Moving Science to Practice: Exploring Implementation Practice Capacity in Community Settings

Enya B. Vroom
University of South Florida

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Moving Science to Practice: Exploring Implementation Practice Capacity in Community Settings

by

Enya B. Vroom

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Behavioral and Community Sciences
Department of Child and Family Studies
College of Behavioral and Community Sciences
University of South Florida

Major Professor: Oliver T. Massey, Ph.D.
Bruce Lubotsky Levin, Dr.P.H., M.P.H.
Dinorah Martinez Tyson, Ph.D., M.P.H.
Amy L. Green, Ph.D, M.A.

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DEDICATION

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ABSTRACT

Due to the significant prevalence of mental and substance use disorders in the United States, the push for the development and implementation of evidence-based practices (EBPs) has grown exponentially in the last 30 years. Community-based organizations (CBOs) (i.e., self-governing and/or not-for profit) have been identified as significant providers of behavioral health services. However, there are gaps in the literature surrounding CBO implementation capacity, meaning their ability to adopt, implement, and sustain EBPs. There is a need for more research examining capacity training initiatives that specifically target CBOs and implementation practice. The purpose of this dissertation research was to investigate how individuals working within Florida CBOs conceptualize implementation practice capacity, what is needed to reach adequate capacity for implementing an EBP, what would be required of an implementation training initiative to increase capacity, and whether these perspectives differ by organizational level.

This dissertation began with a thorough review of the implementation science research and practice literature. This served to inform the first manuscript, which provides a comprehensive overview of the history of EBP practice and implementation science, challenges associated with implementation, discussion of implementation practice, and proposes targeted research efforts to build organizational capacity to implement EBPs most effectively. In addition, the literature review assisted in providing the theoretical foundation for the dissertation study and guiding the second and third manuscripts.
An explanatory sequential design was used to examine participant perceptions of implementation practice areas and building implementation practice capacity both quantitatively and qualitatively. The quantitative portion of the study, which informed the second manuscript, was used to assess how implementation capacity is conceptualized by CBOs at the administrative and practitioner levels and what areas of implementation are deemed essential for success (Phase 1) using the Implementation Practice Survey (IPS) (N=97). The IPS examines perceived importance, presence, and organizational capacity in nine implementation practice areas (IPAs) (fit and adaptation, collaboration and communication, organizational readiness, culture and climate, leadership, external policy, data-based decision-making and evaluation, education, training, and coaching, and sustainability). Differences between subgroups on ratings of importance, presence, and organizational capacity were examined, as well as associations between organizational capacity and the nine implementation practice areas.

Results revealed statistically significant differences between subgroups on their ratings of presence and organizational capacity. Results also revealed the nine IPAs significantly predicted organizational capacity. Of the nine IPAs examined, fit and adaptation, culture and climate, leadership, and collaboration and communication added significantly to the prediction of organizational capacity. Culture and climate, leadership, and collaboration and communication added significantly to the prediction of adoption, and leadership added significantly to the prediction of implementation. The quantitative phase served to inform participant recruitment and protocol development for the qualitative portion of the study.

The qualitative portion, which informed the third manuscript, consisted of semi-structure interviews with eight administrators and nine practitioners currently employed by CBOs who deliver evidence-based behavioral health services for a total sample size of 17. The interviews
allowed for an in-depth exploration of participants’ perceptions of their CBOs’ ability to implement EBPs, what IPAs are deemed essential, if the importance and presence of those areas are related, training needs, and why the participant subgroups may differ when statistically tested (Phase 2). Results showed that IPAs such as leadership, culture and climate, training, data-based decision-making and evaluation, funding, and collaboration/communication (i.e., both internal and external) were all important areas of EBP utilization. The level of importance of the IPAs seemed to differ based on organizational level and the stage of implementation. In addition, themes such as buy-in, importance of EBP use, funding, and the notion of ‘why’ certain things are important for EBP utilization emerged.

As a whole, this dissertation provides a discussion and implications for research and practice regarding implementation practice capacity in community settings, including capacity trainings needs. Incorporating stakeholders’ feedback in the creation of a training initiative aimed at building capacity may result in an adequately tailored framework and training techniques, greater buy-in within the organizations, and increased efficacy in the operationalization of capacity building strategies and interpretation of data evaluating a training initiative.
CHAPTER 1: INTRODUCTION

Prevalence of Behavioral Health Disorders and Services

The prevalence and impact of mental and substance use disorders continues to be a major public health concern in the United States (U.S.), affecting millions of individuals every year (National Institute of Mental Health [NIMH], 2018). In 2019, approximately 51.5 million adults (i.e., 18 or older) had any mental illness (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020), and on average, one in five adolescents (i.e., ages 12-18) had or will have a serious mental disorder (e.g., anxiety and/or depression) (National Alliance on Mental Illness, n.d.; U.S. Department of Health and Human Services, 2017). In 2019, an estimated 20.4 million people who were age 12 or older had a substance use disorder (SUD) (SAMHSA, 2020). The term “behavioral health” can be defined as the promotion of mental health and well-being and the prevention and treatment of mental and substance use disorders (SAMHSA, 2019; Peek et al., 2013). Major strides have been made in the last 20 years regarding funding, research, policy, and service provision for behavioral health services. However, major gaps still exist surrounding the prevalence, service provision, referral to services, and transition of care from adolescence into adulthood (Hyde & Enomoto, 2015).

Despite the high behavioral health prevalence rates present in the U.S., many individuals are still not accessing and/or utilizing timely and effective behavioral health services (NIMH, 2018; SAMHSA, 2020). Among the 51.5 million adults in need of mental health services in 2019, only 44.8% received any services in the last year, and on average, only 15-20% of adolescents were receiving adequate mental health services in the U.S. (McCabe et al., 2013;
Merikangas et al., 2010; Ross & Carpenter Connors, 2018). Among the 20.4 million people aged 12 or older who were in need of substance use services in 2019, only 4.2 million (1.5%) received any substance use services in the last year (SAMHSA, 2020).

One reason for the lack of adequate services may be attributed to significant workforce shortages of behavioral health practitioners in the U.S. A 2016 report published by the Health Resources and Services Administration (HRSA) reported that by 2025, there will be a shortage of 250,000 behavioral health professions based on the projected demand (Beck et al., 2018; Health Resources and Services Administration, n.d.). Due to the significant prevalence of behavioral health problems, shortage of services and service providers, and the need for highly effectively services in the U.S., the push for the development and implementation of evidence-based practices (EBPs) has risen exponentially in the last 30 years (Southam-Gerow et al., 2012) to assist in ensuring efficacious service provision. However, many issues still persist with the effective translation of programs proven of their effectiveness into real-world settings (Massey & Vroom, 2020).

A large gap still exists between research and practice and this may be directly related to the lack of emphasis and understanding of the implementation process of EBPs (Proctor et al., 2009). EBPs have been identified as a critical strategy to combat the ever-rising behavioral health prevalence rates in the U.S. (Aarons et al., 2009b; Olfson et al., 2015). In addition, community-based organizations (CBOs) have been identified as important providers of health and social services and addressing unmet behavioral health needs given their unique access to their communities (Bach-Mortensen et al., 2018; Hogg-Graham et al., 2020).
Statement of the Problem

Many CBOs may struggle with successful integration and implementation of EBPs due to a lack of organizational buy-in, properly trained personnel, funding, fit of the program, insufficient leadership, and difficulties with adaptations (Aarons et al., 2009b; Chinman et al., 2005; Durlak & DuPre, 2008; Willging et al., 2018). Due to the slow integration of research evidence into community practice settings, it is critical for CBOs delivering evidence-based behavioral health services to consider the activities and resources as well as possess the capacity necessary for successful implementation (Aarons et al., 2009a). Building and sustaining organizational capacity for EBP utilization may aid CBOs in meeting the needs of their clients more effectively.

CBOs, which can be described as organizations that are privately owned, self-governing, and not-for-profit, have been identified as significant providers of behavioral health services within the U.S. (Bach-Mortensen et al., 2018). CBOs may provide the opportunity to connect with hard-to-reach populations (e.g., rural or underserved) as well as maintain missions and values that are unique to their specific communities (Wilson et al., 2012). In addition, CBOs also often provide services and supports to marginalized and disadvantaged populations (Wilson et al., 2012).

Although CBOs may present as an important entity to facilitate service provision, there is little research examining CBO’s ability and capacity to implement EBPs (Bach-Mortensen et al., 2018). The majority of implementation research to-date has focused on determining barriers, facilitators, and attitudes towards implementing EBPs (Bach-Mortensen et al., 2018; Beidas et al., 2016; Ramanadhan et al., 2012). The research literature has failed to provide replicable strategies for building internal capacity within CBOs that can be applied generally to EBP
implementation without the need for significant technical assistance (TA), as research has shown that general internal capacity may be necessary to fully benefit from TA (Wandersman et al., 2008).

Research by Proctor et al. (2015) reported concerns surrounding the capacity of health care practitioners and administrators to overcome challenges associated with sustaining EBPs. Important recommendations from the research included providing sufficient training for organizational leaders (i.e., CEOs and/or administrators) and frontline clinical providers for exploring, adopting, implementing, and sustaining EBPs. In addition, Proctor et al. (2015) recommended empirically developing evidence-based training strategies and testing their feasibility and effectiveness. Bach-Mortensen et al. (2018) conducted a systematic review assessing barriers and facilitators to implementing EBPs in third sector organizations (TSOs) (i.e., CBOs). A critical and consistent recommendation was “for funders to invest in technical assistance and capability training for the TSOs they fund” (Bach-Mortensen et al., 2018, p. 7). In addition, it was also recommended TSOs should be assessed for the ability and infrastructure to support the implementation of EBPs during the exploration stage of implementation. This research gives evidence to the notion of building implementation capacity within CBOs in order to improve and sustain behavioral health services.

The purpose of this dissertation research was to explore the areas of implementation practice that CBOs deem essential in successfully adopting, implementing, and sustaining EBPs in their unique service settings and what would be required of a training initiative to increase capacity. In addition, the study will also serve to examine whether these characteristics change based upon the perspectives of individuals in different organizational roles (i.e., administrators
versus practitioners). An explanatory sequential design using both quantitative and qualitative methods were used to examine the aims of this study.

**Background and Significance**

**Evidence-based Practices in Behavioral Health**

Evidence-based practices, programs, interventions, and/or treatments can be defined as activities, frameworks, polices, and/or strategies proven to be effective empirically through rigorous research as well as take into consideration client/participant and provider values (American Psychological Association, 2006; Fixsen et al., 2009; Hoagwood & Johnson, 2003; Kazdin, 2008; Massey & Vroom, 2020; Rabin & Brownson, 2018). Although the number of EBPs increased during the 1990s, the U.S. Surgeon General in 1999 reported many individuals were not actually accessing these evidence-based health services (Forte et al., 2014). The results from the Surgeon General’s report led to the President’s New Freedom Commission on Mental Health report (2003), which suggested all clinical practice should have a foundation in evidence in order to increase the effectiveness of mental health services. Although we have seen an increase in the utilization of EBPs in the last three decades because of the “evidence-based movement”, issues persist with the effective translation of research into practice (Fixsen et al., 2009; Massey & Vroom, 2020).

Although well intentioned, the push in policy and regulation requiring EBPs in health services has widened the gap between research and practice. Research suggests it could take up to 17 years for the transfer of knowledge to make its way from research to real-world practice settings (Green et al., 2009). An organization simply adopting an EBP may not be a sufficient method to ensure effective outcomes among clients (Carvalho et al., 2013). The implementation of EBPs needs to be considered in order to facilitate a smoother transition between effective
interventions and real-world service provision (Massey & Vroom, 2020; Proctor et al., 2009), which is why the science of implementation and its practice has grown increasingly more important in the last three decades.

**Implementation Science**

The field of implementation science (IS), defined as methods or activities that promote and support the use of research findings and EBPs (Aarons et al., 2009a; Bauer et al., 2015; Fixsen et al., 2005), attempts to bridge the gap between research and practice (Massey & Vroom, 2020). The formation of the field of IS and its corresponding research is in response to evidence-based practices, models, and polices often failing to affect services that behavioral health professionals and organizations provide to clients, target populations, and communities (Dearing et al., 2018). Evidence-based services delivery is a complex process that is often met with challenges. Navigating multilayered organizations and communities and their behavioral health services delivery is an intricate process, often requiring extensive time and resource requirements. This frequently hinders improvements in the quality and outcomes of behavioral health services (Aarons et al., 2009b). Because of this, improvements in health services that are based in research often lag behind other industries such as technology or engineering (Aarons et al., 2009a; Fixsen et al., 2009).

In the last 20 years, the field of IS has introduced both *passive* and *active* processes to facilitate the movement of science (i.e., research) to practice (Fixsen et al., 2009). The *passive process* involves researchers simply publishing their findings, making it incumbent on the leaders and practitioners in behavioral health organizations to apply and utilize the innovation (i.e., EBP) with their clients. The *active process* still involves the dissemination of research findings on behalf of researchers, however, external implementation experts such as TA centers,
universities, and/or EBP developers assist organizations with the process and components of implementation (e.g., fidelity, evaluation, and training/coaching) (Fixsen et al., 2009). In addition to the different processes, researchers in the last two decades have been analyzing what has been effective in regard to implementation and have developed theory, conceptual frameworks, and process models (Nilsen, 2015; Tabak et al., 2018) that target important components in the different stages of implementation to assist with the translation of EBPs and the implementation process (Aarons et al., 2011; Fixsen et al., 2009). Over 60 theoretical frameworks exist that provide explanations of the key implementation constructs that facilitate EBP utilization within different settings (Birken et al., 2017).

Researchers and practitioners now recognize the process of implementation is not always linear but can be thought of as a process that happens over stages or phases (Fixsen et al., 2005). Different IS models and conceptualizations exist depicting the different stages of implementation across disciplines, with some including three to four stages involved in the implementation of an EBP, including: 1) adoption; 2) implementation; and 3) sustainability. The different stages may house the core processes that are needed for successful implementation at a given point of time (e.g., adoption).

**Justification for the Study**

CBOs offer important avenues for effective EBP dissemination given their influence on health and capacity to stimulate participation on behalf of the community in behavioral health care (Ramanadhan et al., 2012). Despite this, early attempts at EBP dissemination have been met with barriers that may originate from the “top down” approaches used by the research community to push EBP usage into communities. Research has shown simply training community mental health clinicians in an EBP is not sufficient to ensure success. Accordingly,
there is a great need for strategies that assist with supporting and implementing an innovation for this specific setting (Glisson et al., 2012).

IS has seen a slight shift in the direction of implementation practice, and investments in different strategies and theoretical frameworks have been made in capacity building surrounding implementation of EBPs (Leeman et al., 2015). Implementation practice can be defined as the use of implementation mechanisms and activities informed by research, and used by knowledgeable individuals, to facilitate the adoption, implementation, and sustainment of an evidence-based practice, model, or approach. Although some have been created to serve both populations, IS theoretical frameworks and strategies have mostly targeted IS research and researchers, and have focused less on actual practitioners. Typically, strategies are focused on targeting one specific EBP and often require TA that is external to the service organization.

In addition, many frameworks and training initiatives have focused primarily on implementation *science*, as opposed to implementation *practice*. More emphasis is put on the importance of understanding theory and research and less on practical implementation strategies and increasing knowledge of how to combat implementation barriers and capitalize on facilitators (Carlfjord et al., 2017; Ullrich et al., 2017). This distinction may be a critical predictor of whether an IS framework and its corresponding training initiative is successful.

It may be beneficial for CBOs to acquire the knowledge and skills necessary to form internal capacity, meaning they would be equipped to solve problems and address barriers internally, without having to rely exclusively on external entities (e.g., TA centers, universities). Among the multiple barriers associated with EBP implementation, acquiring the funding for external TA, training, and evaluation that has proven to be beneficial for implementation, can prove to be very difficult, especially when there is no policy or mandate supporting (i.e.,
funding) these components of the implementation process (Cusworth Walker et al., 2019).

Building internal capacity related to the implementation of EBPs that can be sustained long-term could potentially allow issues to be corrected faster due to internal awareness and may result in fewer costs incurred by the CBO. In addition, because organizations tend to be multifaceted (i.e., multiple organizational levels), it may be necessary to target different areas of implementation or training methods to build capacity depending on the organization level (i.e., administrators versus practitioners).

Currently, there are gaps in the literature surrounding implementation capacity building and training initiatives that specifically target CBOs. Incorporating research, theory and frameworks, and practical strategies as well as feedback from stakeholders (i.e., CBOs actually using the EBPs) may lead to the development of optimal content for training aimed at building implementation capacity in community settings. Understanding stakeholders’ perspectives of implementation capacity and how CBOs can be trained to increase internal capacity can provide more context to the development of such a training initiative and increased understanding of how to best implement EBPs in these unique service settings.

**Purpose**

The purpose of this dissertation research was to assess how CBOs that deliver behavioral health services conceptualize an organization’s capacity to implement EBPs in community settings. Due to the current gaps in the literature, there is a need to acquire CBO’s perceptions of the implementation process and what implementation practice areas (IPAs) are important and present within their specific organizational settings. The proposed dissertation research will use quantitative and qualitative methods to explore CBOs’ perceptions of implementation practice capacity building and what skills/resources they think are necessary to successfully adopt,
implement, and sustain an EBP. This will serve to inform future research and practice efforts attempting to build capacity within this unique setting as well as help determine if training and capacity needs differ based on organizational level. Incorporating stakeholders’ feedback in the creation of a training initiative aimed at building capacity should result in an adequately tailored framework and training techniques, greater buy-in within the organizations, and increased efficacy in the operationalization of capacity building strategies and interpretation of data evaluating a training initiative (Minkler et al., 2018).

**Research Questions**

The following research questions were developed for this study:

1. How is implementation practice capacity conceptualized by participants? (Quantitative and qualitative)

2. From the participant’s perspective, what are the specific areas of implementation practice that are critical for successful adoption, implementation, and sustainability of EBPs? (Quantitative and qualitative)

   2a. What would be required of an implementation training initiative (e.g., activities, model, and/or process) to build capacity in these areas? (Quantitative and Qualitative)

3. Does the conceptualization of the overall assessment of implementation practice capacity and the importance and presence of different areas of implementation practice differ by organizational role (i.e., administrators versus practitioners)? (Quantitative and Qualitative)
Overview of Methods

To address the purpose of this study, an explanatory sequential design (Creswell & Creswell, 2018) was used to explore participant perceptions of implementation practice and building implementation capacity both quantitatively and qualitatively. The quantitative portion of the study was used to assess how implementation capacity is conceptualized by CBOs at the administrative and practitioner levels and what areas of implementation are deemed essential for success via the Implementation Practice Survey (IPS) (Phase 1). The goals of the quantitative phase of this study were: 1) explore participant perceptions’ of their organizations’ ability to facilitate EBP implementation; 2) examine what is deemed important in regard to the IPAs and what is currently present within their organizations in terms of the IPAs; 3) determine if the presence of the different IPAs predict a CBO’s capacity to adopt, implement, and sustain an EBP; 4) explore if goals one through three differ based on organizational level; and 5) explore training and professional development needs regarding EBP implementation. In addition, the quantitative phase served to inform participant recruitment and protocol development for the qualitative portion of the study.

The qualitative portion of the study explored, in depth, how implementation capacity is conceptualized, what implementation characteristics are deemed essential for capacity, what would be required of an implementation training initiative to increase and/or build capacity in these characteristics, and if these perspectives differ by organization level (Phase 2) (Creswell & Creswell, 2018). The qualitative interviews served as a follow-up to the quantitative survey and allowed for in-depth explanation of CBO ability to implement EBPs, what IPAs are deemed essential, if and how importance and presence of the IPAs are related, training needs, and why the participant subgroups may differ when statistically tested (Ivankova et al., 2006).
The samples for both the quantitative and qualitative phases of the study included adult participants (i.e., over 18) in administrative and/or practitioner positions who were employed by CBOs that deliver evidence-based behavioral health services in Florida. For this study, participants in administrative positions were those individuals who serve in a leadership, management, or supervisory role, hold decision-making power within the CBO, and/or have significant influence (e.g., program champion) over other clinical providers and staff. Participants in practitioner positions were those individuals who directly provide treatments and/or assist in the facilitation of treatments and do not serve in a leadership or supervisory position within the CBO.

Inclusionary criteria for administrators included: 1) must have been in a leadership, management, or supervisory position for at least six months; 2) work within a CBO that delivers evidence-based behavioral health services; and 3) are located in Florida. Inclusionary criteria for practitioners within CBOs included individuals: 1) with bachelors-level or above education (may also include case managers and those not yet licensed and are completing supervised clinical hours); 2) who deliver or assist with the delivery of evidence-based interventions for mental and/or substance use disorders; and 3) are located in Florida. Exclusionary criteria for both administrator and practitioner subgroups were participants working in CBOs outside of Florida.

**Definitions of Terms**

**Implementation Practice Areas**

To create a foundation for gaining CBO insight regarding implementation practice capacity, it was important to consult the research literature based on the science and practice of implementation. Although much of the information may be rooted in theory and research as opposed to practice, the IS research literature still provides a solid foundation of information,
that allowed for the development and framing of the essential areas of implementation practice that were explored in-depth during this dissertation research.

After a thorough review of the literature, nine critical implementation areas that are essential for the adoption, implementation, and sustainability of EBPs were identified: 1) fit and adaptation; 2) organizational readiness; 3) culture and climate; 4) leadership; 5) education, training, and coaching; 6) external policy; 7) collaboration and communication; 8) data-based decision-making and evaluation; and 9) sustainability. The selections were based on frequency of mention, the significance of findings, and research literature aimed at targeting community-based public health organizations and interventions as well as literature that aimed to develop IS competencies for health researchers and practitioners (Aarons et al., 2011; Damschroder et al., 2009; Ehrhart et al., 2014; Ehrhart et al., 2018; Fixsen et al., 2019; Fixsen et al., 2005; Glasgow et al., 1999; Glisson & Schoenwald, 2005; Massey & Vroom, 2020; Powell et al., 2015; Schultes et al., 2020; Wandersman et al, 2008).

The next sections will provide a brief overview of each IPA. Although some of the areas follow a linear timeline, they are not meant to be seen as linear, as many characteristics are interconnected throughout the stages of implementation (e.g., leadership and communication).

**Fit and Adaptation**

This area focuses on the importance of recognizing the needs, values, and fit of an EBP within a specific population (Massey & Vroom, 2020). Even the most effective EBPs will face challenges if the implementers do not first consider if the EBP aligns with the culture and needs of the target population. Needs assessments and CBO understanding of the target population may be beneficial in order to move forward with an EBP. In addition, necessary adaptations may need to be made to increase the fit and acceptability of an EBP within an organization and/or for the
target population. CBOs need to decipher to what extent the EBP can be adapted and/or modified to meet the needs of the target population the CBO serves, and can those modifications be documented and/or operationalized. If modifications do take place, CBOs should be concerned with monitoring changes and keeping the core components of the EBP intact (Damschroder et al., 2009; Wiltsey Stirman et al., 2013).

**Organizational Readiness**

Organizational readiness deals with indicators of organizational commitment to implement a new intervention (Damschroder et al., 2009). The organization should evaluate if they are ready for change, including assessing resources and infrastructure, have the flexibility to incorporate new methods into their routine, and how an organization’s culture, climate, and implementation climate could potentially affect implementation (Ehrhart et al., 2014). Implementation climate refers to staff attitudes and perceptions toward adopting and implementing an EBP and the extent to which the use of an EBP is expected, supported, and rewarded in an organization (Ehrhart et al., 2014; Weiner et al., 2011). In addition, the CBO may want to assess the structural characteristics of their organization, including the age of the organization, its size, if the organizational dynamic is team-based or predominantly individual work, resource availability, physical space, and if training/education in the EBP leads to confidence in an implementer’s ability to perform (Aarons et al., 2011; Damschroder et al., 2009; Fixsen et al., 2005; Fixsen et al., 2009).

**Culture and Climate**

Organizational culture refers to the underlying belief, assumptions, and missions/values that contribute to the environment of an organization (Aarons et al., 2011). Organizational climate refers to shared perceptions of the psychological impact of the work environment on the
employee (Ehrhart et al., 2014). CBOs that do not have EBPs rooted in their organizational mission/values and if staff do not view their organization as welcoming to innovation and change, even if the innovation/change may combat challenges, are significantly less likely to explore the use of EBPs (Aarons et al., 2011). CBOs looking to create a climate for the successful implementation of EBPs should work to prioritize EBP implementation in their mission, provide training and education opportunities for individuals implementing and facilitating the EBP, reward staff for successful EBP use, and hire employees based on openness to use EBPs and/or previous experience with EBPs (Ehrhart et al., 2014).

**Leadership**

Leadership for the purpose of this study can be defined as a process and/or actions that affect other individual’s understanding and recognition of what and how things should be done and facilitate both individual and team-based efforts to accomplish goals (Ehrhart et al., 2018). Leadership is a critical variable of implementation that has the potential to significantly affect organizational climate, culture, and implementation readiness both positively and negatively. Research has shown that different types of leadership are necessary depending on the organization. However, transformational leadership (i.e., motivational, stimulating, and engaging) has been extensively researched and results show this specific type of leadership is associated with improved implementer attitudes towards EBPs, implementer performance, and client outcomes (Aarons & Sommerfield, 2012).

**Education, Training, and Coaching**

Due to a lack of formal training offered to behavioral health professionals in educational settings (Doumas et al., 2017), training, education, and/or professional development opportunities provided by the CBO may be essential to ensure the proper use of EBPs and
mitigate resistance to change among staff (Parrish & Ruben, 2011). Inservice training facilitates the opportunity to provide the knowledge and background of EBPs as well as provides the space for the practice of new skills and to acquire feedback (Fixsen et al., 2005). Coaching and follow up allows implementers to learn on the job with the assistance of knowledgeable individuals.

Training and coaching are fundamental to behavior change, which the implementation of a new EBP requires (Edmunds et al., 2013; Fixsen et al., 2005). The lack of appropriate training can lead to issues with fidelity and obtaining positive outcomes among clients. In addition, IS is a relatively new and evolving field in health and behavioral health and this could mean that clinical instructors and curriculum may be lacking in experience and information related to this field in formal educational settings (Carlfford et al., 2017). Therefore, providing opportunities for CBOs and providers to learn and build implementation capacity outside of the academic setting is essential.

**External Policy**

This can include policy, mandates, and recommendations and guidelines on the local, state, and federal levels that have the potential to facilitate and/or hinder the implementation of a new intervention as well as the procurement and allocation of funding/resources. External policy often requires public reporting on behalf of the CBO, which includes informing the funding agency of progress and outcomes. However, due to competition between organizations and “late-adopters” of EBPs, this may result in “compliant implementation” (i.e., box-checking), where an evidence-based model or practice is used/implemented because it is required. The implications of “compliant implementation” are often meager and indifferent attempts at implementation (Klein & Speer Sorra, 1996) that can negatively affect client outcomes (Damschroder et al., 2009).
Collaboration and Communication (Internal and External)

Communication networks involve both communication and collaboration that happens internally and externally to an organization. Internally, this can include leadership debriefing with staff, and organizations providing ample opportunity and support for inter-organization collaboration. It is also important for CBOs to communicate the goals and vision of the organization to its staff and institute formal internal policy to ensure support so the organization’s mission can be fulfilled.

Externally, multiple service organizations may be in communication with one another with the intention of sharing insights on the implementation process. When organizations interact with other organizations using the same EBPs, this has the potential to increase their own likelihood of exploring or adopting EBPs, assisting with solving problems during implementation, and creating internal program champions (Aarons et al., 2011; Damschroder et al., 2009).

Data-based Decision-making and Evaluation

Monitoring the implementation of an EBP (i.e., fidelity), conducting evaluation activities targeting EBPs, and utilizing data coming from monitoring and evaluation activities can all assist with informed decision-making, identifying barriers, and can provide explanation as to why an EBP succeeds or fails (Allen et al., 2018). Feedback about the progress of the implementation, both quantitative and qualitative, is essential to ensure outcomes are aligned with the goals set forth by the organization (Damschroder et al., 2009). Monitoring and evaluation can and should take place at both the practitioner and program levels to ensure fidelity and provide useful data that can inform decision-making and combatting barriers over time (Fixsen et al., 2005).
**Sustainability**

Sustainability, also known as maintenance and/or sustainment, can be defined simply as the continued use of an EBP in practice (Aarons et al., 2011). Unfortunately, the discussion of sustainability is often left to the end of the implementation process, leaving limited time to plan for an EBP past its initial round of implementation and/or funding (Aarons et al., 2011; Shelton et al., 2018). This could be the result of changes in organizational priorities or resources, competing demands, external policy, and/or discovery of new/more effective practices. Although initial implementation may be successful, this does not guarantee these results will be sustained long-term (Wiltsey Stirman et al., 2012). Therefore, it is essential for CBOs to consider sustainability from the initial planning stage. Different aspects of sustainability may include maintaining organizational and stakeholder commitments, implementation processes, financing, obtaining resources (i.e., material, staff, and/or technology), and supporting the positive client outcomes of an intervention (Fixsen et al., 2005; Massey & Vroom, 2020).

**Dissertation Manuscripts**

This dissertation was designed to explore different facets and add to the generalizable knowledge of implementation practice in the broader field of implementation science. The dissertation is presented in manuscript style and results are presented in the following three manuscripts:

1. *Moving from Implementation Science to Implementation Practice: The Need to Solve Practical Problems to Improve Behavioral Health Services.* This commentary provides an overview of the history of EBPs and implementation science, describes challenges faced by behavioral health service providers, provides a discussion of implementation
practice, and proposes targeted research efforts to build organizational capacity to implement EBPs most effectively.

2. *Exploring Implementation Practice Capacity in Community-based Behavioral Health Organizations.* This manuscript focuses on the quantitative results of the Implementation Practice Survey, which examines perceived importance, presence, and organizational capacity in nine IPAs (fit and adaptation, collaboration and communication, organizational readiness, culture and climate, leadership, external policy, data-based decision-making and evaluation, education, training, and coaching, and sustainability). In addition, this manuscript explores the notion of what could be included in an implementation-oriented training and the desired delivery methods for such a training.

3. *Conceptualizing Implementation Practice Capacity in Community-based Organizations Delivering Evidence-based Behavioral Health Services.* This manuscript focuses on the results of qualitative interviews examining the results of the Implementation Practice Survey in-depth. The interviews looked to examine two perspectives of how implementation practice capacity is conceptualized and what is necessary to enable the activities associated with each IPA. In addition, this manuscript also explores the notion of the desire for an implementation-oriented training and how such information could be delivered to CBOs.

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CHAPTER 2: MANUSCRIPT 1

MOVING FROM IMPLEMENTATION SCIENCE TO IMPLEMENTATION PRACTICE: THE NEED TO SOLVE PRACTICAL PROBLEMS TO IMPROVE BEHAVIORAL HEALTH SERVICES

Abstract

It is well recognized the use of evidence-based practices (EBPs) is critical to improve service outcomes for those receiving behavioral health services. However, EBPs are not easily implemented in behavioral health settings and there are many challenges to supporting these services over time. Recently, research efforts in implementation science (IS) have greatly expanded our understanding of issues that influence successful implementation of EBPs. Unfortunately, less effort has been devoted to translating this research theory on a practical level to help individual service entities solve the specific problems of putting programs into place. A process is needed where service providers can build their capacity, informed by IS research, to improve service outcomes. The purpose of this commentary is to describe the challenges of the IS research base, provide an introduction to implementation practice, describe challenges confronting service providers, and propose targeted research efforts looking to examine necessary steps in building organizational capacity that enables service providers to implement the most effective services available.

Key words: Implementation science, implementation practice, behavioral health care
Introduction

Advances in research, practice, and policy related to behavioral health care have led to greater availability and emphasis on the use of interventions that have proven their effectiveness through research (Aarons et al., 2009b; Westerlund et al., 2019). As a result, the interest, development, and implementation of evidence-based practices (EBPs) has grown exponentially (Painter, 2012). Evidence-based approaches are now used by many health disciplines including medicine, behavioral health, nursing, and psychology. Evidence-based practices, programs, interventions, and/or treatments can be defined as activities, frameworks, polices, and/or strategies that have proven to be effective empirically through rigorous research and take client and provider values into consideration (American Psychological Association, 2006; Fixsen et al., 2009; Hoagwood & Johnson, 2003; Kazdin, 2008; Massey & Vroom, 2020; Rabin & Brownson, 2018).

Since the implementation of the Affordable Care Act, most notably the expansion of mental health and substance use parity that requires insurers to cover mental health and substance use disorders in the same manner as medical illnesses, behavioral health services are in high demand (Marlowe et al., 2020; Stanhope et al., 2017). In addition, Federal funding organizations such as the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, and the National Institutes of Health now require their grantees to use EBPs as well (Marlowe et al., 2020; Meyers et al., 2012). Although we have seen an increase in the availability and utilization of EBPs in the last three decades because of the “evidence-based movement” and federal legislation changing the landscape of behavioral health services, issues still persist with the effective translation of research into practice (Fixsen et al., 2009; Massey & Vroom, 2020). Many behavioral health practitioners and service
organizations struggle with successful implementation and integration of EBPs due to a lack of organizational buy-in, insufficient leadership, a lack of knowledge surrounding implementation characteristics, funding, fit of the program, and difficulties with adaptations (Aarons et al., 2009a; Chinman et al., 2005; Durlak & DuPre, 2008; Willging et al., 2018). Due to these challenges, there has been extraordinary growth in the science of implementation over the last two decades.

The field of implementation science (IS) can be defined as methods or activities that promote and support the use of research findings and EBP (Aarons et al., 2009b; Baur et al., 2015; Fixsen et al., 2005). Often thought of as an applied science (Westerlund et al., 2019), IS seeks to bridge the gap between research and practice by attempting to translate knowledge into practical applications in behavioral health care settings (Massey & Vroom, 2020). Implementation can include utilizing strategies to incorporate and maintain EBPs as well as systematically changing patterns of practice within settings (Kendall & Beidas, 2014). Failure to address challenges associated with implementing EBP can hinder improvements in the quality and outcomes of behavioral health services (Aaron et al., 2009a).

Navigating multilayered organizations and communities and their service delivery is an intricate process, often demanding extensive time and resource requirements. Early attempts at EBP dissemination have been met with barriers that may originate from the “top down” approaches used by researchers to push EBP usage into behavioral health care settings. Research has shown simply training practitioners in an EBP is not sufficient to ensure success. Accordingly, there is a great need for strategies that build capacity that assists with supporting and implementing innovation in community behavioral health settings (Glisson et al., 2012).
With behavioral health practitioners and service organizations in mind, the purpose of this commentary is to: 1) provide a brief background of IS research and discuss the knowledge to practice gap and challenges to practice translation; 2) provide an introduction to implementation practice and its importance; 3) describe challenges facing practitioners; and 4) discuss recommendations for targeted research efforts looking to examine necessary steps in building organizational capacity that enables service providers to implement the most effective services available.

Implementation Science Research

Due to the growing appreciation and need for theoretical foundation(s) and strategies, the field of IS has seen a massive increase in the development and testing of implementation theory, frameworks, models, and strategies in the last 20 years (Nilsen, 2015). There are now dozens of IS theories, models, and frameworks that support implementation research and practice within different service settings (Birken et al., 2017). They provide a roadmap of the difficult processes that are involved with moving EBPs into utilization in the field. This scientific foundation has synthesized approaches to identify the critical determinants associated with successful implementation. Work has also progressed to identify not only situational determinants of implementation success (e.g., organizational climate), but also relevant implementation strategies, evaluation techniques, and critical measures of implementation outcomes (e.g., fidelity and sustainability) (Nilsen, 2015; Birken et al., 2017). However, the difficulty now rests on the shoulders of behavioral health researchers and practitioners to select the most appropriate approach to translate EBPs into community settings.

The main objective of IS was to assist with translation of EBPs into the field of practice. Yet, we still see significant emphasis put on research and less on the practice and process of
implementation. Limited information exists on how to guide practitioners in the implementation of EBPs. Frequently, research is focused on establishing interval validity within randomized controlled trials (RCTs) at the expense of external validity (Barwick et al., 2020). The complexities of settings and contexts that are critical components to effective implementation may be diminished in highly controlled research settings. This can decrease the usability and usefulness of EBP implementation and its associated IS approaches in real practice settings (Barwick et al., 2020). In addition, what IS researchers and EBP developers choose to research is heavily influenced by what funding is available, which results in EBPs and IS approaches being developed with static protocols that are highly theoretical, that are often disconnected to the end user (i.e., practitioners and service organizations), and do not account for the dynamic nature of behavioral health services (Lyon & Koerner, 2016).

Recently, new research designs have been proposed for IS, such as hybrid trials (Curran et al., 2012) and user-centered designs (Dopp et al., 2020; Lyon & Koerner, 2016; Lyon et al., 2020), that highlight both program effectiveness and implementation research working together to understand not only effectiveness, but how, why, and in what settings/contexts an EBP or IS approach works (Barwick et al., 2020). However, the sheer number of theories, models, frameworks, and measures may pose an impediment to selecting an IS approach and assisting in EBP implementation. This gap may be further exacerbated due to many theories and frameworks being developed across health disciplines with limited cross-discipline collaboration (Nilsen, 2015), research findings being potentially contradictory across disciplines (Wandersman et al., 2008), and existing frameworks providing limited guidance regarding methods that ensure user needs are being met (Lyon & Koerner, 2016). All of these factors have contributed to a lack of
cohesion and transparency among researchers (Barwick et al., 2020), which has led to the issue of a “knowledge to practice” gap (Westerlund et al., 2019).

**Introduction to Implementation Practice**

Westerlund and colleagues (2019) have noted the recurring question of whether findings and evidence from IS research have sufficiently reached the “world of practice” (p. 332). The translation of IS research into practice requires that we answer the question of how IS research findings can be made relevant for practitioners and service organizations. Implementation practice can be defined as the use of implementation mechanisms and activities informed by research, and used by knowledgeable individuals, to facilitate the adoption, implementation, and sustainment of an evidence-based practice, model, or approach. The goal of implementation practice is solving practical problems as a means to successfully enhance services through practitioners and their organizations having the capacity to improve outcomes for clients.

In response to the need for IS at the practice level, the IS discipline has begun to shift in the direction of implementation practice through the development of strategies that build capacity surrounding implementation of EBPs (Leeman et al., 2015). However, these strategies have largely focused on targeting one specific EBP and often require technical assistance (TA) that is external to the service organization. Using consultative models, EBP purveyors and intermediary organizations may provide TA and training regarding their specific intervention and guide the service provider through the process of training and implementation (Proctor et al., 2019). However, these are also sources of support that may require long-term contracts and funding to be sustainable.

To influence professional practice, practitioners and service organizations must know how to: 1) choose between competing theories, frameworks, models, and strategies of
implementation (Leeman et al., 2017); 2) must be able to determine which issues are most central to consider for their agency (Aarons et al., 2011); 3) assess fit for their population (Massey & Vroom, 2020); 4) acquire and/or allocated resources (Damschroder et al., 2009); 5) determine which approach(es) have the highest potential to produce successful implementation in their unique service setting (Damschroder et al., 2009); and 6) marshal resources to ensure continuation and continuity of the supports necessary for sustainability (Shelton et al., 2018).

Unfortunately, implementation knowledge is not often provided to practitioners during their formal education. In addition, limited professional development opportunities are available within service organizations to continue practitioner’s education to assist with practice translation (Westerlund et al., 2019). The lack of knowledge and skills of behavioral health service providers related to EBP implementation has consistently emerged from the literature as a barrier to implementing research-supported interventions (i.e., EBPs and IS strategies) (Albers et al., 2020). Although universities have recently begun to increase and/or adjust curricula surrounding EBPs, the evidence for such teaching techniques and their effectiveness is sparse and it is doubtful that solely those efforts will lead to a behavioral health workforce that can facilitate increased and expanded use of EBPs in their practice (Albers et al., 2020). In addition, general training initiatives or professional development opportunities in IS are heavily focused on engaging academic researchers and have engaged less with other key stakeholders (i.e., practitioners and service organizations) that are essential to the implementation process and its success (Lyon et al., 2020).

The next sections will provide an overview of specific challenges behavioral health service providers and organizations may face when utilizing an EBP that are related to implementation practice. It will also provide recommendations for future research efforts,
informed by key stakeholders, aimed at developing implementation practice capacity with the goal of improving the implementation of EBPs and client outcomes.

**Issues for Consideration in Implementation Practice**

**Challenges to Implementation of Evidence-based Practices**

Although the promotion of EBPs in health services represented a critical advancement in behavioral health care, the well-intentioned push towards the use of EBPs often fails to close the gap between the best available research and practice (Aarons et al., 2011; Barwick et al., 2020; Beidas et al., 2019; Green et al., 2009). EBPs must be effectively matched to community needs, implemented with fidelity to the standards of the intervention, and integrated within regular practices so they may be sustained over time to ensure better outcomes for consumers. An organization adopting an EBP without first considering implementation and its associated barriers may not be able to ensure effective outcomes among clients (Aarons et al., 2011; Carvalho et al., 2013; Damschroder et al., 2009; Durlak & DuPre, 2008). In order to achieve positive outcomes, EBPs must not simply be implemented, but implemented with quality (Albers et al., 2020; Meyers et al., 2012). However, behavioral health organizations and practitioners face many challenges to successful implementation. These include: 1) being able to access and understand the research findings and interpret them for the needs of their clients, agency, and community; 2) being able to identify and select EBPs they can afford and fit with their target population; 3) being able to do the actual work of implementing the EBP through staff training, instituting new policies, and negotiating new contracts; and 4) integrating these changes so these efforts can be sustained.

Practitioners may have difficulty accessing, understanding, and interpreting the research literature regarding EBPs. Synthesizing the research literature surrounding EBPs is difficult and
may not be an intuitive process for practitioners as was originally intended by EBP developers and researchers (Marlowe et al., 2020). Systematic reviews, meta-analyses, and literature reviews tend to predominantly include RCTs. This, coupled with research methodology and EBPs not being topics where clinicians are well-versed (Marlowe et al., 2020), may result in valuable information being omitted from consideration when seeking information about a specific EBP (Wandersman et al., 2008).

Practitioners may also have difficulties in matching EBPs that are often developed with very narrow and specific populations, with the more diverse clientele they serve who may suffer from multiple, complex issues bridging mental and physical health concerns, historic disparities and discrimination, poverty, mobility, and education.

Two challenges to implementation, and a topic that has caused tension in the research community, are fidelity and adaption. While many argue that adaptations are necessary in order to fit and meet the needs of a specific setting, others postulate that an EBP that has been adapted may compromise the core elements of the program and be less effective when compared to the original program (Carvalho et al., 2013; Castro et al., 2004; Chamber & Norton, 2016; Massey & Vroom, 2020). Although fidelity has become the ‘gold standard’ for successful program implementation (Lendrum et al., 2016), it may not take into consideration how a program fits within a context. In addition, organizational characteristics such as readiness for change, climate, staffing, leadership, and funding can significantly impact the adoption, implementation, and sustainability of EBPs (Massey & Vroom, 2020; Powell & Beidas, 2016). Sustainability may require long-term commitments to facilitate change, including the support of new policies, procedures, and infrastructure enhancements. Supporting implementation and sustainability may
require new partnerships and collaborations, sufficient funding, and ongoing problem-solving (Massey et al., 2020; Shelton et al., 2018).

**Implementation Practice Capacity**

Given these challenges and the lack of opportunity for formal training related to EBPs and IS, strategies are needed to build capacity in service organizations for identifying, adopting, implementing, and sustaining EBPs not only on the administrative levels, but also on the practice levels of an organization (Leeman et al., 2017). Albers and colleagues (2020) conducted a systematic integrative review examining what implementation strategies are used by implementation support practitioners (ISPs) (e.g., purveyors or intermediary organizations) to assist service organizations in practice settings. Findings suggest ISPs need to have a certain set of skills and knowledge to assist service organizations in the utilization of EBPs (Albers et al., 2020). However, there was limited discussion on the internal capacities needed on behalf of the service organizations themselves. There is an apparent need to provide professional development to build capacity of current practitioners and service organizations to utilize EBPs and carry out activities associated with implementation practice. The mixed results of IS research conducted in various settings highlights the need for targeted exploration of implementation practice and capacity building in community-based, social service, and school-based behavioral health care settings (Birken et al., 2017; Leeman et al., 2015).

As previously mentioned, many factors such as organizational climate, leadership, and buy-in, can influence knowledge gained from training and have to be considered to enable real world translation (Albers et al., 2020). However, a significant amount of IS research is often conducted with limited collaboration or input from key stakeholders (i.e., clients, practitioners, service organizations) (Lyon et al., 2020). This poses the problem of having a product (e.g.,
implementation strategy) that does not take real-world barriers into consideration, that may be used incorrectly, and/or is unable to be replicated (Birken et al., 2017; Proctor et al., 2013). In order to develop tangible, applicable, and sustainable strategies for capacity building among practitioners and service organizations in implementation practice, it is essential that the strategies are created and tested in collaboration with the key stakeholders intended for its use.

Future Research Recommendations

To create a foundation for gaining insight regarding implementation capacity from key stakeholders, it is important to consult the research literature based on the science and practice of implementation. Although much of the information may be rooted in theory and research as opposed to practice, the IS literature provides a solid foundation of information that has allowed for the development and framing of the essential areas of implementation competencies that may account for successful implementation practice.

Nine critical implementation areas related to practice that have been deemed essential by research for successful adoption, implementation, and sustainability of EBPs have been identified: 1) addressing fit and adaption; 2) establishing implementation/organizational readiness; 3) addressing organizational culture/climate and buy-in; 4) providing leadership; 5) providing education, training, and coaching; 6) navigating external policies; 7) establishing communication and collaboration networks; 8) navigating the use of data to inform and monitoring/evaluating intervention(s); and 9) ensuring sustainability (Aarons et al., 2011; Damschroder et al., 2009; Fixsen et al., 2019; Glasgow et al., 1999; Glisson & Schoenwald, 2005; Massey & Vroom, 2020; Powell et al., 2015; Schultes et al., 2020; Wandersman et al., 2008). The selections were based on frequency of mention, the significance of findings, and research literature aimed at targeting community-based, behavioral health organizations and
interventions. Table 1 provides a brief overview of each implementation practice area and items for stakeholder consideration.

**Table 1**

*Implementation Practice Area Definitions*

<table>
<thead>
<tr>
<th>Implementation Practice Area</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Fit &amp; Adaptation</td>
<td>Refers to the importance of recognizing the need, values, and fit of an EBP within a specific population and making adaptations when necessary to increase the fit and acceptability for the organization and/or population of interest.</td>
</tr>
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<td>Organizational Readiness</td>
<td>Refers to indicators of organizational commitment to implement a new intervention.</td>
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<td>Refers to the degree to which staff within an organization are trained to implement evidence-based practices as well as may be provided mentorship or coaching post-training.</td>
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<td>External Policy</td>
<td>Refers to external policy, mandates, and recommendations and guidelines on the local, state, and federal levels that have the potential to facilitate and/or hinder the implementation of a new intervention as well as acquiring and allocating funding/resources.</td>
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<td>Refers to leadership debriefing with staff and providing ample opportunity and support for inter-organization collaboration. This may include CBOs communicating goals and visions of the organization to its staff and/or instituting formal internal policy to ensure support of the organization’s mission can be fulfilled (Internal).</td>
</tr>
</tbody>
</table>
**Table 1 (Continued)**

*Implementation Practice Area Definitions*

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Definition</th>
</tr>
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<tr>
<td>Multiple Service Organizations</td>
<td>Refers to multiple service organizations that may be in communication with one another with the intention to share insight on the implementation process. In addition, this may also include engagement with the community in which they are providing services (External).</td>
</tr>
<tr>
<td>Data-based Decision-making &amp; Evaluation</td>
<td>Refers to using data from monitoring and evaluation activities to make decisions regarding evidence-based practices as well as conducting monitoring (e.g., fidelity) and/or evaluation activities targeting evidence-based practices. This may also include acquiring feedback from the implementers about the progress of the implementation.</td>
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<td>Sustainability</td>
<td>Refers to maintaining the implementation, resources (e.g., monetary and/or personnel), and activities related to the implementation of an evidence-based practice long-term.</td>
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For community-based service providers and their organizations, these areas define competencies that may be required for the successful process of adopting, implementing, and sustaining EBPs. From a practice standpoint, what remains is the need to identify the importance and presence of these areas from the stakeholder’s perspective and how these areas are or should be made explicit in the organization. In addition, research must determine which of these areas compose a critical baseline capacity within the organization internally and which may be best addressed through external consultation and TA. While TA can assist in building capacity, research has shown that to fully benefit from TA, general capacity must be present among organizations to maximize program effectiveness (Wandersman et al., 2008).

Service providers and/or their service organization must determine the discrepancies between capacities they need, the capacities they have, and the ideal process to bridge this gap. It
is critical for future research to identify and develop methods/tools to measure the areas of implementation practice capacity so they may be operationalized and replicated as well as prospectively identified to enable targeted capacity building efforts. While work on assessing organizational capacity has begun (e.g., State Implementation and Scaling-Up of Evidence-based Practices) (University of North Carolina at Chapel Hill, n.d.), it could benefit from further development. The uptake of an evidence-based program or policy, the size of the organization and its relationship to funders and other agencies, and the local government and community will all influence these considerations.

Among the implementation practice areas described above, it may be hypothesized that some areas could be readily addressed through relying on or bolstering internal capacity. Most behavioral health and social service agencies have the structure for education and training experiences for accreditation purposes and for professional licensure and certification. Educating and training for EBPs may be handled internally or through established educational and training partnerships. Likewise, building and maintaining communication and collaboration within and across the agency and its partners can only survive as part of an internal capacity. Quality circles and continuous quality improvement (i.e., monitoring and/or evaluation) efforts may be hypothesized to logically reside within the agency. The identification and selection of potential capacity building strategies, however, may be hypothesized to most efficiently be accomplished through external consultation and TA. For example, practitioners may not have the time or resources to identify and compare potential new EBPs as they become available.

Other competencies, such as establishing organizational readiness, may be built through a consultative process where the unique components of a proposed EBP are considered in light of organizational needs and positioning. Researchers as well as EBP developers play a crucial role
in the translational of research to practice and it is essential these purveyors work collaboratively with the target population to maximize the usefulness and sustainability of the intended product (Wandersman et al., 2008).

**Implications for Behavioral Health**

Historically, research and its corresponding initiatives (e.g., RCTs, EBPs, and/or trainings) have been conducted and/or developed in the absence of the primary stakeholders: the consumers and service providers. Because of this, certain methods or strategies related to improving the implementation process may prove not to be as efficient and effective as they were originally intended (Stewart et al., 2019). Therefore, the science and practice of implementation needs to be developed and defined in collaboration with primary stakeholders (i.e., service organizations and their frontline staff) instead of in their absence. The development of implementation practice strategies is a critical first step.

The field of IS has provided the foundation and general explanation of what needs to be accomplished for effective services to be in place. The next step is actually doing that work (implementation practice) and prospectively assessing what needs to take place within the service organization regarding EBP implementation for it to succeed and be sustainable. Simply adopting an EBP may not be sufficient enough to address the needs of clients, the practitioner, and/or the service organization. Organizations must often restructure the way they do business to enable them to identify/choose among, implement, and support evidence-based services. Agencies must have continuity and consistency in business practices, and this may contribute to an over reliance on passive compliance and adhering to the status quo. However, the critical nature of IS requires a large effort for successful implementation and outcomes, which may overshadow passive compliance if the organization is not producing positive outcomes.
Due to the current gaps in the literature, there is an additional need to acquire behavioral health organization and practitioner perceptions of the implementation process and to confirm what implementation practice areas are deemed essential within their specific settings. It is suggested that future research explore service organizations’ perceptions of implementation capacity building and what skills/resources they think are necessary to successfully adopt, implement, and sustain an EBP.

Conceptual and operational clarity surrounding implementation science frameworks, models, and strategies is also required to optimize their effectiveness in behavioral health care service settings. These efforts will serve to inform future research and practice efforts attempting to build general/baseline capacity. Incorporating stakeholders’ feedback into the creation of a training initiative aimed at building implementation practice capacity may result in a tailored framework and training techniques, greater buy-in within the organizations, and increased efficacy in the operationalization of capacity building strategies and interpretation of data evaluating a training initiative (Minkler et al., 2018).

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during 5 years of a system-wide effort to implement evidence-based practices in


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CHAPTER 3: MANUSCRIPT 2

EXPLORING IMPLEMENTATION PRACTICE CAPACITY IN COMMUNITY-BASED BEHAVIORAL HEALTH ORGANIZATIONS

Abstract

Community-based organizations (CBOs) have been identified as significant providers of behavioral health services. CBOs provide the opportunity to connect with hard-to-reach populations (e.g., rural or underserved) and maintain the unique missions/values of their communities. Because of the importance of CBOs in the provision of services, it is critical they have the capacity to adopt, implement, and sustain evidence-based practices (EBPs) to improve service provision. However, there is little research examining CBOs’ ability and capacity to implement EBPs. Unfortunately, the research literature lacks replicable strategies for building internal capacity within CBOs that can be applied generally to EBP implementation. The purpose of this study was to investigate how individuals working within CBOs conceptualize implementation capacity, what is needed to reach adequate capacity for implementing EBPs, and examine the degree to which perspectives of capacity are shared across professional levels within organizations.

Ninety-seven administrators and practitioners of behavioral health organizations were surveyed using the Implementation Capacity Survey, which examines perceived importance, presence, and organizational capacity in nine implementation practice areas (IPAs) (1) fit/adaptation; 2) collaboration; 3) organizational readiness; 4) culture/climate; 5) leadership; 6) external policy; 7) data/evaluation; 8) education/training; and 9) sustainability). Differences
between subgroups on ratings of importance, presence, and organizational capacity were examined, as well as associations between organizational capacity and the nine IPAs. Results revealed statistically significant differences between subgroups on their ratings of presence and capacity. Results also revealed the nine IPAs significantly predicted organizational capacity. Of the nine IPAs examined, fit/adaptation, culture/climate, leadership, and collaboration added significantly to the prediction of organizational capacity. Culture/climate, leadership, and collaboration/communication added significantly to the prediction of adoption, and leadership added significantly to the prediction of implementation. Key differences were also observed between organizational levels on ratings of presence and predictions of organizational capacity. Findings serve to inform future research and practice efforts attempting to build capacity within CBOs and help to determine whether capacity building differs based on organizational level. Implications for future research aimed at examining and building implementation practice capacity in community behavioral health settings will be discussed.

Keywords: Implementation practice; Community-based organizations; Implementation science; Behavioral health; Evidence-based practices

Introduction

Community-based organizations (CBOs), which can be described as organizations that are privately owned, self-governing, and/or not-for-profit, have been identified as significant providers of behavioral health services within the United States (Bach-Mortensen et al., 2018). CBOs provide the opportunity to connect with hard-to-reach populations (e.g., rural or underserved) as well as maintain the missions and values unique to their specific communities. In addition, CBOs also often provide services and supports to marginalized and disadvantaged populations (Wilson et al., 2012). The push by the U.S. Surgeon General, Federal legislation
(President’s New Freedom Commission, 2003), and the U.S. Institute of Medicine to increase quality behavioral health services has led to an influx of CBOs implementing evidence-based practices (EBPs) (Beehler, 2016). In addition, the demand for behavioral health services has also increased due to the expansion of coverage and mental health and substance abuse parity via the Affordable Care Act (Stanhope et al., 2017). As EBPs have become increasingly required and more available, CBOs are now tasked with selecting, adopting, implementing, and sustaining practices for use with the unique populations they serve (Beehler, 2016). However, there is little research examining CBO’s ability and capacity to implement EBPs (Bach-Mortensen et al., 2018).

Significant research in implementation science (IS) has been devoted to identifying barriers, facilitators, and attitudes towards implementing EBPs and identifying implementation theory, frameworks, models, and strategies that may increase the successful use of EBPs (Bach-Mortensen et al., 2018; Beidas et al., 2016; Ramanadhan et al., 2012). This body of literature provides a strong foundation for understanding how new programs are brought into use, and the pitfalls and barriers that may hinder their use. While the field of IS has successfully built this foundation, less emphasis has been given to practical considerations and/or guidance on how to utilize IS knowledge effectively in community settings (Westerlund et al., 2019).

A large gap still exists between research and practice in behavioral health that may be directly related to the lack of emphasis and understanding of the implementation process (Proctor et al., 2009). The field of IS attempts to bridge the gap between research and practice by delineating methods or activities that promote and support the use of research findings and EBPs (Aarons et al., 2009a; Bauer et al., 2015; Fixsen et al., 2005; Massey & Vroom, 2020). Many CBOs may struggle with successful integration and implementation of EBPs due to a lack of
organizational buy-in, insufficient leadership, a lack of knowledge surrounding implementation characteristics, funding, fit of the program, difficulties with adaptation, and burnout (Aarons et al., 2009b; Chinman et al., 2005; Durlak & DuPre, 2008; Green et al., 2014). In addition, research has shown that many mental health professionals receive limited or no training in the use of EBPs in routine practice (Frank et al., 2019). Due to the importance of and emphasis on the use of EBPs in behavioral health care, training and coaching of behavioral health professionals (e.g., social workers or mental health counselors) related to EBPs in community settings is paramount.

Proctor et al. (2015) reported concerns surrounding the capacity of health care practitioners and administrators to overcome challenges associated with sustaining EBPs. Important recommendations from their research included providing sufficient training for organizational leaders (i.e., CEOs and/or administrators) and frontline clinical providers for exploring, adopting, implementing, and sustaining EBPs. In addition, Proctor et al. (2015) recommended empirically developing evidence-based training strategies and testing their feasibility and effectiveness. These recommendations are further emphasized by Bach-Mortensen and colleagues (2018), who conducted a systematic review assessing barriers and facilitators to implementing EBPs in third sector organizations (TSOs) (i.e., CBOs). Based on this review, a critical and consistent recommendation was “for funders to invest in technical assistance (TA) and capability training for the TSOs they fund” (Bach-Mortensen et al., 2018, p. 7). It was also recommended that ability and infrastructure to support the implementation of EBPs should be assessed during the exploration stage of implementation.

While research findings emphasize the importance of the provision of training and TA to facilitate successful implementation and sustainability of EBPs in CBOs, there are currently gaps
in the literature surrounding implementation capacity building and training initiatives that specifically target these organizations. Research on training initiatives typically targets graduate students, researchers, policymakers, and primary care physicians (Amaya-Jackson et al., 2018; Moore et al., 2018; Newman et al., 2015; Park et al., 2018). In addition, many IS frameworks and training initiatives have focused primarily on implementation science, as opposed to implementation practice. More emphasis is placed upon the importance of understanding theory and research and less on practical implementation strategies and increasing knowledge of how to overcome implementation barriers and capitalize on facilitators (Carlfford et al., 2017; Ullrich et al., 2017). This distinction may be a critical predictor of whether an IS strategy and its corresponding training initiative is successful. To assist with informing training needs, it is essential to gain practitioner input in order to address gaps in competencies (Tabek et al., 2017) and to determine what is critical to implementation practice capacity in community behavioral health settings.

To create a foundation for gaining CBO insight regarding implementation capacity, it was important to consult the research literature based on the science and practice of implementation. Although much of the information may be rooted in theory and research as opposed to practice, the IS research literature still provides a solid foundation of information, which allowed for the development and framing of the essential areas of implementation practice that were explored in-depth for this study. After a review of the literature, nine critical implementation areas that are essential for the adoption, implementation, and sustainability of EBPs were identified: 1) fit and adaptation; 2) organizational readiness; 3) culture and climate; 4) leadership; 5) education, training, and coaching; 6) external policy; 7) collaboration and communication; 8) data-based decision-making and evaluation; and 9) sustainability (see Table 2
for implementation practice area definitions). Selections of the implementation practice areas (IPAs) were based on frequency of mention, the significance of findings, and research literature aimed at targeting community-based public health organizations and interventions as well as literature that aimed to develop IS competencies for health researchers and practitioners (Aarons et al., 2011; Damschroder et al., 2009; Ehrhart et al., 2014; Ehrhart et al., 2018; Fixsen et al., 2019; Fixsen et al., 2005; Glasgow et al., 1999; Glisson & Schoenwald, 2005; Massey & Vroom, 2020; Powell et al., 2015; Schultes et al., 2020; Wandersman et al, 2008).

Table 2

Implementation Practice Area Definitions

<table>
<thead>
<tr>
<th>Implementation Practice Area</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fit &amp; Adaptation</td>
<td>Refers to the importance of recognizing the need, values, and fit of an EBP within a specific population and making adaptations when necessary to increase the fit and acceptability for the organization and/or population of interest.</td>
</tr>
<tr>
<td>Organizational Readiness</td>
<td>Refers to indicators of organizational commitment to implement a new intervention.</td>
</tr>
<tr>
<td>Organizational Culture &amp; Climate</td>
<td>Refers to the underlying belief, assumptions, and missions/values that contribute to the environment of an organization and the shared perceptions of the psychological impact of the work environment on the employee.</td>
</tr>
<tr>
<td>Leadership</td>
<td>Refers to a process and/or actions that affect other individual’s understanding and recognition of what and how things should be done and facilitate both individual and team-based efforts to accomplish goals.</td>
</tr>
<tr>
<td>Education, Training, &amp; Coaching</td>
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<td>Refers to utilizing data coming from monitoring and evaluation activities to make decisions regarding evidence-based practices as well as conducting monitoring (e.g., fidelity) and/or evaluation activities targeting evidence-based practices. This may also include acquiring feedback from the implementers about the progress of the implementation.</td>
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Current Study

The purpose of this study was to explore the perceptions of professionals working in CBOs regarding implementation practice capacity within their organization. More specifically, this study assesses how implementation capacity is conceptualized by CBOs at the administrative and practitioner levels and what areas of implementation are deemed essential for success. The goals of this study were to: 1) explore participants’ perceptions of their organization’s ability to
facilitate EBP implementation; 2) examine what is deemed important with regard to IPAs and what is currently present within organizations in terms of the IPAs; 3) determine if the presence of the different IPAs predict a CBO’s perceived capacity to adopt, implement, and sustain an EBP; 4) explore if participant perceptions’ of organizational ability, what is important and present, and their CBO’s capacity to adopt, implement, and sustain EBPs differ based on organizational role; and 5) explore training and professional development needs regarding EBP implementation and IS.

Methods

Participants

The study sample included adult participants (i.e., over 18) who were employed by CBOs who deliver evidence-based behavioral health services. Purposive, snowball, and convenience sampling techniques were used to identify potential participants who served in administrative and/or practitioner positions within CBOs in Florida (Creswell & Creswell, 2018). For this study, participants in administrative positions were individuals who serve in a leadership, management, or supervisory position, hold decision-making power within the CBO, and/or have significant influence (e.g., program champion) over other clinical providers and staff. Participants in practitioner positions were individuals who directly provide treatments and/or assist in the facilitation of treatments and do not serve in a leadership or supervisory position within the CBO.

Inclusionary criteria for administrators included: 1) must have been in a leadership, management, or supervisory position for at least six months; 2) work within a CBO that delivers evidence-based behavioral health services; and 3) work within a CBO in Florida. Inclusionary criteria for practitioners within CBOs included individuals: 1) with bachelors-level or above
education (may also include case managers and those not yet licensed and are completing supervised clinical hours); 2) who deliver or assist with the delivery of EBPs for individuals with mental and substance use disorders; and 3) work within a CBO in Florida. This study was reviewed by the University of South Florida’s Institutional Review Board. Every 25th participant to complete the survey received a $25 Amazon gift card.

The following recruitment strategies were employed to recruit a representative sample using a layered approach. First, leadership within CBOs in Florida that deliver evidence-based behavioral health services were identified and contacted to request permission to distribute the survey. CBOs were identified by general internet searches (including SAMHSA and Florida health websites) and contacting CBOs which have established relationships with the authors’ academic institution (i.e., via academic programs). Second, the survey was distributed to graduate students in selected clinical programs (i.e., Social Work and Rehabilitation and Mental Health Counseling) at the authors’ academic institution. Third, the survey was distributed on community Facebook pages and a forum-based website (i.e., Reddit) that are specifically meant for individuals working in CBOs delivering behavioral health services. Finally, the survey was promoted using virtual newsletters and membership emails via behavioral health associations such as the Children’s Mental Health Network, the Florida Counseling Association, and the National Council for Behavioral Health.

G-Power software was used to calculate statistical power prospectively. The sample size of 102, with 51 participants per group, would provide 80% power to detect an effect size of .5, which is sufficient to detect meaningful differences between two groups (Stevens, 1999). In addition, a sample size of 114 would provide 80% power to detect an effect size of .15, which is sufficient to detect significance among nine predictor variables (i.e., the IPAs) (Cohen, 1988).
Instrumentation: Implementation Practice Survey

Data for the current study were collected from a newly developed instrument known as the Implementation Practice Survey (IPS). The survey was developed based on a thorough review of the literature (Aarons et al., 2011; Damschroder et al., 2009; Fixsen et al., 2019; Glasgow et al., 1999; Glisson & Schoenwald, 2005; Massey & Vroom, 2020; Powell et al., 2015; Schultes et al., 2020; Wandersman et al, 2008), including a review of validated measures used to assess common IS constructs (Aarons et al., 2014; Dobni, 2008; Ehrhart et al., 2014; Fernandez et al., 2018; Langford, 2009; Luke et al., 2014; Stamatakis et al., 2012). Input from experts in the field of IS, behavioral health, and community-based service delivery was also acquired to gain feedback regarding face validity. Expert reviewers included individuals from universities as well as those working in an administrative and/or practitioner capacity at CBOs. The survey’s structure and items were amended based on feedback from expert reviewers related to the survey’s: length; organization of items; comprehension of items; and item content. The final survey consisted of 74 Likert-scale and rank order questions and was administered online via Qualtrics Survey Software (see Appendix B).

Survey participants were required to complete a pre-screener questionnaire (embedded at the beginning of the survey) to assess if they met the study’s inclusion criteria. Participants provided demographic and organizational information including: 1) race/ethnicity; 2) age; 3) gender; 4) level of education; 5) role in the organization; 6) length of time in current role; 7) age of population(s) served; 8) categorization of the area where their CBO is located (e.g., rural, urban, or suburban); and 9) if the organization where they are employed utilizes EBPs.

The IPS includes three scales assessing perceptions of implementation practice in three overarching categories: 1) Importance, what participants consider important for CBOs when
utilizing EBPs; 2) *Organizational Capacity*, participants’ perceptions of their CBO’s ability to adopt, implement, and sustain EBPs; and 3) *Presence*, participants’ perceptions of their CBO’s ability to conduct specific activities related to the IPAs. The Organizational Capacity scale includes four items. The first item of the scale is rated on a five-point Likert scale (i.e., strongly disagree to strongly agree). The other items ask participants to rate their organization’s ability to adopt, implement, and sustain EBPs on a scale of one to five (i.e., “1” being the lowest ability and “5” being the highest ability). The Importance and Presence scales include 24 and 35 items, respectively. All items on both scales are rated on a five-point Likert scale (i.e., strongly disagree to strongly agree). Individual questions in the Importance and Presence scales address nine subscales that represent the specific IPAs. The nine subscales are: 1) fit and adaptation; 2) organizational readiness; 3) climate and culture; 4) leadership; 5) education, training, and coaching; 6) external policy; 7) use of data-based decision-making and evaluation; 8) collaboration and communication; and 9) sustainability (see Table 2 for IPA definitions and Figure 1 for a breakdown of the IPS scales and subscales).

Lastly, the IPS includes 11 items that assess training needs. Ten items assess the identification of implementation practice areas where participants believe more training would be beneficial in their CBO and are rated on a five-point Likert scale (i.e., strongly disagree to strongly agree). The last item allows participants to select all options that apply from a predefined list of how they would prefer training information be delivered (i.e., webinars, in-person workshops, online modules, and/or coaching). To measure the internal consistency of the IPS scales, Cronbach’s alphas were calculated. The Importance scale consisted of 24 items (α = .96), the Organizational Capacity scale consisted of four items (α = .78), and the Presence scale consisted of 35 items (α = .96).
Figure 1

IPS Scales and Subscales

Data Analysis

Descriptive statistics were used to examine frequencies, mean distributions, and standard deviations across items, scales, and subscales as well as the overall training scale. To assess relationships between the Importance, Presence, and Organizational Capacity scales, simple correlations were used to examine strength and direction of the associations overall and by the nine subscales (i.e., the IPAs). Paired samples t-tests were used to examine baseline differences in means between Importance and Presence scales within the entire sample (i.e., both administrators and practitioners together). To determine if there were differences in group means between the two organizational levels, independent-samples t-tests were conducted with the Importance, Presence, and Organizational Capacity scales as well as the Importance and Presence subscales (i.e., the IPAs).

Multiple regression analyses were conducted to predict overall assessment of Organizational Capacity (i.e., dependent variable [DV]) from the Presence subscales, including fit/adaptation, organizational readiness, culture/climate, leadership, education/training/coaching,
external policy, data/evaluation, collaboration/communication, and sustainability (i.e., predictor variables). In addition, multiple regression analyses were conducted to predict Organizational Capacity to adopt, implement, and sustain EBPs (i.e., DVs) from the Presence subscales. Lastly, multiple regressions were conducted to predict Organizational Capacity and capacity to adopt, implement, and sustain EBPs from the Presence subscales by organizational level. Data analysis was conducted with SPSS v.26, a quantitative data analysis software (please see Figure 2 for data analysis methods linked to their corresponding study goal).

**Figure 2**

*Study Goals Matched to Corresponding Data Analysis Method(s)*

<table>
<thead>
<tr>
<th>Correlation</th>
<th>Paired Samples T-test</th>
<th>Multiple Regression</th>
<th>Independent Samples T-test</th>
<th>Descriptive Statistics (e.g., means &amp; standard deviations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Explore participant perceptions of their organization’s ability to implement EBPs</td>
<td>2) Examine what is important and present within organizations regarding implementation practice areas</td>
<td>3) Determine if presence of the different implementation practice areas predict a CBO’s capacity to adopt, implement, and sustain an EBP</td>
<td>4) Explore if participant perceptions of organizational ability, what is important and present, and their CBO's capacity to adopt, implement, and sustain EBPs differ based on organizational role</td>
<td>5) Explore training and professional development needs regarding EBP implementation and is.</td>
</tr>
</tbody>
</table>

**Results**

**Participant Demographics**

Participants included 97 individuals working within CBOs in administrative ($n = 38$), practitioner ($n = 48$), or both administrative/practitioner ($n = 11$) roles ($N = 97$). Participants ranged in age from 18-65+, with 48.5% selecting the 30-45 age category and a majority identified themselves as Caucasian (62.9%). A majority of the participants were also female (63.9%) and indicated that a master’s degree was the highest level of education completed
(58.7%) (see Table 3 for full sample demographics as well as participants’ organizational and career information).

**Table 3**

**Sample Demographics (N=97)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>34</td>
<td>35.1%</td>
</tr>
<tr>
<td>Female</td>
<td>62</td>
<td>63.9%</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-30</td>
<td>18</td>
<td>18.6%</td>
</tr>
<tr>
<td>30-35</td>
<td>47</td>
<td>48.5%</td>
</tr>
<tr>
<td>45-65</td>
<td>31</td>
<td>32%</td>
</tr>
<tr>
<td>65+</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>61</td>
<td>62.9%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>9</td>
<td>9.3%</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>15</td>
<td>15.5%</td>
</tr>
<tr>
<td>Asian</td>
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<td>5.2%</td>
</tr>
<tr>
<td>Native American</td>
<td>4</td>
<td>4.1%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>2</td>
<td>2.1%</td>
</tr>
<tr>
<td>Caucasian/Hispanic</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>29</td>
<td>29.9%</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>57</td>
<td>58.7%</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>11</td>
<td>11.3%</td>
</tr>
<tr>
<td>CBO Position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrator</td>
<td>38</td>
<td>39.2%</td>
</tr>
<tr>
<td>Practitioner</td>
<td>48</td>
<td>49.5%</td>
</tr>
<tr>
<td>Both</td>
<td>11</td>
<td>11.3%</td>
</tr>
<tr>
<td>Length in Position (Administrator)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-6 months</td>
<td>2</td>
<td>2.1%</td>
</tr>
<tr>
<td>6-11 months</td>
<td>5</td>
<td>5.2%</td>
</tr>
<tr>
<td>1 to 3 years</td>
<td>13</td>
<td>13.4%</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>16</td>
<td>16.5%</td>
</tr>
<tr>
<td>Over 5 years</td>
<td>15</td>
<td>15.5%</td>
</tr>
<tr>
<td>Length in Position (Practitioner)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-6 months</td>
<td>3</td>
<td>3.1%</td>
</tr>
<tr>
<td>6-11 months</td>
<td>5</td>
<td>5.2%</td>
</tr>
<tr>
<td>1 to 3 years</td>
<td>23</td>
<td>23.7%</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>13</td>
<td>13.4%</td>
</tr>
<tr>
<td>Over 5 years</td>
<td>14</td>
<td>14.4%</td>
</tr>
<tr>
<td>CBO Location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>57</td>
<td>58.8%</td>
</tr>
<tr>
<td>Suburban</td>
<td>30</td>
<td>30.9%</td>
</tr>
<tr>
<td>Rural</td>
<td>8</td>
<td>8.2%</td>
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</table>
Table 3 (Continued)

Sample Demographics (N=97)

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<thead>
<tr>
<th>Location</th>
<th>Count</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>Rural/Suburban</td>
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<td>1%</td>
</tr>
<tr>
<td>Urban/Rural/Suburban</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>

Primary Analyses

Correlation analyses revealed the Presence and Organizational Capacity scales were strongly positively correlated $r(86) = .61, p < .000$. The Importance and Organizational Capacity scales were not significantly correlated, $r(91) = .20, p < .052$. The Importance and Presence scales were not significantly correlated, $r(91) = .06, p = .609$. These results indicate participant perceptions of Importance of the IPAs were not correlated with their Presence in the organization. However, the Presence of the IPAs was correlated with perceptions of whether an organization has the capacity to utilize EBPs. Correlation analyses between the nine individual Importance and Presence subscales indicated the external policy subscales for importance and presence were the only subscales that were significantly correlated $r(96) = .28, p < .005$ (see Tables 4 and 5 for correlation results).

Table 4

Correlation Results of Importance, Presence, and Organizational Capacity Scales

<table>
<thead>
<tr>
<th>Variables</th>
<th>Importance</th>
<th>Presence</th>
<th>Organizational Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence</td>
<td>.056</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational Capacity</td>
<td>.202</td>
<td>.611*</td>
<td></td>
</tr>
</tbody>
</table>

Note. *$p < .01$. 

71
A paired-samples t-test was conducted to compare means between the Importance and Presence scales to assess differences in the scales within the entire sample. There was a significant difference in the mean scores for Importance ($M=4.35$, $SD=.56$) and Presence ($M=3.84$, $SD=.58$); $t(96)=6.53$, $p = .000$. Participants, on average, rated items on the Importance scale higher than they rated items on the Presence scale (see Table 6 for the paired-samples t-test results).
Table 6

Results of the Paired-Samples T-Test

<table>
<thead>
<tr>
<th>Importance</th>
<th>Presence</th>
<th>95% CI for Mean Difference</th>
<th>r</th>
<th>t</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td>4.35</td>
<td>.56</td>
<td>3.84</td>
<td>.58</td>
<td>97</td>
<td>.356,.667</td>
</tr>
</tbody>
</table>

Note. * p < .05.

Three independent samples t-tests were conducted to compare means between administrators and practitioners (i.e., organizational level) on the Importance, Presence, and Organizational Capacity scales. There was a significant difference in the means between administrators \((M = 4.05, SD = .413)\) and practitioners \((M = 3.68, SD = .620)\) on the Presence scale, \(t(79) = 3.17, p = .022\). There was no significant difference in means between administrators \((M = 4.32, SD = .423)\) and practitioners \((M = 4.30, SD = .704)\) on the Importance scale, \(t(79) = .165, p = .111\). There was no significant difference in means between administrators \((M = 3.77, SD = .474)\) and practitioners \((M = 3.59, SD = .512)\) on the Organizational Capacity scale, \(t(79) = 1.61, p = .829\) (see Table 7 for independent-samples t-tests results).

Table 7

Results of the Independent Samples T-tests by Scale

<table>
<thead>
<tr>
<th>Administrators</th>
<th>Practitioners</th>
<th>95% CI for Mean Difference</th>
<th>t</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>SD</td>
<td>n</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>4.32</td>
<td>.42</td>
<td>38</td>
<td>4.30</td>
<td>.70</td>
</tr>
<tr>
<td>Presence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>SD</td>
<td>n</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>4.05</td>
<td>.41</td>
<td>38</td>
<td>3.68</td>
<td>.62</td>
</tr>
</tbody>
</table>
Table 7 (Continued)

Results of the Independent Samples T-tests by Scale

<table>
<thead>
<tr>
<th>Organizational Capacity</th>
<th>Administrators</th>
<th>Practitioners</th>
<th>95% CI for Mean Difference</th>
<th>t</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>n</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td></td>
<td>3.77</td>
<td>.47</td>
<td>38</td>
<td>3.59</td>
<td>.51</td>
</tr>
</tbody>
</table>

Note. *p < .05.

In addition, independent sample t-tests were used to compare means between administrators and practitioners (i.e., organizational level) on the Importance and Presence subscales. With the exception of the external policy subscale, there were no significance differences between administrator and practitioner means on the Importance subscales of fit and adaption, organizational readiness, culture and climate, leadership, education, training, and coaching, data and evaluation, collaboration and communication, and sustainability. This indicates individuals in the organization levels generally agree these IPAs were important to using an EBP. There were significant differences in means found between administrators and practitioners on the Presence subscales, including culture and climate, leadership, and collaboration and communication. Participants in administrative positions rated these three subscales higher when compared to practitioners. There were no significant differences found between means on the remaining Presence subscales. These results indicate discrepancies in the perceptions among individuals in the organizational levels of what is actually present within an organization related to the IPAs (see Table 8 for independent-samples t-tests results by scale and subscale).
Table 8

Results of the Independent Samples T-tests by Scale and Subscales

<table>
<thead>
<tr>
<th>Importance Scale</th>
<th>Administrators</th>
<th>Practitioners</th>
<th>95% CI for Mean Difference</th>
<th>t</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fit &amp; Adaptation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational Readiness</td>
<td>4.25 (.50)</td>
<td>38</td>
<td>4.11 (.78)</td>
<td>43</td>
<td>.148, .440</td>
</tr>
<tr>
<td>Culture &amp; Climate</td>
<td>4.27 (.58)</td>
<td>38</td>
<td>4.29 (.80)</td>
<td>43</td>
<td>-.329, .299</td>
</tr>
<tr>
<td>Leadership</td>
<td>4.31 (.58)</td>
<td>38</td>
<td>4.25 (.80)</td>
<td>43</td>
<td>-.256, .371</td>
</tr>
<tr>
<td>Education, Training, &amp; Coaching</td>
<td>4.35 (.53)</td>
<td>38</td>
<td>4.33 (.86)</td>
<td>43</td>
<td>-.291, .350</td>
</tr>
<tr>
<td>External Policy</td>
<td>4.35 (.48)</td>
<td>38</td>
<td>4.35 (.77)</td>
<td>43</td>
<td>-.281, .294</td>
</tr>
<tr>
<td>Data &amp; Evaluation</td>
<td>4.33 (.53)</td>
<td>38</td>
<td>4.45 (.72)</td>
<td>43</td>
<td>-.197, .367</td>
</tr>
<tr>
<td>Collaboration &amp; Communication</td>
<td>4.31 (.63)</td>
<td>38</td>
<td>4.47 (.70)</td>
<td>43</td>
<td>-.462, .130</td>
</tr>
<tr>
<td>Sustainability</td>
<td>4.36 (.57)</td>
<td>38</td>
<td>4.34 (.86)</td>
<td>43</td>
<td>-.308, .344</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Presence Scale</th>
<th>Administrators</th>
<th>Practitioners</th>
<th>95% CI for Mean Difference</th>
<th>t</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fit &amp; Adaptation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational Readiness</td>
<td>4.08 (.54)</td>
<td>38</td>
<td>3.67 (.68)</td>
<td>43</td>
<td>.130, .679</td>
</tr>
<tr>
<td>Culture &amp; Climate</td>
<td>4.12 (.53)</td>
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<td>3.60 (.78)</td>
<td>43</td>
<td>.220, .819</td>
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<tr>
<td>Leadership</td>
<td>3.92 (.43)</td>
<td>38</td>
<td>3.61 (.62)</td>
<td>43</td>
<td>.069, .545</td>
</tr>
<tr>
<td>Education, Training, &amp; Coaching</td>
<td>4.12 (.49)</td>
<td>38</td>
<td>3.72 (.80)</td>
<td>43</td>
<td>.104, .700</td>
</tr>
<tr>
<td>External Policy</td>
<td>4.00 (.64)</td>
<td>38</td>
<td>3.62 (.76)</td>
<td>43</td>
<td>.067, .693</td>
</tr>
<tr>
<td>Data &amp; Evaluation</td>
<td>4.07 (.61)</td>
<td>38</td>
<td>3.88 (.63)</td>
<td>43</td>
<td>-.079, .469</td>
</tr>
<tr>
<td>Collaboration &amp; Communication</td>
<td>4.03 (.62)</td>
<td>38</td>
<td>3.75 (.72)</td>
<td>43</td>
<td>-.025, .579</td>
</tr>
<tr>
<td>Sustainability</td>
<td>4.19 (.44)</td>
<td>38</td>
<td>3.79 (.78)</td>
<td>43</td>
<td>.114, .687</td>
</tr>
<tr>
<td></td>
<td>4.07 (.56)</td>
<td>38</td>
<td>3.63 (.71)</td>
<td>43</td>
<td>.161, .733</td>
</tr>
</tbody>
</table>

Note. * p < .05.
A multiple linear regression was conducted with the entire sample to predict Organizational Capacity from the nine Presence subscales including fit and adaptation, organizational readiness, culture and climate, leadership, education, training, and coaching, external policy, data and evaluation, collaboration and communication, and sustainability (i.e., predictor variables). The full model, including all predictor variables, significantly predicted Organizational Capacity, \( F(9, 76) = 10.31, p < .0005, R^2 = .550 \). Further analysis showed that four predictor variables, fit and adaptation, culture and climate, leadership, and collaboration and communication, added significantly to the prediction, \( p < .05 \).

Next, three multiple regressions were used to see if the nine Presence subscales differentially predicted organizational capacity to adopt, implement, or sustain an EBP within the entire sample. This analysis was done to identify the IPAs that may be responsible for an organization’s capacity to independently adopt, implement or sustain an EBP. Items representing adoption, implementation, and sustainability were the four items that make up the Organizational Capacity scale. The full model, including all predictor variables, significantly predicted adoption, \( F(9, 76) = 5.38, p < .0005, R^2 = .389 \). Further analysis showed only culture and climate, leadership, and collaboration and communication added significantly to the prediction of adoption, \( p < .05 \). The full model, including all predictor variables, significantly predicted implementation, \( F(9, 76) = 5.04, p < .0005, R^2 = .374 \). Further analysis showed only leadership added significantly to the prediction of implementation, \( p < .05 \). The full model, including all predictor variables, significantly predicted sustainability, \( F(9, 76) = 5.10, p < .0005, R^2 = .376 \). However, further analysis showed no specific predictor variable on its own added significantly to the prediction of sustainability, \( p < .05 \) (see Table 9 for multiple regression results including the entire sample).
Table 9

Multiple Regression Results for Nine Predictor Variables on Organizational Capacity and Capacity for Adoption, Implementation, and Sustainability in the Entire Sample

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>B</th>
<th>SE  B</th>
<th>β</th>
<th>F</th>
<th>t</th>
<th>df</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Model**</td>
<td></td>
<td></td>
<td></td>
<td>10.31*</td>
<td>2.04*</td>
<td>9, 76</td>
<td>.550</td>
</tr>
<tr>
<td>Fit &amp; Adaptation</td>
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<td></td>
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<tr>
<td>Organizational Readiness</td>
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<td>.228</td>
<td>.262</td>
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<td></td>
</tr>
<tr>
<td>Culture &amp; Climate</td>
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<td>.098</td>
<td>.049</td>
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<td>.310</td>
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<tr>
<td>Leadership</td>
<td>.228</td>
<td>.096</td>
<td>.397</td>
<td></td>
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<td>2.36*</td>
</tr>
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<td>.549</td>
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<td></td>
</tr>
<tr>
<td>Data &amp; Evaluation</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration &amp; Communication</td>
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<td>Outcomes</td>
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<td>1.450</td>
<td>9, 76</td>
<td>.389</td>
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<tr>
<td>Overall Model**</td>
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</tr>
<tr>
<td>Fit &amp; Adaptation</td>
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<td>-.053</td>
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<td>Leadership</td>
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<td>2.297*</td>
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<td>.052</td>
<td>-.175</td>
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<td>External Policy</td>
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<td>.069</td>
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<td>Data &amp; Evaluation</td>
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<td>.035</td>
<td>-.030</td>
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<td>Collaboration &amp; Communication</td>
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<td>.044</td>
<td>-.425</td>
<td></td>
<td></td>
<td></td>
<td>-2.561*</td>
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<tr>
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<td>.038</td>
<td>-.026</td>
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<td>-.150</td>
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</table>

<table>
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<tr>
<th>Outcomes</th>
<th>B</th>
<th>SE  B</th>
<th>β</th>
<th>F</th>
<th>t</th>
<th>df</th>
<th>R²</th>
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<td>Implementation</td>
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<td></td>
<td></td>
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<td>1.129</td>
<td>9, 76</td>
<td>.374</td>
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<tr>
<td>Overall Model**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fit &amp; Adaptation</td>
<td>.112</td>
<td>.099</td>
<td>.171</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>.043</td>
<td>-.014</td>
<td></td>
<td></td>
<td></td>
<td>-.073</td>
</tr>
<tr>
<td>Culture &amp; Climate</td>
<td>.049</td>
<td>.042</td>
<td>.235</td>
<td></td>
<td></td>
<td></td>
<td>1.186</td>
</tr>
<tr>
<td>Leadership</td>
<td>.186</td>
<td>.066</td>
<td>.451</td>
<td></td>
<td></td>
<td></td>
<td>2.809*</td>
</tr>
<tr>
<td>Education, Training, &amp; Coaching</td>
<td>.015</td>
<td>.060</td>
<td>.041</td>
<td></td>
<td></td>
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<td>.251</td>
</tr>
</tbody>
</table>

77
Table 9 (Continued)

Multiple Regression Results for Nine Predictor Variables on Organizational Capacity and Capacity for Adoption, Implementation, and Sustainability in the Entire Sample

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>F</th>
<th>t</th>
<th>df</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Model**</td>
<td>5.099</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fit &amp; Adaptation</td>
<td>.138</td>
<td>.079</td>
<td>.275</td>
<td>1.752</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Organizational Readiness</td>
<td>.010</td>
<td>.034</td>
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Note. * p < .05. **Indicates all nine predictor variables are included in the regression model.

Two multiple regressions were also used to predict Organizational Capacity from the nine Presence subscales using data from the two organizational levels separately. The full model using only administrators’ data, and including all predictor variables, significantly predicted Organizational Capacity among administrators, $F(9, 24) = 2.49, p < .0005, R^2 = .483$. The full model using only practitioners’ data, and including all predictor variables, also significantly predicted Organizational Capacity among practitioners as well, $F(9, 28) = 4.29, p < .0005, R^2 = .580$. Further analysis revealed only leadership added significantly to the prediction of Organizational Capacity for both administrator and practitioner subgroups, $p < .05$ (see Tables 10 and 11 for multiple regression results by organizational level).
Finally, six multiple regressions were used to see if the nine Presence subscales differentially predicted organizational capacity to adopt, implement, or sustain an EBP by organizational level. For administrators, the full model, including all predictor variables, did not significantly predict adoption or sustainability, but did significantly predict implementation, $F(9, 24) = 2.28, p < .0005, R^2 = .461$. For practitioners, the full model, including all predictor variables, significantly predicted adoption, $F(9, 28) = 3.70, p < .0005, R^2 = .543$, implementation, $F(9, 28) = 2.83, p < .0005, R^2 = .476$, and sustainability, $F(9, 28) = 2.87, p < .0005, R^2 = .479$. However, further analysis revealed only culture/climate added significantly to the prediction of adoption for practitioners, $p < .05$ and only leadership added significantly to the prediction of implementation for administrators, $p < .05$ (see Tables 10 and 11 for multiple regression results by organizational level).

**Training**

Questions surrounding training needs in the nine IPAs were asked at the end of the survey (see Appendix B). Means and standard deviations can be found in Table 12. Results show the highest training needs were in leadership development ($M = 4.15, SD = .85$), identifying EBPs ($M = 4.15, SD = .67$), and internal collaboration and communication ($M = 4.11, SD = .83$). Participants were also asked their desired method(s) of delivery for an implementation-oriented training. Participants indicated that online webinars ($n = 56$) were the most desired method of delivery, followed by in-person workshops ($n = 53$), coaching ($n = 41$), and online modules ($n = 41$). Many participants indicated a combination of these methods would also be desirable, especially in-person workshops and/or online webinars coupled with coaching ($n = 37$).
Table 10

Multiple Regression Results for Nine Predictor Variables on Organizational Capacity and Capacity for Adoption, Implementation, and Sustainability by Administrator Level

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80
Table 10 (Continued)

*Multiple Regression Results for Nine Predictor Variables on Organizational Capacity and Capacity for Adoption, Implementation, and Sustainability by Administrator Level*

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Note. * p < .05. **Indicates all nine predictor variables are included in the regression model.
Table 11

Multiple Regression Results for Nine Predictor Variables on Organizational Capacity and Capacity for Adoption, Implementation, and Sustainability by Practitioner Level

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Note. * p < .05. **Indicates all nine predictor variables are included in the regression model.
### Table 12

*Training in Implementation Practice Areas Means and Standard Deviations (N=97)*

<table>
<thead>
<tr>
<th>Item*</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Science and practice of EBPs</td>
<td>3.97</td>
<td>.76</td>
</tr>
<tr>
<td>Identifying EBPs</td>
<td>4.15</td>
<td>.67</td>
</tr>
<tr>
<td>Adaptation</td>
<td>4.09</td>
<td>.82</td>
</tr>
<tr>
<td>Leadership development</td>
<td>4.16</td>
<td>.85</td>
</tr>
<tr>
<td>Data and evaluation tools and use</td>
<td>3.92</td>
<td>.92</td>
</tr>
<tr>
<td>Internal collaboration and communication</td>
<td>4.11</td>
<td>.83</td>
</tr>
<tr>
<td>External collaboration and communication</td>
<td>4.01</td>
<td>.81</td>
</tr>
<tr>
<td>Strategic plan for implementation</td>
<td>3.92</td>
<td>.80</td>
</tr>
<tr>
<td>Strategic plan for sustainability</td>
<td>4.03</td>
<td>.71</td>
</tr>
</tbody>
</table>

Note. *Training items assessing implementation practice areas needs were rated on a five-point Likert scale (i.e., strongly disagree to strongly agree).

### Discussion

The purpose of the current study was to examine CBOs and their employee’s perceptions of IPAs deemed important by the literature, how they conceptualize implementation capacity and EBP utilization, and assess whether these perceptions differ based on organizational level. Results of the current study indicated the presence of IPAs is related to the perception of organizational capacity for CBOs to adopt, implement, and sustain EBPs, however, there may still be discrepancies between what is deemed important and what is actually present in terms of IPAs. Participant ratings of the importance of the IPAs were much higher when compared to the presence of the different IPAs. This may suggest although CBOs consider these areas to be important, it does not necessarily guarantee every single IPA is going to be present in an organization.

There appeared to be a general consensus related to what is important for the utilization of EBPs on both organizational levels. However, discrepancies were seen in terms of what is present in CBOs among organizational levels. Results of the current study identify a gap between
IPAs that leadership in CBOs find important and what is actually present in their organizations. This finding suggests a disconnect between the different organizational levels and sheds light on the realities of passive leadership agreement with what the research literature deems important and what is actually taking place within an organization (Mandell, 2020). Practitioners in the study consistently showed lower ratings of the presence of different IPAs when compared to administrators. More specifically, analyses revealed administrators rated the presence of leadership, collaboration and communication, and culture and climate higher than practitioners. This may give evidence to the need for capacity building approaches that are catered to different organization levels and corresponding needs and could be related to issues with specific IPAs, such as communication or lack thereof. Administrators may not be communicating and monitoring frontline staff at the level that would be required to be accurately informed about an EBP being used, and therefore, may be more likely to over report due to a lack of oversight and the need to meet the potential demands of funders and/or external policy.

More research is needed to determine the certainty of perspectives and the specific needs of each IPA by organizational level in order to have applicable, tangible materials and content included in a capacity building initiative for implementation practice (Schultes et al., 2020). For example, a study conducted by Beehler and colleagues (2016) examining ripple effects of implementing EBPs in community mental health settings stressed that foreseeable effects such as hiring new staff also came with unforeseeable effects like role confusion. This is important to consider as employees of CBOs may understand the need or importance of a specific area of implementation practice, such as organizational culture and climate, but may unaware of the different processes involved with having adequate culture and climate, such as buy-in from staff and open communication. Further, results of the current study showed a negative trend for
collaboration and communication and how that can significantly influence organizational capacity. This result could be interpreted as just because something is present and can influence capacity statistically, does not ensure it is being done correctly and/or exhibiting the intended effect.

Further investigation is also warranted to explore what is considered “true capacity”, as capacity among IPAs may look different and require unique solutions depending on the CBO. For example, if an organization says that leadership is important and proper leadership is present, that may not be a target goal of a capacity building strategy. In contrast, there may be instances where an organization does not think an IPA is important and it is not present and this may have to do with the stage of implementation they are currently in with their EBP(s) (i.e., adoption vs. implementation). For instance, a CBO may not have a high rating of importance or presence for organizational readiness as they have moved past that stage of implementation. It will also be necessary to consider if and what IPAs will precede others in importance, and which will remain consistent in importance over the course of the adoption, implementation, and sustainability of an EBP. For example, in a study examining barriers and facilitators to implementing EBPs over time and among different organizational levels in a large-scale school-based behavioral initiative found things such as collaboration, communication, and leadership remained consistently important throughout the lifespan of the initiative and EBP implementation (Massey et al., 2020).

The process of how to confirm areas for capacity building may be assisted by measures such as the IPS that allow for broad investigation of IPAs and incorporates the stakeholder’s perspectives as well as what research and IS theory has shown. It may be necessary to develop a ‘baseline’ for organizational implementation practice capacity to determine what can be accomplished internal to the organizational and where there is a need for external TA or
consultation. While research has shown that TA can assist in capacity building, it has also been shown that for an organization to fully benefit from TA, a certain amount of ‘general capacity’ must be present within an organization to maximize effectiveness (Wandersman et al., 2008).

In terms of presence and capacity, results of the current study showed leadership to be a significant predictor of capacity for both adopting and implementing an EBP and this seemed to be consistent between organizational levels. In addition, culture and climate were also significant factors that predicted capacity. This is in line with the literature stating the importance of relationships between different organizational and implementation areas, like leadership, culture, and climate (Beidas et al., 2019), which provides evidence for capacity building strategies to take the multifaceted structure of these characteristics into consideration. Mixed results have been found regarding organizational and implementation characteristics (Beidas et al., 2019) and the same can be seen in the current study. The IPS may have the ability to serve as an organizational scan to inform and streamline the process of identifying implementation determinants to target implementation strategies towards a specific implementation effort (Williams & Beidas, 2019). However, more research is needed to solidify the accuracy of the measure and to account for moderating factors such as organization size, funding/resources available, and experience of the administrators and practitioners and their differences in terms of what is importance during the different stages of implementation, including sustainability (Stanhope et al., 2017). The results of the current study indicate that sustainability may be something that is not dictated by one or more IPAs, but may be many areas working together simultaneously, which is consistent with IS literature (Shelton et al., 2018).

In terms of training for capacity building, participants generally thought capacity building would be beneficial for all of the IPAs, most notably identification of EBPs, leadership
development, and facilitating internal collaboration. This is an interesting finding as leadership and collaboration and communication were IPAs that were consistently identified as being important and impacting organizational capacity generally, in different stages of implementation, and among organizational levels. The most desired delivery methods for such a training were online webinars and in-person workshops, which is consistent with the literature stating these methods put presumably less burden on the organization as well as have effective results and tend to be cost effective (Stanhope et al., 2017). In this study, the goal of asking questions related to the potential for training in the different IPAs was an attempt to examine the level of interest for capacity building within this unique setting as well as if any area(s) were particularly important. Determining what is important and present within an organization related to the IPAs will be critical to effectively target and build capacity in specific areas of implementation practice. Additional investigation is warranted to further explore training needs from the perspective of the stakeholder to ensure assessment of critical learning opportunities and content are accounting for the individual needs of each CBO and organizational level.

Limitations

The results of the current study, while informative, have several limitations that should be discussed. The sample was limited to administrators and practitioners currently employed within CBOs in Florida. Therefore, the perceptions of the participants in this study may not be representative of other states and/or regions in the country. In addition, although the survey did include definitions of terms and circumstances (e.g., CBO, EBP, adoption, implementation, and sustainability, and training), this may not have been sufficient enough to provide a complete understanding of the concepts being measured. However, the measure was piloted with experts
in the fields of behavioral health and IS and with current administrators and practitioners in CBOs to assist with clarity and understanding. Further development of the measure is warranted.

The results showing differences in ratings of importance and presence within different organizational levels should also be interpreted with caution. Given the limited ability to account for the potential nesting of participants and subgroups in certain organizations, it is difficult to address whether these results are the unique perspectives of the subgroups or if it may be an unmeasured organization effect. Future research using quantitative methods to examine these constructs would benefit from controlling for the nesting of subgroups within organizations.

Lastly, for the multiple regression analyses, the lack of significance for some predictor variables may be related to sample size. Although power analyses were conducted prospectively, recruitment for this study proved to be difficult due to unforeseen global events (i.e., COVID-19). Future quantitative research would benefit from having multiple and reliable recruitment strategies that can be conducted virtually when in-person recruitment is no longer possible.

**Implications for Behavioral Health**

Due to the slow integration of research evidence into community practice settings, it is critical for CBOs delivering evidence-based behavioral health services to consider the activities, resources, and capacity necessary for successful implementation (Aarons et al., 2009a). Building and sustaining organizational capacity for EBP utilization may aid CBOs in meeting the needs of their clients more effectively. Due to IS training efforts predominantly taking place in university settings and having more of an emphasis on research rather than practice, there is a critical need to increase the amount of professional development and education opportunities for CBOs and their staff to increase their knowledge and skill sets in both implementation science and practice (Schultes et al., 2020).
More specifically, it may be beneficial for CBOs to acquire the knowledge and skills necessary to build internal general capacity, meaning they would be equipped to solve problems and address barriers related to EBP implementation internally, without having to rely on external entities (e.g., TA centers and/or universities). Among the multiple barriers associated with EBP implementation, things that have proven to be beneficial for implementation such as acquiring funding for external TA, training, and evaluation, can be very difficult to acquire and sustain, especially when there is no policy or mandate supporting (i.e., funding) these components of the implementation process (Cusworth Walker et al., 2019). Building internal capacity related to the implementation of EBPs that can be sustained long-term could potentially allow issues to be corrected faster due to internal awareness and may result in fewer costs incurred by the CBO.

In addition, because organizations tend to be multifaceted (i.e., multiple organizational levels), it may be necessary to target different characteristics of implementation or training methods to build capacity depending on the organization level (i.e., administrators versus practitioners). Acquiring perspectives of the stakeholders responsible for the delivery of EBPs has provided the opportunity for a deeper understanding of how implementation practice is realized in community settings.

As seen in the development of an EBP, any IS strategy or training requires their core components to ensure effectiveness. However, behavioral health CBOs that are constantly evolving due to operating in a dynamic public health sector may also require capacity building strategies having the flexibility to cater to the unique needs of each organization. The IS literature has established a well-defined foundation of barriers and facilitators for the implementation of EBP. However, future research would benefit from moving past the discussion of barriers and facilitators and instead start to discuss strategies to enable the effective
practice of EBP implementation in community settings that includes key stakeholder perspectives. Internal capacity building, informed by the direct stakeholders (i.e., CBOs and their staff), may serve as a tangible and feasible strategy to facilitate EBP utilization long-term. More research is needed to guide the development of capacity building in these settings and future research would benefit from using qualitative methodologies to explicate the results of the IPS. Assessing CBO perceptions of IPAs aimed at building capacity may result in adequately tailored frameworks and training techniques, greater buy-in within CBOs, and increased efficacy in the operationalization of capacity building strategies and interpretation of evaluation data.

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CHAPTER 4: MANUSCRIPT 3

CONCEPTUALIZING IMPLEMENTATION PRACTICE CAPACITY IN COMMUNITY-BASED ORGANIZATIONS DELIVERING EVIDENCE-BASED BEHAVIORAL HEALTH SERVICES

Abstract

Due to the significant prevalence of mental and substance use disorders in the United States, the push for the development and implementation of evidence-based practices (EBPs) in the behavioral health field has risen exponentially in the last 30 years. Community-based organizations (CBOs) (i.e., self-governing and/or not-for profit) have been identified as significant providers of behavioral health services. However, there are gaps in the literature surrounding CBO implementation capacity, meaning their ability to adopt, implement, and sustain EBPs, and capacity training initiatives that specifically target CBOs and implementation practice. The purpose of this study was to investigate how individuals working within Florida CBOs conceptualize implementation practice capacity, what is needed to reach adequate capacity for implementing an EBP, what would be required of an implementation training initiative to increase capacity, and whether these perspectives differ by organizational level.

An explanatory sequential design was used to examine participant perceptions of implementation practice areas (IPAs) and building implementation practice capacity both quantitatively and qualitatively. The qualitative study consisted of semi-structure interviews with eight administrators and nine practitioners currently employed by CBOs who deliver evidence-based behavioral health services (N=17). The interviews allowed for an in-depth exploration of
participants’ perceptions of their CBOs’ ability to implement EBPs, what IPAs are deemed essential, if the importance and presence of those areas are related, training needs, and why the participant subgroups may differ when statistically tested. Results showed that IPAs such as leadership, culture/climate, training, data-based decision-making and evaluation, and collaboration/communication (i.e., both internal and external) were all important areas of EBP utilization. The level of importance of the IPAs seemed to differ slightly based on organizational level. In addition, important themes emerged including buy-in, importance of EBP use, funding, and the notion of ‘why’ certain things are important for EBP utilization. Implications for future research aimed at examining and building implementation practice capacity in community behavioral health settings will be discussed.

**Key words: Implementation practice; Implementation science; Community-based organizations; Behavioral health; Evidence-based practices**

**Introduction**

Due to the significant prevalence of behavioral health problems, shortage of services, and the need for highly effectively services in the United States, the push for the development and implementation of evidence-based practices (EBPs) has risen exponentially in the last 30 years (Southam-Gerow et al., 2012). EBPs have been identified as a critical strategy to combat the ever-rising prevalence of behavioral disorders in the U.S. (Aarons et al., 2009b; Olfson et al., 2015). In addition, community-based organizations (CBOs) have been identified as important providers of health and social services and addressing unmet behavioral health needs given their unique access to their communities (Bach-Mortensen et al., 2018; Hogg-Graham et al., 2020; Wu et al., 2019).
CBOs offer important avenues for effective EBP dissemination given their influence on health and capacity to stimulate participation on behalf of the community in behavioral health care (Ramanadhan et al., 2012). Despite this, early attempts at EBP dissemination have been met with barriers that may originate from “top down” approaches used by the research community to push EBP usage into communities. Research has shown that simply training community behavioral health clinicians in an EBP is not sufficient to ensure success. Accordingly, there is a great need for strategies that assist with supporting and implementing an innovation for this specific setting (Glisson et al., 2012).

The field of implementation science (IS) attempts to bridge the gap between research and practice by outlining methods or activities that promote and support the use of research findings and EBPs (Aarons et al., 2009a; Bauer et al., 2015; Fixsen et al., 2005; Massey & Vroom, 2020). The formation of the field of IS and its corresponding research is in response to evidence-based practices, models, and polices often failing to affect services that behavioral health professionals and organizations provide to clients, target populations, and communities (Dearing et al., 2018).

Evidence-based service delivery is a complex process that is often met with challenges, and this frequently hinders improvements in the quality and outcomes of behavioral health services (Aarons et al., 2011). Navigating multilayered organizations and communities and their behavioral health service delivery is an intricate process, often requiring extensive time and resources. Because of this, improvements in health services that are based in research often lag behind other industries such as technology or engineering (Aarons et al., 2011; Fixsen et al., 2009).

IS has seen some shift in the direction of implementation practice, and investments in different strategies and theoretical frameworks have been made in capacity building surrounding
implementation of EBPs (Leeman et al., 2015). Implementation practice can be defined as the use of implementation mechanisms and activities informed by research, and used by knowledgeable individuals, to facilitate the adoption, implementation, and sustainment of an evidence-based practice, model, or approach. Many CBOs may struggle with successful integration and implementation of EBPs due to a lack of organizational buy-in, insufficient leadership, a lack of knowledge surrounding implementation characteristics, funding, fit of the program, and difficulties with adaptations (Aarons et al., 2009b; Chinman et al., 2005; Durlak & DuPre, 2008; Willging et al., 2018). Due to the slow integration of research evidence into community practice settings, it is critical for CBOs delivering evidence-based behavioral health services to consider the activities, resources, and possess the capacity necessary for successful implementation practice (Aarons et al., 2009a). The purpose of this study was to investigate how individuals working within Florida CBOs conceptualize implementation practice capacity, what is needed to reach adequate capacity for implementing an EBP, what would be required of an implementation training initiative to increase capacity, and whether these perspectives differ by organizational level.

To create a foundation for gaining CBO insight regarding implementation practice capacity, it was important to consult the research literature based on the science and practice of implementation. Although much of the information may be rooted in theory and research aimed at obtaining internal validity as opposed to external validity, the IS research literature provides a solid foundation of information, which allowed for the development and framing of the essential areas of implementation practice that were explored in-depth during this study. After a thorough review of the literature, nine critical implementation practice areas (IPAs) that are essential for the adoption, implementation, and sustainability of EBPs were identified: 1) fit and adaptation;
2) organizational readiness; 3) culture and climate; 4) leadership; 5) education, training, and coaching; 6) external policy; 7) collaboration and communication; 8) data-based decision-making and evaluation; and 9) sustainability (see Table 13 for IPA definitions). The selections were based on frequency of mention, the significance of findings, and research literature aimed at targeting community-based public health organizations and interventions as well as literature that aimed to develop IS competencies for health researchers and practitioners (Aarons et al., 2011; Damschroder et al., 2009; Ehrhart et al., 2014; Ehrhart et al., 2018; Fixsen et al., 2019; Fixsen et al., 2005; Glasgow et al., 1999; Glisson & Schoenwald, 2005; Massey & Vroom, 2020; Powell et al., 2015; Schultes et al., 2020; Wandersman et al., 2008).

**Table 13**

*Implementation Practice Area Definitions*

<table>
<thead>
<tr>
<th>Implementation Practice Area</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fit &amp; Adaptation</td>
<td>Refers to the importance of recognizing the need, values, and fit of an EBP within a specific population and making adaptations when necessary to increase the fit and acceptability for the organization and/or population of interest.</td>
</tr>
<tr>
<td>Organizational Readiness</td>
<td>Refers to indicators of organizational commitment to implement a new intervention.</td>
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<tr>
<td>Organizational Culture &amp; Climate</td>
<td>Refers to the underlying belief, assumptions, and missions/values that contribute to the environment of an organization and the shared perceptions of the psychological impact of the work environment on the employee.</td>
</tr>
<tr>
<td>Leadership</td>
<td>Refers to a process and/or actions that affect other individual’s understanding and recognition of what and how things should be done and facilitate both individual and team-based efforts to accomplish goals.</td>
</tr>
<tr>
<td>Education, Training, &amp; Coaching</td>
<td>Refers to the degree to which staff within an organization are trained to implement evidence-based practices as well as may be provided mentorship or coaching post-training.</td>
</tr>
</tbody>
</table>
### Table 13 (Continued)

*Implementation Practice Area Definitions*

<table>
<thead>
<tr>
<th>Area</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>External Policy</strong></td>
<td>Refers to external policy, mandates, and recommendations and guidelines on the local, state, and federal levels that have the potential to facilitate and/or hinder the implementation of a new intervention as well as acquiring and allocating funding/resources.</td>
</tr>
<tr>
<td><strong>Collaboration &amp; Communication (both internal and external)</strong></td>
<td>Refers to leadership debriefing with staff and providing ample opportunity and support for inter-organization collaboration. This may include CBOs communicating goals and visions of the organization to its staff and/or instituting formal internal policy to ensure support of the organization’s mission can be fulfilled (Internal). Refers to multiple service organizations may be in communication with one another with the intention to share insight on the implementation process. In addition, this may also include engagement with the community in which they are providing services (External).</td>
</tr>
<tr>
<td><strong>Data-based Decision-making &amp; Evaluation</strong></td>
<td>Refers to utilizing data coming from monitoring and evaluation activities to make decisions regarding evidence-based practices as well as conducting monitoring (e.g., fidelity) and/or evaluation activities targeting evidence-based practices. This may also include acquiring feedback from the implementers about the progress of the implementation.</td>
</tr>
<tr>
<td><strong>Sustainability</strong></td>
<td>Refers to maintaining the implementation, resources (e.g., monetary and/or personnel), and activities related to the implementation of an evidence-based practice long-term.</td>
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**Current Study**

To address the purpose of this study, an explanatory sequential design was used to explore participant perceptions of implementation practice and building implementation practice capacity both quantitatively and qualitatively (Creswell & Creswell, 2018). The results of the
quantitative portion of the study are described elsewhere (c.f., Manuscript 2). Qualitative interviews, informed by the results of the Implementation Practice Survey (IPS), were used to explore, in depth, the results of the survey. More specifically, the interviews explored: 1) what participants consider to be important in order to engage the IPAs and/or what an organization should have/be capable of in terms of using an EBP; 2) why administrators perceived more IPAs to be present in their organization than practitioners when surveyed; 3) what are the IPAs critical to adopting, implementing, and sustaining an EBP; 4) if these perceptions of IPAs differ by organizational level; and 5) what would be required of an implementation-oriented training initiative to increase and/or build practice capacity in these areas.

Researchers and practitioners now recognize the process of implementation is not always linear but can be thought of as a process that happens over stages or phases (Fixsen et al., 2005). Different IS models and conceptualizations exist depicting the different stages of implementation across disciplines, with some including three to four stages involved in the implementation of an EBP (c.f., Aarons et al., 2011; Fixsen et al., 2019), including: 1) adoption; 2) implementation; and 3) sustainability. The different stages may house the core processes that are needed for successful implementation at that given point of time (e.g., adoption). Thus, this study examined, from the perspective of CBOs, what IPAs are critical in the adoption, implementation, and sustainability of EBPs.

**Methods**

**Sample and Recruitment**

The study sample included adult participants (i.e., over 18) who were in administrative and/or practitioner positions in CBOs who deliver evidence-based behavioral health services in Florida. For this study, participants in administrative positions were individuals who serve in a
leadership, management, or supervisory position, hold decision-making power within the CBO, and/or have significant influence (e.g., program champion) over other clinical providers and staff. Inclusionary criteria for administrators included: 1) must have been in a management or supervisory position in their specific organization for at least six months; 2) work within a CBO that delivers evidence-based behavioral health services; and 3) work within a CBO in Florida.

Participants in practitioner positions were individuals who directly provide services and/or assist in the facilitation of services and do not serve in a leadership or supervisory position within the CBO. Inclusionary criteria for practitioners within CBOs included individuals: 1) with bachelors-level or above education (may also include case managers and those not yet licensed and are completing supervised clinical hours); 2) who deliver or assist with the delivery of evidence-based interventions for individuals with mental and substance use disorders; and 3) work within a CBO in Florida. This study was reviewed by the University of South Florida’s Institutional Review Board. Every participant that completed an interview received a $5 Starbucks gift card.

Purposive and snowball sampling techniques were used to identify potential participants (Bernard & Ryan, 2010). The following recruitment strategies were employed to recruit a representative sample. First, interested participants were identified via the IPS used in the quantitative phase of this study. Participants were asked to provide their contact information, that was not attached to their survey responses, if they were interested in participating in a follow-up interview. Second, study flyers were virtually disseminated within CBOs that met the study’s criteria through leadership. Finally, participants were identified through other study participants from within their organizations or through acquaintances. In total, 17 participants were recruited for qualitative interviews, eight individuals in administrative positions and nine practitioners (n=17). The number of participants per subgroup was selected based on research literature.
suggesting eight or more interviews are recommended to reach sufficient data and theme saturation on a particular domain/phenomenon within a group of knowledgeable informants (Fusch & Ness, 2015; Guest et al., 2006).

Data Collection

All interviews were audio recorded with participant consent, lasted on average 35 minutes, and were conducted by the Principal Investigator (PI) over the telephone. Before interviews were conducted, participants were provided with an informed consent form as well as simplified definitions of the IPAs. The PI acquired verbal consent from all participants. The PI allowed participants time to review the informed consent and/or definitions at the beginning of the interview if they did not have an opportunity to review the document beforehand. A semi-structured interview guide with open-ended questions was used to elicit participants’ perceptions of implementation practice and building implementation capacity. The interview guide was developed based on the results of the IPS, including questions that targeted: 1) ways to get organizations to actively engage and/or carry out activities related to the IPAs; 2) why perceptions of how many IPAs were present in organizations differed based on organizational level; 3) discussion of significant IPAs found in the survey related to an organization’s ability to adopt, implement, and sustain EBPs; and 4) preferences for information/training regarding the utilization of EBPs (See Appendix E). The same questions were used for each participant to ensure consistency and to allow comparisons between subgroups.

Data Analysis

Qualitative interview data were transcribed and reviewed for accuracy against the audio recordings by the PI. Thematic analysis was used (Guest et al., 2012) to create codes based on a priori interview guide themes as well as themes that emerged from the data. After reviewing
several transcripts, a preliminary codebook was created that included a brief definition of the code, a full definition, and examples. The PI coded the first interview transcript of each subgroup utilizing the preliminary codebook, met with doctoral committee members to discuss inconsistencies until they reach concurrence, and amended the codebook accordingly. A graduate student was recruited and trained to assist in assessing inter-coder reliability. Two interview transcripts (i.e., 1 per subgroup) were randomly selected to assess inter-coder reliability using subjective agreement (Bernard & Ryan, 2010). Subjective agreement between coders was assessed and allowed for revisions to the codebook (Guest et al., 2012). In terms of code segmenting, both coders identified a beginning and end point for each code segment while reading the text during the coding process. To avoid confusion, only complete thoughts were coded and did not include text from the interviewer unless it provided context. Once coding was completed and agreement was reached, the codebook was modified accordingly. The remaining interviews were coded by the PI. Once all transcripts had been coded, codes were put into broader thematic categories and relevant participant quotes were selected to represent a priori and emergent themes. Comparisons were made across subgroups.

**Results**

Participants reported working in CBOs that serve youth, families, and adults with behavioral health issues such as mood disorders, psychosis, substance use disorders, trauma-related disorders, anxiety disorders, and/or eating disorders in both outpatient and inpatient treatment settings. The most commonly used EBPs mentioned by participants included cognitive behavioral therapy (CBT), trauma-focused therapy, child-parent psychotherapy, mindfulness, motivational interviewing, life skills training, and medication-assisted treatment (MAT).
Findings will be presented based on the most salient and well-developed themes that appeared in each of the key questions asked in the interviews. The key questions of the interview guide included eliciting participant perceptions of: 1) what an organization should be capable of and/or have to implement EBPs and how to engage CBOs in the IPAs; 2) why there were differences seen between what administrators and practitioners think is present in terms of the IPAs in their organizations when surveyed; 3) why are the specific IPAs found to be significant in the IPS critical for adopting, implementing, and sustaining EBPs; and 4) what would the ideal implementation-oriented training include and what are the best delivery methods for such a training in this setting. In addition, differing perceptions related to the IPAs between administrators and practitioners will be discussed.

The major themes for this study were rooted in five of the IPAs including: 1) culture and climate; 2) leadership; 3) collaboration and communication (i.e., internal and external); 4) training; and 5) data-based decision-making and evaluation. Emergent themes such as importance of using EBPs, buy-in, funding, confidence, disconnect and accountability, and the ‘why’ will be also be discussed. Four hypothesized IPAs (1) organizational readiness, 2) external policy, 3) fit and adaption, and 4) sustainability) were mentioned only infrequently. Discussion of these IPAs will be worked into the major themes in which they appeared including importance of using EBPs, funding, and culture and climate. Sustainability will be discussed exclusively within key question 3, which focuses on the stages of implementation. The following themes are those most frequently mentioned by both administrators and practitioners, unless otherwise specified.
Key Question 1: Organizational Capacity and Engaging Implementation Practice Areas

The results of the IPS revealed that only some of the hypothesized IPAs significantly influenced an organization’s implementation practice capacity. Therefore, participants were asked to discuss, in-depth, what CBOs should be capable of in terms of using an EBP and how to get CBOs to engage in the IPAs in order to acquire additional explanation on what is considered the most important general aspects of organizations using EBPs. The themes presented in this section are intended to be spoken about broadly and were not connected to a specific stage of implementation (i.e., adoption, implementation, or sustainability), however, still represent what participants consider as overall implementation practice capacity. The following themes, including both major and emergent themes, will be presented in this section: 1) importance of using EBPs; 2) training; 3) funding; 4) data-based decision-making and evaluation; and 5) buy-in.

**Importance Using of EBPs**

The first major theme that emerged from the data was the importance of using EBPs. Participants noted that using treatments and interventions that have established evidence of their effectiveness via research is critical to ensure successful results with their clients and they are using the best quality services. They also reported EBP use is important to keep clinicians accountable in terms of why or why not they are demonstrating good results with their clients (i.e., fidelity), to satisfy requirements of their funders, and have the outcome data to prove positive results.

Practitioner 1: “And also because these theories or models are evidence-based practice. They’ve been researched, you know, the results are there. And they understand that these are appropriate modeled techniques to use in order to affect change.”

Administrator 5: “I know all of the programs are geared towards having some degree of evidence-base, and we are very committed to that process and those tools because of the
Participants also discussed the importance of staying up to date with research and updates made to EBPs and how this can assist with having the best fit for their clients as well as the needs of the organization.

Practitioner 2: “Because I mean, if they're not looking at the research, they're not being informed. So things change all the time in the world in general. So if they're not actively trying to inform themselves, you know, progressively over time, over their agency’s timeline, then they could get stuck or could be using inappropriate treatment interventions for clients.”

**Training**

Participants noted the importance of organizations having the capacity or acquiring the resources necessary to provide training in regard to specific EBPs as well as ongoing training, coaching, and train the trainer opportunities generally related to EBPs to maintain their mission and stay on target with their clients. Practitioners discussed the significance of having leadership that advocates for adequate training opportunities for their staff. Practitioners considered this important due to changing needs of their clients which may require professional development and/or practitioners not having the means to attend certain trainings without the financial support of their organization. Practitioners also mentioned trainings are often not available or do not have sufficient content regarding specific EBPs they would like to implement and discussed how this has the potential to negatively impact client outcomes.

Practitioner 1: “One, I think they need to make sure that their staff are properly trained or that they're using trainings that are appropriate to the model that they're trying to implement. You know, not all trainers or organizations, educate appropriately, you know, therapists or they're not approved to train therapists. So, one making sure that how they're going about training therapists or clinicians is appropriate.”

Administrators discussed the importance of CBOs being able to provide ongoing training and coaching to staff throughout the implementation of the EBP. It was considered important to
ensure staff are properly educated and provided the supports and coaching needed to combat problems with implementation. One administrator also noted the importance of CBOs being able to provide trainings of substance in order to avoid boredom, “to keep things fresh”, and encourage buy-in and engagement in the material.

Administrator 4: “And the will to not just get some training and then say you're doing it. But to really, you know, go in full circle for that. As far as, you know, the training, the coaching supervision, becoming trainers ourselves.”

**Funding**

Funding in this study was described by participants as the financial capital, along with infrastructure (i.e., building, technology), training, and staff capacity (i.e., resources) needed to utilize an EBP successfully. Funding was a critical emergent theme, not originally identified as an IPA, but that heavily surfaced within the data. Participants reported it essential for CBOs to have enough financial capital to facilitate the use of an EBP, including acquiring EBP materials and adequate training. Participants discussed insufficient funding can lead to turnover and burnout due to heavy caseloads and implementing without fidelity because of the lack of the necessary materials and “staff power”. Practitioners specifically talked about the importance of having enough finances to have adequate frontline staff capacity needed for an EBP. They noted this could potentially help with burnout among clinicians as well as improve fidelity due to having enough support to execute the core components of the EBPs they utilize or would like to adopt.

Practitioner 2: “And I think the one other thing I forgot to mention was actually having the ability to implement appropriately because they have enough staff available. I think that's the biggest thing too, is a lot of times a therapist or a clinician... has to do so much in their day that following a EBP with fidelity, or implementing it with fidelity doesn't necessarily like, it might be more time consuming. And they may cut corners in order to do all the documentation... I've seen that before a lot. So even though they're trained appropriately and they cut corners because they're so boggled down and burnt out.”
Administrators also specifically talked about how CBOs should be very aware of their relationship with their funder(s). They reported open communication with the funder is critical as it can provide the opportunity to be transparent about the need to acquire the time and oversight necessary to overcome implementation challenges or seek assistance in overcoming challenges from the funder.

Administrator 1: “And the other piece is really having and establishing our relationship with our funder, our managing entity locally who manages the fund, but also DCF. Just especially to have those ongoing conversations about implementation challenges and fidelity challenges and things like that. So again, I guess confidence would be the right word of like being able and willing to ask questions and to really gather information from people [funder] who know more than you.”

Data-based Decision-making and Evaluation

Data-based decision-making and evaluation can be defined as CBOs monitoring, supervising, and evaluating services and/or staff. Participants reported the importance of CBOs using data from monitoring and evaluation activities to make decisions regarding client needs and the EBPs provided and identifying and addressing training/professional development needs. Participants reported that understanding fidelity and using monitoring and assessments to ensure fidelity is an essential activity that CBOs should be engaging in on a regular basis. Specifically, administrators reported that regular assessments of ‘implementers’ (i.e., practitioners) keeps them accountable as well as provides the data and opportunity for coaching and feedback when barriers arise. For example, one administrator discussed, “I think the other is whether they do any kind of evaluation on a regular basis. And whether the results of that evaluation of the outcome measures is woven into supervision or coaching. Cause I think that's really important.”

Administrators also mentioned routine data collection and review, coupled with feedback, is important as it allows for more transparent conversations of performance with staff and has led
to improved agreement between different organizational levels (e.g., management and providers).

Administrator 5: “It also takes away the subjectivity of it, right. It's much easier to have a discussion with an employee if there's a performance issue, when you can relate it to some measurables and their performance and compare them to what their peers are achieving.”

Lastly, administrators discussed that collecting data and evaluating outcome data allows the organization to remain on target with their clients and alignment with the mission of the organization. In addition, participants described that organizations using outcome data showing positive results can also be an effective tool to increase buy-in to a specific EBP.

Administrator 8: “Really just the data. I think that's what people try to follow the best. I think wherever we can illustrate positive outcomes related to evidence-based practices, I think that's where the most buy-in comes from both from leadership and from people that are actually clinically working with patients.”

**Buy-in**

Buy-in, for the purpose of this study, was described by participants as an organization and their employee’s acceptance, willingness, and/or commitment to an EBP and the activities associated with adopting, implementing, and sustaining an EBP. Buy-in was a critical emergent theme, not originally identified as an IPA, but that surfaced within the data and is interconnected with other major themes in this study. Participants discussed that feeling invested in the EBP and knowing that it will bring the best results was one of the most important features of using an EBP in a community setting. Participants noted that it was essential for organizations to acquire the feedback of the frontline staff (e.g., practitioners) in order to build consensus within the organization on an EBP as well. For example, asking staff to provide feedback on whether they think a particular EBP would benefit their clients and workloads.

Practitioner 8: “I guess maybe just seeing the value of the program, you know, like kind of having that investment that you feel at work. I guess I think the word is efficacy. Like
you see the benefit, you feel like it works, so then you put in the time and effort, to make that practice fit well in your agency and within your existing team.”

Practitioner 5: “Well, it's a question of being like-minded, I believe. And receptive to change. And if administration can present something to us that's like possibly more open ended and subject to discussion and change as we go along. It seems to work out better.”

On a broader level, administrators discussed the importance of having the buy-in of the entire organization, especially upper management. One administrator noted that utilizing an EBP requires the “right commitment” by the organization, because often, an EBP requires proper resource allocation and determination on behalf of the staff. They reported if buy-in is non-existent, the EBP is less likely to be successful.

Administrator 2: “I think it's an agency that, one, you have to make a commitment. Evidence-based practices when you're implementing them are not cheap. It's an investment of time and money and people power and if you're committed to true evidence-based practice, you have to continue to be committed to training, trained to fidelity of the model. Not just for the staff, any new staff that comes in, but also for the current staff that's here. There's a level of commitment that's needed by your supervisor, administrative team, and staff.”

Key Question 2: Explanation of Differing Perceptions among Administrators and Practitioners of the Presence of Implementation Practice Areas in the IPS

Results of the IPS showed individuals in administrative positions tended to rate the presence of the IPAs higher than practitioners within the survey. In other words, administrators perceived more IPAs to be present in their organizations than practitioners. In order to gain a better understanding of this particular finding from the analysis of the IPS, participants in the interviews were asked to discuss their perceptions. The emergent theme of disconnect, and its subtheme of accountability, are the main explanations participants provided for this specific dichotomy seen between the organizational levels.
**Disconnect**

Disconnect was described by participants as a major separation in communication and awareness experienced between different organizational levels of CBOs, most importantly, administrator and practitioner levels. Interestingly, every single participant, both administrators and practitioners, alluded to this notion in some capacity. Participants, especially practitioners, discussed how this disconnect can negatively affect implementing an EBP, including a lack of implementation fidelity, client outcomes, and a tension between practitioners and management that can influence buy-in and trust. Participants reported that leadership is often not present on the ‘frontline’, and therefore, rely on gaining information about the EBP from outcome data, session notes, and/or data spreadsheets instead of direct supervision and monitoring. Many participants specifically noted this disconnect is heavily influenced by a lack of transparent communication between the levels in a CBO, and this can lead to leadership making assumptions about what activities are taking place on the ‘ground level.’

Practitioner 1: “I think with the upper-level management or the higher in the chain you go, I think there's automatically a disconnect from what's happening on the frontline because they're not on the frontline. They're relying on communication from the lower line staff or the immediate supervisors. And two, it's almost just kind of like word of mouth. They're not in the trenches gathering the data themselves. They're relying on others to relay the data to them. And so one either it's not getting relayed correctly, or two, is not being collected and then relayed appropriately, or three, they're either overestimating or underestimating. They're just assuming and not actually gathering data, you know, the higher ups.”

Administrator 1: “…and this is the first thing that comes to mind. I would guarantee you that the people that said where there was a huge discrepancy between frontline and leadership, is probably because of a lack of open and transparent communication.”

Administrators also mentioned this disconnect can be influenced by the level of documentation that is happening on the frontline and leaders making determinations from limited information.
Administrator 7: “And then second one is documentation. So very typical to, depending on the setting, documentation can be very light. It could be very limited. So it makes it very difficult to see the model within documentation. Again, I think for clinicians, we get very focused on, "I want you as my boss to see that I am doing a good idea." So I write the notes very narrative, versus focusing on the clients and what the client has done and how they've responded and what the purpose is for next session.”

**Accountability.** Participants discussed the disconnect experienced between levels in CBOs may also be a result of leadership’s accountability to upper management and/or funder(s). Participants reported that leadership’s attention may often be focused on macro level issues (i.e., accountability to funders) and they may have to fulfil many roles (e.g., management, clinician, and/or administrator), which may ‘cloud the reality’ of small activities and details associated with EBPs such as supervision, monitoring, and/or open communication. Participants noted these difficulties could result in missing critical opportunities to engage in open communication and/or supervision duties, which can impact buy-in and practitioner performance.

Practitioner 8: “I think maybe because, you know, leadership focuses on a lot more macro issues and they have a lot of different, obligations, maybe that frontline staff don't have. I personally don't need to necessarily worry about like, you know, I know it's important as part of our program to do survey collection data collection, like funding requirements, but I don't have to ever come face to face with those people or it's not a major part of my job role. So I think that that macro lens can sometimes cloud what the reality is like when you're really focused on outcomes, versus what it actually is like to do an evidence-based practice with the participant.”

Administrator 1: “…there's also like some additional challenges being in a middle management position where, especially when you are an outside funder. So like in my position, I've got my entire team. I've got my boss, he's got his boss, we have our funder, we have DCF. And so there's all of these like pressures. Then we have our data gathering that we're doing with [University name] on the side of all that. So there's all this like constant pressure from all sides. And it's like a lot of people aren't good at balancing that.”
Key Question 3: Implementation Practice Areas Critical for Adopting, Implementing, and Sustaining EBPs

The results of the IPS showed specific IPAs were found to be significant predictors for adopting, implementing, and sustaining an EBP respectively. Participants were asked to comment on why they thought culture and climate, collaboration and communication (internal and external), and leadership were critical to adopting an EBP. Participants were also asked why they thought leadership was critical to implementing an EBP. For sustainability, not one single IPA was found to be a significant predictor of sustainability. However, all of the IPAs interacting together did influence sustainability and participants were asked to share their perceptions on that specific finding. Participants were also asked to comment on anything else they perceive to be essential in adopting, implementing, and sustaining an EBP outside the results of the IPS. The following sections provide an overview of major themes as well as themes that emerged from the data related to these key questions. The most salient themes related to adoption, implementation, and sustainability will be discussed separately.

Adoption

Culture and Climate. Organizational culture was viewed by participants as the mission and values of an organization. Climate was viewed by the participants as shared perceptions of the overall ‘tone’ in an organization that can affect buy-in and workplace well-being. A large number of participants noted it was important CBOs include using EBPs in their organization’s mission statement. It was reported this sets the standard of care in an organization and can create a culture that is willing to change and adopt innovation based on the needs of their clients. Participants mentioned CBOs that embrace a culture that is inclusive of EBPs increases the likelihood of an organization being ready to adopt an innovation.
Practitioner 3: “I just imagine… if an organization has a culture where they're very focused on providing the best services or providing the things that they know are going to be the best practice for their clientele, then they're going to adopt whatever becomes new.”

Administrators specifically mentioned promoting the use of EBPs as one of their main goals of their organization’s mission attracts the type of practitioner they would prefer to employ as well as helps to create the buy-in needed for successful adoption.

Administrator 8: “I think that if that's set as the standard, I think it'll, outside of leadership, it'll attract people that will be delivering direct patient care, a certain type of person. Because there is some stability in that. So I think if that foundation is there, it will attract a certain type of employee.”

Participants also discussed the mission and values of the organization need to be properly communicated to staff and it is important there is cohesion occurring between leadership and provider levels regarding why the EBP is being adopted, which can lead to greater buy-in and potentially significantly influence organizational climate.

Administrator 2: “A lot of it has to go and it goes back through the top down is, if the top is able to say, "this is this practice here we support it and adopted for this reason. It's going to meet the mission and vision of the organization that of our clients that we're serving, we believe in this." And then they can demonstrate an understanding of the practice. Then you'll have a buy-in and a culture of change as it trickles down. Cause you have to create the culture of change before you can do any evidence-based practice because things change.”

Lastly, participants discussed that leadership can significantly influence an organization’s culture and climate and this can either hinder or facilitate the adoption of an EBP. Leadership can set the ‘tone’ of the organization in terms of trust, comfortability, workload, and communication styles, and whether these workplace characteristics are perceived positively or negatively by staff can significantly impact if an EBP is successfully adopted.

Practitioner 7: “I would say with the culture and climate piece there has to be from, how I understand culture and climate and how it looks in our organization, I would have to say that there has to be a good trusting relationship. There has to be cohesion
within the organization and trust that leadership has the best interest of their clinicians in mind and not just trying to get paid.”

**Leadership.** Leadership can be considered one of the main overarching themes of this study, often interconnected and/or facilitating many other themes and/or subthemes. However, this theme was most prominent when discussing adopting an EBP. Participants reported that CBOs benefit from having leadership that prioritizes and is knowledgeable about EBPs in order to set the appropriate culture and climate within the organization. One administrator explained that leadership has to be willing to except change before they can expect other individuals to follow suit, “The leadership has to support it and they have to be willing to change procedures… to be able to implement it.” Participants also discussed the importance of open communication and trust between leadership and staff, including leadership providing feedback and coaching to staff in the early stages of adoption.

Practitioner 4: “…when we communicate in team meetings or if I approach someone or one of my higher ups independently and I'm like, "Hey, this is kind of what's going on." If we can't, if you and I can't communicate effectively, it has a direct impact on what I am and what I can and cannot adopt and what I can and cannot implement with my clients.”

Practitioners also noted the importance of leadership being aware of the resources (i.e., staff capacity, training, and time) involved in the EBP the CBO plans to adopt as well as adjust their expectations based on the resources made available to staff.

Practitioner 5: “So management will make request to do this and that, but, you know, manpower wise, budget wise, it doesn't quite match. So sometimes the expectations can be somewhat unrealistic.”

**Collaboration and Communication (Internal).** Participants reported that frequent communication between levels is essential for successful adoption of an EBP in a CBO. Practitioners noted it is important for frontline staff to have the ability to confidently communicate and share feedback with leadership on EBPs. Both administrators and practitioners
reported that it is important for leadership to create an environment (i.e., culture) that welcomes open communication without fear of consequence.

Practitioner 3: “…but everybody needs to feel confident in the ability to communicate and be able to share like, "Hey, maybe this isn't the best practice." And if you don't have that open flow of communication, then there's not going to be, the culture is not going to be able to adapt.”

Administrator 2: “If leadership is not allowing the culture, the frontline folks to say, "okay, leadership, I know you think this, but this is really what we see from you, that your actions aren't matching words." If you don't create an environment that has that dialogue, then you're not going to have a commitment to, "okay, guys, we think this [EBP] is good. Let's go.””

In addition, participants reported collaboration between ‘peers’ and departments within an organization can assist with prospectively identifying barriers and with staff gaining knowledge and feedback from others who may be more well versed in the practice and/or the idea of change.

Practitioner 5: “Peers. Just talk to peers about this. The door is open for talking to peers and to the supervisors if there's problems. It's kind of an open-door policy. If there are issues, problems, or something's not working or something's working very well, then we have that open door policy where we feel we can share that. And if it's not working, we've looked towards different solutions. If it is working, then we continue a practice.”

Administrators discussed the importance of clearly communicating roles and expectations and stated leadership communicating with staff can be a key component in combatting barriers with adopting an EBP.

Administrator 8: “I mean communication internally, obviously it’s kind of crucial… the majority of issues that have been internally in an organization are a communication break downs the majority of the time. So if it's something stressful, like a fundamental change in how someone was doing something, if there's not communication, that's going to be nothing but stressful and uncomfortable feelings. So definitely in communication as far as the, you know, ‘why are we doing this? What's the point of this? Why do I have to do this kind of thing?’ Those are kind of common questions, but communication can usually get ahead of all that if it's done correctly.”
**The Why.** This emergent theme, housed within internal collaboration and communication, can be described as CBOs and leadership providing justification to staff for why certain protocols and procedures are in place while using an EBP, as well as why they have decided to adopt and implement an EBP. Participants discussed the importance of CBOs having leadership that is aware of the potential benefits of adopting an EBP, that CBOs are transparent about why an EBP is being adopted, and appreciate when staff are not, as one practitioner noted, “just told to do it without explanation.” This may include leadership providing explanation to practitioners of how the EBP fits with their clients and demonstrating potential benefits for their clients with data, clearly communicating staff roles and responsibilities for the EBP, and outlining expectations regarding goals and performance.

Practitioner 1: “…if communication is increased, you know, that the upper management or the, the higher in the chain you go that there's openness and there's transparency, you know, this is “why” we want to do it. You know, I'm not just being a micromanager and telling you what needs to be done. Like if the lower line level staff understand why we're doing something, they're more likely to do it, rather than just being told to do it.”

Administrator 6: “…but you need to be letting people know, "yeah, this is important. It's still important. And here are examples of how and why this is important to me." And you need to be kind of reminding people on an almost daily basis of why. If you let people know the why of what you're doing, particularly if you're the one in charge, that makes it one, a lot clearer, and two, a kind of a lot more motivating on my part.”

Collaboration and Communication (External). Participants reported collaborating with other organizations, that are similar in size, services, resources, and staff capacity, can be helpful during the adoption process as it allows an organization to ask questions regarding barriers, costs, resources, and effectiveness of an EBP that was experienced by an external entity. Participants discussed this can give CBOs a preview into what an EBP would look like full-scale and an opportunity to gain knowledge from external organizations regarding what the core components of the program are and how flexible they can be with adaptations.
Practitioner 8: “I guess maybe seeing like, others, maybe agencies or organizations that have used similar evidence-based practice. Like with our program, seeing how successful another program that’s similar to us was really important because then they thought, "okay, well, if it worked for them, it probably can work for us too."

In addition, participants reported external collaboration also could lead to referral opportunities as well as the opportunity to leverage resources between agencies (e.g., training, consultation), which could bolster client outcomes.

Practitioner 2: “And then collaboration of course, you know, it's good for opportunity supports once the EBP is implemented. You can kind of collaborate between different agencies. So maybe one agency can't afford to do the EBP, but because another one in the community is doing it, they can kind of collab and figure out how can we work together.”

**Implementation**

**Leadership.** Specific to implementing an EBP, participants noted the importance of CBOs having leaders that serve as program champions and are modeling, supervising, and providing oversight for the behavior and activities necessary is critical for successful implementation.

Administrator 7: “Leadership is generally the entity responsible for ensuring their clinical staff is providing the services they're contractually obligated to provide. So again, leadership to ensure that those charts are being reviewed, that the clinicians have the support that they need to provide the implementation of the model. So they can do checks and balance. Again, if a clinician is not providing evidence-based treatment or at least with fidelity, leadership is again, is just the entity… responsible for that. So they are going to play a very critical role in engaging and supporting and monitoring, observing, growing their clinical staff.”

One practitioner used a computer analogy to describe the importance of leadership laying the foundation for policies and procedures, and without adequate leadership, implementation can be cumbersome:

Practitioner 6: “I think leadership really lays the framework. I see leadership as the hard drive and all of the other subsidiaries or frontline providers are the software. You can't really have Adobe if you don't have a windows computer. So I think that they set that.”
think they set the kind of framework for the ability for all of the other providers to fill in.”

**Confidence.** Participants also discussed the importance of practitioners having the confidence to implement an EBP. Participants reported staff confidence in the ability to implement an EBP can be facilitated by leadership communicating performance expectations and providing/acquiring professional development opportunities to ensure practitioner knowledge is up to date. One administrator noted this is especially important when staff is tasked with making decisions in their practice:

Administrator 5: “I would say leadership has to be able and be comfortable with empowering staff to make decisions and help them grow as decision makers. So when they're out in the field and they come across scenarios, they feel comfortable and confident in making a decision and knowing that if it's not the right decision, but it was based on good intentions and good analysis of the data that they'll get support.”

**Sustainability**

**General.** Participants were asked to discuss why they thought results from the IPS showed no one single IPA significantly predicting sustainability, as in adoption and implementation. Participants reported there are multiple facets to sustaining an EBP, and many of them, including leadership, buy-in, training, and culture and climate, are complex and often interconnected. For example, one practitioner noted, “It’s never just one thing. If you said it was just leadership, I would have been shocked.” One administrator discussed:

Administrator 7: “Because it's not just one piece that's going to be the answer to sustainability. It is multiple components. You know, to maintain that it wouldn't be sustainable, I think, if it was only determined on one factor, whether it be organization, leadership, any of those areas. It needs to be a multitude of areas. That's part of the reason why you need everybody on board, whether it be from your board members to your leadership, to your clinical staff, your community members, etc. cetera. Because it does take all of that in order to adopt and implement evidence-based practices on all levels.”
**Funding.** Participants frequently discussed funding as being critical for sustainability. Participants reported having a reliable funding source, a good relationship with the funder(s), infrastructure, staff capacity, and external policy that supports, requires, and/or funds EBPs as critical financial and resource factors that should be established to successfully sustain and/or expand an EBP. Please see Figure 3 for theme linkages in key questions 1-3.

Administrator 7: “So when a funder, when an agency has more money and can hire more staff, they can expand their hours, they can go into a different part of the county. They can have an outreach program, you know, there’s other opportunities to implement evidence-based treatment effectively if we had the money to do so.”

**Figure 3**

*Network of Theme Linkages for Key Questions 1-3*

Note. *1) Green boxes represent major themes; 2) Orange and yellow boxes represent emergent themes; 3) Blue boxes represent the stages of implementation and their corresponding themes; 4) Black lines indicate relationships between major themes and the stages of implementation; 5) Green lines indicate relationships between major themes and emergent themes; and 6) Orange and yellow lines indicate relationships between emergent themes and major themes.*
Key Question #4: Implementation-oriented Training

Results from the IPS showed survey participants thought it would be beneficial for CBOs to receive capacity building training in all of the IPAs. Therefore, participants of the current study were asked to discuss what they would consider to be the ideal content for an implementation-oriented training. Participants struggled with discussing what implementation-oriented information they and their organization would benefit from learning that was not connected to a specific EBP. However, they were able to report general information that would be beneficial to know about EBPs, which led to the theme of EBP information. Participants also provided recommendations for creating buy-in among staff for an implementation-oriented capacity building training and were asked to discuss the ideal delivery methods for a training.

EBP Information

EBP information refers to an implementation-oriented training providing information about EBPs, including how EBPs can address the services need of their clients, theory of change, what may change in their routine practice, explanation of why change is happening, and specific roles and responsibilities of everyone in the CBO related to the EBP(s). Participants reported that it would be advantageous to learn information about the effectiveness of the EBP, including showcasing data from similar organizations that have shown success with a specific EBP or EBPs in general and the cost and resources necessary to utilize the EBP.

Administrator 4: “Well, that's salesmanship actually. I think for one thing I would, if I was that executive director or somebody in leadership, I would want to know some information about why evidence-based practices are effective. I'd want to know examples from people that have implemented it. I want to know outcomes in general. And I wouldn't be necessarily looking for specific evidence-based practice outcomes, but more on the lines of some general analysis of improvement by, you know, several of them… Cost, and, and what you have to able to change your infrastructure, to be able to do it.”
In addition, participants noted capacity building surrounding fidelity and data collection, what the core components of an EBP are, why it is important to implement with fidelity, and what is expected from staff in regard to adopting an EBP would be beneficial to incorporate into a general implementation-oriented training.

Practitioner 6: “That's it's an evidence-based practice. So when you deviate from that, what are some of the negative consequences, or maybe not negative consequences, why are we not seeing so many positive outcomes? Because the evidence says it's working, but we're doing it this way. We tweaked it a little bit, but it's not giving anything, therefore, it doesn't work for us to stop doing it. Fidelity is very important.”

**Recommendations for Creating Buy-in Among CBO Staff for an Implementation-oriented Training**

**Feedback.** Participants recommended that acquiring feedback from both leadership and frontline staff on what professional development opportunities are desired as well as to identify any barriers, such as CBO procedures or policies that may be hindering implementation, is critical for establishing a training initiative. More specifically, administrators stated when staff are engaged in the process of decision-making about trainings and professional development, they are more likely to fully commit to the opportunity.

Administrator 2: “And then by doing that, because when you report back to everybody, who's been a participant in all of this, they can see the active role they've played in the direction of this new practice. And so then you have buy-in, because I've had say from the get go of what's going to happen here.”

**Ideal Delivery Methods for an Implementation-oriented Training**

Results of the IPS showed participants indicated that online webinars were the most desired method of delivery for an implementation-oriented training, followed by in-person workshops, coaching, and online modules. Many participants in the survey indicated a combination of these methods would also be desirable, especially in-person workshops and/or online webinars coupled with coaching. Interestingly, all administrators and practitioners in the
current study reported that in-person trainings allowing for discussion, role play, and the opportunity to ask questions would be the ideal delivery method for trainings with an implementation focus. Participants also discussed that it may be beneficial to couple training with coaching from leadership or external experts as well as provide follow-up training/professional development opportunities via computer.

Practitioner 8: “I really prefer in person. I just feel like, it's just easier to talk face to face, to give examples. I know compared to when we've had our in-person trainings, when we first started this program, to recently when we've been online. Like you still get the information, but I don't know. I just feel like there's something to be said about being in that environment versus like just sitting at home. But like being in the environment with your team, being able to bounce ideas off each other and kind of have that group discussion, I think it's definitely different in person.”

Participants also discussed that it would be beneficial for experts of the EBP, whether a provider and/or trainer with significant experience or an EBP developer, to facilitate trainings. However, this recommendation was made more for training focused on specific EBPs as opposed to broad implementation. In addition, administrators discussed who would need to receive implementation-oriented training and what specific content should be included needs to be determined by the organizational level. For example, one administrator stated:

Administrator 8: “I would say the training would need to kind of just be built towards whatever specific group that is. You know, outside of the training for the modality itself. You know, leadership, executive leadership isn't probably gonna know a lot of the lingo, but can certainly kind of understand liability, kind of reimbursement and critical outcomes, retention, those kinds of things. So I think it was built like that. I think people on the ground can understand those things as well, and that might be interesting for them, but I don't think the converse would be true. I don't think, you know, more of the down in the weeds kind of stuff would be interesting to some of the leadership folks.”

**Differences between Organizational Levels**

One goal of this study was to identify any key differences between administrator and practitioner subgroups within any of the major and/or emergent themes. The next three sections
outline where the data showed the most apparent differences in language and content among the subgroups related to buy-in, data-based decision-making and evaluation, and funding.

**Buy-in**

Although the subgroups generally agreed about certain components of buy-in, administrators seemed to discuss buy-in as something that is needed at a broader level. In other words, administrators discussed buy-in as something that is necessary at all levels of the organization, including the funder, and some discussed how they seek employees (i.e., frontline staff) that are already bought into the idea of using EBP. However, administrators may be conceptualizing buy-in as staff coming into the organization with expertise and training from the start. Practitioners seemed to discuss buy-in as if the organization and leadership is responsible for building trust and proper communication with frontline staff and modeling certain behaviors that would elicit better commitment and engagement from staff. Practitioners may consider it the organization’s and leadership’s responsibility to provide the foundation needed to create buy-in.

**Data-based Decision-making and Evaluation**

This theme seemed to be significant for both subgroups, however, administrators most frequently discussed the use of data to not only make decisions, but to also improve performance of staff by demonstrating results using data. Administrators discussed using data as a tool to inform and fulfil funder requirements and meet expectations of their clients. While administrators talked about the use of data and evaluation most frequently in the initial key questions of the interview, practitioners were more focused discussing fidelity and it being essential to implementing and sustaining an EBP and its results.
Funding

Funding was of the upmost importance to both subgroups, however, differences were seen in the focus of what specific resources were needed. Administrators talked about funding more generally and referred to budgets, budget plans, and funder relationships, while practitioners talked about the need for sufficient and sustainable funding, the need for funds to support adequate training and professional development, and enough staff capacity to meet the demand and avoid burnout and turnover.

Discussion

The purpose of this study was to investigate how individuals working within Florida CBOs conceptualize implementation practice capacity, what is needed to reach adequate capacity for adopting, implementing, and sustaining EBPs, what would be required of an implementation training initiative to increase capacity, and whether these perspectives differ by organizational level. Leadership presented as a very important theme of implementation practice capacity, often facilitating many other IPAs within all stages of implementation. Similar to results of this study, other research has shown leadership prioritizing EBPs and making evidence-based services a part of the CBO’s overall mission can lead to increased buy-in and willingness to use EBPs among staff, increase the motivation of staff to improve competencies in the latest efficacious practices, and acquire more opportunities for professional development via training (Beidas et al., 2019; Rogers et al., 2020).

In addition, leadership taking steps to acquire support structures such as supervision, infrastructure, time for training and coaching, and communicating roles and responsibilities may result in higher implementation fidelity and successful outcomes (Brookman-Frazee et al., 2020). Role clarity, staff having a clear understanding of their role, responsibilities, and fit within an
organization, has been identified as an important component of a functional organizational climate that can be facilitated by leadership. Research has shown leadership and role clarity are significantly related to staff burnout and personal accomplishment (Green et al., 2014). These findings align with the results of the current study suggesting having invested leadership that clearly communicates roles and responsibilities, supervises, and coaches may lead staff to experience higher levels of confidence, perceived efficacy, and buy-in (Green et al., 2014; Rogers et al., 2020).

In addition to leadership, internal and external collaboration and communication presented as a critical IPA for implementation practice capacity in adoption, especially internal communication. Results of this study give evidence to the importance of clearly communicating the ‘relative advantage and priority’ of adopting and/or implementing an EBP (Barwick et al., 2020). When clear and distinct advantages of utilizing a specific EBP are communicated and staff perceive EBP use as an organizational priority, there is an increased likelihood of successful adoption and implementation. Transparent communication through leadership can be used as a tool to combat staff tension surrounding change as well as to review why an EBP may be the optimal service option based on the needs of their clients (Barwick et al., 2020).

Results of the study showed external collaboration can also serve as an important resource outlet for CBOs. Research has shown that service partnerships between different CBOs assist with providing a foundation for acquiring and leveraging the expansion of connections, resources, and access to new information (Aarons et al., 2011; Concha, 2014). Results of this study also highlighted the desire for collaboration with experts such as EBP developers and/or individuals with extensive EBP experience. Collaborative adaptations of EBPs may assist staff of CBOs with viewing EBPs as more flexible as well as more likely to fit the client and community
(Brookman-Frazee et al., 2020). In addition, and in line with the results of the current study, research has shown that partnerships between funders and CBOs can facilitate EBP implementation more successfully and lead to more sustainable resources, infrastructure, and provide a cushion for the ever-changing landscape associated with behavioral health service provision (Willging et al., 2016).

Results showed leadership, internal collaboration and communication, culture and climate, and buy-in proved to be areas that define implementation practice capacity, that are interconnected, and may influence each other in all stages of implementation, but especially adoption and implementation. For example, leadership can often set the culture and climate of an organization, which research has shown to affect open communication and buy-in to adopting and implementing an EBP (Aarons et al., 2011). Research examining clinician practice change within an EBP supportive system showed an increase in clinician’s use of EBPs system-wide, although only half of the clinicians participated in the system-sponsored EBP initiative (Beidas et al., 2019). Beidas and colleagues (2019) reported these results may be due to leaders trained in EBPs through the initiative may have provided support to other staff in using such techniques, peer to peer interactions may have led to increased interest in the techniques, and/or changing the system’s culture may have influenced the priorities of the organizations involved in the initiative. Results of the current study and prior research suggest CBOs implementation practice capacity would benefit from having leadership that creates a culture that is accepting of EBPs, a climate that is open and welcoming for staff, and advocates/strategizes for trainings (Stanhope et al., 2017), which can all facilitate communication and buy-in to EBPs.

The current study showed collecting and using data to make decisions and critique implementation performance as a critical capacity CBOs should be capable of and conducting
frequently. CBO staff may have programmatic knowledge and skillsets for EBPs, but may lack skills in major areas of monitoring and evaluation (e.g., data collection/analysis or measure development) (Kelly et al., 2014). In addition to a lack of formal training and/or experience with data and evaluation, staff may often have limited time to conduct evaluation activities sufficiently and/or the task is not specifically outlined or communicated in their responsibilities as an employee (Kelly et al., 2014). This is in line with the results of the current study showing staff of CBOs would like to receive capacity building in EBP information, including data and evaluation activities, and improved communication surrounding roles and responsibilities related to EBPs.

Although results of the current study specifically show the importance of adequate funding in facilitating the sustainment of EBPs in CBOs, other clear determining factors were not elucidated. Researchers have frequently conceptualized sustainability as the final stage of implementation. However, due to changes in organizations and client populations’ needs, planning for sustainability has now been recognized as an important activity that should be considered through all stages of implementation and should allow for “adaptation and capacity building in response to new evidence, policies, or other influences” (Shelton et al., 2018, p. 59).

Results from the current study suggest the need for most IPAs to be maintained in order to obtain successful outcomes long-term.

Interestingly, there were limited differences between the organizational levels on the perceptions of implementation practice capacity. The main dichotomy seemed to be related to a breakdown of communication between the levels as well as a lack of inclusion of staff feedback in decision-making processes for EBPs. Although leadership was found to be a central finding of this study, the incorporation of feedback from frontline staff to build consensus within a CBO is
also essential. Research has shown the immense impact power structures (i.e., levels of leadership) can have over implementation and it is important staff know not only where they fit into such a hierarchy, but also are allowed the opportunity to have their knowledge valued, as both can influence commitment to an EBP (Rogers et al., 2020).

Strengths and Limitations

Strengths of the study should be noted. Within the IS literature, there has been a call for an increased understanding of the practitioner context related to implementing EBPs, especially within community settings, as this is a setting that has access to a large number of diverse clientele within behavioral health care (Barwick et al., 2020; Beidas et al., 2016; Last et al., 2021; Westerlund et al., 2019; Wolfenden et al., 2020). This study allowed for the in-depth exploration of implementation practice and building capacity of CBOs to utilize EBPs. This is an innovation approach to collecting rich data on this topic where there is a gap in the literature, as a significant amount of IS research tends to be quantitative (Last et al., 2021) and focused on building IS theory and frameworks.

Limitations of the study should also be noted. The interview guide was designed based on the results of the IPS, which included specific IPAs that were significant when assessed within the different stages of implementation (i.e., adoption, implementation, and sustainability). However, during data analysis of the current study, it was difficult to differentiate whether participants were referring to some IPAs within a specific stage of implementation or if they were discussing them generally. This was especially true when participants were asked to respond to different IPAs being important for adoption and implementation. This may have been a result of the stage of implementation they were currently in with an EBP at the time of the interview, length in position, and/or organizational role. This limitation is mitigated by safeholds
such as definitions that were provided beforehand of stages and IPAs and the interviewer being explicit about the stage of implementation in which they were inquiring about. Future research may benefit from inquiring in more detail where each organization and participant stood in terms of implementation stages and EBP utilization.

More codes appeared within the adoption stage than other any other implementation stage. This may have been a result of how the questions were asked (i.e., order) and/or participants not fully understanding the differences in the stages of implementation. Given this limitation, it may be important to incorporate the stages of implementation into a training initiative to ensure employees of CBOs are well-informed of the implementation process.

Lastly, results of the current study show an interest in an implementation-oriented training among participants, however, the content of such training still needs to be explored among key stakeholders. It was difficult to elicit information about what content participants would want in such a training. Most participants related the information to a specific EBP as opposed to general implementation, which was the desired information the interviews aimed to elucidate. This may have been a result of question format, insufficient explanation, and/or participants truly being unable to respond to this question without relating the information to a specific EBP. Therefore, results focused on specific training content should be examined with caution.

**Implications for Behavioral Health**

Although IS and implementation practice are closely related, each facet requires its own set of capacities and needs (Barwick et al., 2020). Therefore, pragmatic training initiatives aimed at building capacity to utilize EBPs in community behavioral health settings are essential. The long-term goal of implementation practice capacity building is to shift the perspective of
thinking of areas such as training/coaching and organizational readiness as implementation strategies and instead consider these areas as activities organizations need to be capable of for implementation practice and successful outcomes. The results of the current study add to the generalizable knowledge of the science and practice of implementation by highlighting the critical areas of implementation practice capacity and what CBOs should be capable of in order to adopt, implement, and sustain EBPs.

Leadership presented as being the cornerstone of implementation practice capacity in this study, often facilitating other important IPAs such as culture and climate and collaboration and communication. Future research would benefit from further exploration of what is considered effective leadership in regard to EBP utilization, what is needed specifically for ‘implementation practice leadership’, and how effective culture and climate and collaboration and communication can be achieved among staff and leadership. The results of IPS showed that leadership can often agree on what is important for utilization of an EBP, but the results of the current study suggest that may only guarantee passive compliance in IPAs. This gives evidence to why training initiatives may benefit from having different areas of focus for capacity building based on organizational role and level. Future research would benefit from further exploration of the dichotomies seen between organizational levels and how that may impact capacity building within implementation practice. In addition, prospectively assessing capacity building needs in each unique organization using measures such as the IPS as well as organizational feedback may assist with developing a more appropriately tailored capacity building approach (Kapucu et al., 2011).

Stakeholder perspectives on the process of implementation, including barriers and facilitators, are frequently overlooked due to research suggesting quantitative methods and
models surpass the service provider perspective (Last et al., 2021). However, the field of IS has come to realize that using stakeholder perspective in tandem with scientific theory can elucidate why or why not researched implementation strategies are effective. Incorporating scientific theory with lived experience can assist with the organization of concepts that may allow for the establishment of criteria for the use, evaluation, and potential revision of IS theory (Last et al., 2021). The combination of theory and stakeholder perspective can further the development of a capacity building initiative that is sensitive to the unique needs of each organization and the community context and incorporate key IS concepts based in research. Due to considerable budget cuts at Federal and state levels, the everchanging economic environment in the U.S. regarding behavioral health, and the increased demand for services in community settings, CBOs would benefit from building implementation practice capacity for utilizing EBPs to manage the dynamic landscape involved in evidence-based behavioral health service provision (Kapucu et al., 2011) to ensure positive outcomes among clients.

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CHAPTER 5: SUMMARY, RECOMMENDATIONS, AND CONCLUSIONS

Summary

The purpose of this dissertation research was to examine how community-based organizations (CBOs) delivering evidence-based behavioral health services conceptualize an organization’s capacity to utilize EBPs in community settings. The goal was to acquire key stakeholder perspectives that would serve to inform future efforts aimed at building implementation practice capacity.

Each manuscript in this dissertation contributed to a deeper understanding of implementation practice in behavioral health care settings and shed light on gaps in the implementation science (IS) literature incorporating stakeholder perceptions of implementation practice capacities. The first manuscript lays the foundation for the history and challenges facing the field of IS in developing strategies for implementation practice and combatting the knowledge to practice gap. The second manuscript explores: 1) the importance and presence of different activities and individuals associated with implementation practice capacity; 2) if the presence of the different implementation practice areas (IPAs) predicts a CBO’s capacity to adopt, implement, and sustain an EBP; and 3) how these perspectives differed based on organizational level and role (i.e., administrators vs practitioners). The third manuscript allowed for a more in-depth understanding of the results described in manuscript two as well as examined the intricacies of IPAs, examined what IPAs are critical for adopting, implementing, and sustaining EBPs, and provided more explanation as to why there is a disconnect between perceptions of administrators and practitioners.
This dissertation utilized IS research findings as the groundwork to develop both quantitative (i.e., Implementation Practice Survey [IPS]) and qualitative measures (i.e., interviews) to collect data and information from key stakeholders that specifically target the notion of implementation practice. The distinction between research and practice was not clearly distinguishable in the survey, however, it did provide the foundation for further exploration of key IPAs and the differences in responses between administrators and practitioners. IPAs such as leadership, collaboration and communication, and culture and climate were significant findings in both phases of the research. Interestingly, not all IPAs identified from the IS literature were found to be important and/or present in CBOs. For example, external policy and organizational readiness were not significant findings in the survey and were rarely spoken about directly in the interviews.

The lack of discussion surrounding external policy may be related to external entities, including technical assistance and intermediary organizations, having the relationships with funding entities and/or limited individuals internal to an organization handle the bureaucratic responsibilities. Organizational readiness was alluded to in other IPAs such as organizational culture and climate, however, the lack of significance of this particular IPA is surprising given its cited importance in IS research. This may have to do with the participants being past the adoption phase of implementation where organizational readiness is most prominent. In general, more IPAs were discussed in the interviews, including additional IPAs such as buy-in, importance of EBP use, and funding, compared to the number IPAs that were significant in the survey. The interviews may have allowed for further explanation of IPAs that were explicitly asked about (i.e., leadership) and that may also have allowed for further exploration of how IPAs are interconnected and may influence one another.
Recommendations for Research

What IS researchers and EBP developers choose to research is heavily influenced by what funding is available. This can result in EBPs and IS approaches being developed with static protocols, are highly theoretical, are often disconnected to the end user (i.e., practitioners and service organizations), and do not account for the dynamic nature of behavioral health services (Lyon et al., 2016). This poses the problem of having a product (i.e., implementation strategies) that does not take real-world barriers into consideration, that is used incorrectly, and/or is unable to be replicated (Birken et al., 2017; Proctor et al., 2013).

Future research efforts aimed at providing more structure to the notion of implementation practice and capacity building should consider incorporating stakeholder feedback to ensure relevancy. More specific to the results of this dissertation research, it may be beneficial to examine the implementation practice capacity needs prospectively from CBOs using comprehensive measures, such as the IPS and key stakeholder feedback, to ensure appropriate consideration of where capacity building efforts should be focused. In addition, further development, refinement, and testing of the IPS is needed to ensure not only the reliability and validity of the measure, but also to ensure its practicality for this specific setting.

Next, more research is needed to fully understand the activities and individuals involved with the IPAs in the context of practice and explore if the lack of participants’ ability to answer questions related to certain IS concepts is related to organizational role, time of hiring, knowledge base, and/or training. It would also be prudent to inquire if it is appropriate to categorize practice areas in certain stages of implementation for CBOs. Further exploration may be guided by questions such as: 1) what IPAs are important through the entire process of implementation for CBOs?; and/or 2) what IPAs are most important during what stage and for
whom? There may be a need to emphasize certain areas at specific stages and with individuals in specific roles (i.e., administrator vs. practitioner). It is important to examine these concepts more closely and build off of the results of the current dissertation research, as it will affect the sequencing of a capacity building initiative.

In addition, more research is needed to determine whether a capacity building effort could be delivered using general information about EBPs as opposed to specifically focusing on capacity building for one EBP. Participants had difficulties answering questions focused generally on an implementation-oriented training and the majority of responses were connected to a specific EBP. More inquiry is needed to determine if the internal capacity built focusing on one EBP could be transferred to subsequent EBPs a CBO may plan to adopt.

Another consideration for future research efforts is to assess whether internal capacity can in fact stay completely internal or will there be a need to bolster capacity efforts with follow-up initiatives and technical assistance to account for inevitable changes known to behavioral health care organizations (e.g., turnover). The questions that still need to be answered are: 1) can internal capacity be created and eventually sustained without the assistance of purveyors and/or intermediary organizations and will this differ based on the organization?; and 2) is internal capacity possible in all aspects of implementation practice or is this dependent on the organization?

The importance of leadership and the disconnect between leadership and frontline staff were significant findings of this dissertation research in both the quantitative and qualitative phases of the study. Research has shown the immense impact that leadership and power associated with organizational roles can have on the implementation process and organization culture and climate (Aarons et al., 2011; Aarons & Sommerfield, 2012; Rogers et al., 2020).
Further exploration of how leadership, and the power and authority associated with leadership, can affect implementation practice within CBOs would be beneficial. This may assist in determining what collaborative structures might be necessary to successfully overcome the disconnect between organizational levels and facilitate organizational capacity building most effectively.

Lastly, further examination of capacity needs by organization level and role is needed to inform the development of a capacity building initiative. Future research would benefit from moving beyond the general leadership and frontline staff levels and further examine the needs of individuals in different organizational roles. For example, a middle level manager may have different capacity needs and perceptions of implementation practice compared to upper management.

**Recommendations for Practice**

The largest dichotomy observed between organizational levels in this study was the disconnect in communication and awareness experienced between the different levels related to EBPs. The knowledge gained from this study may assist CBOs in navigating this disconnect more effectively. Results provide evidence for the importance of CBOs prioritizing open and direct communication between administrators and practitioners. It is recommended that administrators provide clear instructions for roles, responsibilities, and performance expectations for practitioners related to EBPs. It may be also be critical for administrators to provide practitioners the space to dialogue and freely provided feedback related to EBPs, including organizational and personal needs (e.g., training or professional development). Leadership can often set the tone of an organization (i.e., culture and climate), which research has shown to affect open communication (Aarons et al., 2011). Administrators providing the opportunity for
practitioners to provide feedback may lead to greater buy-in during the adoption and implementation of an EBP and its corresponding training initiative.

**Conclusions**

Frequently, research is focused on establishing interval validity within randomized controlled trials (RCTs) at the expense of external validity. The complexities of service delivery settings and contexts, critical components to effective implementation, may be diminished in highly controlled research settings. This can decrease the usability and usefulness of EBP implementation and its associated IS approaches in real practice settings (Barwick et al., 2020). This gap may be further exacerbated due to many IS theories and frameworks being developed across health disciplines with limited cross-discipline collaboration (Nilsen, 2015), research findings being potentially contradictory across disciplines (Wandersman et al., 2008), and existing frameworks providing limited guidance regarding methods that ensure user needs are being met (Lyon et al., 2016). All of these factors have contributed to a lack of cohesion and transparency among researchers (Barwick et al., 2020), which has led to the issue of a “knowledge to practice” gap (Westerlund et al., 2019).

This dissertation research study introduces a baseline conceptualization of implementation practice capacity and highlights different areas of importance for utilizing EBPs in community settings by acquiring feedback directly from key stakeholders. IS has been introduced as an applied science that has assisted in forming an influential relationship between research and practice in behavioral health care aimed at improving service provision and client outcomes (Albers et al., 2020). Westerlund and colleagues (2019) have noted the recurring question of whether findings and evidence from IS research have sufficiently reached the “world of practice” (p. 332). The main objective of IS was to assist with translation of evidence-based
practices (EBPs) into the field of practice. Yet, we still see significant emphasis placed on research and less on the practice and process of implementation. Limited information exists on how to guide practitioners in the implementation of EBPs. The translation of IS research into practice requires that we answer the question of how IS research findings can be made relevant for practitioners and service organizations. IS research that incorporates the perspectives of key stakeholders may provide closer linkages between research and practice (Albers et al., 2020).

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Appendix A: Informed Consent to Participate in Research – Phase 1

Moving Science to Practice: Exploring Implementation Capacity Building in Community Settings – Phase 1

Study IRB# __686__

Overview: You are being asked to take part in a dissertation research study. The information in this document should help you to decide if you would like to participate. The sections in this Overview provide the basic information about the study.

Study Staff and Details: We are asking you to participate in a survey that is a part of the principal investigator’s, Enya Vroom, dissertation research project being conducted at the University of South Florida that is guided by her faculty advisor, Dr. Tom Massey. The purpose of the study is to explore how community-based organizations that deliver behavioral health services to adolescent and/or young adult populations perceive an organization’s capacity to implement evidence-based practices in community settings. You are being asked to complete 15-20 minute survey.

Participants: We are asking you to take part in this study because you are an administrator/manager/supervisor and/or behavioral health professional from a community-based organization that delivers or assists with the delivery of evidence-based practices related to mental health and/or substance use with adolescent and/or young adult populations in Florida. It is hoped that through your participation, researchers may gain a better understanding of how evidence-based practices are implemented in community settings that deliver behavioral health services to adolescents and young adults.

Voluntary Participation: Your participation is voluntary. You do not have to participate and may stop your participation at any time. There will be no penalties or loss of benefits or opportunities if you do not participate or decide to stop once you start. Your decision to participate or not to participate will not affect your job status, employment record, employee evaluations, or advancement opportunities.

Benefits, Compensation, and Risk: We do not know if you will receive any benefit from your participation. Every 25th participant to complete the survey will receive a $25 Amazon gift card. This study is considered to be minimal or no risk. Minimal risk means that study risks are the same as the risks you face in daily life.

Confidentiality: We will do our best to keep your records private and confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. The information collected will be available for review only by: the Principal Investigator, the faculty advisor, and members of the USF Institutional Review Board. It is possible, although unlikely, that unauthorized individuals could gain access to your responses because you are responding online. Confidentiality will be maintained to the degree permitted by the technology used. No guarantees can be made regarding the interception of data sent via the Internet.

However, your participation in this online survey involves risks similar to a person’s everyday use of the Internet. If you complete and submit an anonymous survey and later request your data be withdrawn, this may or may not be possible as the researcher may be unable to extract anonymous data from the database.

We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are. You can print a copy of this consent form for your records.

We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are. You can print a copy of this consent form for your records.
Contact Information
If you have any questions, concerns, or complaints about this study, call Enya Vroom at 813-974-6921, (evroom@usf.edu). If you have questions about your rights, complaints, or issues as a person taking part in this study, call the USF IRB at (813) 974-5638 or contact the IRB by email at RSCH-IRB@usf.edu.

I freely give my consent to take part in this study. I understand that by proceeding with this survey, I am agreeing to take part in research and I am 18 years of age or older.
Appendix B: Implementation Practice Survey

Welcome to the Implementation Practice Survey!
The purpose of this survey is to explore your perceptions of implementing evidence-based practices at your community-based organization.

Community-based organizations can be described as organizations that are privately owned, self-governing, and/or not-for-profit and aim to maintain the values and needs that are specific to their communities.

To begin, please answer these questions based on the community-based organization you physically work at. If you work at more than one, please answer the following questions based on the organization you have been employed with the longest and/or you spend the most time at.

Do you work within a community-based organization that is located within Florida?
Yes  
No  
What Florida city is your community-based organization located in? (Please specify)

How would you categorize the area where your organization is located: (choose one)
   a. Rural
   b. Suburban
   c. Urban
   d. Other (Please specify)

Do you work within a community-based organization that delivers evidenced-based behavioral health services (i.e., mental health and substance use) to adolescents (ages 12-17) and/or young adults (ages 18-25)?
   An evidence-based practice is any practice, program, intervention, and/or treatment that has been proven effective via research.
   Yes
   No

Please indicate the number of people employed by your organization.
   a. Less than 10
   b. 10-20
   c. 20-30
   d. 30-40
   e. 40-50
   f. 50+

Please select what type of service setting your organization provides to its clients. (Please select all that apply)
   a. Outpatient
   b. Inpatient
   c. Residential
   d. Intensive Outpatient
   e. Partial hospitalization
   f. Other (Please specify)
Which option(s) best describes your current position at your organization?
   a. Administration/Management/Supervisor
   b. Behavioral health professional (e.g., psychologist, social worker, case manager, behavioral health technician, etc.)
   c. Both
   d. Other (please specify)
If you selected administration/management (or both), please indicate which of the following options best reflect your current administration/management position at your organization. Please select all that apply.
   a. CEO
   b. Executive Director
   c. Clinical Director
   d. Clinical Supervisor
   e. Operations Manager
   f. Program Director
   g. Other (Please specify)
If you selected behavioral health professional (or both), please indicate which of the following options best reflect your current behavioral health professional position(s) at your organization. Please select all that apply.
   a. Behavioral health technician
   b. Case manager
   c. Social work intern
   d. Mental health counselor intern
   e. Register clinical social work intern
   f. Registered mental health intern
   g. Licensed social worker
   h. Licensed mental health counselor
   i. Certified addiction counselor
   j. Board certified applied behavioral analyst
   k. Applied behavioral analyst
   l. Psychologist
   m. Psychiatrist
   n. Other (please specify)
How long have you been in your current administration/management position at your organization?
   a. 0-6 months
   b. 6-11 months
   c. 1 to 3 years
   d. 3 to 5 years
   e. Over 5 years
How long have you been in your current behavioral health professional position at your organization?
   a. 0-6 months
   b. 6-11 months
   c. 1 to 3 years
d. 3 to 5 years
e. Over 5 years
As a behavioral health professional, do you provide and/or facilitate evidence-based practices for mental and/or substance use disorders? (For behavioral health professionals)
Yes
No
Does your organization provide evidence-based practices for mental and/or substance use disorders? (For administration/management)
Yes
No
Please select the specific age group(s) you provide or assist with providing evidence-based behavioral health services to: (For behavioral health professionals) (Please select all that apply)
  a. 0-7
  b. 8-11
  c. 12-17
  d. 18-25
  e. 26-40
  f. 40+
Please select the specific age group(s) your organization provides evidence-based behavioral health services to: (For administration/management) (Please select all that apply)
  a. 0-7
  b. 8-11
  c. 12-17
  d. 18-25
  e. 26-40
  f. 40+
**Demographic Questions:**
What gender do you identify as?
  a. Male
  b. Female
  c. Other
  d. Prefer not to answer
What is your age?
  a. 18-30
  b. 30-45
  c. 45-65
  d. 65+
  e. Prefer not to answer
Please choose one or more options that best reflects your race/ethnicity.
  A. Caucasian
  B. Black or African-American
  C. Latino/a or Hispanic
  D. Asian
  E. Native American
  F. Native Hawaiian or Pacific Islander
What is the highest degree or level of education you have completed?
   a. Some high school
   b. High school
   c. Bachelor’s Degree
   d. Master’s Degree
   e. Doctorate Degree
   f. Trade School
   g. Other (Please specific)

Importance
We would like to better understand what is generally important to you regarding the implementation of evidence-based practices. The following questions are focused on your perceived importance of different implementation activities related to evidence-based practice in community settings.

An evidence-based practice is any practice, program, intervention, and/or treatment that has been proven effective via research.

Community-based organizations can be described as organizations that are privately owned, self-governing, and/or non-for-profit and aim to maintain the values and needs that are specific to their communities.

Fit and Adaptation
Directions: Please indicate the degree to which you agree or disagree with each statement regarding the importance of such activities as they relate to evidence-based practices implemented in community-based organizations in general.
1) It is important that a community-based organization can assess the fit of an evidence-based practices for the community they serve.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

2) When an evidence-based practice is available, it is important for an organization to have the ability to adapt an evidence-based practice to meet the needs of the community they serve.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
3) It is important that an organization can quickly change to meet the requirements of a new evidence-based practice.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

Readiness
4) It is important that an organization has sufficient staff in order to adopt new evidence-based practices.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
5) It is important that an organization has the infrastructure (e.g., space and/or technology) needed in order to adopt new evidence-based practices.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
6) It is important that an organization has the funding needed in order to adopt new evidence-based practices.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
Culture
7) It is important that staff are connected to the mission and values of their organization in order to implement evidence-based practices.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
8) It is important that an organization is open to change and innovation.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

Climate
9) It is important that the use of evidence-based practice is a core value in community-based organizations.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
10) It is important that community-based organizations have clear policies and protocols for how work should be done regarding evidence-based practices.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

Leadership
11) It is important that administration/management are knowledgeable about evidence-based practices.
    Strongly Disagree Disagree Neutral Agree Strongly Agree
12) It is important that administration/management support employees’ efforts to use evidence-based practices.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

Education/Training/Coaching
13) It is important that all individuals who provide evidence-based practices within community-based organizations are adequately trained to do so.
    Strongly Disagree Disagree Neutral Agree Strongly Agree
14) Mentorship and/or coaching provided post-training is important for evidence-based practices.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

External Policy
15) It is important that an organization is aware of external policies (e.g., legislation, regulations, mandates) that require the use of evidence-based practices.
    Strongly Disagree Disagree Neutral Agree Strongly Agree
16) It is important that an organization has the ability to navigate regulations/mandates that involve the use of evidence-based practices.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

Data/Evaluation/Monitoring
17) It is important an organization can collect evaluation data to monitor and improve the evidence-based practices they provide (e.g., fidelity).
    Strongly Disagree Disagree Neutral Agree Strongly Agree
18) It is important that an organization has procedures in place to frequently evaluate the effectiveness of the evidence-based practices they use (e.g., client outcomes).
    Strongly Disagree Disagree Neutral Agree Strongly Agree
19) It is important that organizations can use feedback/quality assurance to improve the evidence-based practices they deliver.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

Collaboration/Communication
20) Good communication between administration/management and behavioral health professionals is important in community-based organizations.
Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree
21) Within an organization, it is important to have an effective environment (e.g., open, honest, and/or trusting) for internal collaboration.

Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree
22) It is important that an organization collaborates with other mental and/or substance use organizations and/or providers in their community.

Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree
23) It is important that an organization has a plan to sustain evidence-based practices.

Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree
24) It is important that an organization has the resources (e.g., staff, infrastructure, and/or funding) necessary to sustain evidence-based practices.

Overall Assessment (Capacity)
Now we would like to better understand your organization’s ability to adopt, implement, and sustain evidence-based practices.

Directions: Please indicate the degree to which you agree or disagree with each statement regarding your organization’s ability to implement evidence-based practices.

25) Evidence-based practices are readily adopted within my organization.

Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree
26) On a scale of 1 to 5 (1 being the lowest ability and 5 being the highest ability), how would you rate your organization’s ability to adopt (i.e., identify, select, and/or assess organizational readiness) new evidence-based practices?
   a. 1
   b. 2
   c. 3
   d. 4
   e. 5

27) On a scale of 1 to 5 (1 being the lowest ability and 5 being the highest ability), how would you rate your organization’s ability to implement (i.e., train, address policies and procedures, and fully integrate) evidence-based practices?
   a. 1
   b. 2
   c. 3
   d. 4
   e. 5

28) On a scale of 1 to 5 (1 being the lowest ability and 5 being the highest ability), how would you rate your organization’s ability to sustain/maintain evidence-based practices long-term?
   a. 1
   b. 2
   c. 3
   d. 4
   e. 5
Implementation Capacity

We would like to better understand your organization’s ability to conduct different activities regarding the implementation of evidence-based practices.

Fit and Adaption

Directions: Please indicate the degree to which you agree or disagree with each statement regarding your organization’s ability to implement evidence-based practices.

29) When an evidence-based intervention is available, my organization has the ability to adapt it to meet the needs of the community we serve.

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<th>Strongly Disagree</th>
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30) My organization can quickly facilitate changes to our evidence-based practices based on client need.

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Readiness

31) My organization has a large resource base as it relates to funding the implementation of evidence-based practices.

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32) My organization has sufficient infrastructure (i.e., space, technologies) to support the implementation of evidence-based practices.

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33) My organization has the staff and partners needed to implement evidence-based practices.

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34) My organization has adequate policies and procedures in place to ensure proper use of evidence-based practices.

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35) My organization has the ability to develop a strategic plan to guide the implementation of evidence-based practices.

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Culture

36) There is trust and mutual respect between administration/management and behavioral health professionals in my organization.

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37) I am connected to the mission and values of this organization.

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38) It is hard to get things to change in our organization.

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<th>Strongly Disagree</th>
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39) I feel confident the behavioral health professionals in my organization can provide evidence-based practices to our clients effectively.

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<th>Strongly Disagree</th>
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Climate/Implementation Climate

40) My organization is open to using new evidence-based practices.

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<th>Strongly Disagree</th>
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<th>Agree</th>
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41) Members of my organization have up-to-date knowledge surrounding evidence-based practices.

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42) There are clear policies and protocols for how work should be done in my organization regarding evidence-based practices.
Leadership
43) Administration/management within my organization is aware of evidence-based practices.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
44) Administration/management within my organization can help break down barriers that stand in the way of implementing evidence-based practices.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
45) Administration/management in my organization support employees’ efforts to use evidence-based practices.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

Education/Training/Coaching
46) My organization has the ability to offer training regarding the implementation of evidence-based practices.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
47) My organization has the ability to offer mentorship and/or coaching post-training for evidence-based practices.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
48) When there is agreement that change needs to happen in my organization regarding evidence-based practices, we have the necessary supports in terms of training to do so.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

External Policy
49) My organization is aware of external policies (e.g., legislation, regulations, and mandates) that involve the use of evidence-based practices.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
50) My organization has the ability to navigate external policy (e.g., legislation, regulations, and mandates) that may affect the use of evidence-based practices.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

Data/Evaluation/Monitoring
51) My organization has the ability to conduct needs assessments of our clientele to ensure the evidence-based practices provided continue to meet their needs.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
52) My organization collects evaluation data to monitor and improve the evidence-based practices we provide (e.g., fidelity).
   Strongly Disagree Disagree Neutral Agree Strongly Agree
53) My organization has procedures in place to frequently evaluate the effectiveness of the evidence-based practices we use (e.g., client outcomes).
   Strongly Disagree Disagree Neutral Agree Strongly Agree
54) My organization has the ability to develop plans for monitoring and evaluating an evidence-based practice prior to implementation.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
55) My organization has procedures in place to monitor any adaptation or modifications made to an evidence-based practice being implemented.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

Collaboration/Communication
56) My organization has an effective environment (e.g., open, honest, and/or trusting) for internal collaboration.
Strongly Disagree        Disagree       Neutral         Agree       Strongly Agree
57) There is good communication between administration/management and behavioral health professionals.
   Strongly Disagree        Disagree       Neutral         Agree       Strongly Agree
58) My organization has communication strategies (e.g., community outreach and/or Facebook) to secure and maintain public support for evidence-based practices.
   Strongly Disagree        Disagree       Neutral         Agree       Strongly Agree
59) My organization collaborates with other mental and/or substance use organizations and/or providers in our community.
   Strongly Disagree        Disagree       Neutral         Agree       Strongly Agree

Sustainability
60) My organization has a plan to sustain evidence-based practices.
   Strongly Disagree        Disagree       Neutral         Agree       Strongly Agree
61) My organization has the fiscal resources necessary to sustain evidence-based practices.
   Strongly Disagree        Disagree       Neutral         Agree       Strongly Agree
62) My organization has the infrastructure (e.g., space and/or technology) necessary to sustain evidence-based practices.
   Strongly Disagree        Disagree       Neutral         Agree       Strongly Agree
63) My organization has the amount of staff needed to sustain evidence-based practices.
   Strongly Disagree        Disagree       Neutral         Agree       Strongly Agree
64) My organization when looking to adopt a new evidence-based practice can pilot the EBP before implementing the practice organization-wide.
   Strongly Disagree        Disagree       Neutral         Agree       Strongly Agree
65) Which of the following are most important to sustaining an evidence-based practice within your organization? (Please select your top 3 choices).
   - Buy-in among management and staff
   - Funding
   - Leadership turnover
   - Clinical provider turnover
   - Leadership/management
   - Training
   - Skills of clinical providers
   - Supervision
   - State/federal/local policy
   - Monitoring and/or evaluating EBPs
   - Perceived effectiveness of the EBP

Training
We would like to better understand you and your organization’s training needs as they relate to implementing evidence-based practices.
Directions: Please indicate the degree to which you agree or disagree with each statement regarding the importance of such training and professional development activities at your organization.
1) My organization would benefit from learning more about the science and practice of implementing evidence-based practices (e.g. research, frameworks, or models).
   Strongly Disagree        Disagree       Neutral         Agree       Strongly Agree
2) My organization would benefit from learning more about places and resources to identify evidence-based practices that are relevant for our clients.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
3) My organization would benefit from learning more about how to adapt an evidence-based practice to better fit the needs of the clients we serve.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
4) My organization would benefit from learning more about leadership development.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
5) My organization would benefit from learning more about needs assessment, monitoring, data-based decision-making, and evaluation (e.g., data collection, analysis, etc.).
   Strongly Disagree Disagree Neutral Agree Strongly Agree
6) My organization would benefit from learning more about how to facilitate internal collaboration and communication.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
7) My organization would benefit from learning more about how to facilitate external collaboration and communication with other organizations/providers.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
8) My organization would benefit from learning more about developing a strategic plan for implementation.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
9) My organization would benefit from learning more about developing a strategic plan for sustainability.
   Strongly Disagree Disagree Neutral Agree Strongly Agree
10) What would be the best delivery method(s) for an implementation-oriented training for your organization? (Please select all that apply)
    - In-person workshops
    - Online modules
    - Online webinars
    - Coaching

**Follow-Up Survey**

Thank you for completing the Implementation Practice Survey! If you have any questions, please do not hesitate to contact Enya Vroom (evroom@usf.edu).

Every 25th participant will receive a $25 Amazon gift card. Would you like to provide your contact information in the event that you are one of the 25th participants to complete the survey?

Yes
No

*Participants who select Yes will be routed to a separate Qualtrics Survey*

Please provide the following information so I am able to contact you in the event that you are one of the 25th participants:

Name:
Phone number (if applicable):
Email address:

Are you interested in being contacted for a brief qualitative interview as a follow-up to this survey?

Yes
No
Appendix C: Recruitment Flyer – Phase 1

IMPLEMENTATION IN COMMUNITY SETTINGS
IRB#686

WHAT
A chance to participate in research on implementation science in community settings. I want to know about your experiences with the delivery of evidence-based behavioral healthcare practices at your community-based organization.

WHO
I am surveying administration/management (e.g., CEOs, clinical/program directors) and/or behavioral health professionals (e.g., clinicians, case managers, and/or techs) of community-based organizations that deliver evidence-based practices to adolescents and young adults. Must be 18 years or older. All information gained from the survey will be kept confidential.

WHY
This information will increase our understanding of what is needed to improve trainings and implementation of evidence-based practices in community-based organizations that deliver behavioral health services.

About the researcher
My name is Enya Vroom. I am a Doctoral Candidate at the University of South Florida. My passion is to assist with closing the research to practice gap in behavioral healthcare.

How long will the survey take?
The survey will take 15-20 minutes.

Potential benefits
Participants will help researchers have a better understanding of how evidence-based practices are implemented in community settings.

**Every 25th participant to complete the survey will receive a $25 Amazon gift card**

How do I participate?
Use this link or QR code to access the survey:
https://usf.az1.qualtrics.com/jfe/form/SV_0Nz2beq0mqLALS5

Contact: Enya Vroom
Email: evroom@usf.edu
Or call 813-974-6921 for more information.
Appendix D: Informed Consent to Participant in Research – Phase 2

Information to Consider Before Taking Part in this Research Study
Moving Science to Practice: Exploring Implementation Capacity Building in Community Settings – Phase 2
Study #1379

Overview: You are being asked to take part in a dissertation research study. The information in this document should help you to decide if you would like to participate. The sections in this Overview provide the basic information about the study.

Study Staff and Details: We are asking you to participate in an interview that is a part of the principal investigators’, Enya Vroom, MS, dissertation research project being conducted at the University of South Florida that is guided by her faculty advisor, Dr. Tom Massey. The purpose of the study is to explore how community-based organizations that deliver behavioral health services perceive an organization’s capacity to implement evidence-based practices in community settings. You are being asked to participate in a 30-45 minute interview.

Participants: We are asking you to take part in this study because you are an administrator/manager/supervisor and/or behavioral health professional from a community-based organization that delivers or assists with the delivery of evidence-based practices related to mental health and/or substance use in Florida. It is hoped that through your participation, researchers may gain a better understanding of how evidence-based practices are implemented in community settings that deliver behavioral health services.

Voluntary Participation: Your participation is voluntary. You do not have to participate and may stop your participation at any time. There will be no penalties or loss of benefits or opportunities if you do not participate or decide to stop once you start. Your decision to participate or not to participate will not affect your job status, employment record, employee evaluations, or advancement opportunities.

Benefits, Compensation, and Risk: We do not know if you will receive any benefit from your participation. Every participant that participates in an interview will receive a $5 Starbucks gift card. This study is considered to be minimal or no risk. Minimal risk means that study risks are the same as the risks you face in daily life.

Confidentiality: We will do our best to keep your records private and confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. The information collected will be available for review only by: the Principal Investigator, the faculty advisor, a graduate research assistant, and members of the USF Institutional Review Board. We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are. You can print a copy of this consent form for your records.

Contact Information
If you have any questions, concerns or complaints about this study, call Enya Vroom at 813-974-6921, (evroom@usf.edu). If you have questions about your rights, complaints, or issues as a person taking part in this study, call the USF IRB at (813) 974-5638 or contact the IRB by email at RSCCH-IRB@usf.edu.
I freely give my consent to take part in this study. I understand that by proceeding with this interview, I am agreeing to take part in research and I am 18 years of age or older.
Appendix E: Qualitative Interview Guide

Introduction
The purpose of this study is to help us understand community-based organizations and their employees’ perceptions of adopting, implementing, and sustaining evidence-based behavioral health services. The interview will take approximately 30-45 minutes. We can stop at any time. Your participation is voluntary and anything you say to me will be kept confidential.
Before we get started, do you have any questions about the informed consent I sent you? Because what you have to say is very important to me, and I want to make sure I do not miss anything, do I have your permission to record our interview?

Opening Questions
The questions in this interview are going to focus on getting your perceptions and further explanation on some results we found when conducting a survey looking to understand community-based organizations and their use of evidence-based practices. In this interview, I am going to be asking about specific implementation areas that research has deemed important to using evidence-based practices – but I would like your take on these different things. Did you have an opportunity to review the definitions of the implementation areas?
If yes: Great! Let’s get started with our questions.
If no: No problem! Let’s review them now together.
To get us started:
Can you tell me a little bit about the evidence-based practices you are familiar with at your organization you’re employed?
What comes to mind when you think of an organization that has the capacity/abilities to implement evidence-based practices?

Key Questions
Now I would like to ask you some questions specifically related to the survey results. We found in the survey that individuals working in community-based organizations thought these implementation areas were important, but they may not be necessarily present or carried out effectively in organizations.
When using an evidence-based practice, what are the best ways to get organizations to actively engage or carrying out activities related to these different implementation areas?
We also found in the survey that whether these implementation areas are present or taking place in an organization differed based on the participant’s role within the organization. For example, those in leadership positions tended to think more implementation areas were present than frontline staff and clinicians.
Why do you think that is?
Next, I would like to ask you some questions related to results from our survey that are focused on an organization’s ability to adopt, implement, and sustain evidence-based practices.
Let’s first start with Adoption – meaning when an organization is first adopting/integrating an EBP
In the results of our survey, we saw that only culture and climate, leadership, and collaboration/communication had significant influence on an organization’s ability to adopt an evidence-based practice.
Why do you think culture and climate is critically related to EBPs in terms of adoption? Probe: What about leadership? What about collaboration and communication?
Probe: What are some other critical things related to adoption that an organization should be capable of other than climate/culture, leadership, and collaboration/communication?

Next let’s talk about Implementation – meaning when an organization has put a program/practice into place and is actually utilizing it.

In the results of our survey, leadership was the only thing that had a significant influence on an organization’s successful implementation of an evidence-based practice.

Why do you think leadership is critical to the implementation of an EBP?

Probe: What are some other things other than leadership that an organization should be capable of to assist with implementation?

Now let’s focus on Sustainability – meaning maintaining the EBP long-term.

In our analyses of the survey, we found that none of these items alone had a significant influence on an organization’s ability to sustain an evidence-based practice, but all of them together did influence sustainability.

Why do you think that is?

Probe: In your opinion, what is critical for the sustainability of evidence-based practices in a community-based organization?

Training

For our last couple questions, I would like to ask you about you and your organization’s training preferences for information regarding the process of implementing evidence-based practice. In terms of content, what would the ideal implementation-oriented training (e.g., professional development or education) look like for you and your organization? What would it include?

Probe: What would be the best delivery methods for a training like this? Is there a preferred sequence for delivery methods?

Closing Question

As of now, those are all the questions I have for you. If there anything else you would like to share regarding the implementation of evidence-based practices at your organization?
IMPLEMENTATION IN COMMUNITY SETTINGS

WHAT
A chance to participate in research on implementation science in community settings. I want to know about your experiences with the delivery of evidence-based behavioral healthcare practices at your community-based organization.

WHO
I am interviewing administration/management (e.g., CEOs, clinical/program directors) and/or behavioral health professionals (e.g., clinicians, case managers, and/or techs) of community-based organizations that deliver evidence-based practices in Florida. Must be 18 years or older. All information gained from the interviews will be kept confidential.

WHY
This information will increase our understanding of what is needed to improve trainings and implementation of evidence-based practices in community-based organizations that deliver behavioral health services.

About the researcher
My name is Enya Vroom. I am a Doctoral Candidate at the University of South Florida. My passion is to assist with closing the research to practice gap in behavioral healthcare.

How long will the survey take?
The interview will take 30-45 minutes.

Potential benefits
Participants will help researchers have a better understanding of how evidence-based practices are implemented in community settings.

**Every interview participant will receive a $5 Starbucks gift card**

How do I participate?

Contact: Enya Vroom
Email: cvroom@usf.edu
Or call 813-974-6921 for more information.
March 31, 2020

Enya Vroom
430 3rd Ave S Apt 151 St. Petersburg, FL 33701

EXEMPT DETERMINATION

Dear E. Vroom:
On 3/31/2020, the IRB reviewed and approved the following protocol:

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<th>Application Type:</th>
<th>Initial Study</th>
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<td>STUDY000686</td>
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<tr>
<td>Review Type:</td>
<td>Exempt 2</td>
</tr>
<tr>
<td>Title:</td>
<td>Moving Science to Practice: Exploring Implementation Capacity Building in Community Settings</td>
</tr>
<tr>
<td>Funding:</td>
<td>None</td>
</tr>
<tr>
<td>Protocol:</td>
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The IRB determined that this protocol meets the criteria for exemption from IRB review.

In conducting this protocol, you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Please note, as per USF policy, once the exempt determination is made, the application is closed in BullsIRB. This does not limit your ability to conduct the research. Any proposed or anticipated change to the study design that was previously declared exempt from IRB oversight must be submitted to the IRB as a new study prior to initiation of the change. However, administrative changes, including changes in research personnel, do not warrant a modification or new application.

Ongoing IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities impact the exempt determination, please submit a new request to the IRB for a determination.

Sincerely,
Various Menzel  
IRB Research Compliance Administrator  

A PREEMINENT RESEARCH UNIVERSITY

Institutional Review Boards / Research Integrity & Compliance

FWA No. 00001669  
University of South Florida / 3702 Spectrum Blvd., Suite 165 / Tampa, FL 33612 974-5638

/ 813- 974-5638
Appendix H: IRB Exempt Notice – Phase 2

August 6, 2020

Enya Vroom
430 3rd Ave S Apt 151 St. Petersburg, FL 33701

EXEMPT DETERMINATION

Dear Enya Vroom:
On 8/5/2020, the IRB reviewed and approved the following protocol:

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<tr>
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<tr>
<td>Title:</td>
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<td>Protocol:</td>
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</tr>
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</table>

The IRB determined that this protocol meets the criteria for exemption from IRB review.

In conducting this protocol, you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Please note, as per USF policy, once the exempt determination is made, the application is closed in BullsIRB. This does not limit your ability to conduct the research. Any proposed or anticipated change to the study design that was previously declared exempt from IRB oversight must be submitted to the IRB as a new study prior to initiation of the change. However, administrative changes, including changes in research personnel, do not warrant a modification or new application.

Ongoing IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities impact the exempt determination, please submit a new request to the IRB for a determination.

Sincerely,

Jennifer Walker
IRB Research Compliance Administrator
Institutional Review Boards / Research Integrity & Compliance

FWA No. 00001669
University of South Florida / 3702 Spectrum Blvd., Suite 165 / Tampa, FL 33612 / 813-974-5638