. This could include consultation with outside experts such as university-affiliated faculty members, or hiring quality improvement experts or implementation professionals.

We have used this strategy at our organization
We have not used this strategy at our organization

S48) Use Data Experts - Involve, hire, and/or consult experts to inform management and use of data generated by implementation efforts.

We have used this strategy at our organization
We have not used this strategy at our organization

S49) Use Train-the-Trainer Strategies - Train designated clinicians or organizations to train others in the clinical innovation.

We have used this strategy at our organization
We have not used this strategy at our organization

S50) Visit Other Sites – Visit sites where a similar effort has been considered.

We have used this strategy at our organization
We have not used this strategy at our organization

Practice-Based Evidence Questions
You will now be asked a series of questions about the effectiveness, feasibility, and compatibility of the strategies that you endorsed as having been used by your organization in the past year or two.

P1) Access New Funding - Access new or existing money to facilitate the implementation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P2) Alter Incentive/Allowance Structures - Work to financially incentivize the adoption and implementation of the clinical innovation

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P3) Assess for Readiness and Identify Barriers and Facilitators - Assess various aspects of an organization to determine its degree of readiness to implement, barriers that may impede implementation, and strengths that can be used in the implementation effort.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P4) Audit and Provide Feedback - Collect and summarize clinical performance data over a specified period and give it to clinicians and administrators to monitor, evaluate, and modify provider behavior.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P5) Build a Coalition - Recruit and cultivate relationships with partners in the implementation effort.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P6) Capture and Share Local Knowledge - Capture local knowledge from implementation sites on how implementers and clinicians made something work in their setting and then share it with other sites.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P7) Change Physical Structure and Equipment - Evaluate current configurations and adapt, as needed, the physical structure and/or equipment (e.g., changing the layout of a room, adding equipment) to best accommodate the targeted innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P8) Change Record Systems - Change records systems to allow better assessment of implementation or of outcomes of the implementation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P9) Change Service Sites - Change the location of clinical service sites to increase access.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P10) Conduct Cyclical Small Tests of Change - Implement changes in a cyclical fashion using small tests of change before taking changes system wide. Results of the tests of change are studied for insights on how to do better. This process continues serially over time and refinement is added with each cycle.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P11) Conduct Educational Meetings - Hold meetings targeted toward different stakeholder groups (e.g., providers, administrators, other organizational stakeholders, and community, patient/consumer, and family stakeholders) to teach them about the clinical innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P12) Conduct Educational Outreach Visits - Have a trained person meet with providers in their practice settings to educate providers about the clinical innovation with the intent of changing the providers' practice.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P13) Conduct Local Consensus Discussions - Include local providers and other stakeholders in discussions that address whether the chosen problem is important and whether the clinical innovation to address it is appropriate.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P14) Conduct Local Needs Assessment - Collect and analyze data related to the need for the innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P15) Conduct Ongoing Training - Plan for and conduct training in the clinical innovation in an ongoing way.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P16) Create a Learning Collaborative - Facilitate the formation of groups of providers or provider organizations and foster a collaborative learning environment to improve implementation of the clinical innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P17) Create New Clinical Teams - Change who serves on the clinical team, adding different disciplines and different skills to make it more likely that the clinical innovation is delivered or more successful.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P18) Develop a Formal Implementation Blueprint - Develop a formal implementation blueprint that includes all goals and strategies. The blueprint should include: 1) aim/purpose of the implementation; 2) scope of the change (e.g., what organizational units are affected); 3) timeframe and milestones; and 4) appropriate performance/progress measures. Use and update this plan to guide the implementation over time.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P19) Develop Academic Partnerships - Partner with a university or academic unit for the purposes of shared training and bringing research skills to an implementation project.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P20) Develop an Implementation Glossary - Develop and distribute a list of terms describing the innovation, implementation, and the stakeholders in the organizational change.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P21) Develop and Organize Quality Monitoring Systems - Develop and organize systems and procedures that monitor clinical processes and/or outcomes for the purpose of quality assurance and improvement.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P22) Develop Educational Materials - Develop and format manuals, toolkits, and other supporting materials in ways that make it easier for stakeholders to learn about the innovation and for clinicians to learn how to deliver the clinical innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P23) Develop Resource Sharing Agreements - Develop partnerships with organizations that have resources needed to implement the innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P24) Distribute Educational Materials - Distribute educational materials (including guidelines, manuals, and toolkits) in person, by mail, and/or electronically.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P25) Identify and Prepare Champions - Identify and prepare individuals who dedicate themselves to supporting, marketing, and driving through an implementation, overcoming indifference or resistance that the intervention may provoke in an organization.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P26) Increase Demand - Attempt to influence the market for the clinical innovation to increase competition intensity and to increase the maturity of the market for the clinical innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P27) Inform Local Opinion Leaders - Inform providers identified by colleagues as opinion leaders or "educationally influential" about the clinical innovation in the hopes that they will influence colleagues to adopt it.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P28) Intervene with Patients/Consumers to Enhance Uptake and Adherence - Develop strategies with patients to encourage and problem solve around adherence.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P29) Involve Executive Boards - Involve existing governance structures (e.g., boards of directors, medical staff boards of governance) in the implementation effort, including the review of data on implementation processes.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P30) Make Billing Easier - Make it easier to bill for the clinical innovation. This might involve requiring less documentation, "block" funding for delivering the innovation, and creating new billing codes for the innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P31) Make Training Dynamic - Vary the information delivery methods to cater to different learning styles and work contexts, and shape the training in the innovation to be interactive.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P32) Mandate Change - Have leadership declare the priority of the innovation and determination to have it implemented.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P33) Obtain and Use Patients/Consumers and Family Feedback - Develop strategies to increase patient/consumer and family feedback on the implementation effort.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P34) Obtain Formal Commitments - Obtain written commitments from key partners that state what they will do to implement the innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P35) Organize Clinician Implementation Team Meetings - Develop and support teams of clinicians who are implementing the innovation and give them protected time to reflect on the implementation effort, share lessons learned, and support one another's learning.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P36) Provide Clinical Supervision - Provide clinicians with ongoing supervision focusing on the innovation. Provide training for clinical supervisors who will supervise clinicians who provide the innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P37) Provide Local Technical Assistance - Develop and use a system to deliver technical assistance focused on implementation issues using local personnel.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P38) Provide ongoing consultation – Provide ongoing consultation with one or more experts in the strategies used to support implementing the innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P39) Purposefully Reexamine the Implementation - Monitor progress and adjust clinical practices and implementation strategies to continuously improve the quality of care.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P40) Recruit, Designate, and Train for Leadership - Recruit, designate, and train leaders for the change effort.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P41) Remind Clinicians - Develop reminder systems designed to help clinicians to recall information and/or prompt them to use the clinical innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P42) Revise Professional Roles - Reassess and revise roles among professionals who provide care and redesign job characteristics. This includes the expansion of roles to cover provision of the clinical innovation and the elimination of service barriers to care, including personnel policies.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P43) Shadow Other Experts - Provide ways for key individuals to directly observe experienced people engage with or use the targeted practice change/innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P44) Stage Implementation Scale Up - Phase implementation efforts by starting with small pilots or demonstration projects and gradually moving to system wide rollout.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P45) Tailor Strategies - Tailor the implementation strategies to address barriers and leverage facilitators that were identified through earlier data collection.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P46) Use Advisory Boards and Workgroups - Create and engage a formal group of multiple kinds of stakeholders to provide input and advice on implementation efforts and to elicit recommendations for improvements.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P47) Use an Implementation Advisor - Seek guidance from experts in implementation. This could include consultation with outside experts such as university-affiliated faculty members, or hiring quality improvement experts or implementation professionals.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P48) Use Data Experts - Involve, hire, and/or consult experts to inform management and use of data generated by implementation efforts.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P49) Use Train-the-Trainer Strategies - Train designated clinicians or organizations to train others in the clinical innovation.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

P50) Visit Other Sites – Visit sites where a similar effort has been considered.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
This strategy was effective for our organization					
This strategy was more effective than other strategies					
This strategy was feasible for our organization					
This strategy fit well with the way our organization operates					

Appendix D: Cross-Case Analysis Summary

Agency	Aim 2 (Decision Making)	Aim 1 (Strategy Use)	Aim 3 (Strategy Perceptions)	Aim 4 (Contextual Influences)
Agency B	***Treatment Decision Making:*** Outer Setting Factors -Client need -Dictated by funders -Networking with other organizations -Expert consultation Inner Setting Factors -Clinical supervisors/peers -Market niche and expertise -Organizational capacity Characteristics of Individuals -Training and clinical experiences ***Imp. Decision Making:*** -No implementation plan -No implementation model -No formal assessment/evaluation of need prior to or after implementation -No use of QI/imp. literature *Influential Factors:* -Funder expectations -Reliance on outside consultants -Widespread collaboration -Past experience -Monthly process meetings	***Qualitative Results:*** Characteristics of Intervention -Adapting intervention Outer Setting -Soliciting client feedback -Carefully timing sessions -Accessing new funding -Collaborating with other agencies Inner Setting -Infrastructure development -Changes to the org. structure -Shifting philosophy toward prevention Characteristics of Individuals -Training -Supervision -Weekly staff consultations -Informal consultation -Intensive training program Process -Outcome monitoring -Reassessing/evaluating imp. processes -Monthly staff meetings ***Quantitative Results:*** -Respondents (N = 6) -Strategies endorsed by >50% (N= 34)	***Qualitative Results:*** -Clinicians valued robust training infrastructure at agency (including CEU opportunities) -Clinicians wanted more intensive training in EBTs -Peer supervision was valued -Peer supervision and 1:1 supervision more valued than staff consultations -Adaptation was valued ***Quantitative Results:*** -Effectiveness range = 2.00-4.67 -Comp effect. range = 2.00-5.00 -Feasibility range = 3.00-4.50 -Approp. range = 2.50-4.50 -18 strategies w/effectiveness > 4, 13 of which endorsed by >50% -*Most effective*: tailor strategies, identify and prepare champions, educational strategies, change service sites, change structure and equipment, supervision, re-examining implementation, implementation team meetings -*Least effective*: Develop implementation blueprints, train-the-trainer, change record systems, quality monitoring systems, audit and feedback	***Qualitative Results:*** -Strong commitment to psychodynamic orientation -Balance between openness and organizational identity -Personal responsibility for learning and growth -Tension between professional loneliness and community -Not data driven or research based ***Quantitative Results:*** -LPA Score: 3.00 *Culture* -Proficiency: 61.08 -Rigidity: 48.5 -Resistance: 52.53 *Climate* -Engagement: 67.83 -Functionality: 70.09 -Stress: 43.65
Agency E	***Treatment Decision Making:*** Characteristics of the Intervention -Evidence strength and quality	***Qualitative Results:*** Outer Setting -Accessing new funding	***Qualitative Results:*** -Not enough attention given to choice of interventions	***Qualitative Results:*** -Hasty decision making -Disconnect between

	-Adaptability <u>Outer Setting</u> -Client need -Availability of funding <u>Inner Setting</u> -Gap in preventive services offered at agency -Existing expertise and capacity ***Imp. Decision Making:*** -No implementation plan -No implementation model -No formal assessment/evaluation of need prior to or after implementation -No use of QI/imp. literature *Influential Factors:* -Dictated by intervention developer -Expectations of funders -Financial constraints -Guidance from fellow organizational leaders -Guidance from frontline workers -Consultation with other agencies -Web-based information	-Collaborating with other organizations -Marketing to clients -Client engagement -Mechanisms for client feedback <u>Inner Setting</u> -Structural changes -Credentialing and accreditation -Peer review of files for Intervention E2 and E3 <u>Characteristics of Individuals</u> -Hiring with implementation in mind -Training requirement -Training allowance -Intervention E1 training -State training for Intervention E2 and E3 -Federal Development Credential Training -Weekly in-service trainings -Monthly brown bag sessions -Online training modules -Supervision -Providing feedback to supervisors -Fidelity monitoring (eventually) -Auditing documentation compliance -Informal peer support <u>Process</u> -Weekly staff meetings -Informal meetings ***Quantitative Results:*** -Respondents (N = 8) -Strategies endorsed by >50% (N	-Importance of planning emphasized -Autonomy in program development and implementation prized -Agency-based trainings perceived as too basic -Online training not perceived to be effective -Supervision and staffing is perceived as too compliance driven; more clinical focus and more clinical expertise in supervisors desired -Shadowing perceived as effective -Informal consultation viewed as helpful -Audit and feedback not perceived as helpful -Peer review of files not fed back; not perceived as helpful -Consulting with other agencies not always helpful -Developing community partners viewed as effective/essential ***Quantitative Results:*** -Effectiveness range = 2.60-4.25 -Comp effect. range = 3.14-4.14 -Feasibility range = 3.00-4.14 -Approp. range = 3.17-4.25 -15 strategies w/effectiveness > 4, 11 of which endorsed by >50% -*Most effective*: resource sharing agreements, tailor strategies, develop educational materials, ongoing training, educational outreach visits, distribute educational materials, educational	organizational leaders and frontline staff -Lack of role clarity -Shift from relaxed to more rigid culture ***Quantitative Results:*** -LPA Score: 1.99 *Culture* -Proficiency: 56.55 -Rigidity: 52.22 -Resistance: 61.33 *Climate* -Engagement: 53.38 -Functionality: 53.52 -Stress: 52.03

		= 43)	meetings -*Least effective*: formal implementation blueprint, mandate change, assess barriers and facilitators, involve executive boards, conduct local consensus discussions, shadow other experts, use data experts, audit and feedback	
Agency C	***Treatment Decision Making:*** <u>Characteristics of the Intervention</u> -Adaptability of the intervention -Compatibility with org., personnel, and clients -Empirical evidence -Replicability -Ownership of the program <u>Outer Setting</u> -Client need -Funding -Learning from other organizations and consultants <u>Inner Setting</u> -Strategic plans and board input ***Imp. Decision Making:*** -No evaluation of org. performance prior to or after implementation -No implementation plan -No implementation model -Not use of QI/imp. literature *Influential Factors:* -Guidance from treatment developers	***Qualitative Results:*** <u>Characteristics of the Intervention</u> -Adapting intervention delivery -Adapting assessment tools <u>Outer Setting</u> -Accessing new funding -Developing marketing materials -Obtaining client feedback -Educational materials for families -Collaborating with other agencies <u>Inner Setting</u> -Pursuing accreditation -Spreading word about Intervention C1 -Shift to empowerment philosophy <u>Characteristics of Individuals</u> -Hiring with implementation in mind -Training -Educational materials -Informal refresher training -Live observation of sessions -Case presentation -Consultation w/ experts and other agencies	***Qualitative Results:*** -Sequential implementation viewed as effective -Active strategies such as shadowing viewed as effective -Video demonstrations viewed as ineffective -Clinicians rarely receive supervision, desire more accountability and support ***Quantitative Results:*** -Effectiveness range = 2.75-4.67 -Comp effect. range = 2.75-4.50 -Feasibility range = 2.50-4.50 -Approp. range = 2.00-4.75 -25 strategies w/effectiveness > 4, 16 of which endorsed by >50% -*Most effective*: assess barriers/facilitators, build a coalition, identify/prepare champions, make training dynamic, educational meetings, ongoing training, train-the-trainer, make billing easier, create new clinical teams, change service sites, change physical structure and equipment, revise professional roles, implementation team meetings, clinical supervision, develop	***Qualitative Results:*** -Orientation toward improvement and growth -Collegiality and respect -Autonomy and trust -Vision and innovation over follow through ***Quantitative Results:*** -LPA Score: 1.99 *Culture* -Proficiency: 60.28 -Rigidity: 51.19 -Resistance: 64.55 *Climate* -Engagement: 53.83 -Functionality: 52.45 -Stress: 52.53

		-Supervision -Record review/chart audits <u>Process</u> -Engaging champions/opinion leaders -Sequential role-out -Funder's reporting requirements ***Quantitative Results:*** -Respondents (N = 5) -Strategies endorsed by >50% (N=24)	quality monitoring systems -*Least effective*: Use an implementation advisor	
Agency D	***Treatment Decision Making:*** <u>Outer Setting</u> -Client need -Opportunity (Funding) -Collaborating w/ other agencies -CEU opportunities/passive receipt of research findings -National trends <u>Inner Setting</u> -Conferring with colleagues ***Imp. Decision Making:*** -No implementation plans -No implementation models -Nor formal evaluations of org performance before/after imp. -No use of QI/imp. literature *Influential Factors:* -Direction from highest levels of leadership -Conferring w/ managers -Conferring w/ staff members	***Qualitative Results:*** <u>Characteristics of the Intervention</u> -Adapting interventions <u>Outer Setting</u> -Accessing new funding -Obtaining client feedback -Direct marketing to clients -Outreach to clients -Providing incentives for clients -Waiting room notices -Collaborating with other agencies <u>Inner Setting</u> -Increasing staff salaries -Staff appreciation committee <u>Characteristics of Individuals</u> -Funds and paid time off for training -In-house training opportunities -E-learning modules -Shadowing -Supervision -Weekly staffing meetings -Informal peer support	***Qualitative Results:*** -Clinicians very appreciative of training allowance/paid time off -Passive strategies such as didactic lectures and E-learning as ineffective -Clinicians wanted more in-house training -Outcome monitoring not appreciated as means of improvement -Annual reviews not helpful -Supervision not helpful due to disconnect between clinicians and supervisors -Weekly team meetings viewed as essential -Staff driven initiatives more effective -Perceived need for more management training ***Quantitative Results:*** -Effectiveness range = 3.13-4.30 -Comp effect. range = 3.00-4.25 -Feasibility range = 3.00-4.25 -Approp. range = 3.00-4.25	***Qualitative Results:*** -Collegiality and strong communication within teams -Top-heavy organization prone to disconnects between administrative layers -Punitive culture -Documentation compliance over quality -Elevating new growth over current program excellence ***Quantitative Results:*** -LPA Score: 1.97 *Culture* -Proficiency: 51.90 -Rigidity: 59.93 -Resistance: 59.99 *Climate* -Engagement: 46.11 -Functionality: 62.65 -Stress: 55.71

		-Monitoring notes/production -Annual staff evaluations <u>Process</u> -Assessing barriers and facilitators -Outcome monitoring; -Program review meetings -Seeking anonymous feedback from staff ***Quantitative Results:*** -Respondents (N = 16) -Strategies endorsed by >50% (N = 39)	-12 strategies w/effectiveness > 4, 8 of which endorsed by >50% -*Most effective*: local needs assessment, educational meetings, educational materials, accessing new funding, change physical structure and equipment, change service sites, create new clinical teams, reminders, technical assistance -*Least effective*: mandate change, change record systems, use data experts, audit and feedback	
Agency F	***Treatment Decision Making:*** <u>Characteristics of the Intervention</u> -Looking for interventions via national websites/organizations <u>Outer Setting</u> -Client need -Funding <u>Inner Setting</u> -Agency's mission -Input from organizational leaders -Input from frontline workers <u>Characteristics of Individuals</u> -Previous training/experiences <u>Process</u> -Opportunities to process in individual and group supervision ***Imp. Decision Making:*** -No evaluation of org performance prior/after to imp.	***Qualitative Results:*** <u>Outer Setting</u> -Accessing new funding -Client satisfaction surveys -Client engagement <u>Inner Setting</u> -Strategic planning -Infrastructure development -All staff meetings -Competitive salary analysis -Adapting policies <u>Characteristics of Individuals</u> -Training -Educational materials -Individual supervision -Staffing -Auditing files -Informal consultation <u>Process</u> -Outcome monitoring ***Quantitative Results:***	***Qualitative Results:*** -Perceived need for more and better in-house training -Need for financial support for training -Supervision viewed as essential, but supervisor characteristics often limit helpfulness -Supervision may not occur as it is supposed to -Not enough clinical content in weekly staffing meetings; too compliance focused -Outcome monitoring not appreciated -Audit and feedback valuable to leadership, but not appreciated by clinicians for the most part ***Quantitative Results:*** -Effectiveness range = 3.00-4.50 -Comp effect. range = 2.83-4.17 -Feasibility range = 3.00-4.50 -Approp. range = 3.00-4.60 -20 strategies w/effectiveness >	***Qualitative Results:*** -Lack of clinical and administrative oversight -Underdeveloped infrastructure -Poor inter-organizational communication (including lack of role clarity) -Failure to embrace the perspective of a "learning organization" ***Quantitative Results:*** -LPA Score: 1.92 *Culture* -Proficiency: 49.83 -Rigidity: 61.56 -Resistance: 65.12 *Climate* -Engagement: 51.76 -Functionality: 61.95 -Stress: 50.32

	-No implementation plan -No implementation model -No use of QI/imp. literature *Influential Factors:* -Implementation meetings that are largely compliance focused	-Respondents (N = 9) -Strategies endorsed by >50% (N = 28)	4, 11 of which endorsed by >50% -*Most effective*: developing a formal implementation blueprint, train-the-trainer, educational outreach visits, develop educational materials, conduct ongoing training, access new funding, develop and organize quality monitoring systems, provide clinical supervision, implementation team meetings, audit and feedback, use an implementation advisor -*Least effective*: make billing easier, change record systems, change service sites, obtain and use consumer and family feedback, capture and share local knowledge	
Agency A	***Treatment Decision Making:*** <u>Characteristics of Intervention</u> -Reliance on research literature -Endorsements from experts/key mental health organizations -Compatibility with agency <u>Outer Setting Factors</u> -Availability of funding -Client need -Visiting other sites -Cost-savings to community ***Imp. Decision Making:*** -No implementation plan -No implementation model -No formal assessment of org. performance prior or after imp. -Limited use of QI/imp. literature *Influential Factors*:	***Qualitative Reports:*** <u>Outer Setting</u> -Accessing new funding -Client engagement strategies -Soliciting client feedback -Collaborating w/ other agencies <u>Inner Setting</u> -Mandating change -Promoting shifts in philosophy -Infrastructure development -Networks and communications -Quality improvement tools <u>Characteristics of Individuals</u> -Efforts to build buy-in -Training -Live supervision and structured feedback -Supervision in Intervention A -"Regular" supervision	***Qualitative Results:*** -Passive strategies such as didactic training, the use of workbooks, and video demonstrations viewed as ineffective -Active strategies such as role playing, shadowing, and live supervision effective; however, audit and feedback and outcome monitoring not perceived as effective -Fidelity monitoring was viewed as negative/punitive, and CM's wanted more positive feedback -CM's wanted more empathy in supervision and other interactions with management ***Quantitative Results:*** -Effectiveness range = 2.57-4.50	***Qualitative Results:*** -Inconsistent organizational expectations -Leader's too removed from "the work" -Lack of psychological safety -Case managers don't' feel heard -Punitive environment ***Quantitative Results:*** -LPA Score: 1.00 *Culture* -Proficiency: 47.24 -Rigidity: 58.89 -Resistance: 77.90 *Climate* -Engagement: 35.56 -Functionality: 50.39 -Stress: 69.75

	-Availability of funding -Grant/contract expectations -Visiting other sites -Guidance from treatment developers/expert consultants -Literature from developers -Quality improvement process knowledge	-Fidelity monitoring -Provision of written educational materials -Consultation -Peer coaching -Incentivizing w/ praise -Random audits -Hiring for implementation <u>Process</u> -Barrier collection and analysis -Adapting implementation strategies -Outcome monitoring -Reassessing and evaluating implementation processes ***Quantitative Results:*** -Respondents (N = 8) -Strategies endorsed by >50% (N = 42)	-Comp effect. range = 2.43-4.50 -Feasibility range = 2.67-4.50 -Approp. range = 2.86-4.50 -7 strategies w/effectiveness > 4, only 2 endorsed by >50% -*Most effective*: conduct local needs assessments, make training dynamic -*Least effective*: mandate change, involve boards, develop formal implementation blueprint, ongoing consultation, change record systems, capture and share local knowledge, technical assistance, reminders, audit and feedback	
Similarities and Differences:	***Treatment Decision Making:*** <u>Characteristics of the Intervention</u> -Agencies implementing EBTs highlighted research evidence as driving factor. This was usually assessed by some 3rd party source (CEBC, NREPP, treatment developer) -2 of 3 implementing EBTs cited the adaptability of the intervention as critical -Only one agency mentioned compatibility with org., personnel, and clients; replicability, and ownership of the program as essential intervention characteristics that drove their choice -Many organizations placed a lot	***Qualitative Results:*** <u>Characteristics of the Intervention</u> -Adaptation fairly common; 3 of 6 reported that adapting interventions in some way <u>Outer Setting</u> -6 of 6 agencies reported soliciting client feedback; this generally involved generic satisfaction surveys -4 of 6 agencies reported client engagement strategies such as phone calls, community visits, and incentives to ensure clients remain in treatment -3 of 6 agencies reported developing marketing and/or educational materials for clients	***Qualitative Results:*** -Active strategies such as dynamic training, role-playing, shadowing were viewed as effective -Passive strategies such as didactic lecture, video demonstrations, online learning modules, and workbooks viewed as ineffective -There was a cross-cutting expression of need for increased clinical content in training, supervision, team meetings, etc. (rather than paper work compliance and other admin concerns) -The content of many training efforts were deemed too basic,	***Qualitative Results:*** -The majority of agencies had serious issues with communication between leaders and frontline workers -The majority of agencies had concerns with the basic infrastructure for services (e.g., IT issues, documentation issues, availability of basic supports, etc.) -At least 3 agencies raised concerns about a punitive environment or a lack of psychological safety -3 of the agencies were dealing with shifts toward more structure/systematic practice, and discussed the challenges therein

	of value on endorsements from experts/key mental health organizations <u>Outer Setting</u> -Client need and funding are primary drivers for all agencies ("funding always dictates" -4 of six agencies relied upon collaborations with other agencies to guide treatment decision making, including 2 of the 3 implementing EBTs and 3 of 4 implementing formal programs -While many agencies talked about CEU opportunities, one in particular talked about using them to guide treatment decision making in addition to national trends, both of which are passive. -Only one agency mentioned cost-savings to the community as a factor influencing treatment decision making, suggesting an opportunity to make a better case for EBTs <u>Inner Setting</u> -5 of 6 cited fit with agency's mission and/or existing capacity as major drive. Interestingly, 1 that didn't had more diffuse focus, and some criticized its lack of focus on existing programs. -3 of 6 cited consultations with peers within organization. Seemed largely informal. Often leadership emphasized more than frontline workers.	-5 of the 6 agencies reported collaborating with other organizations as an imp/QI strategy. The one that did not was perhaps least innovative. -6 of 6 agencies relied upon new funding to implement new programs and practices <u>Inner Setting</u> -2 of 6 agencies discussed structural changes (e.g., hiring/firing staff members, changing supervision structures) -At least half of agencies mentioned infrastructure development such as developing more robust documentation processes or adopting EMRs -3 agencies talked about efforts to shift organizational philosophies (e.g., to more preventive or empowerment-based perspectives) -All 3 agencies implementing EBTs discussed the pursuit of accreditation -3 agencies discussed strategies to promote intra-organizational communication (e.g., all staff meetings) generally or about a specific EBT -1 agency talked about efforts to improve morale through a staff appreciation committee -1 agency described the strategic planning process as a key strategy -1 agency mandated change -1 agency used a range of QI tools (not specific to the EBT)	and clinicians expressed a need for more depth in both specific EBTs and diagnoses -Financial support for training, even in small amounts, was generally appreciated. This was expressed as a need where not available. -In-house trainings were desired, though current offerings were too basic and generally not perceived as helpful -Supervision was universally desired, though not universally perceived as helpful. Clinicians wanted more of a clinical focus, supervisors with more expertise, and more empathy and respect from supervisors. -At least one exception to the active/passive finding is that clinicians almost universally disliked audit and feedback and fidelity monitoring in its various forms. These (and other strategies) were marred by punitive/negative bent. -Leaders generally found that auditing processes were effective for their purposes -Outcome monitoring was not embraced by the vast majority of frontline workers -Formal and informal peer support was viewed as essential by the majority of agencies -Adaptation and/or flexible interventions were very much valued -Participants voiced mixed	-At least two agencies discussed issues with role clarity -2 agencies struggled with hasty decision making and/or program growth. Another struggled with innovation with not much follow-through. -5 of 6 organizations had a substantial amount of autonomy, but the extent to which frontline workers were supported in clinical decision making varied widely -Many frontline workers from 5 of 6 agencies expressed concern that documentation compliance has been elevated over quality service delivery -Only one agency expressed a strong commitment to a specific theoretical orientation. The others claimed to be more eclectic, though leaders rarely discussed if/how they integrate various theoretical approaches -2 of 6 organizations specifically talked about an orientation toward continuous improvement, though one emphasized individual clinicians' responsibility for growth. Participants from another agency alluded to the fact that it was not a "learning organization." -At least two agencies demonstrated a clear level of collegiality and respect, whereas in others there was a level of animosity that was palpable

	Characteristics of Individuals -Two agencies discussed training and experience of staff as important. Other potentially missing an important component of EBT fit with frontline workers. Process -One agency mentioned individual/group supervision as a driver of decision making ***Imp. Decision Making*** -At least half of agencies cited grant/contract expectations as major driver of imp. decision making, suggesting need solid imp. principles to be integrated into grants and contracts -All 3 agencies implementing EBTs cited guidance from treatment developers. Another consulted with outside experts. May be over-reliant on treatment developers. -3 of 6 agencies used collaborations and informal consultation with other orgs to guide their implementation efforts -4 of 6 agencies cited organizational leaders or staff members as influential, though it seemed as if consultation at the highest levels of agencies was most common	Characteristics of Individuals -Training was central for all agencies, though the form and intensity of training varied widely -2 agencies provided a training allowance for providers -Agency A was the only organization with a robust internal training infrastructure -Similarly, supervision was reported by all agencies, but varied in frequency and content -5 of 6 organizations reported some type of audit focusing on fidelity or documentation compliance -Frontline workers from 5 of 6 organizations reported informal peer support and consultation -The majority of agencies had some sort of weekly staffing or team meeting -4 agencies reported hiring staff intentionally to fit a specific EBT or a therapeutic modality -3 agencies discussed the dissemination of educational materials -2 agencies discussed consultation with experts -Unique strategies included: providing feedback to supervisors to help them improve, live observation of sessions, case presentations, shadowing, and live supervision and feedback Process -The majority of agencies	feelings about collaborations. Sometimes they seemed mere formalities, other times they are essential to the agency's ability to deliver services. -Staff evaluations generally too generic and not helpful for improvement Unique Perceptions/Suggestions: - Not enough attention given to choice of interventions -Importance of planning emphasized -Sequential implementation viewed as effective -Staff driven initiatives more effective -Perceived need for more management training ***Quantitative Results:*** -See Table 12 for results of quantitative survey aggregated across agencies -See "impact on implementation processes" for differences between agencies	***Quantitative Results:*** -One agency qualified for "best" OSC, one qualified for "worst," and the other 4 were in the "average" range -LPA scores ranged from 1.00 (worst) to 3.00 (best) -Ranges of Culture Domains -Proficiency: 47.24 to 61.08 -Rigidity: 48.50 to 61.56 -Resistance: 52.53 to 77.90 Ranges of Climate Domains: -Engagement: 35.56 to 67.83 -Functionality: 50.39 to 70.09 -Stress: 43.65 to 69.75 ***Impact on Imp. Processes:*** -Agencies with the best 3 OSC profiles (of the current sample) were more likely to be implementing formal programs (3/3 as opposed to 1/3 of the worst 3 OSC profiles). -Agencies with best 3 OSC profiles had far narrower foci than the agencies with the worst 3 OSC profiles -Agencies with the best 3 OSC profiles used fewer strategies (M=33.67) than worst 3 (M=36.33) -Agencies with the best 3 OSC profiles rated strategies more positively than those with the worst 3 profiles. Best three rated a mean percentage of 43% of

		engaged in some type of outcome monitoring, though most did not use the results to inform direct practice -2 of 6 agencies discussed assessing barriers and facilitators in some form, primarily through informal consultation with staff members -2 of 6 agencies reported meetings to specifically reassess and reflect on implementation processes specific to an EBT. These included leadership only, not frontline workers or clients. -3 of 6 agencies reported more regular meetings that are more generic in focus but allowed for reflection on programs/practices -Most agencies talked about informal ways of reflecting on implementation process -Unique implementation strategies at the process level included engaging champions/opinion leaders, sequential role-out, seeking anonymous feedback from staff, and adapting implementation strategies as necessary ***Quantitative Results:*** -Number of strategies endorsed by at least 50% of employees varied by agency, ranging from 24 to 43 -Range of strategies endorsed by at least 50% by category: -Planning: 7 to 14 -Education: 5 to 11		strategies endorsed by at least 50% or respondents a "4" or better on effectiveness scale, whereas the worst three had a mean of 21% rated a "4" or higher -This largely held in qualitative reports as well, most noticeably with Agency A and B.

		-Finance: 1 to 3 -Restructuring: 3 to 5 -Quality Improvement: 5 to 13		
Additional Omissions/ Critiques:	***Treatment Decision Making:*** -Most not driven by empirical evidence; those that are mostly place a lot of trust in outside sources -Most do not involve frontline workers in a meaningful way -Most do not involve clients in a meaningful way -Some decisions appear hasty and too funding driven -Perhaps too much reliance upon "therapy as art" -No move toward modular treatments or common elements approach despite potential need -Not always clear that alternative approaches are fully considered ***Imp. Decision Making:*** -No implementation plan -No implementation model -No formal assessment/evaluation of need prior to or after implementation -No use of QI/imp. literature with one nominal exception	-Overall, strategy use could be characterized by a relative lack of depth and intensity -Provider-focused strategies (training, supervision, etc.) were dominant -Though passive strategies were prevalent, agencies also employed more active strategies such as shadowing, role-playing, etc. -Strategies at the inner setting level were minimal despite a multitude of suggestions that the inner contexts were problematic for the majority of agencies -The earnest involvement of frontline workers and clients in implementation decision making and processing was minimal across agencies		-Though not highlighted as cultural themes for most agencies, none of them appeared to be particularly data-driven -Similarly, not one agency expressed that they embraced an evidence-based practice process model as an agency