Influence of External Pressures on the Adoption of Evidence-Based Practices for Youth Experiencing Homelessness

Dissertation

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Abstract

Research documents high rates of behavioral health needs among youth experiencing homelessness (YEH); however, recent evidence indicates that behavioral health evidence-based practices (EBPs) may not be widely used by organizations serving YEH. Implementation and organizational theory describe the importance of the external organizational environment on EBP adoption, including the influence of external social pressures such as policy mandates, professional norms, funder expectations, and competition and collaboration with peer organizations. This cross-sectional multiple case study explored the influence of external pressures on EBP adoption among organizations serving YEH. Theory-based sampling was used by combining expert opinion and stakeholder involvement to obtain nominations of organizations for study inclusion. Thirteen organizations were recruited for focus groups/interviews, surveys, and collection of EBP funding documents. Qualitative content analysis described the type of external pressures experienced by organizations and organizational responses to those pressures. Convergent mixed-method analysis was used to classify organizational-level adopter behavior using a modified version the Fidelity, Attitudes, and Influence Typology (FAIT) and specify the most common external pressures associated with each FAIT category.

Results showed that organizations adopted a high number of EBPs (median = 7) and the most significant pressure for EBPs is federal and state/county funders; however,

expectations for EBP adherence/oversight varied across funding sources. Organizations learn about EBPs through their government funders, a variety of external professional support groups, and peer organizations who help appraise EBPs prior to adoption. Positive reactions to external pressures included the mission alignment of adopted EBPs, the ability of EBPs to provide concrete skills and structure to novice staff, an increase in organizational data informed decision making, and the competitive advantages of EBPs for obtaining new funding, recruiting new staff, and accessing new clients. Negative reactions included the incompatibility of funder approved EBPs with organizational structures and workflows, EBPs being too narrowly focused and stifling innovation, high implementation costs, and challenges with oversight.

Organizations were classified into five out of the eight FAIT adopter categories. First, adopting active supporters (n = 5; moderate to high fidelity, positive EBP attitudes, influence on peers) reported pressure from multiple levels of government funding sources. Non-adopting passive resisters (n = 3; unclear to low fidelity, negative EBP attitudes, low peer influence) reported a combination of funders and peers as the most salient external pressures. Non-adopting active supporters (n = 2; unclear to low fidelity, positive EBP attitudes, influence on peers) differed in external pressures. One reported their funders as the strongest external pressure and the other organization reported research institutions and professional development groups as the main external pressure. Adopting passive supporters (n = 1; moderate to high fidelity, positive EBP attitudes, low peer influence) reported pressure from funders as the most significant influence. Lastly, non-adopting passive supporters (n = 1; unclear to low fidelity, positive EBP attitudes,

and low peer influence) reported a combination of funder and peer influence as the most salient external pressure.

These findings suggest that organizations respond to external pressures in a variety of ways that influence the quality and degree of EBP adoption. The combination of limited capacity and lack of dedicated external resources/support may also contribute to equity issues in EBP adoption and implementation among smaller and lower resource organizations. Findings also reveal the interdependence among organizations as peers serve as important sources of information, support, and competition that influence EBP adoption. The findings can inform outer setting strategies to increase EBP adoption, including payer focused strategies to enhance organization capacity for high-quality EBP adoption, targeted training and technical assistance, and use of influential organizations as opinion leaders and champions to endorse and support EBP adoption. Additional recommendations for policy, practice, and research are discussed.

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Fields of Study

Major Field: Human Development and Family Science

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Chapter 1. Introduction

Homelessness among youth is a major public health issue (Gultekin et al., 2020). Among the multi-faceted needs of youth experiencing homelessness (YEH), extensive research documents elevated rates of substance use which ranges between 70-95% of samples, as well as high rates of youth meeting diagnostic criteria for a substance use disorder, ranging from 69-71% (Baer et al., 2003; Chen et al., 2006; Edidin et al., 2012; Martijn & Sharpe, 2006; Zerger, 2008). Evidence-based practices (EBPs) are promoted as a standard for care for reducing adolescent substance use in the United States (Bond & Campbell, 2008; Garner, 2009; Hogue et al., 2018; McCarty et al., 2010). Despite the availability of EBPs to address the behavioral health needs of YEH, some evidence shows that these interventions are not widely used in routine practice settings that serve this population, which suggests a research-to-practice gap (Kull et al., 2021; Morton et al., 2020; Pedersen et al., 2018). The National Institutes of Health (2001) has called for closing the service quality gap in systems of care by applying scientific knowledge to practice and delivering EBPs in direct service settings; however, we know little about the determinants of adoption of EBPs among community-based organizations (CBOs) serving YEH.

The external environment of an organization, which is defined as "factors existing outside the boundaries of the entity or entities leading the implementation of one or more

evidence-based interventions", is important to EBP adoption because it can influence how organizations learn about and adopt new interventions (Fenwick et al., 2020; Palinkas et al., 2011; Watson et al., 2018, p. 1; Wisdom et al., 2014). Additionally, human service organizations, including CBOs serving YEH, operate under increasing pressures for improved performance and greater accountability from funders, policymakers, and regulatory and licensure bodies (Collins-Camargo et al., 2019; Mosley & Smith, 2018; National Network for Youth, 2015; U.S. Department of Housing and Urban Development [HUD], 2015). Human service organizations, who seek to maintain their legitimacy and competitiveness for funding and resources, may respond to these pressures by adopting different types of EBPs (Deephouse et al., 2017; DiMaggio & Powell, 1983).

No studies to date have examined how these external pressures may influence EBP adoption in the YEH service system. In fact, most research on adoption and implementation of EBPs ignore outer context/setting determinants, which are critical for supporting system-wide adoption efforts (Bruns et al., 2019; Moullin et al., 2019; Novins et al., 2013; Raghavan et al., 2008). This multiple case study sought to identify factors that can close the research-to-practice gap in the CBOs serving YEH by specifying the influence of external pressures on EBP adoption. The findings from the current study can inform funders, policymakers, and intermediary and purveyor organizations who can develop and employ strategies that increase system wide adoption of EBPs.

The Need for Evidence-Based Practices

Research evidence is estimated to take 17 years to enter routine use in real-world direct care settings (Balas & Boran, 2000; Green et al., 2009). In behavioral health care, many known effective interventions for substance use disorder are not utilized in practice settings (Carroll, 2012; Garner, 2009). This delay creates a research-to-practice gap, which prevents individuals from benefiting from the best available interventions and can further extend their suffering (President's New Freedom Commission on Mental Health, 2003).

The consequences of unaddressed substance use among YEH is stark. Substance use can make it difficult for youth to obtain and retain employment, excel in academics, attend school, and increases the likelihood of involvement in the criminal justice system (Kipke et al., 1993; Zlotnick et al., 2003). Additionally, the long-term consequences of substance use among YEH are shown to lead to the development of mental health problems, heightened substance abuse, and long-term homelessness (Auerswald & Eyre, 2002; Kidd & Carroll, 2007; Thompson et al., 2015). Most YEH report using substances to cope with their past trauma and current stressful living circumstances (Bender et al., 2015; Nyamathi et al., 2007; Thompson et al., 2009; Whitbeck, 2009). Tragically, substance use is found to predict suicidal ideation and attempts (Kidd & Carroll, 2007). In fact, drug overdose and suicide are the two leading causes of death among YEH (Auerswald et al., 2016; Roy et al., 2004).

The dire outcomes of untreated behavioral health issues among YEH indicate a clear need for delivering behavioral health EBPs in settings that reach the population.

While YEH may access behavioral health services through several pathways, including hospital emergency rooms, urgent/crisis centers, community clinics, and programs for individuals and families experiencing homelessness, research documents extensive barriers and frustrations when youth access care through these systems (Solorio et al., 2006; Thompson et al., 2010). Engaging and retaining marginalized and underserved populations into services requires specialized training, coordination, and programming responsive to their life circumstances (Lamb et al., 2011; Slesnick et al., 2016; Slesnick et al., 2009; Substance Abuse and Mental Health Services Administration, 2021). The established service system for YEH is the front-line response for young people who often "slip through the cracks" of traditional health systems, thus these organizations are uniquely positioned to engage YEH into behavioral health EBPs (Family and Youth Service Bureau [FYSB], 2018a).

The YEH service system was created by the United States Runaway and Homeless Youth Act (1974), later amended by the Runaway, Homeless and Missing Children Protection Act of 2003, which created three programs: Basic Center, Street Outreach, and Transitional Living Programs (FYSB, 2018b). The Basic Center provides short-term shelter (up to 21 days) for youth up to age 18 (FYSB, 2020a). The Street Outreach program provides tangible and immediate services with no or low demands, opportunities to socialize and rest, and access to supportive services, like counseling and healthcare, and function as a gateway to intensive services for youth under the age of 21 (FYSB, 2020b). The goal of the street outreach program is to help young people get off the streets. Lastly, the transitional living program is a long-term residential service for

16- to 22-year-olds (FYSB, 2020c). The transitional living programs focus on planning for young people to be independent through life skills and counseling, job attainment, educational advancement, and interpersonal skill-building.

There are currently 338 federally funded organizations serving YEH across the United States (Kull et al., 2021). These organizations include a combination of community and faith-based non-profits and public organizations, who collectively provide 118 outreach programs, 223 temporary shelters, and 239 transitional housing programs (FYSB, n.d.; FYSB, 2020a; FYSB, 2020b; FYSB, 2020c). Esparza (2009) examined the influence of funding supply on the prevalence of several types of services for YEH (including, but not limited to, the three pillar programs listed above) among diverse non-profit organizations across 26 metropolitan areas between 1989 to 2006. They found the majority (71%) of programs received at least some federal funding and the median program derives 65% of its funding from federal grants. In fact, the study found that federal funding had a significant, and positive, effect on the increase in available YEH programs across time. Federal support is a major driver of YEH programs; however, there is still a significant number of CBOs who operate programs without federal funding. Given possible differences in EBP adoption between these groups, the current study included both federally and non-federally funded organizations.

Supporting the adoption and implementation of EBPs within the service system for YEH is appropriate and justified for two reasons. First, these CBOs are tasked with addressing the multi-faceted needs of YEH. Behavioral health concerns are typically addressed by offering treatment services in-house or through referrals to a local treatment

provider (Thompson et al., 2010; Winiarski et al., 2020). CBOs may not have a local treatment provider in which to refer youth, particularly in rural settings (Edwards et al., 2009). Additionally, one study indicates that CBO's existing in-house treatment services are inadequate (Brooks et al., 2004). Among 30 organizational providers of YEH in Los Angeles County, only 29% of CBOs perceived that other YEH serving agencies within their geographic area were providing drug and alcohol treatment services "well" or "very well." This finding suggests that the existing service system may not have the specialty expertise or effective treatments for meeting the behavioral health needs of YEH; however, this study is limited to only one United States metropolitan area.

Second, improved behavioral health outcomes can help youth succeed in other life domains, such as obtaining a high school diploma, gaining employment, maintaining housing stability, and increasing positive social connections. Research has shown that many formerly homeless youth and young adults continue to struggle with behavioral health issues, which can threaten their housing stability (Henwood et al., 2018; Mercado et al., 2021). Kidd et al. (2019) found that a quarter of formerly homeless young adults had a subsequent mental health crisis that resulted in a hospitalization or substance use relapse. Behavioral health EBPs can support youth as they adjust and integrate back into society and prevent reoccurrence of homelessness. The current study sought to identify factors that can enhance the adoption of behavioral health EBPs in the existing service system for YEH, which will enable greater success of young people in multiple areas of their life.

The Service Quality Gap

An important and early step for closing the service quality gap is to identify what EBPs are available and how widely these interventions are used in the existing service system (Stetler et al., 2008). A recent review of EBPs for YEH showed that behavioral health interventions have the largest supporting evidence base (Morton et al., 2020). Some of these intervention approaches include Community Reinforcement Approach (CRA) and Ecologically Based Family Therapy (EBFT; Morton et al., 2020; Pergamit et al., 2016; Slesnick et al., 2009). CRA acknowledges the power of the reinforcing environment on youth substance use behaviors and works to replace maladaptive behaviors with alternative adaptive behaviors (Meyers & Smith, 1995; Slesnick et al., 2007; Zhang & Slesnick, 2018). Whereas EBFT works to address one of the root causes of youth homelessness: family conflict. EBFT is a family systems therapy that supports family connection, communication, and problem solving, with the goal of changing family patterns that contribute to problem behaviors (Slesnick & Prestopnik, 2005; Slesnick et al., 2013).

Motivational Enhancement Therapy (MET) is another behavioral health practice showing some success with YEH (Baer et al., 2007; Peterson et al., 2006; Slesnick et al., 2013; Slesnick et al., 2016). The guiding philosophy of MET is that the ability to change comes from within youth and needs to be evoked. Additionally, emerging evidence shows the Housing First intervention, which provides support navigating the rental market, rental subsidies, and intensive case management and support, significantly increases in the number of days stably housed, decreases drug use, and decreases the size

of social network members who use drugs from baseline to the six month follow up (Kelleher et al., 2021; Kozloff et al., 2016). Lastly, other behavioral health intervention models tested among different adolescent populations with similar needs as YEH include Multidimensional Family Therapy, Multisystemic Therapy, Seeking Safety, and Seven Challenges (Korchmaros, 2018; Liddle et al., 2018; Najavits et al., 2006; Ogden & Hagen, 2006).

While these are some of the most effective interventions for reducing substance use among YEH, some evidence shows that most of these interventions are not reaching the population in routine practice settings. One study reported that only 48% of YEH who had previous experience accessing any drop-in centers in Los Angeles, California and screened positive for substance use disorder by the study investigators had received any treatment or referrals for substance use from the drop-in centers they recently accessed (Pedersen et al., 2018). Additionally, Gwadz et al. (2017) examined fifty organizations serving YEH across New York State and found only about 10% of CBOs had youth participants report the organization provided any substance use counseling. These studies suggest that youth may not be receiving needed services; however, reliance on youth self-report is a limitation. It is possible that drop-in centers are offering these services and youth are declining them. In fact, a recent review of research on program implementation in settings serving YEH found that most studies rely on youth to assess program and staffing characteristics (Curry et al., 2021). The current study focused on organizational staff perspectives to assess the use of EBPs and specify influential factors that can close the service quality gap in these settings.

Only one study identified EBP usage among CBOs serving YEH (Kull et al., 2021). These authors surveyed organizational leadership and direct program/practitioner staff on all EBPs used in their agency. Nationally, CBOs indicated seven individual behavioral health intervention or prevention programs (out of 84 total interventions) were currently in-use. These included Motivational Interviewing (MI; 77% reported using; Miller & Rollnick, 2012), Seeking Safety (11% reported using; Najavits et al., 2006), Street Smart (9% reported using; Rotheram-Borus et al., 1991), Multisystemic Therapy (8% reported using; Ogden & Hagen, 2006), Botvin Life Skills (7% reported using; Botvin et al., 2001), Adolescent Community Reinforcement Approach (2% reported using; Slesnick et al., 2007), and Multimodal Substance Abuse Prevention (1% reported using; no literature identified).

These findings provide a snapshot into the extent that CBOs self-report use of specific interventions. MI is reported as the most widely used intervention model (77%) among CBOs and the second most used behavioral health EBP, Seeking Safety, is implemented by only 11% of CBOs. The wide use of MI suggests a degree of isomorphy within the YEH service system; however, we are unable to determine what factors may be driving this similarity because Kull et al. (2021) does not specify the reasons CBOs select specific EBPs. McGraw et al. (2010) claim that the widespread use of MI among adult homeless service providers participating in a federally funded initiative may be due to the high compatibility of MI's philosophy fitting well within organizations that promote housing as a human right. However, MI may be spread through other mechanisms, such as peer influence or through professional development opportunities

promoted to CBOs by groups viewed as authorities or experts in the field (Runaway and Homeless Youth Training and Technical Assistance Center [RHYTTAC], n.d.1). This study explored the motives of CBOs for adopting specific EBPs, including the influence of peers and professional training groups, by conducting focus groups/interviews with key organizational staff and administering quantitative surveys.

An additional limitation of Kull et al. (2021) is their sole reliance on self-report of EBPs in a survey that was not anonymous and administered by a federally funded technical assistance provider. CBOs may have felt pressure to provide socially desirable responses, resulting in some CBOs reporting EBPs that are partially adopted or not adopted at all. For example, the survey findings on the usage of all EBPs (including anger management, case management, life skills education, parent education, teen dating violence prevention, pregnancy prevention, substance use treatment, trauma and mental health treatments) show that more than half of the organizations (59%) offered *six to nine* discrete EBPs, fifteen percent (15%) reported offering *10 or more* discrete EBPs, and only two percent (2%) of CBOs serving YEH reported that they do not use any type of EBP. The high number of delivered EBPs is surprising because it contradicts the previously discussed research. Additionally, many CBOs contend with operational challenges, including insufficient and unstable funding, elevated job stress, and high job turnover, which can influence their ability to effectively adopt and implement EBPs (Brooks et al., 2004; Heinze et al., 2010; Lemieux-Cumberlege & Taylor, 2019; National Network for Youth, 2015; Nichols, 2008).

Lastly, Kull et al. (2021) does not specify the length of time that CBOs have been operating their reported EBPs. In fact, most studies do not specify a timeframe when measuring implementation outcomes, including adoption (Proctor et al., 2011). Lack of information on the timing of EBP adoption prevents researchers from determining causal relationships and limits implementation practitioners from knowing when adoption of EBPs is best supported. Some CBOs may have extensive experience operating EBPs, whereas others may be just starting, thus it is possible that the determinants of adoption of EBPs differ for CBOs depending on when program adoption occurs. The current study obtained funding documents and conducted focus groups/interviews with organizational staff to identify when EBP adoption occurred.

The current study addressed several limitations of Kull et al. (2021), such as verifying the use of EBPs through examination of funding documents and conducting focus groups/interviews to explore motives for adoption and when CBOs adopted specific interventions. Furthermore, studies that focus on adoption determinants of one individual EBP may yield findings on an intervention that is perceived as inappropriate or unfeasible across other CBOs. Thus, the current study examined the use of diverse interventions to promote broad based adoption of EBPs. No studies to date have examined the determinants of adoption among CBOs serving YEH. In fact, most implementation research has been conducted in healthcare and education settings, which may not sufficiently generalize the human service organizations (Roll et al., 2017). Greater attention is needed on diverse contexts to specify unique determinants to enhance adoption of EBPs in these settings.

The Outer Setting/Context of EBP Adoption

Adoption of EBPs is a key outcome because it lays the foundation for effective implementation (Moullin et al., 2019; Wisdom et al., 2013). Adoption, defined as the "intention, initial decision, or action to try or employ an innovation or evidence-based practice", is a highly complex process that is influenced by multi-leveled factors across the external system, organization, individual program staff and clients, and the EBP (Damschroder et al., 2009; Moullin et al., 2019; Proctor et al., 2011, p. 69; Wisdom et al., 2013). Among the many adoption determinants in the literature, the outer setting/context remains the most understudied in implementation research (Bruns et al., 2019; Moullin et al., 2019; Novins et al., 2013). The outer setting/context includes economic, financial, policy/political, and social/relational factors (Damschroder et al., 2009; Moullin et al., 2019; Watson et al., 2018). These factors may be key to enhancing adoption of EBPs in CBOs serving YEH.

Understanding the outer setting/context determinants of adoption across CBOs serving YEH is an appropriate and important first step in a service system with nascent research for two reasons. First, the lack of knowledge regarding outer setting/context determinants prevents EBPs from reaching YEH at the population scale. Given the size and severity of substance use among YEH, large scale adoption of EBPs requires an ecological understanding of the setting and contexts that CBOs operate under for EBPs to reach population-level impact (Nilsen et al., 2013; Raghavan et al., 2008). Outer setting determinants that promote broad based adoption of EBPs across the YEH service system can inform dissemination strategies that can increase system wide adoption of EBPs. The

current study's focus on the outer setting/context has value potential for enhancing adoption of a wide array of behavioral health EBPs across diverse CBOs and contexts.

Second, focusing on the inner/setting is likely to yield findings that are too narrow to enhance EBP adoption in the YEH service system because their adoption decisions are made at the organizational level. Federally funded CBOs serving YEH detail their EBPs in funding applications that they must comply with during their funding cycle (FYSB, n.d.2). Organizational directors, administrators, and heads of clinical services oversee planning and resource allocation, including if an EBP is adopted or discontinued and how, thus the unit of analysis should be the organizational level (National Institutes of Health, 2020). Organizations operate in an open system as part of a larger interdependent network across their social environment, which can influence decisions to adopt and implement a new intervention (Katz & Kahn, 1966; Scott & Davis, 2007; Wisdom et al., 2014). By examining only inner setting factors to explain EBP adoption, research ignores the interconnectedness of the service system. Additionally, efforts to enhance the inner setting/context for effective adoption will be wasted if the organizational external environment is not well understood.

Theories and Frameworks

Consolidated Framework for Implementation Research

Implementation frameworks can help researchers identify important influences on EBP adoption. First, the Consolidated Framework for Implementation Research (CFIR) is a "meta-theoretical" framework that combines multiple theories into one overarching typology of determinants of adoption and implementation (Damschroder et al., 2009).

The framework consists of multiple constructs across five domains: intervention characteristics, outer setting, inner setting, characteristics of the individuals involved and the process of implementation. The outer setting/context domains include peer pressure, patient needs and resources, cosmopolitanism, and external policies and incentives.

Peer pressure is defined as "mimetic or competitive pressure to implement an intervention" (Damschroder et al., 2009, p. 7). External policies and incentives consist of "broad constructs that encompass external strategies to spread interventions, including policy and regulations, external mandates, recommendations and guidelines, and collaboratives" (p. 7). Cosmopolitanism is "the degree to which an organization is networked with other external organizations" (p. 7). Finally, patient needs and resources is "the extent to which patient needs, as well as barriers and facilitators to meet those needs, are accurately known and prioritized by the organization" (p. 7).

A key limitation of CFIR is its inability to specify how these constructs drive EBP adoption. There is an increased call for implementation studies to use organizational theories because these theories provide relevant, yet underutilized, explanations on how and why organizations adopt and implement new interventions (Birken et al., 2017; Bunger & Lengnick-Hall, 2019; Yano, 2008). Organizational theory is "the study of how organizations function and how they affect and are affected by the environment in which they operate" (Jones, 2013, p.30). These theories have potential for informing studies on the influence of the outer setting.

Institutional Theory

Institutional theory, a mid-range organizational theory, states that organizations adopt new practices to appear legitimate, which promotes isomorphy within the system (Deephouse et al., 2019; DiMaggio & Powell, 1983; Meyer & Rowan, 1977). Institutional theory specifies three distinct external pressures that increase the adoption of new interventions. First, *mimetic pressure* occurs when an organization identifies model peers and emulates their structures or practices, which overlaps with CFIR's peer pressure domain. Additionally, *coercive pressure* comes from funders, government mandates, regulatory bodies, and other organizations that CBOs depend on or by cultural expectations in society or the population served. Lastly, *normative pressure* occurs when organizational field becomes professionalized and obtains a set standards and norms for their work, such as professional societies, higher education institutions, or standards for practice from intermediary organizations.

Institutional Theory is well-suited for the current study for two reasons. First, Institutional Theory fits the analytical level and primary outcome of interest, which is organizational adoption of EBPs. Furthermore, Institutional Theory is a plausible explanation of EBP adoption among human service organizations. The YEH service field, and other human service organizations serving similar populations (e.g., child welfare involved, populations experiencing homelessness), contend with funding challenges, licensure and regulatory changes, staff turnover, and increased competition for resources while simultaneously experiencing high demands for improved client outcomes (Collins-Camargo et al., 2019; Mosley & Smith, 2018). No studies to date have

explored how these environmental conditions have influenced YEH service providers. While the outer setting/context is an understudied in the YEH service system, research on external pressures among human service organization serving similar populations can inform this study.

Coercive pressure. Mosley (2014) conducted qualitative interviews with homeless service CBOs in Chicago to examine their involvement in two different regional collaborative groups dedicated to addressing local homelessness. This study found CBOs reported strong coercive pressures to be involved in a newer interagency collaborative called The Chicago Alliance to End Homelessness, instead of the older advocacy organization, because the Alliance operates as Chicago's Continuum of Care (CoC), which controls federally funding and resources. The U.S. Housing and Urban Development requires CBO participation in a Continuum of Care to guide regional strategic planning and allocate local federal funding (Mosley, 2021). Nationally, the CoC plays a vital role in eliminating youth homelessness; however, no studies were identified that examine how active CBOs serving YEH are in these collaboratives and CoC influence on CBOs goals and operations, including adoption of EBPs (HUD, 2016).

While federal funding in the homeless service system encourages use of EBPs, about 40% of programs serving YEH are not supported by federal grants or contracts (Esparza, 2009; HUD, 2016; Kull et al., 2021; RHYTTAC, n.d.3). These funding sources may differ in how and when they demand and support EBP adoption, which may influence the action taken by CBOs. Institutional theory suggests that organizations are more likely to "decouple" (i.e., superficially adopt a new intervention) under strong

coercive pressure or if they do not believe in the new practice (Seidman, 1983). Lack of financial support for EBPs or implementation guidance from strong coercive pressures may drive superficial adoption (low fidelity implementation) for CBOs to comply and maintain legitimacy. In fact, demand for increased service quality and un- or underfunded mandates, such as low reimbursement rates or funding that does not cover costs, are reported as some of the most pressing concerns among CBOs serving child welfare involved populations (Collins-Camargo et al., 2019).

Institutional theory states that coercive pressures are greater when organizations do business with state agencies and/or depend on a small number of sources for important resources (DiMaggio & Powell, 1983). In addition to the federal government, CBOs serving YEH can formally contract with child welfare or juvenile justice systems to address the high number of system-involved youth among the YEH population (Narendorf et al., 2020). Contracting with state agencies may activate coercive pressures due to increasing use of results-based contracting (contracting with a focus on results) and increasing expectations for EBPs from systems of care (Collins-Camargo et al., 2019; Collins-Camargo et al., 2011; Mosley & Smith, 2018). In fact, recent federal child welfare reform efforts have implications for youth homelessness, including increasing supply of behavioral health EBPs; however, the extent that CBOs serving YEH experience this pressure is unknown (Bipartisan Budget Act, 2018; National Network for Youth, 2021).

Mimetic pressure. The peer networks of organizational leaders are shown to influence how leaders learn about innovative practices and obtain advice about these

practices in the mental health services field (Fenwick et al., 2020; Palinkas et al., 2011). Human service organizations report pressure to develop relationships, collaborate, and integrate services with other organizations (Collins-Camargo et al., 2019; Mosley & Smith, 2018). CBOs serving homeless populations reported feeling strong mimetic pressure to start participating in a local interagency collaborative because other successful organizations in the region were involved (Mosley, 2014). These collaboratives may facilitate the spread of innovative practices and operate as a form of mimetic pressure among those who wish to keep pace with their peers. The use of EBPs in peer organizations may be particularly influential because it serves as an endorsement and conveys legitimacy.

Institutional theory posits that mimetic pressures are greater when an organizational field has high levels of uncertainty (DiMaggio & Powell, 1983; Meyer & Rowan, 1977). Human service organizations face uncertainty from many sources, including increases in market-based competition through funding mechanisms (Collins-Camargo et al., 2011; Mosley & Smith, 2018). Competition for resources is particularly salient in a service setting marked by scarcity, such as the homeless service field (Lemieux-Cumberlege & Taylor, 2019; Mosley, 2021; National Network for Youth, 2015). Adopting and implementing EBPs may increase CBO competitiveness and convey legitimacy to competitive funding sources (Alexander, 2000). However, no studies to date have examined how competitiveness drives EBP adoption in the homeless service field.

These mimetic pressures may differ by the type of geographic location (urban, rural, frontier). Less competition and collaboration may be present in rural or frontier regions; however, mimetic pressures may still occur for CBOs located in these remote settings. Rural or frontier located CBOs may look to other similar organizations located in neighboring counties or states for innovative ideas. Homophily, which is the "likeness between individuals in a network based on specific criteria" may influence EBP adoption (Palinkas et al., 2011, p. 5). For example, rural agencies may look to other rural agencies in different parts of the country because they face similar struggles. Or rural agencies may look to agencies in neighboring cities for innovative ideas because of geographic proximity and pre-established relationships. Exploring the degree of similarity in CBO reported mimetic pressures can aid dissemination efforts by identifying respected opinion leaders to share innovative practices, including EBPs.

Normative pressure. Institutional theory states that normative pressures are greater in systems with higher levels of professionalization (DiMaggio & Powell, 1983). The YEH service field has several avenues that may activate normative pressures to adopt EBPs, including professional development trainings and technical assistance opportunities. The YEH service field has several intermediary organizations that offer conferences, trainings, and technical assistance opportunities, including topics on use of research evidence (Point Source Youth, 2021; RHYTTAC, n.d.3). Research shows that organizational leaders in mental health clinics report learning about innovative practices directly from their clinical and direct service staff when they share information from their trainings and licensing bodies (Fenwick et al., 2020). CBOs may also have partnerships

with research institutions or universities. Research shows that organizations with ties to universities are able to identify new practices (Fenwick et al., 2020).

Additionally, professional education standards in psychology and social work emphasize EBPs in their training (American Psychological Association, 2006; National Association of Social Workers, 2013). CBOs with greater number of staff with degrees and credentials may serve as normative pressure for EBP adoption. However, one study found that smaller CBOs tended to have fewer staff with degrees or credentials, and they valued life experiences of staff more than larger organizations (Brooks et al., 2004). Additionally, smaller CBOs tended to self-rate their organization's services for behavioral health problems as low compared to larger organizations. This study suggests that CBOs serving YEH vary in size and their staffing education, which may influence their ability to adopt EBPs.

Assessment of Institutional Pressures

The reviewed literature suggests that there are multiple types of external pressures experienced by human service organizations. Only two implementation-focused studies have used Institutional Theory (both in healthcare settings) and these studies apply the theory descriptively to their lessons learned (Clauser et al., 2009; Novotna et al., 2012). Very few studies have quantitatively examined the influence of the outer setting/context on EBP adoption and implementation (Bruns et al., 2019; McHugh et al., 2020). In fact, a recent systematic review of quantitative measures on outer setting/context domains found no measures of external pressures with supporting psychometric information (McHugh et al., 2020). Use of qualitative methods to assess institutional pressures is equally sparse.

Only two identified studies examine external pressures on human service organizations using qualitative methods, which included interviews and open-ended survey questions (Collins-Camargo et al., 2019; Mosley, 2014).

Only one identified study, called the National Survey of Private Child and Family Serving Agencies, collected quantitative data on external pressures (McBeath et al., 2012, 2011). McBeath et al. (2012, 2011) listed multiple external pressures and asked respondents to rate how much each pressure influenced organizational functioning in the following domains: development of new programs, delivery of long-standing programs, training front-line caseworkers, and forming new interagency relationships. Response options used a five-point scale ranging from *No influence at all* to *A very strong influence*. Coercive pressure included five external sources: (1) performance expectations, (2) data reviews on agency performance/outcomes, (3) state regulators, (4) court requirements, and (5) lawsuits. Mimetic pressure included one external source: (1) keeping ahead of other agencies. Lastly, normative pressures included two external sources: (1) advice from experts or researchers and (2) staying abreast of best practices. Additional items asked respondents if their agency was accredited through various accreditation bodies in their field. Alpha reliability was reported in a separate study (Bunger et al., 2017). Reliability scores for coercive, mimetic, and normative pressure scales were .94, .87, and .91, respectively.

Competition was assessed separately from mimetic pressure (McBeath et al., 2012, 2011). The competition measure listed different types of agencies and asked respondents to rate how much they compete with these agencies in the following areas:

public funding (from government sources), private funding (donors or fee-for-service), staff, and clientele. Response options used a five-point scale ranging from *No competition* to *Constant competition*. Eleven agencies were listed: other private child and family serving agencies within your agency's immediate area, other private child and family serving agencies outside your immediate area, public child welfare, family/juvenile courts, mental health service providers, drug/alcohol service providers, policy departments, juvenile justice agencies, schools, welfare offices, state association of private providers.

Results on external pressures were presented descriptively as standard means at the item level (McBeath et al., 2012, 2011). Findings from coercive pressures on the development of new programs, the closest outcome to adoption of EBP, showed state regulators were rated as the highest influence (M = 3.4), followed by data reviews on agency performance/outcomes (M = 3.2), then performance expectations (M = 3.0). Mimetic pressure findings showed efforts to stay ahead of peer agencies on development of new programs had a mean of 3.4. Normative pressure findings showed staying knowledgeable of best practices had the most influence across all pressures (M = 3.8), whereas research/expert advice had the least influence (M = 2.8). In general, competition was rated low. Competition with other similar local service providers for both public (M = 3.7) and private funding (M = 3.1) was rated as the most common.

This study demonstrates an acceptable approach for measuring external pressures and has been used in one other study (Bunger et al., 2017). However, the measure has limitations. First, the variables assess broad external pressures, which prevents

specification of pressures that influence important outcomes. For example, the item "data reviews of agency performance/outcomes" does not specify who is reviewing data, such as federal funders, state/county contractors, or licensing oversight bodies. Identifying the actor of these pressures is critical to understanding and targeting different sources of external pressures that promote successful adoption. Additionally, mimetic pressures were assessed using only one item (keeping ahead of other agencies), which suggests competition. CBOs may imitate similar agencies with whom they are not in competition (DiMaggio & Powell, 1983).

Furthermore, the outcomes assessed covered broad organizational functioning domains. Increased specificity on what the external pressure is influencing is needed. The study author modified the measure developed by McBeath et al. (2011) to include language specific to the YEH service system and conducted interviews/focus groups to expand on how and why organizations responded to external pressures.

Mixed Method Multiple Case Studies.

A multiple case study includes two or more cases (i.e., an individual, organization/entity, or event) for investigating a phenomenon of interest (Stake, 1995; Yin, 2003). Multiple case studies are utilized in many disciplines, including economics, education, political science, sociology, and many others, to study real-life contexts and specify how outcomes vary by contexts (Kaarbo & Beasley, 1999; Malin et al., 2018; McCutcheon & Meredith, 1993; Verschuren, 2001). Implementation research uses multiple case study designs to compare variation in key influences across different implementation sites (Kim et al., 2020; Powell et al., 2013). A multiple case study is

useful for exploring complex phenomena, such as adoption of EBP, when cases are contained within a bounded system but spread across diverse contexts (Gustafsson, 2017; Stake, 1995). Specifically, *instrumental* case studies detail the characteristics, inner workings, and contexts of cases to gain an understanding of a specific interest or phenomena (Stake, 1995). Given that there is a paucity of studies on CBOs serving YEH, a multiple case study design is suitable because it can explore and specify important contextual features in an understudied service setting.

Multiple case studies employ a methodology of triangulation, which entails using multiple data sources to verify findings, rule out rival explanations, and enhance validity and reliability (Creswell & Poth, 2017; Patton, 1990; Yin, 2003). Triangulation is also made possible using mixed methods (Palinkas et al., 2019). Mixed methods involve "collecting, analyzing, and interpreting quantitative and qualitative data in a single study or in a series of studies that investigate the same underlying phenomenon" (Leech & Onwuegbuzie, 2009, p. 267). Mixed methods are common in implementation research because they allow researchers to obtain a comprehensive understanding of organizations beyond what an individual data source could contribute alone (Beidas et al., 2014; Palinkas et al., 2019).

This study followed a *convergent mixed-method design* by collecting and analyzing quantitative surveys and qualitative interviews in a similar timeframe (Fetters et al., 2013). Qualitative data are the dominant method and quantitative data are used to complement and confirm the qualitative findings (QUAL + quant). This design was selected because it streamlines data collection and decreases the likelihood of response

burden by contacting participants multiple times. Focus groups are instrumental in implementation research because they uncover the multi-leveled processes and interactions between an organization and their environment by gathering rich information through group discussion (Anderson et al., 2014; Hamilton & Finley, 2019). The current study utilized focus groups (and individual interviews when limited by staff availability or organizational structure) to understand the "how" and "why" of EBP adoption.

The Current Study

This study sought to understand how outer setting/context determinants, specifically external social pressures, influence EBP adoption by conducting a cross-sectional exploratory mixed-method multiple case study. The aims of the current study, the data sources, and the implication for each aim are described below and depicted in Figure 1.

1) Explore evidence-based practice adoption decisions, including interventions used or de-implemented, length of intervention use, and type of implementation support strategies used. Data sources include focus groups/interviews and agency funding documents.
2) Understand how coercive, mimetic, and normative pressures influence the adoption of evidence-based practices. Data sources include focus groups/interviews and quantitative surveys.
3) Classify organizations based on their attitudes, influence, and fidelity toward EBP adoption and implementation and specify the external pressures

associated with each classification. This aim was achieved by integrating data from aim 1 and 2.

These aims have value potential for organizations serving YEH and for external entities seeking to advance adoption of EBPs across the wider service system. First, funding documents and focus groups/interviews help specify organizations' capacity to implement EBPs, including common or under-reported implementation strategies employed by organizations. Funders and intermediary organizations can use this information to inform allocation of resources and guidance to develop organization capacity for effectively implementing EBPs. Second, funders, policymakers, intermediary organizations, and other key external support groups will benefit from knowing how organizations respond to their expectations for EBPs. This information can guide their messaging of expectations, the development of their request for proposals, and oversight mechanisms. Lastly, identifying subgroups of organizations based on adopter behavior can aid in the development of targeted strategies that address specific group-based needs, including organizations hesitant to adopt EBPs or are at-risk for implementation failure.

Chapter 2. Research Method & Design

Study Procedures

Sampling Strategy

The current study engaged in theory-based sampling, which is a continuous purposive sampling method that aims to "find manifestations of a theoretical construct so as to elaborate and examine the construct and its variations" (Palinkas et al., 2015, p. 536). Theory-based sampling was employed by combining expert opinion and stakeholder involvement to elucidate distinct external pressures on EBP adoption, including mimetic/peer pressure and normative pressure. The recruitment process started with obtaining nominations of organizations, via Qualtrics, requesting up to fifteen organizations that nominators know who are implementing one or more evidence-based practices, thus non-adopters of EBPs were not recruited in the current study. Self-nominations were accepted; however, nominators were encouraged to list at least three other organizations located locally, regionally, or nationally. Nominators listed their name, organization, role, and indicated if they're completed the survey with other members of their team, which assisted with identifying self-nominations.

Nominators included two sources: (1) a national training and technical assistance center for CBOs serving YEH (referred to as an Intermediary Organization) (Runaway Homeless Youth Training and Technical Assistance Center, n.d.) and (2) peer

nominations from other CBOs in the service field were solicited through an "opt-in" membership email listserv, which is maintained and operated by the Intermediary Organization (there is no comprehensive database identifying the entire study population). The membership listserv contains emails of agency directors and administrators of an estimated 100 organizations that are either federally or non-federally supported. Additional peer organizations were nominated through a snowball sampling at the end of the focus group (Naderifar et al., 2017).

Table 1 details the peer nomination type, nominator geographic region, and nominator role. A total of 17 organizations were nominated across the peer and intermediary organization surveys. Thirteen unique organizations were nominated in the peer survey: 6 self-nominated and 7 nominated organizations. An additional 12 nominations were collected using a snowball sampling method conducted at the end of focus groups/interviews.

Case Screening and Selection

The study author screened each organization's website prior to contacting them to ensure services were provided to the target population. Case selection started with overlapping nominations across the peer and intermediary surveys. Only two organizations overlapped between the peer and intermediary nominations. Of those, one declined to participate due to high staff transitions/workload and the other did not respond. Of the intermediary and peer survey nominations, 5 organizations declined to participate, and 12 did not respond. One CBO was nominated by two different peer

organizations and was recruited into the study. Case selection was supplemented using nominations from the snowball method.

All organizations included in the study met the inclusion criteria:

- Federally or non-federally supported housing, shelter, outreach, drop-in services, or other key services (e.g., health, case management) for youth who meet the definition of homelessness specified in the McKinney Vento Act. The McKinney Vento Homeless Assistance Act (2002) defines youth homelessness as those who lack a fixed, regular, and adequate nighttime residence; or live in a welfare hotel, or place without regular sleeping accommodations; or reside in a shared residence with other persons due to the loss of housing or economic hardships.
- Hold an agency leadership, administrative, supervisor, clinical, or front-line role in the organization. All participants are 18 years or older and English-speaking. The type of positions and number of respondents varied because CBOs serving YEH are diverse in size and structure (Brooks et al., 2004; Esparza, 2009; Gwadz et al., 2017; Heinze et al., 2010).

Exclusion criteria included:

- Organizations contracted or external professionals of organizations serving YEH (affiliated with programs, but not employees of the organization).
- Youth will not be recruited into the study.

Participants

The final sample included 13 organizations. Table 2 describes key organizational characteristics. A total of 30 staff members across all 13 organizations were recruited into

the study: 6 directors, 3 program directors, 7 program managers, 6 clinical managers/supervisors, 5 administrators, 2 therapists, and 1 case worker. Table 3 detail participant demographics across the full sample.

Informed Consent

This study was approved by the Ohio State Behavioral and Social Sciences Institutional Review Board. Informed consent was obtained through site level permission from directors or administrators. The study author contacted each organization for participation initially through email and conducted follow-up phone calls when necessary. The study author electronically forwarded the consent form, which details the protocol for protection of sensitive data, and asked for the contact information of other staff members who have knowledge in their EBP adoption and implementation. The study author contacted these individuals directly to invite them to the focus group. Additional consent procedures occurred for the focus groups. Focus group or one-on-one interviews (depending on the staffing structure and availability) were scheduled to occur through Zoom. Interviews were scheduled for 60 minutes total. Verbal consent was obtained at the start of the focus group and documented by the study author.

Data Collection

Document Review

The study author requested the narrative sections of one or more funding documents, including current and past funding cycle applications, that best represented the organization's adopted EBP(s) and any EBP implementation oversight mechanisms or processes. Eleven of the thirteen organizations shared their funding documents. Two

organizations declined to share: one due to the burden of the request and one verbally agreed but did not respond to follow-up requests. A total of twenty-six funding documents were received. The number of documents shared per organization ranged between 1 – 4 (Median = 2). The level of the funding source included: 14 federal, 5 state/county, and 3 private. Table 4 highlights the sources of funding and number of funding documents received across each funding source.

Focus Groups / Interviews

Ten individual interviews and four focus groups were conducted with 13 organizations. Of the 13 organizations recruited, one organization required two separate staff interviews due to scheduling. The number of focus group participants ranged between 2 – 8 employees. A semi-structured interview protocol was utilized to create consistency between interviews but also allowed for probing and follow-up questioning (Padgett, 2008). The protocol was developed based on the study's theoretical framework, including Institutional Theory and the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009; DiMaggio & Powell, 1983).

The current study used an adapted version of the CFIR interview guide (CFIR, 2021). Focus group questions focused on: (1) the adoption process, (2) intervention characteristics, and (3) external pressures from various sources, including peers, policy reform initiatives or funding mandates, local or regional collaboratives and partnerships, intermediary organizations, and other professional affiliations. Organizations that reported using one or more EBPs were asked about EBP implementation details, including how staff training is conducted, what modifications were made, and how

fidelity assessment and supervision is conducted. Fidelity was defined as "the degree to which an intervention was implemented as it was prescribed in the original protocol or as it was intended by the program developers" (Proctor et al., 2011, p. 69). A definition of fidelity was not provided to respondents. Fidelity was qualitatively assessed by asking "what types of fidelity requirements do these models have?" and "How do you assess fidelity?" Organizations that were not able to able to provide any details or had no knowledge of fidelity were considered superficial adopters.

Interview audio was transcribed, cleaned, and de-identified for protection of confidentiality. Transcripts were stored on the university-managed cloud storage, OneDrive, and audio recordings were deleted after transcription.

Quantitative Survey

The link to the quantitative survey was provided to participants via the chat function of the Zoom conference platform and a follow-up email was sent to each participant to remind them to complete the survey. Each interview attendee was asked to complete the survey on a separate computer. Thirty surveys total were completed by focus group/interview participants. Six surveys were excluded due to extensive missing data; however, the study obtained at least one completed survey from each organization.

Demographic questionnaire. Quantitative surveys asked age, gender, ethnicity, level of education, role in the organization, and years of experience working in the field and with the YEH population. To assess organizational setting, the survey asked for the agency/program name, number of full-time staff employed, percentage of staff that are non-Caucasian in racial/ethnic background, percentage of agency clients that are non-

Caucasian, types of services provided, the types of public and private contracts supporting their programs, percentage of revenue coming from various sources, and the percentage of revenue that comes from various sources (federal, state, local, private).

External pressures. There are no psychometrically supported quantitative measures that assess external pressures on the adoption of EBPs (McHugh et al., 2020). Because of the lack of measures available, the current study adapted an existing 18-item measure of external pressures on various organizational operations (McBeath et al., 2012, 2011). Using existing literature and theory, the current study included items to specify coercive, normative, and non-competitive sources of mimetic pressures, revised the response prompt to instruct respondents to specify the degree that each listed external pressure influences adoption of new programs/interventions, and adapted some language to fit the YEH service system. The adapted measure includes 16-items total. Response format uses a five-point response scale ranging from one (*this had no influence at all*) to five (*this had a very strong influence*). Reliability scores for the original measures, including coercive, mimetic, and normative pressure, were .94, .87, and .91, respectively (Bunger et al., 2017).

Competition and Collaboration. The competition scale and collaboration scales are adapted from McBeath et al. (2012, 2011) to fit the YEH service system. The competition scale includes 8-item scales that ask respondents to indicate the degree of competition for public funding, staff, and/or clients. Each item listed a distinct source of competition, including other local youth-serving organizations, other homeless serving agencies, public child welfare, behavioral health treatment providers (i.e., mental health

service providers and/or substance use), juvenile justice agencies. Response format uses a five-point response scale ranging from one (no competition) to five (constant competition). The collaboration scale asks respondents to rate the extent the agency collaborates around data sharing, staff training, joint service delivery, and/or resource allocation. Each item lists the same organizations as the competition scale and uses the same response options ranging from no (1) to constant (5). Psychometric properties were reported in Bunger et al. (2017) for competition ($\alpha = .68$) and collaboration ($\alpha = .68$).

Opinion Leadership Scale (Childers, 1986; King & Summers, 1970). There are no psychometrically supported measures that assess the influence of peers on the use of evidence-based practices. This study adapted a widely used marketing measure called the Opinion Leadership Scale, which has 7-items that assesses personal communication between individuals on specific products. Item language has been edited to fit organizations and programs for the target population of the current study. Items assess the extent that organizations talk to their peers about their programs, the extent they give or receive information about their programs, and the extent they are used as a source of advice on programs. Each item uses a four-point response scale. Higher scores mean greater influence and promotion of programs. Flynn et al. (1994) reported alpha coefficients conducted four studies using the Opinion Leadership Scale (.75 - .87).

Evidence-Based Practice Attitude Scale (EBPAS; Aarons 2004; Aarons et al., 2010). Respondents were asked to complete a 15-item measure of attitudes towards evidence-based practices. Each item uses a four-point Likert-scale. Response options range from 0 (not at all) to 4 (to a very great extent) to indicate their agreement with each

item statement. Higher scores suggest more favorable attitudes towards evidence-based practices. The measure consists of four sub-scales (1) appeal of EBPs, (2) EBP use is required by the organization, (3) openness to trying EBPs, and (4) unfavorable attitudes towards EBPs. Aarons (2004) reports good psychometric support for the EBPAS. Cronbach's alpha for the full scale is .77, the appeal subscale is .80, the requirement subscale is .90, the openness subscale is .78, and the divergence subscale is .59. EBPAS scores for the current study are presented in Table 6.

Data Analysis

Document Review

Qualitative content analysis was used to analyze text data (Forman & Damschroder, 2008). The study author and a second coder, a doctorate level student with graduate-level coursework in qualitative methods, completed two identical but separate coding sheets for all funding documents. Information within each funding document was placed into categories based on existing codes. The study author compared the two coding sheets and noted differences. Ten total differences were noted across all coded funding documents. Most coding differences (six out of 10) were details from one funding document, which had a lengthy narrative section that made EBP implementation details difficult to identify. The remaining differences were minor intervention-specific details.

The existing codes include organizational specific features, such as the number of full-time staff, age of organization, special populations served, and their geographic setting (rural or urban). EBP specific details included the number of EBPs reported in the

funding document, descriptions of each EBP reported, number of staff involved in EBP, and the date of EBP adoption. The presence/absence of implementation supports were coded as individual strategies, which were informed by the compilation of implementation strategies published in Powell et al. (2015). The presence or absence of an *implementation team* was defined as a dedicated team of organizational leaders, administrators, managers/supervisors, and/or clinicians who meet regularly to discuss and support implementation efforts. The presence or absence of *EBP fidelity monitoring/assessment* was defined as intervention-specific measures or procedures to monitor staff adherence to the delivery of the program.

The presence or absence of an *EBP training plan* was defined as details on how front-line, clinical, and other staff will learn to deliver the program (e.g., who is the trainer, frequency, and duration of training, and/or any booster sessions). The presence of absence of *EBP supervision* was defined as direct service staff are provided with ongoing supervision focusing on the EBP. Lastly, the presence or absence of *consultations and/or technical assistance* was coded as receiving consultation with experts in the EBP (e.g., intermediary or purveyors) on strategies to support the implementation of the EBP.

Focus Groups / Interviews

The study stopped recruitment at 13 organizations then used a code meaning strategy, using the theoretical framework, to assess data saturation (Hennink & Kaiser, 2021; Nascimento et al., 2018). Summative content analysis was used using priori codes, based on the study's theoretical framework, and definitions provided from these theories (Hsieh & Shannon, 2005). The study author and a second coder (same individual

specified in *Document Review* above) met weekly to hold data discussions for clarification and triangulation. A coding disagreement log was completed during discussions. Codes were compared and both raters discussed their rationale for using each code when disputes occur. The process for addressing coding discrepancies started with the study author presenting the coded transcript statement along with the conflicting codes with the second coder. Both coders shared their rationale for selecting their code. The study author kept a documentation trail for dispute resolutions and all changes in coding processes, the coding manual, and summary documents. Transcripts were uploaded into NVivo and code summaries were generated based on the study's primary aims and theoretical framework (Bazeley & Jackson, 2013).

Quantitative Surveys

Descriptive statistics on key study variables were analyzed using SPSS software version 29. During this process the study author examined any divergence across qualitative and quantitative data sources at the individual case level. For within case discrepancies, the coders considered if the divergence is due to the data revealing different aspects of the phenomena (for example: a Director and Manager differ in their survey response on the influence of coercive pressures) or if it is due to methodological problems (for example: timing of adoption exceeds the quantitative assessment period resulting in interview reports differing from survey findings). The study author used contextual findings from other data sources, when possible, to explain divergent findings.

Mixed Method Analysis

Qualitative and quantitative data were merged to develop adopter categories based on a modified version of the "Fidelity, Attitudes, and Influence Typology" (FAIT; Swindle et al., 2022). This typology classifies organizations or sites into categories based on their self-report fidelity, their positive or negative attitudes towards EBPs, and their active or passive influence in their context. The original authors of this typology conducted intensive site observations to monitor fidelity, which is not feasible for this study. In lieu of site visits, the study author conducted a comprehensive examination of funding documents, interviews/focus groups, and survey data to make all classifications. First, "Moderate to High Fidelity" and "Low or Unclear Fidelity" groups were derived using the following criteria:

- *Moderate to High Fidelity* = Organization self-reports meeting fidelity in their interview/focus group for at least one of their EBPs, and funding documents describe fidelity oversight, and/or fidelity documents do not describe oversight mechanisms but focus group/interview respondent provided detailed descriptions of their fidelity oversight mechanisms.
- *Low or Unclear Fidelity* = Organization either self-reports unclear or low fidelity in their interview/focus group, and/or funding documents do not detail oversight mechanisms and focus group/interview respondent does not provide any fidelity oversight details.

Second, *positive and negative attitudes towards EBPs* were derived from focus groups and quantitative surveys (mean splits were used to determine cutoff scores) using the following criteria:

- *Positive attitudes* = Focus group/interview respondents made supportive statements about EBPs in general and/or positive experiences using specific EBPs and quantitative scores on the overall EBPAS scale for their organization were > 3.34.
- *Negative attitudes* = Focus group/interview respondent made critical statements about EBPs in general and/or majority unfavorable experiences using specific EBPs, and/or quantitative scores on the overall EBPAS scale for their organization was < 3.34.

Lastly, *active and passive influence* groups was derived from focus groups and quantitative surveys (mean splits were used to determine quantitative cutoff scores) using the following criteria:

- *Active* = Focus group/interview respondent self-report their organization as being a source for information and/or support on youth programming for outside entities, and/or Opinion Leadership Scale scores were > 3.96.
- *Passive* = Focus group/interview respondent self-reported seeking out external entities for information/support on youth programming, and/or Opinion Leadership Scale scores were < 3.96.

This study classified each organization into one of eight categories based on their combinations of fidelity, attitudes, and influence. The FAIT categories include:

(1) Non-adopting active supporters show positive attitudes towards EBPs, indicate low or unclear fidelity implementation, and indicate an influence on peers' programs. (2) *Non-adopting passive resisters* indicated low or unclear fidelity and indicated unsupportive views of EBPs. This group indicates low influence on their peers' programs. *(3) Non-adopting active resisters* were strongly vocal about their complaints implementing EBPs, indicate low or unclear fidelity, and report an influence on their peers' programs. *(4) Non-adopting passive supporters* indicate low or unclear fidelity, low influence on their peers' programs, and shows positive attitudes towards EBPs. *(5) Adopting active supporter* were organizations that hold supportive attitudes towards adopting EBPs, positive influence in their field, and moderate to high EBP fidelity. *(6) Adopting active resisters* indicate moderate to high fidelity, influence on their peers' programs, and negative attitudes towards EBPs. *(7) Adopting passive resisters* indicate moderate to high fidelity, low influence on their peers' programs, and generally negative attitudes towards EBPs. *(8) Adopting passive supporter* indicates moderate to high fidelity, low influence on their peers' programs, and supportive attitudes towards EBPs.

Once organizations were classified, external pressures associated with each adopter category were identified both qualitatively and quantitatively. The study author classified organizations in NViVo and generated codes for external pressures for each classification. Descriptive statistics for external pressures were examined using SPSS by selecting cases by each classification.

Chapter 3. Results

The purpose of this study was to gain an understanding of how organizations make decisions to adopt EBPs. Specifically, the objectives of the study were to identify how external social pressures may influence their decision-making, provide an overview of their EBP implementation, and classify organizational adopter behavior. The Results chapter reports these findings across three sections. The first section highlights EBPs and implementation strategies used by participating organizations and describes their decisions to de-implement or switch use of specific EBPs.

Section 1: EBPs Adopted, Implementation Supports, and De-Implementation

The Number, Types, and Length of Use of EBPs

The study author used focus groups/interviews and contracts to identify the type and number of EBPs used by each organization. A total of 47 discrete EBPs were reported. Table 5 details EBPs reported by organizations with a comparison of usage rates from the National Needs Assessment (NNA) conducted by Kull et al. (2021). The most reported program was Motivational Interviewing (92%), which is consistent with the NNA. The median number of EBPs reported by organizations was 7. Eight percent (8%) reported use of one EBP, 15% reported using 2-5 EBPs, 46% reported using 6-9 EBPs, and 31% reported using 10+ EBPs in their organization. The NNA reported a similarly high number of EBP use: 8% reported 0 – 1 EBPs, 64% reported using 2 – 5

EBPs, 23% reported using 6-9 EBPs, and 5% reported using 10+ EBPs (Kull et al., 2021).

Due to the high number of self-reported EBPs and how some organizations cost allocate their EBPs to multiple funding sources, the study was not able to obtain funding documents for all EBPs reported during interviews / focus groups. The number of listed EBPs in funding documents ranged between 0 – 9 EBPs. Of the 4 organizations that provided SAMHSA funding documents, the number of EBPs listed in the application ranged between 2 – 9 (Median = 4). Of the 5 organizations that shared ACYF-FYSB applications, the number of EBPs listed in the application ranged between 0 – 9 EBPs (Median = 3). Of the 4 organizations that shared state, county, and city government funding documents, the number of EBPs listed between 0 – 4 (Median = 1). Lastly, two organizations shared 3 documents detailing funding received from local non-profit organizations and foundations: Two of these private funding documents listed 0 EBPs and one listed 4 EBPs.

The years of experience implementing an EBP was calculated using the difference between the year of first EBP adopted and current year. The date of adoption was obtained for 35 EBPs, of the 47 reported, across the full sample. Organizational experience implementing EBPs ranged between 3-28 years. The earliest date of EBP adoption was 1995. The second earliest EBP adoption occurred in 2003 by a different organization. Most of the remaining organizations adopted their first EBP between 2005 - 2015 (n = 8).

Implementation Supports

Dedicated EBP implementation support was assessed using funding documents and focus groups/interviews. Table 4 specifies implementation supports detailed per each funding source across all 26 documents received from 13 organizations. The unit of analysis is the number of funding documents.

Implementation team. Six organizations described a dedicated team that meets to monitor and support their EBPs in their funding documents. Of those six organizations, only three organizations specified team members whose roles are dedicated to oversight and fidelity to their EBP(s). The remaining six organizations do not mention their EBPs in their team's oversight responsibilities. Team members included a Branch Director or Executive Director, an Evaluator/Data Manager, Program Coordinator/Manager, and external community partners who influence implementation (e.g., business community, education system, social services, universities, etc.). One organization listed a Youth Advisory Board as providing additional oversight on data, program assessments, and recommendations. The frequency of team meetings ranged from weekly, monthly, quarterly, only twice a year, to an "as needed" basis.

EBP fidelity monitoring. Fidelity assessment procedures or tools were described by three organizations in their funding documents. Of the three organizations, one organization indicated they received a "Good Fidelity" rating by the EBP Purveyor during a recent audit. Additionally, this organization has an Executive-level staff member who conducts regular internal fidelity assessments, coordinates vendor training for direct service staff, and help with an annual fidelity audit.

A second organization described in their SAMHSA funding documents the role of dedicated staff members who oversee fidelity using a standardized EBP-specific fidelity measure, monitoring caseload ratios to ensure high-fidelity, and following a pre-specified timeline for site monitoring and delivering reports. This organization is the only participant to detail any intervention-specific fidelity measure. The third organization, in their SAMHSA funding documents, listed individual team members who monitor fidelity, a specific data system, and the frequency of reports (i.e., monthly, or as necessary), but lacked details on fidelity specific data or measures.

Among the organizations that did not detail fidelity assessment in their funding documents, focus group/interview findings were mixed on how much respondents could describe their fidelity monitoring processes. One organization detailed multiple fidelity monitoring activities from the funder for one of their EBPs:

> With [EBP], we're absolutely maintaining fidelity a hundred percent.…. We have quarterly fidelity visits. There are certain things that we have to monitor. And then we have an annual refresher training for everyone [peer organizations].

Another organization reported a spectrum of fidelity monitoring activities that occur for the multiple EBPs they implement.

> It varies per EBP, so some of them are very, very strict. Some you have weekly calls, you tape your meetings, you debrief with the individual. Some of them are trained and you get trained the next year. The ones where you have to record your meetings and have the debrief, those usually require even, uh, on a monthly basis, sitting down with your coach, your coach reviews everything, gives you feedback.

A Supervising Caseworker from another organization was able to detail the fidelity elements for each intervention component, including standardized case

reviews/audits and caseload size caps. Additionally, one Program Manager from another organization specified the role of outside monitors.

Four organizations asked or alluded to what fidelity meant when asked about their EBP implementation. While Motivational Interviewing was the number one reported EBP among participants, no organizations reported fidelity monitoring, or an awareness of fidelity to the Motivational Interviewing, in their focus groups/interviews and funding documents. One Director stated:

> But with motivational interviewing, there isn't [fidelity] right? It's just, I think it's us. The onus is on us as managers, and as an agency to ensure that we're constantly training and then implementing and like reviewing and evaluating how that's working, whether that's motivational interviewing or harm reduction or positive youth development.

One Program Manager pays attention to relationship-based problems between staff and youth and uses supervision with individual staff to probe into their use of practices, like Motivational Interviewing, to assess fidelity. Similarly, a Program Manager from another organization relies on case files to determine if program service goals are met but does not monitor staff performance on their delivery of practices. Lastly, one organization shared that they rely on staff training documents and electronic health records to track fidelity to Motivational Interviewing.

EBP Training Plan. Staff training was the highest reported implementation support listed in funding documents. A total of 14 funding documents from 9 organizations mentioned staff training. Of those 14 documents, 11 documents describe a training plan specific to their adopted EBP. Organizations vary in the level of detail provided on their EBP training plan, including who conducts training and the frequency

and duration of training. Most organizations use an internal site-based trainer/leader who provides training to new staff and booster sessions (n = 4). Only one organization specified that the site-based trainer is certified by the EBP Purveyor, one organization received direct training from the EBP Purveyor, and another specified no cost online training through their state on EBP-specific related topics/issues. Three organizations detailed a time frame for training delivery, the number of total training hours required for their funding (including training in their EBP), or both.

EBP Supervision. Nine funding documents mention staff supervision. Of these 9 documents, 4 describe the supervision of staff delivering the EBP. Three funding documents from two organizations list dedicated internal leaders who supervise the direct service staff through group supervision with case managers, field mentoring, and the develop action plans following reviews. One organization mentioned regular supervision with directors, but no additional details were provided. One EBP supervisor stated that they have no training in the EBP but supervise direct service staff for their license:

> We have a couple [EBP trained therapists]. I'm not and I'm supervising them for their license. I'm reviewing their documentation, their, you know, their treatment planning their diagnostic assessments, their case notes. So I'm ensuring that we're compliant with state standards for how we're offering behavioral health services. But you'd have to have a whole team of people supervised by someone also trained in that model to be able to really know the way that they're going about doing it.

Consultation and Technical Assistance. Eleven funding documents mention the use of consultation or technical assistance for implementation support. Two funding documents (one city and one SAMHSA) specified consultation services for their EBP, including with a state technical assistance provider or with the original EBP

developer/researcher. All ACYF-FYSB funding documents state they access services from a federally funded national training and technical assistance provider to incorporate recommendations and best practices, but no other details are provided. Lastly, one SAMHSA funding document, detailed consultation with a local indigenous organization to improve their organizations response to the needs of indigenous youth and families.

Reasons for De-Implementing or Switching EBPs

Three organizations reported de-implementing an EBP. Of those organizations, one organization reported the loss of funding as the reason for EBP de-implementation. Another organization chose not to re-apply for their EBP-specific funding due to the EBP's low relative advantage compared to their other practices. The Director explained:

> Usually, it's the ones that are tied to a funder and the funder wants us to use it, and we're like, "Yeah, we'll give it a shot" and we'll run through in maybe two years of doing it. Then we realize, heck no, it's not getting us better outcomes. We're not seeing this massive impact. Now, if it'd get us 3% more, um, outcomes, or I would even settle for like one or 2% higher outcomes, but generally it doesn't happen. So, then the question is, the amount of time and effort, money it takes to implement this EBP doesn't compare to some other ones that are much more cost efficient and get you the same outcome…. And as soon as that funding ended, we just went back to doing [EBP] and [EBP]. ... This funding allowed us to try out this EBP and we're always open because in the end, it could help us become better, but if it doesn't, we're gonna drop it and we're gonna go back to what we have.

Three organizations reported stopping their EBPs because of disruptions from the COVID-19 pandemic. One Clinical Manager stated their parent focused EBP "disappeared" because less youth with children came to their program since the pandemic. A Case Manager from another organization shared that the pandemic and their administration's low prioritization of EBPs resulted in an unplanned discontinuation with ambiguous intentions to restart the program.

Lastly, two organizations shared their de-implementation was due to intervention characteristics. One Clinical Director stated that they had replaced their EBP curriculum with a newer one because it had aged poorly. One Clinical Therapist, from a different organization, stated that the intensive homework and writing component of their trauma EBP was a poor fit with the youth due to their literacy struggles and inability to do homework outside of sessions.

Section 2: External Pressures to Adopt EBPs

This section highlights major findings on the role of external social pressures on organizational operations, including the adoption of EBPs. Qualitative results are described for coercive, mimetic, and normative pressures below.

The external pressure scale asked organizations the extent that outside forces influenced their organizational operations using a five-point scale (1 - no influence to 5 – a very strong influence). Table 6 details means and standard deviations for each participating organization. For the full sample, the strongest influence on organization operations was coercive pressure (M = 3.38, SD = .77), the second strongest was normative pressure (M = 3.30, SD = .62), and mimetic pressure was the least strong (M = 3.23, SD = .86). Only two other studies provide comparison scores on external pressures experienced by human service organizations (Bunger et al., 2017; McBeath et al., 2012). McBeath et al. (2012) reported that mean values of external pressures were greater than 3.4 for their sample, which included private child and family serving organizations with partnerships with the child welfare system. The participants in McBeath et al. (2012) may

report greater pressures because of having closer ties to government systems and modify their operations to meet these demands (Collins-Camargo et al., 2019).

Coercive Pressure

Focus groups and interviews revealed multiple types and levels of coercive pressure among CBOs serving YEH. Twelve organizations confirmed the expectations to use EBPs from their funding sources. Of those 12 organizations, 11 indicated that the federal government was the strongest source of pressure to use EBPs. Within the federal government, expectations to use EBPs varied across different government departments. Among the organizations who have received funding through SAMHSA (n = 4), there are clear guidelines for using EBPs. A program manager from one organization stated that a specific need within their service population resulted in their pursuit of SAMHSA funding, which led to adoption of an EBP. Another respondent explained their recent pursuit of SAMHSA funding was necessary for expanding their organization's reach across their state; however, SAMHSA reporting requirements are more challenging.

The push to use EBPs from the ACYF: FYSB was mixed compared to SAMHSA. Three organizations stated that ACYF: FYSB expects evidence-based approaches across their different funding streams. In contrast, four organizations viewed the ACYF: FYSB expectation as flexible and encouraging use of EBPs, but not a requirement. According to one respondent, the extent that EBPs are integrated into a grant application can vary depending on the program type. Two directors, from different organizations, described how EBPs are written into their competitive ACYF grants and how EBPs in grants are scored:

> No, I mean, they ask you "is this an evidence-based practice?" and you might get a point, a bonus point for it, but they have so many other opportunities to get a point some other way. So I wouldn't say that they're as prescriptive or tied to evidence-based models.
>
> So, for runaway, homeless youth, it's moving in this direction, but it's not that tight, if that makes sense… FYSB wants evidence-based practices, and they want you to show that, but they haven't gotten as prescriptive to say, you need to use X, Y, and Z. So, they're easy.

While respondents provided mixed responses on the requirements for EBPs from ACYF, several underscored the importance of using other types of practice approaches, including positive youth development and trauma-informed care, to receive ACYF funding. One Director illustrates how important these general principles are for funding applications:

> If you don't have Positive Youth Development, you're not gonna get funded. You're gonna get docked. There's no way you'll get it. Motivational interviewing is so common as well. If you don't have motivational interviewing, meh [maybe]. And something addressing trauma. You don't have those, you're not gonna get funded. I've been a peer reviewer for FYSB and ACYF and whenever I've done site visits, they're the ones that I always see pop up time and time again.

State and local pressures. Six organizations described strong coercive pressure at the state and county level. Four of these organizations are located within the same state. The Family First Prevention Services Act was the most reported state-level coercive pressure (FFPSA; n = 3, all organizations located within the same state), which is a federal legislation that allows states to fund community-based services to deliver EBPs to support parents, children, and youth with their needs and keep the family together (Child Welfare Information Gateway, n.d.). One Case Worker stated that they are using the FFPSA to adopt two new EBPs, but that they must be listed in a website registry of approved EBPs.

Participants reported other types of state and county level pressure to adopt EBPs; however, there are differences in how much freedom organizations have in selecting a specific EBP. Two organizations describe their state/county EBP priorities:

> Request for proposals that come out our county… *County* is actually very big on use of evidence-based practices ... And oftentimes they actually put out grants that are very specific, "we want you to use [specific EBP name]" or another EBP.
>
> For [county] funding it absolutely makes a difference… There's a full section on "Is it evidence-based? If so, what's reported? What are the outcomes? How has it been rated?" [*on website of EBPs*] ... And those things make a difference for our funders, especially for *the county*. Those are requirements for us.

Only one organization reported no external expectations to adopt EBPs despite receiving funding from federal, state, and local government sources. The Director stated these "funders know the model that we use is based on science." This finding is consistent with the organization's survey results, which reports the lowest score on the coercive pressure scale; however, the survey reported they had no government sources of funding.

Private foundation pressure. Four organizations described their philanthropic and private foundation funding as non-prescriptive and supportive of their general programming. However, one organization Director stated that they adopted a new EBP that was pre-determined by the private foundation's extensive research on the topic. In the Request for Proposals, the private foundation listed two EBPs that both addressed the targeted need and let applicants select the one they preferred.

Positive Responses to Coercive Pressure

Eight organizations shared their positive views on EBPs considering their requirements, including the mission alignment (n = 4), staff structure and guidelines for working with youth (n = 3), and EBP-specific funding supporting data systems to inform organizational decisions (n = 1).

EBP is mission aligned. Four organizations mentioned their funder required EBP aligned well with their organization's mission. One administrator expressed positive attitudes towards the alignment between their mission and their funder's promoted programs and therapies. Two other organizations reported their service/treatment philosophy as the basis for how they adopt new EBPs. One clinical director stated:

> At the foundation there is a set of beliefs which are based in evidence and based in the results that we get…. And then we also look for evidence-based practices like [EBP], [EBP], [EBP]… I do not think we veered from it since its inception to the values and philosophy of [EBP]. We will always look to enhance it and to meet the gaps and needs of youth that we have…. [EBP] philosophy kind of grounds us, lays the foundation.

The same respondent shared that their organization learned about a new EBP through a funding notification. Their organization was not awarded the funding, but they still decided to adopt the EBP because it aligned well with their mission and philosophy. This example illustrates a combination of coercive and normative influences.

> We were invited to apply for the [EBP] grant. We were a little surprised when we didn't get it. We looked back at what we had learned in the process of making the application, it was such a good idea, we said "Let's do it anyway!" And so, you know we're getting information about what the evidence supports, what's the best practice…. They didn't give us anything! We didn't win the grant, but we learned something about what the best practices were. We've since got a bunch of grants for [program], by the way. But you know we started out on our own.

A different organization reported a similar experience that involved both coercive and normative pressure due to being a research site for an effectiveness study. The organization continued to use their funder required EBP even after the federal government removed their EBP registry because of how it benefited the youth. An Administrator explained:

> …. [EBP] for instance. So that came out of SAMHSA. So that was an evidence-based SAMHSA curriculum that we actually were required to do under the *State/County*. It was a grant that we had received to reduce substance use and misuse. And when SAMHSA had taken down their evidence-based practices, it was like this period where they weren't listing any evidence-based projects, but we continued to use it because the evidence in the research really showed that it worked with diverse populations of young people. It was universal… so that initially came with funding essentially, but it ended up being a good fit.

One organization mentioned their county's use of performance-based contracting, which involves payment based on delivery of successful outcomes. While performance-based contracting doesn't stipulate use of EBPs, the respondent stated that the pressure to deliver positive outcomes for youth keeps them aware of EBPs but doesn't motivate them to adopt a new EBP by itself because they already implement EBPs in standard cost reimbursement contracts.

Staff training and structure. Three organizations discussed the EBP benefits for their staff by providing them with necessary structure and clear guidelines for working with youth populations. One Director shared how their drop-in center staff benefit from curriculum based EBPs:

> For the drop-in center, oftentimes you have to hire somebody that's a good fit for the space and the clients that we're working with… We probably rely more on lived experience than we do on education because it's just a unique place that needs a unique set of people there. I think that's the other piece about evidence-based practices and these curriculums, is that it does provide that structure for

> staff where we can ensure that they're getting training with us regardless of what they've learned in life, in school, in other places. So not that it gives us control, but it gives us the tools and then the staff can feel more confident in facilitating those groups, which is usually the most nerve-wracking thing that most people have to do.

A respondent, from a different organization, highlighted the EBP's observable benefits for their staff when compared to "business as usual."

> So often providers, regardless of their training and education, and how common sense some aspects of evidence-based practices may be, business as usual is provided in that "crisis response way", there is no pro-action, no pro-active planning. And I think oftentimes, coming from a youth perspective, clinicians, case managers, social workers, they suck to work with. Despite their years of education, they're stigmatizing. No matter how much the social work education program pounds into their head "use strength-based models." If they aren't told how to do strengths-based models, they're not going to do strengths-based models. They're just going to attempt to provide humanist-oriented services without applying critical evaluation as to the efficacy of what they're doing. And so from a youth perspective, when people are using evidence based practices, we know that what they're doing is actually going to be helpful to young people. And they need it…. Once providers started using [EBP] the stark differential between staff who are trained in [EBP] versus staff who are not trained in [EBP] and are becoming trained in [EBP] is incredibly different in regards to how our young people experience them, and how they experience our providers versus providers and other programs…. it's a drastic difference.

EBP funding supportive of using data systems. One organization shared their federal EBP-specific funding allowed them to make an additional investment in a data system to track various metrics, which has led to growth for their organization. A respondent shared:

> One of the smartest investments we made with some of our initial [Federal Grant] was we had a little money left over which they allowed us to invest in the startup of our management information system, which has been phenomenal … We've got a lot of access to information, real time, which is incredible.

An administrator who oversees data reporting, shared coercive pressures to track specific metrics, how their metrics align with their values, and how they use data for oversight and accountability:

> We have metrics that are required for our funding stream. So obviously we need to adhere to those but the way that we have them organized typically is centralized around our values … The reason we care about *timeliness* is not just because Medicaid makes us care about timeliness, … but then what does that mean for best practice? What's the "Why" behind that? ….. There are dashboards and things that we look at internally from an administrative team perspective. And then there are specialized reports that are available for lots of groups of people who have a specific interest or a specific expertise in an area. And then there are also reports that are given out to our provider agencies, so that they can do some internal monitoring, some self-monitoring…. We're also tracking those over time. And also, I'm holding them accountable for those pieces.

Negative Responses to Coercive Pressure

Negative attitudes towards EBPs were expressed by multiple respondents. EBPs were viewed as too costly and resource intensive (n = 5), too prescriptive or narrowly focused (n = 4), challenging to oversee and adhere to (n = 4), and stifling innovative and unique approaches (n = 2).

Too expensive and resource demanding.

Five organizations described EBPs as too costly and/or resource demanding. One organization called out the numerous fees attached to specific EBPs, such as annual recertifications, re-training, and fidelity monitoring. Two organizations shared that when they are searching for EBPs to adopt they specifically look for programs with a train-the-trainer component to help keep re-training costs low. Another organization shared their desire to adopt two specific EBPs that are a good fit for their population, but they do not have enough funds. The program director from this organization asked that EBP

developers be mindful of costs and perceived a recent trend for older practices to be repackaged and made more expensive:

> I've been around and in this field for over 40 years, so I've seen many things come and go. And sometimes what I see happen is I just see a repackaging and a remarketing of the same thing with a much heavier price tag on it.... I look at different practices and I'm like, oh my God, I've been doing that for, you know, 10 years. I just wasn't smart enough to give it a nice name and put a bow around it and make a boatload of money.

Another organization pointed out that many YEH serving organizations are unable to implement EBPs because they are small and under-resourced, which can lead to inequities:

> What seems to happen is the very large organizations that are really well resourced tend to be the ones that can more easily adopt these. But then that leaves out the smaller, more like neighborhood-based community organizations that I see in the city. They're just like, "We don't have the staff, the time, the money for this" and so it leads to inequities, I think, in terms of which young people, which families, are getting these services.

Too prescriptive or narrowly focused. Respondents from four different organizations stated that their organization will only apply for funding if the EBP addresses the service population's needs and fits the organization's values, structures, and workflows. Two organizations expressed negative reactions to the EBPs approved by their State to receive FFPSA funding. One director described the incompatibility between their organization and the list of EBPs approved by the State, which has led their organization to decline to participate in the FFPSA:

> Some of these [FFPSA EBPs] we were looking at were like, "Well, I don't know that seems like that would require 3 other staff, and not really sure why we would have somebody do this, and then send the kid to somebody else to do this", and it just seems like a we would be creating some kind of bureaucracy within our agency to accomplish this thing that we really weren't sure about….. "you want us to adopt this thing that we either aren't ready to do, or we don't think it aligns with

> the way we do the work." You know when you work in crisis like situations like we do with youth who have experienced commercial sexual exploitation, youth have been living out on the streets, youth who have been arrested and have been in and out of group homes, and if you're really stuck in a box, and you're very rigid about your policies and procedures, and we have to do this, it really puts up barriers to having a relationship with youth and being able to serve them effectively… [FFPSA EBPs] just felt a lot more rigid than the way we do our work…. And you know there's a timeframe the County wants to hear back, "Hey? When can you do this thing?" "Well, you know, I don't know that we can do this right now. We can talk about it in the future. Maybe."

A director from one organization expressed negative attitudes because EBPs slow their work down and are too narrowly focused, which doesn't address the dynamic and multi-faceted needs of YEH.

> The processes that they have to go through to get something to be stamped Evidence-Based or even Promising is not useful for what I'm doing today. Nothing comes out useful even if you spend a bunch of money and pay for all the training, and you then have to pay the yearly fees and the licensing fees, which we did when we used to do [EBP] and we did to fidelity and we're doing the supervision and the train the trainer, and all this stuff. We did that with [EBP] and we have done this for [EBP]. Not one of those things actually works in a community-based organization such as ours because by the time it hits the ground it's obsolete. The reality is, if I did my job today, the nature of what I need tomorrow should be different. Evidence-based practices model, to get evidence-based, doesn't account for that. They don't account for the fact that by the time you get that model on the ground to me I've already changed the game through the work we did yesterday.

The same respondent acknowledged funders desire for EBPs and their effectiveness in achieving targeted outcomes, but viewed them as superficial and burdensome to staff retention:

> Now where EBPs are good: It's super cute. It's so pretty. Funders love it. They think it's so pretty, and it is, I agree it is pretty to be able to say, hey, if I follow this stepwise approach, you know, [EBP], BOOM, I'm going to get this outcome. 80%. That's so pretty to look at. But the reality, is it doesn't it didn't account for whether that young person was fed that morning, and doesn't count for the fact that I have a 23 year old right out of grad school, who in 2 years going to use that training that I gave them, and go do something else and not even going to use that

> evidence-based practice because it's not even practical for them when they go into private practice and make 4 times as much. So, in reality it's like frosting. And you know we do it because it is frosting, and yes, you trip and fall, and you get some outcomes along the way, and any outcome for any young person anytime is worth it.

Lastly, a respondent from a different organization that was trying to implement a local initiative described resistance from a critical community partner, who said "We don't want that funding because they're asking to use this [EBP] and we don't' believe in it."

Challenges with oversight and fidelity adherence. Four respondents from four organizations shared their experiences and challenges with adherence to EBP fidelity. One organization stated that EBPs subcontracted to partners are incorporated and "eventually organizations put their own slant on them." A director at another organization shared that their EBP, under their funder's direction, has been significantly modified over the years, which they support:

> But in reality ... the *Funder* appropriated [EBP]. It's not being done per its evidence-based approach that was 10 years ago when we started doing this thing. They've taken bites out of this thing, and that's the funder! The funder wanted to use this, and now they're like taking bites out of it however they want to use it, which I get it. I support that. I think that's the best way to use these things.

One director at another organization stated that funders do not prioritize the use of implementation tools, such as fidelity measures, and their staff view tracking of intervention delivery as a burden. The respondent shared:

> It is not a priority for the funders to have the supporting tools being used or mandated. ... Oftentimes the fidelity piece of using the tools regularly has been a challenge…. And we know that consistent use of the tools allows for greater probability that this individual will find some stability, and those aren't the things that are necessarily being prioritized… And so [we're] trying to find the space for

> prioritizing understanding [among direct service staff] the balance between direct service and administrative services.

General oversight of funders emerged in two other organizations. A Program Manager from one organization said ACYF-FYSB audits are conducted by two individuals: a federal staff member and a peer reviewer with qualifications in the field and auditor training. The respondent described the auditing process, which included submitting internal agency documents in advance, in-person or virtual tours of facilities, and interviews with staff and community partners. When asked about any EBP-specific auditing, the respondent replied:

> We didn't really get dinged on much. Little things. They suggest little things that we could do that will strengthen our next application that will provide a little bit more clarity on some of our services. It's not really a punitive thing. Of course, they wanna make sure we're in compliance, but they're also there to support us with any kinds of struggles we might have.

In contrast, a director from another organization described their experience with a county funder, who recently placed their organization on corrective action because productivity goals were not met, which the respondent attributed to the pandemic and high staff attrition negatively impacting their ability to hire staff and serve youth. The director responded by significantly altering their application for re-bid.

> We wrote in the bare minimum of everything we had to do to be responsive to those grant applications which is very different from the years past where we're all like "Let's do better. Let's drive ourselves. Let's just like, let's just do this thing." … It's stripped down in terms of staff qualifications, outcomes what we had to do or use as evidence based. And then, even then, if I could put in a qualifying statement: "if", "maybe", "based on this we could." We put in qualifiers everywhere…. and we got funded for those stripped-down versions. I think [corrective action] was their mechanism for us to build in flexibility…. They refunded us but they could've not….

Lastly, one respondent, from an organization with a strong history of EBP adoption, described significant challenges, including high staff attrition, large caseloads, lack of administrative support, and no EBP supervision/oversight, has led to poor fidelity adherence.

> We have to adopt some evidence-based practices and pay for them but I honestly don't think that they're being done because there isn't the support or oversight to ensure that they are being done properly.... So many people have quit *Parent Organization* that it's fundamentally unable to run. And so the *Parent Organization* is pushing shorter appointments with people and get their basic needs met and do the basic services. And as a result, they just kind of go back to business as usual despite thousands and thousands and thousands of dollars being spent to train them [in EBPs].…. If people that work with the young person met and talked about the young person, we're going to count that as the [EBP] versus actually doing what [EBP] is supposed to be. It's very bad, especially considering for many years *Parent Organization* was kind of the beacon of progress in the State in regards to our integration, adoption of evidence based practices, and the outcomes that were happening through our programming

This same respondent later highlighted the how the coercive pressure to adopt EBPs from the FFPSA has helped their department overcome their Parent Organization administration's de-prioritization of EBPs and receive needed training in a new EBP:

> …. but *Department* is privileged in that we straddle the line between a Family Resource Center and a division of *Parent Organization*, so we are the only aspect of *Parent Organization* that is a part of the primary prevention plan and the FFPSA cross-site collaborative….as a result, we are doing an [EBP] training right now with our staff.

<u>*Stifles innovation*</u>. Two organizations discussed how structured programs prevent new ideas or innovative approaches. A director shared their organization's experience as a recipient of unique federal funding that provided freedom to explore their community's needs and implement a new type of service.

> Often, it's difficult to try new things because your funding is going to be assigned to what is proven and existent. And this [federal funding] has allowed … for

> "courageous innovation." It allows us to say, "well, we don't know if this is gonna work, but we're gonna try it." ... [Federal Funder] is often very prescriptive. Like, do this, this is the way you do it. And the one thing that it was hard for anyone to believe would be [Federal Department] saying to you, "okay, be innovative", because there's nothing about that system that allows for innovation.

The same director expressed a low priority for adopting EBPs but desired their organization to be labeled "evidence-based" because they see their approach work with young people. Additionally, this director explained that their organization preferred to focus on housing and contracts-out their services for higher needs, such as behavioral health. When asked how much their organization oversees behavioral health services delivered by their contracted partners, the respondent stated they weren't sure.

The second organization shared how they remain scientifically minded and evidence-informed, but they don't feel the need to adopt new EBPs to be successful. The respondent shared an example of using their internal data system to identify a need, generating an idea to address the need, and securing new funding to implement it:

> … we might even generate our own ideas about how we could improve things.…. So, one example of that would be: we have a lot of kids that have been affected by sexual exploitation … [respondent describes their idea]. We found actually a grant [for their idea] … which allowed us to really implement a best practice serving specifically this population. … So, our thinking has been that we want to be evidence informed. Do we really need to go after all these manualized evidence-based practices in order to be good at what we want to do? Not necessarily. We want to be data driven. We want to be evidence informed. We want to stay in touch and be scientifically minded in what we do. But there's times where, for example, people make the argument about using [alternative EBP]. "Why not do [alternative EBP] instead of [respondents currently used EBP] or do [alternative EBP] within [respondents currently used EBP]?" And it's like we're already doing [type of work]. We're kind of like [alternative EBP] on steroids in terms of our individualization and reach.

Mimetic Pressure

Focus groups and interviews revealed specific types of mimetic influences on organization decisions to adopt EBPs, including peers as sources of information (n = 8), providing support to other peers (n = 10), and a competition with peers over recruiting new staff (n = 7), competing for new funding (n = 5), and obtaining new clients (n = 1).

Peers as sources of information. Eight organizations reported using peer organizations to learn about new EBPs and vet them before adopting them. Three directors reported using the EBP developers to identify implementation sites to learn about their experience. Additionally, two organizations reported making site visits in different states before adopting the model.

Five organizations described formal and informal funder-specific peer networks, including the ACYF-FYSB and SAMHSA. A director at one organization highlighted a state-level SAMHSA coalition that promotes and supports specific EBPs in their state. A Director at another organization in a different state described how they utilize peers in their informal network to respond to specific coercive pressure from funders to adopt EBPs.

> *Funders* have gotten better at those lists, who can be on the list and who they're recommending. And again, that's when I call my colleague up in *City*. "What are you doing? How do you use this? What's it like on the street? How's it look? Are you able to move? Can you move in real time? Adjust, pivot? They tell me: "Yeah" and I'm like "Cool, I'm on. Let's try it. Let's research that."

Another participating organization belonged to a large multi-state umbrella organization. The director explained that their umbrella organization offers lots of knowledge sharing, shared data platforms, and annual investments to each site that can be

flexibly spent. Their program manager shared how their umbrella organization has influenced a new EBP adoption:

> *Umbrella Organization* gathered nine of our different sites that we're working with parenting youth in our programs and families and of those nine sites we collaborated on what programs people were using …. Most of them have some components of [EBP] and so that was identified as the model that we were going to all do so that we could compare the data on.

Lastly, one clinical supervisor reported that they adopted an EBP at their former employer and brought it with them when they started at their new organization because the philosophical approach was aligned with their clinical approach.

Supporting other peer organizations. Ten organizations reported that they are sources of support and information for disseminating best practices, including EBPs. Four organizations explained that they provide training related to their EBP to other organizations, thus acting as a mimetic and normative influence within their field. Two organizations have formalized mechanisms for their training and consultations. One organization has formal contracts with a federal funder to train new grantees in two specific EBPs because of their long-standing implementation of the models. Another organization shared their evaluation of their EBP was disseminated at conferences, which lent them credibility and leadership in the model.

> When we started out there weren't that many [EBP] programs around and there wasn't a lot of evidence. And so we were pretty intentional, and put a lot of energy and finance into evaluation and research, which we presented at conferences … that kind of positioned us as a credible messenger in the world of [EBP]. And so we took on kind of a leadership role nationally in providing trainings. So, there was credibility that came from the research.

The program manager from the same organization shared they have formalized their leadership role in the field into a technical assistance program within their

organization. Their technical assistance includes working with organizations to develop their models, policies, and procedures through training, site visits, and providing guidelines and resources.

Competitive Advantage. Qualitative responses to competitive pressure tended to focus on the advantage that EBPs provide when recruiting new staff, particularly clinical therapists. Seven respondents reported that their new hires are often looking for additional training and experience in specific modalities. A clinical supervisor shared that staff development, training, and certifications in established clinical modalities are highly desirable and help recruit new hires because staff salaries can't keep up with other local entities.

Five organizations reported EBPs help strengthen applications and increase competitiveness for new funding. Additionally, an organization that recently expanded into a new region highlighted how EBPs have opened doors for their organization. The respondent shared:

> We moved into a really saturated market, where the [Local Government Funder] has decades long partnerships with [community providers], and regardless of whether or not they're doing a really good job or there's room for improvement, those relationships are pretty cemented…. I think [newly adopted EBP] will help with that because of [state initiative] … We're trying to work with the [Local Government Funder] to potentially get some funds in our way, which would be a first for us here. So I think if we're talking fidelity models…. [EBP] has open doors that our more generalized, less defined services hadn't.

The same respondent also stated that they recently agreed to a request from a local school principal to co-facilitate the school's longstanding EBP. The respondent agreed to the request because they see it as an opportunity to expand their reach to new clients for

their own services. This example highlights both a mimetic influence and coercive pressure because the organization is co-facilitating the EBP by request of a partner who they depend on to access new clients in a market saturated area.

Normative Pressure

Multiple sources of normative influence were described by participants, including conferences and professional development groups/businesses (n = 5), technical assistance organizations (n = 5), higher education/research (n = 6), and accreditation commissions (n = 1).

Conference Venues and Professional Development. Five total organizations reported learning about general best practices at state-wide or national conferences. Of those, two organizations described learning about specific EBPs. Only one organization adopted an EBP because of learning about it at a conference, which was a SAMHSA sponsored conference. Lastly, two organizations reported utilizing resources from professional groups to learn about best practices and new EBPs. One therapist shared using a national online training conglomerate to receive continuing education units in different modalities. A clinical supervisor from a different organization mentioned multiple professional development and advocacy groups for learning general research and best practices.

Higher Education and Research. Six total organizations discussed their connection to higher education and research institutions, which influenced their EBP adoption decisions. A director stated one of their EBPs was an easy decision to adopt because they learned about the model in graduate school and liked it. Two organizations

reported developing relationships with their local university, including one organization that learned about their EBP from a social work professor who provided them with training in the model. Another organization stated they were able to adopt a group-based curriculum EBP because they have access to social work students who use internship hours to help co-facilitate groups.

Three organizations shared a unique experience of serving as research sites. One organization participated in an evaluation through a private health care agency that supported their adoption of a new standardized assessment. Another organization shared that their organization serves as a site for research on EBPs for a university, which was the genesis for many of the reported interventions used by their staff. In fact, the same organization shared that their organization has been contacted for consultation because their organization is represented in academic journal articles, newspapers, and on television, which has given them legitimacy and serves as a mimetic influence.

Intermediary Organizations and Consultation Services. Three organizations reported learning about various types of best practices through their ACYF-FYSB funded training and technical assistance provider for YEH serving organizations. Of these three organizations, one reported attending a Motivational Interviewing training from the technical assistance provider.

Three directors shared receiving coaching and technical assistance from outside entities. One director described an intensive technical assistance program that aided them in the development of new data infrastructure, which has resulted in major growth and operational changes.

> *Intermediary organization* they have this [program]….it was two of the hardest years of my entire life…. You got to pick an individual project and so I picked a project on [respondent describes project] …for almost two years we worked on. *Intermediary organization* basically support a lot of data analytics in order to help lift whatever your projects are… There was a lot of evidence-based facilitation. They did a lot to help our organizational infrastructure… for many years we were a $5 million organization, to now more like a $16 million organization.

As a result of the technical assistance and expanded data infrastructure of their organization, the Director described how they approach identifying performance benchmarks and selection of new models or tools:

> I do a lot of data for a director. I meet with my data team every other week. A lot of that was from my experience with *Intermediary organization*…. Our team, we'll say "what is a great rate for exit to permanent housing?" There's no real model out there that exists that gives you what that is. But what we do is we will, I'll have my data team kind of Google what are published rates of success, and then dial back down. If there is a particular practice, a tool that they're implementing in something that makes their numbers, ... But we're constantly trying to find benchmarks to validate either we're in the trenches and nobody's got it figured out, or that, hey, they've got something going on there that's working.

Another organization shared their experience receiving implementation support on a model to align different service sectors.

> If you look at [Model]…. it's not so much focused on clients, it's more administration. [Respondent describes initiative to support model] …. there was a lot of TA in that one…. *Intermediary Organization* actually funded this incredibly expensive [initiative description] … They work incredibly intense. A lot of work. Probably one of the best experiences that I've had. Absolutely incredible because after that, you come back thinking, a lot of people just have the blinders on just their programs. They don't see an ecosystem. And it was absolutely incredible, but it was incredibly expensive. There's no way we would've done it without *Intermediary Organization*.

Accreditation Commission. One organization reported going through a national accreditation commission (not affiliated with an EBP or contract) to receive external and independent evaluation of their organization. A respondent in the focus group stated the

accreditation includes 633 standards with extensive policies and procedures on each standard. This respondent viewed their accreditation as a form of legitimacy for their organization.

> It lets people know that [standard of care] is not all talk. It tells other people that we've proven it to this external, unbiased organization. In addition to that, it helps us to continue to do good work. It holds us accountable on a day-to-day, week-to-week, year-to-year basis.…. And the structure that it provides us is another area. There are funders who, in part of our annual application process, expect to see our policies and procedures as it relates to the programs they're funding.… I think it improves our ability to maintain those contracts.

Section 3. Organization Classification

The current study classified 12 organizations into groups based on their fidelity, attitudes towards EBPs, and influence in the field. The classification criterion for each domain is detailed in the analysis section for aim 3. One organization was excluded because they declined to share their funding documents. Another organization did not share funding documents, but interview and survey findings provided sufficient data to classify the organization. Table 7 depicts the FAIT categories and number of organizations meeting the criteria for each domain.

The first step of classification involved placing organizations into one of two groups: (1) Moderate to High fidelity, or (2) Unclear to Low Fidelity. Six were categorized as “Moderate to High Fidelity” and six organizations were categorized as “Unclear to Low Fidelity.” Next, the organization’s attitudes towards evidence-based practices were classified as (1) Negative or (2) Positive. Nine organizations were classified as having positive attitudes towards EBPs and three were classified as holding negative attitudes towards EBPs. Finally, organizations were classified into one of two

groups based on their level of influence in the service field: (1) Active influence, or (2) Passive influence. Seven organizations were placed into the active influence category and five organizations were placed into the passive influence category.

The final organizational classification describe combinations of fidelity, attitudes, and influence categories. The 12 organizations were categorized across five of the eight typology groups: *Adopting Active Supporters* (n = 5), *Adopting Passive Supporter* (n = 1), *Non-Adopting Passive Resisters* (n = 3), *Non-Adopting Passive Supporter* (n = 1), and *Non-Adopting Active Supporters* (n = 2).

External Pressures Associated with Adopter Classifications

Additional analyses specified external pressures, using quantitative and qualitative findings, across each adopter behavior classification:

Adopting Active Supporters (n = 5). These organizations indicate moderate to high fidelity, influence on peer organizations, and positive attitudes towards EBPs. Quantitative results show coercive pressure is the strongest influence (M = 3.63, SD = 0.71), mimetic pressure was the second strongest (M = 3.46, SD = 0.71), and normative the least strong (M = 3.17, SD = 0.28). Qualitative findings confirmed the role of coercive pressure on EBP adoption. This classification encompasses all SAMHSA-funded programs in the sample, which is a funding source that requires EBPs and descriptions of EBP oversight mechanisms in funding applications. Additionally, three organizations reported strong pressure from state/county government funders to use EBPs. Lastly, three of these organizations also serve as strong mimetic influence by providing formal consultations and trainings on EBPs to other organizations in the field.

Adopting Passive Supporters (n = 1). One organization indicated moderate to high fidelity, low influence on their peers, and held positive attitudes towards EBPs. Survey findings indicate mimetic pressure as the strongest influence (M = 3.00), coercive pressure the second strongest (M = 2.86), and normative pressure the least strong (M = 2.83). Qualitative findings diverge from the survey results, which showed coercive pressure from local and federal funders as the strongest influence on EBP adoption. The interview respondent reported a low awareness of peer organizations using similar EBPs. They also only self-nominated their organization during the nomination process. However, the mimetic influence mentioned by the respondent in the interview was the competitive advantage that EBPs bring when recruiting new clinical staff.

Non-Adopting Active Supporters (n = 2). Two organizations indicated unclear to low fidelity, active influence on their peers, and positive attitudes towards EBPs. Survey results showed normative influence as the strongest pressure (M = 3.50, SD = 1.11), coercive pressure as the second strongest (M = 3.05, SD = 0.95), and mimetic pressure the weakest influence (M = 2.61, SD = 0.95); however, qualitative findings report different organizational experiences with external pressures between these two organizations. One organization was a public organization that reported coercive pressure as the strongest source of influence both in the survey and interview. The other organization was a private nonprofit, which reported no funder requirement to use EBPs. The focus group with the private nonprofit described strong normative pressure from a local research university and various professional development groups.

Non-Adopting Passive Supporters (n = 1). This organization implemented at low to unclear fidelity, indicated low influence among their peers, and were positive towards EBPs. Survey results showed coercive pressure was the strongest (M = 3.57). This organization expanded into a new region with a high number of existing service providers. Due to the high level of competition for funding and clients, the respondent reported how two specific models have helped them secure new funding and access to clients. One EBP was adopted at the request of a local school, which they agreed to access and obtain new clients at the school site. Additionally, a supervisor received training in a specific EBP while employed at a different agency, then brought the EBP with them to their current organization. Fidelity to intervention models was a challenge because their expansion efforts have been hampered by high staff attrition and challenges hiring new staff.

Non-Adopting Passive Resisters (n = 3). These three organizations were classified due to their unclear to low fidelity, low/no peer influence, and negative attitudes towards EBPs. Survey results report mimetic pressure was the highest (M = 3.56, SD = 1.07), coercive pressure the second strongest (M = 3.43, SD = 0.14), and normative pressure was the least strong (M = 3.39, SD = 0.38). While mimetic was quantitatively the strongest pressure, it also had the highest standard deviation. Only one organization qualitatively reported strong mimetic influence when they use their peers for advice and to vet EBPs they learn about. Qualitative findings show coercive pressure was the strongest amongst these three organizations. All three reported funders, specifically

federally sources, as the strongest push for EBPs. All three organizations receive ACYF-FYSB funding.

Chapter 4. Discussion

The first research aim was to identify the different types of EBP implementation supports and experiences among CBOs serving YEH. While a recent national needs assessment survey identified the wide range of EBPs implemented by CBOs, no details were provided on how long models have been implemented, CBOs experiences de-implementing or switching EBPs, nor how CBOS are supporting their EBPs, including dedicated oversight, fidelity assessment, training, and consulting and technical assistance (Kull et al., 2021). Few studies have focused on this population of human service organizations, and no studies have been identified that focus on EBP implementation within this setting. Therefore, identifying the needs and experiences of these organizations is vital for effectively closing the research-to-practice gap for YEH.

EBPs Reported, Implementation Supports, and De-Implementation

Results showed that organizations commonly reported using many EBPs that the national needs assessment (NNA) also identified as commonly implemented EBPs, including Motivational Interviewing, which was the most adopted program (Kull et al., 2021). The number of EBPs reported per organization was also consistent with the NNA. Most organizations reported using a high number of EBPs: 46% reported implementing 6-9 EBPs and 31% reported using 10+ EBPs in their organization. The high number of

reported EBPs was further investigated using funding documents to determine the degree to which EBPs are described and supported by organizations.

Funding document review showed a low number of EBP implementation details. The presence of specific implementation supports and the level of detail that organizations provided varied across funding sources. ACYF-FYB funding documents detailed robust training plans for their staff on diverse topics with a specified number of hours and timeframes for completion of required training, which is required in the Request for Proposals. Descriptions of fidelity assessments and procedures were mixed across funding sources. SAMHSA funding documents listed EBP specific oversight and supervision (n = 4) and fidelity assessment (n = 2). In fact, one SAMHSA funding document asks applicants to describe how they will "adhere to practice fidelity or standards." One county/state funding document reported a fidelity monitoring process and dedicated staff oversight, including consultation with a program developer.

Three of the organizations reporting EBP supervision details identified a supervisor role, their responsibilities, and frequency of supervision. Lastly, the majority of consultations and technical assistance were detailed in ACYF-FYSB funding documents (n = 7). This high number was due to a funder requirement in the Request for Proposals that organizations access resources provided by a dedicated training and technical assistance organization. EBP specific technical assistance was not detailed in these sections. Two SAMHSA-funded documents utilize available resources in their community/state for guidance and best practices related to their EBPs.

Focus group/interviews explained why organizations may vary in how much detail they provide on their EBP implementation in each type of funding application. Five SAMHSA funded organizations were interviewed in the study. Respondents explained that SAMHSA requires EBPs from a pre-approved list and the application asks for implementation specific details, such as monitoring to fidelity adherence. In contrast, the ACYF-FYSB applications are written to address the core service model of the funding application (i.e., shelter, transitional living, street outreach) and applicants incorporate evidence-based approaches sections. Given that SAMHSA funding applications request organizations specify their EBP implementation in greater detail compared to ACYF-FYSB applications, these organizations are exposed to both coercive and normative influences that increase isomorphy in the service field.

The study also investigated the historical context of EBP adoption and implementation. Organizations varied in amount of experience implementing EBPs; however, the sample has at least 8 years' experience. The study also investigated experiences of organizations de-implementing EBPs. Overall, de-implementation appears to be an uncommon event (n = 3); however, limited sample size and lack of longitudinal prospective data limits generalizability. The most common reasons reported were the loss of funding, the low relative advantage of the EBP compared to other EBPs provided, the EBPs characteristics fitting poorly with the youth population, and the covid pandemic disrupting implementation. The poor fit of specific models and their limited relative advantage for the target population is important because EBPs can be costly and contain extensive requirements that are burdensome for an already overwhelmed service system,

which may contribute toward negative attitudes among staff and negative service experiences among YEH (Slesnick et al., 2000; Walsh-Bailey et al., 2021).

External Pressures

Coercive Pressure

The second research aim focused on exploring the role of external social pressures on CBOs serving YEH. Focus groups/interviews and a follow-up quantitative survey indicated that coercive pressure was the strongest external force on organizational operations, including the adoption of EBPs. Federal and state/county funder expectations was the strongest source of coercive pressure. This finding is consistent with another study that reported coercive pressure for better quality services was the highest reported concern among child and family serving organizations (Collins-Camargo et al., 2019).

Nine ACYF-FYSB funded organizations were interviewed in the study. These organizations were less consistent with how much their funder expects them to use EBPs. This difference may be due to the broad definition for EBPs among some respondents in the study. Organizations supported by ACFY-FYSB funding often listed many different types of practices as EBPs, like positive youth development and trauma-informed care, which are less defined approaches than a manualized intervention with fidelity standards. While existing research shows that these approaches are associated with positive outcomes among YEH, the ability to replicate consistently across sites can be challenging without specific and measurable criteria for implementation (Gwadz et al., 2017; Heinz et al., 2010).

Responses to coercive pressure. CBOs responded to coercive pressures in a variety of ways, including both positive and negative. Many respondents indicated that their organization doesn't pursue funding for the sole purpose of receiving additional funding. The current study found that organizations are primarily motivated to apply for funding if the Request for Proposal aligns with their mission/values and responds to a relevant community need. Other research has found that human service organizations facing high external pressures will look to expand/diversify their programs and seek additional funding streams as a strategy to meet these external pressures (Collins-Camargo et al., 2019).

Two organizations applied to SAMHSA-funding as a mechanism to grow their organization and address unmet community needs within their local or wider geographic region. One respondent indicated that their organization was initially reluctant to apply for SAMHSA funding because the administrative and reporting requirements are challenging, which may be a barrier for many other smaller and less resourced organizations that may have aligned goals with SAMHSA and benefit from their funding. SAMHSA funding appears to be an important source of dedicated EBP support and expansion and may serve as a normative influence on organizations applying for their funding because SAMHSA funding applications require EBP implementation-specific details. However, organizations in the current study may have already had strong implementation capacity prior to applying to their SAMHSA funding.

County/State FFPSA expectations were only mentioned by respondents located within the same state. One organization disapproved of the list of FFPSA-approved EBPs

as being incompatible with their organization's existing workflow and structures. This organization viewed highly structured policies and procedures as creating barriers to engaging and developing relationships with vulnerable youth populations. Three organizations noted concerns with strict protocols of manualized interventions inhibiting their ability to form positive and responsive relationships with youth who have faced chronic traumatic and stressful living situations. This concern has been noted in the broader literature on interventions addressing the needs of YEH, which calls for the need to balance strict versus flexible policies and procedures (Curry et al., 2021). According to Institutional Theory, the FFPSA-approved EBPs were viewed by this respondent as an illegitimate approach to working with YEH. Given that FFPSA is voluntary, they declined to participate but may reconsider in the future when the list of approved EBPs expands to include more acceptable service modalities.

Alternative approaches to EBPs, specifically transdiagnostic models, have been suggested as a potentially more feasible and appropriate method for meeting the multi-dimensional treatment needs of YEH in common service settings accessed by youth (Winiarski et al., 2020). For example, Common Elements Treatment Approach (CETA) provides common intervention practices and tools from a range of effective interventions to address multiple problems, including anxiety, depression, substance use and traumatic stress (Chorpita et al., 2005; Murray et al., 2018; Engell et al., 2020). Given the high rates of mental health comorbidity among YEH and the significant challenges of engaging youth into services, organizations serving this population may perceive adoption of CETA as a more flexible and cost-efficient option compared to adopting multiple EBPs

for separate needs. No participants in the current study reported using CETA; however, future research should investigate the comparative advantage of transdiagnostic approaches on implementation and client outcomes compared to standard EBPs.

Oversight/Fidelity Adherence. Funder oversight and expectations on organizational adherence to EBP fidelity varied. Most organizations self-monitor their own implementation. Some organizations assign dedicated staff to oversee fidelity monitoring, training, and other compliance procedures; however, most funders typically do not require the use of implementation tools, such as fidelity measures, for their EBPs. The organizations with dedicated implementation mechanisms tend to have SAMHSA funding or have staff with advanced educational degrees. Organizations without these attributes report relying more on supervision check-ins with direct service staff to receive updates on general program implementation.

The current study identified low fidelity may be influenced by minimal funder expectations regarding implementation, lack of organizational capacity, or a general lack of knowledge of intervention fidelity. Clear expectations, guidance, and organization capacity building to oversee their implementation may help improve implementation efforts. Only one organization with county funding was required to participate in quarterly fidelity visits and refresher training with peer organizations in their cohort as a stipulation of receiving the funding. In contrast, one respondent shared that a county funder asks contractors to implement a version that is not consistent with the original model.

Site-level accreditation by EBP developers is another avenue in which model adherence is established and monitored. EBP developers in one study reported accreditation as an important for tracking fidelity, ensuring quality, protecting their brand, and positively reinforcing high-quality implementation sites (Lengnick-Hall et al., 2023). In the current study, only one organization brought up their general accreditation, which included a broad assessment of organizational policies and procedures related to non-profit youth care organizations. Collins-Camargo et al. (2019) found that contract-related pressure was the main external pressure that drove accreditation; however, the organization's motivation for accreditation was independent of any formal contracts or EBP requirements. The organization viewed accreditation as providing legitimacy and supported their ability to maintain contracts because of more formalized policies and procedures. The extent that general accreditation standards benefit the organization, influence EBP adoption, or create positive impact for youth is worth exploring in more detail.

Normative Pressure

The survey results found that normative influence was the second strongest external pressure on CBO operations. Focus group/interview findings report conferences and professional development groups/businesses, technical assistance organizations, higher education/research, and an accreditation commission as the most common sources of normative pressure. Staying abreast of new practices using articles, online resources, and webinars was the highest item endorsed in the survey for normative pressure. Focus

groups/interview respondents cited multiple professional development and advocacy groups that release briefs, webinars, and resources on general research and best practices.

A combination of coercive and normative influence was exerted over organizations to access technical assistance, specifically the ACYF-FYSB funded organizations. Funding documents describe the requirement of applicants to attend a yearly grantee conference and demonstrate access to their technical assistance provider. Technical assistance is a type of implementation strategy that provides guidance and resources to organizations, often based on "best practice" guidelines (Powell et al., 2015). Interviews/focus groups show that two CBOs utilized the ACYF technical assistance program to learn about EBPs and one received EBP-specific training through an online website training portal then received more intensive in-person training in the EBP afterwards from a local agency. Technical assistance providers can be a crucial resource for CBOs needing support with their adoption and implementation of EBPs; however, little else is known about their role or capacity to address EBP adoption and implementation. More research is needed on the technical assistance provider models, capacity, skills, and effectiveness when supporting implementation of EBPs in the YEH service system.

The current study also found that external pressures can influence investments in data infrastructure. The influence of coercive pressure (EBP funder approved investment in data system) and normative pressure (professional education promoting instilling scientist-practitioner approach) drove the data system adoption for one organization. Whereas normative pressure (technical assistance program examining equity issues

among youth accessing programs) influenced data system adoption for another participating organization. This finding is consistent with Collins-Camargo et al. (2019), which found that human service organizations commonly report making investments in technology/data systems to demonstrate their effectiveness in response to external pressures, including demands for EBPs. Both organizations report using data to inform their own unique solutions and has resulted in positive benefits for their organization.

Interestingly, the two organizations that viewed EBPs as limiting innovation or creative new ideas were the same organizations that detailed the most use of data to inform their organizational operations. One of these organizations countered against mimetic pressure to use an alternate EBP, in replacement of their current one, because their organization perceived that their expansion and diversification has surpassed other models. The other organization secured federal funding to generate innovative solutions to youth homelessness; however, the respondent shared early difficulties "thinking outside of the box" because the federal funder historically rejected their innovative ideas. It appears that external pressures can facilitate creative solutions for organizations that have the resources and prioritize the use of data. These priorities may be instilled by normative influences, such as higher education institutions (disciplines that promote the scientist-practitioner approach) or through technical assistance programs (data infrastructure development and coaching on how to use the data).

Mimetic Pressure

Mimetic pressure was the least strong influence on organizational operations. Organizations reported giving and receiving information about EBPs to/from their peers,

including state/local coalitions, informal funder networks, and one organization reported their umbrella organization influenced their EBP adoption. Under coercive pressure, some respondents reached out to their informal peer networks to learn about their "on the ground" experiences implementing the funder approved EBPs. These findings are consistent with other research showing the influence of peer organizations on EBP adoption decisions among leaders in county-based child and family serving systems (Palinkas et al., 2011).

Open information sharing across peer organizations was reported by one respondent as necessary "because we just don't have the resources, so we have to rely on each other. I think everyone knows we're underfunded." Peers with implementation experience help the service system evaluate intervention characteristics and their acceptability based on important service outcomes (e.g., timeliness, youth centeredness, efficiency). If peers provide endorsements that a new model enables speedy and flexible responses to the needs of vulnerable youth, then the practice may be viewed as legitimate by others. Based on Institutional Theory, peer vetting of EBPs furthers the degree of isomorphic practices within the YEH service field.

Recruiting staff was the most common competitive benefit of EBPs. In fact, competition for staff was a major challenge also reported in another study on broader human service organizations (Collins-Camargo et al., 2019). Providing additional staff training was one strategic response provided by leaders in their study. While additional professional development and training is viewed as a competitive advantage of EBPs, one respondent from another organization shared frustrations that staff leave their

organization after receiving their training in EBPs and take their skills to work in private practice. Based on the current study's findings, individuals new to the field are attracted to EBP training opportunities, particularly clinically focused interventions; however, organizations must invest in retention strategies for EBP-trained staff.

Overall, competition was not a strong external pressure in the current study. Qualitative findings from the current study showed multiple respondents emphasized the "giving" nature of peers and of themselves. Only one organization qualitatively reported strong competition, which influenced EBP adoption. This finding is consistent with another study, which showed increased competition was positively associated with greater mimetic influence of peers (such as training staff, developing new programs, and forming new relationships) among private child and family serving organizations (Bunger et al., 2017).

Overall, these situations demonstrate how organizations are inherently linked and navigating multiple external pressures. Additional research is needed to better understand the role that peers play in vetting EBPs, the types of peers that organizations turn to for information, and the types of intervention characteristics praised by peers. This information can inform EBP purveyors of key communication channels in the field and potential sources of influence for disseminating EBPs.

Organization Categorization

The current study utilized a newly developed typology to specify distinct adopter behavior (Swindle et al., 2022). The classification method was modified to fit the wide range of interventions reported and type of data collected. The sample was split in half

between “High to Moderate” and “Low or Unclear” fidelity. Lack of fidelity monitoring was the primary reason for organizations being labeled low fidelity. Nine organizations indicated positive attitudes towards EBPs. This may be due to the high number of respondents with graduate degrees, which has been shown to positively influence attitudes (Aarons, 2004). Lastly, most organizations fell into the active influence category (n = 7). This may be an indication of the current study utilizing peer nominations and snowball sampling to recruit participants, thus increasing the high opinion leader influence in the sample.

FAIT classification and associated external pressures for each category provides a more nuanced understanding of adopter behavior under diverse external contexts, can help uncover mechanisms to quality of EBP adoption, and inform implementation strategies to address barriers to adoption. Participating organizations were categorized into five of the eight groups. Adopting active supporters were the largest category (n = 5). The classification includes organizations that indicate moderate to high fidelity, positive attitudes towards EBPs, and influence on peer organizations. All five organizations reported a high number of coercive pressures, including 4 organizations with dedicated SAMHSA funding.

Two of these organizations actively influence peer organizations through formal consultations and trainings in their EBPs. Similarly, adopting passive supporters (n = 1) indicate performing well and holding positive attitudes towards EBPs; however, their influence on the field is low due to a lack of awareness of other organizations. Both adopting passive supporters and adopting active supporters may be strong candidates for

system-level strategies as opinion leaders to encourage and support other organizations who are resistant to adoption or struggling with their implementation efforts. More work is needed to better understand their efforts to sustain their EBPs and optimize their impacts.

Non-adopting passive resisters was the second largest classification (n = 3), which includes organizations indicating unclear to low fidelity, negative attitudes towards EBPs, and low influence on peer organizations. Qualitative results revealed that coercive pressure from funders was the strongest; however, peer influence was quantitatively the strongest pressure. All three organizations in this group receive ACYF-FYSB funding for their YEH programs, which does not require EBP oversight to ensure model adherence in their funding documents. Respondents from these organizations expressed the strongest negative attitudes towards EBPs in their interviewers due to EBP incompatibility, high implementation costs, and the narrow focus of EBPs. Given that these organizations do not value EBPs, traditional implementation strategies may not be effective for obtaining buy-in or organizational change among these organizations (Stewart et al., 2019). Future work can partner with these organizations to better understand their needs and values to develop unique strategies to bring EBPs into their setting or identify alternate approaches, such as developing the evidence base for their "homegrown" programs.

Non-adopting active supporters (n =2) and non-adopting passive supporters (n = 1) were the final two classification groups. Both organizations indicate unclear to low fidelity and positive attitudes towards EBPs; however, they differ in their influence over peer organizations. The non-adopting passive supporter demonstrated a heightened

awareness of their peer environment due to their organization's recent expansion into a market saturated region. The two organizations classified as non-adopting active supporters differed in their main external pressures: one stated coercive and the other stated normative. Given that this category holds supportive attitudes towards EBPs, this classification would benefit from resources to help them meet fidelity requirements and move their classification from non-adopting to adopting.

Strengths and Limitations

The current study has several strengths. First, this study examined adoption of a broad range of EBPs, which increases applicability to the wider service system of organizations serving YEH. In fact, many implementation studies focus on only one specific EBP model. This study is also among the first to examine organizations serving YEH. Little is known about this subpopulation of human service organizations, including their characteristics, needs, and strengths. Furthermore, this study addressed multiple limitations of the national EBP survey conducted by Kull et al. (2021) by collecting funding documents to confirm EBP usage and implementation details and by collecting qualitative data from organization leaders and other key figures to specify key adoption influences. Utilizing a mixed-method approach enabled a richer understanding of organizational processes and experiences than only one data source could provide.

Second, the current study is among the first to apply Institutional theory to the adoption of EBPs in human service organizations. Human service organizations are exposed to numerous external pressures; however, no studies to date have identified how these pressures facilitate EBP adoption. Additionally, this study furthers the field by

increasing our understanding of how organizations respond to these external social pressures to adopt EBPs. Use of Institutional Theory and the FAIT classification enabled this study to specify adopter behavior in response to external pressures, including superficial adoption. Relatedly, the current study's use of theory-based sampling through nominations from the field is a strength. The case recruitment and selection process provided greater specification of mimetic and normative influences through expert opinion and stakeholder feedback.

Lastly, the current study's use of the FAIT classification of organizational-level adopter behavior is a strength. This study is among the first to apply the classification approach using a broad range of EBPs and contexts. The modified classification approach, and the findings generated, can help refine and specify important influences on adopter behavior. Additional implications on the FAIT classification approach are discussed in more detail below.

The current study contained several limitations that should be considered when interpreting the findings. First, the initial round of nominations yielded a small number of responses. Of those that were nominated, a high number did not respond or declined to participate. The most common reason cited was limited time and a busy workload. Given the small number of nominations, the study author relied primarily on snowball sampling methods, which limited the spread of organizations. Six organizations were located within the same state. Additionally, most organizations employed over 100 full-time staff, had a graduate-level degree (n = 18), and all had > 8 years' experience delivering EBPs. It is possible that participating organizations were more likely to implement EBPs,

value research, and hold more positive attitudes towards EBPs compared to organizations who declined to participate. Additionally, the use of nominations for study inclusion resulted in recruitment of older and more established organizations, which may have influenced the findings on the degree of perceived competition for funding, staff, or clients. Newer organizations may be more likely to perceive stronger competition and be susceptible to mimetic influence for EBP adoption compared to older organizations.

Additionally, the study author only conducted focus groups with four of the participating organizations. Single respondent interviews occurred with the remaining nine organizations. It is possible that the interviews provided a limited organizational perspective on external influences and EBP implementation was obtained, which may have resulted in inaccurate classification of their organization in the FAIT typology. Additionally, staff attrition made obtaining historical knowledge about EBP adoption decisions and outer context features difficult to capture among some participating organizations. For example, some respondents did not know when specific EBPs were adopted, and most funding documents did not report the date of adoption.

Data collection methods were susceptible to social desirability. Ideally, observational methods would verify use of EBPs, and implementation strategies utilized; however, site visits are resource and time intensive to conduct. The study author attempted to address this limitation by requesting funding documents. Unfortunately, many organizations cost allocated their EBPs to multiple funding streams, which resulted in an inability to receive contracts for all 47 reported EBPs across the 13 participating organizations. Additionally, two organizations declined to submit their funding

documents (one director stated the request was too burdensome and one verbally agreed during the interview but did not respond upon follow-up). Due to the nature of how organizations fund their EBPs, it is possible that the funding documents reviewed by the study do not represent the full range of implementation strategies used by participating organizations. Participants may have withheld key funding documents due to social desirability or the perception of protecting their "trade secrets."

The disagreement between qualitative and quantitative data emerged for two respondents who came from different organizations. These individuals expressed the most salient negative attitudes towards EBPs; however, their EBPAS survey results for both organizations were just above the cutoff score for positive attitudes. Moving the cutoff score to include these two organizations would have included other organizations who expressed positive views towards EBPs in their focus groups/interviews. The study author categorized both organizations as holding negative attitudes towards EBPs due to the strong negative attitudes towards EBPs expressed throughout the interviews. It is unclear why EBPAS scores diverged with their qualitative data. While these respondents expressed disapproval of funder approved EBPs, they may still value research in general. If additional participants from these organizations were recruited, they may have yielded more variation in attitudes scores within their organization.

Missing data in the quantitative survey is also a limitation. Some focus group participants did not complete the EBPAS or influence scales. Upon investigating the data, respondents who skipped these measures were all practitioner or direct service staff members who completed the initial demographic survey but stopped completing the

survey once they were prompted to answer organizational details. While these questions were skippable, it is possible these respondents did not know their organizational details and assumed the remaining survey questions were about their organization, thus the study lost important data on key measures of attitudes and influence. However, the study was able to obtain survey responses for at least one respondent for each recruited organization.

Limitations in the current study should caution interpretation of the FAIT classification findings. First, only the study author conducted the categorizing of organizations. The original FAIT classification study employed a team of coders to analyze a large amount of qualitative data and iteratively refine the typology over time (Swindle et al., 2022). In contrast, the current study developed study-specific criteria for each domain and applied it to a smaller sample. While the study author was able to categorize organizations using the criteria with ease, future research should verify and, if needed, refine the modified classification with a second coder. Secondly, the current study used mean scores for the Opinion Leadership Scale and the Attitudes towards EBPs Scale as cutoffs to classify high and low organizations due to the lack of valid metrics or other clear criteria. It is unknown whether the cutoff scores created meaningful distinctions and are of practical utility. Additional research is needed to develop standardized benchmarks for determining high and low attitudes and influence for a broad range of interventions and settings/contexts.

Lastly, the current study modified criteria for determining fidelity adherence by relying on funding documents and respondent self-report. The current study assumed that

lack of oversight would inhibit an organization's ability to meet fidelity standards; however, capacity for fidelity oversight may be independent from quality of implementation fidelity. Organizations may be monitoring fidelity standards through other means (e.g., routine clinical check-ins with staff) or the respondent may not be aware of practitioner use of fidelity adherence measures because the respondent's role (e.g., director or administrator) is not directly involved in implementation, which may have resulted in organizations being classified as low fidelity despite meeting fidelity standards for their EBPs. Additionally, the study author did not provide a definition of fidelity to interview/focus group participants. It is possible that practitioners and frontline staff are still following the model without knowledge of or explicit activities for fidelity monitoring (Lengnick-Hall et al., 2019). Future research with these organizations should provide a definition of fidelity to respondents and, if possible, obtain measures of fidelity capacity and quality to ensure more accurate classification.

Implications

The results from the current study can inform research, practice, and policy. Minimal research has been conducted on how organizations respond to their environmental demands, including expectations for EBPs (Bunger et al. 2018; Collins-Camargo, 2019). This study indicates that Institutional Theory is useful for examining external setting/context and exploring how human services organizations respond to their environment. Additional research should explore how responses to external pressures may vary across key organizational characteristics such as type, size, age, or geographic/service context. A more thorough assessment of organizational context with a

larger sample of organizations can help specify distinct types of organizations serving YEH. For example, existing research has identified five types of human service organizations based on their internal management capacity, service diversification, integration, and policy advocacy (Chuang et al., 2014). A similar typology could help further specify quality of adopter behavior based on important organizational differences.

Additional research is needed on the role of funders in EBP adoption and implementation. Coercive pressure serves as a major driver of EBP adoption within organizations serving YEH. Implementation science frequently depicts the importance of funding for enhancing EBP adoption and implementation; however, research is currently limited in this area (Moullin et al., 2019; Raghavan et al., 2008). Two studies focused on state mental health agencies characteristic and strategies to support adoption of EBPs in community mental health services; however, no studies were identified that have explored funders of human service organizations and their use of strategies to support the adoption of EBPs (Bruns et al., 2019; Stewart et al., 2018). Future research can help further our understanding of funder priorities and perspectives towards EBP implementation, including strategies to support adoption and oversight, in human services organizations.

Deeper insights into funder knowledge, capacity, and priorities toward EBP implementation can inform development and testing of implementation strategies on external pressures and their influence on key outcomes. Tailored multi-level strategies can target funder strategies, organizational adoption, and practitioner adherence. For example, two organizations in the current study shared satisfaction with their decision to

pursue a county driven EBP funding opportunity because it provided cohort-based learning and monitoring, which has helped them maintain fidelity. Funder-sponsored incentives may enhance implementation and service outcomes compared to other types of coercive pressure.

The findings from the current study also highlights the need for an equity perspective when studying system-level activities to promote adoption of EBPs. Several respondents noted that EBPs are expensive and resource intensive. The types of organizations that have capacity to implement them are limited, particularly in rural areas. Unfortunately, the current study was not able to suitably determine if organizational size or geographic setting influenced EBP adoption due to the small sample size. However, other research has noted larger geographic differences in the prevalence of YEH programs themselves as a result of investments (Esparza, 2009). Esparza (2009) notes that wealthy cities with more democrat voters spend more in YEH services, regardless of the number of youth in need, and lower income cities spend less on YEH programs. The positive influence of socio-political factors for policy and fiscal supports on EBP adoption has also been demonstrated (Bruns et al., 2019). More work is needed to better understand and address system-driven inequities that perpetuate the lack available EBPs for YEH in geographically and politically diverse areas. Taking an equity lens when examining implementation outcomes can also inform selection and tailoring of implementation strategies to close inequities (Baumann & Cabassa, 2020).

Additional research questions can be explored using the FAIT classification. First, more work is needed to refine the cutoff criteria for developing meaningful group

distinctions for good or low fidelity, negative or positive attitudes, and active or passive influence for a broad range of interventions and settings/contexts. Additionally, FAIT classifications should incorporate distinctions between fidelity oversight mechanism and fidelity quality, which can provide additional nuance to the findings and increase the generalizability of the classification method to a wider range of interventions and settings.

Furthermore, the study author noted that some respondents were labeled EBP "resisters" because of their scores on the negative attitudes towards EBPs; however, these individuals also expressed legitimate challenges and frustrations about EBPs in their context during the focus group/interview (e.g., intervention costs too expensive, extensive work conducting pre-implementation certification and on-going re-certifications, difficulty sustaining due to staff attrition). In some contexts, negative perceptions of EBPs may not be determinantal to implementation adoption. Individuals with negative attitudes may put aside their feelings to be successful. Even so, these individuals may place the organization at vulnerability for implementation failure when challenges are encountered. Future research using the FAIT classification should consider disentangling differences in adopter behaviors of individuals with negative attitudes, specifically acquiescence versus resistance toward EBP adoption.

Practice and policy can also benefit from the current study. First, funder's clarity of expectations for their grantees to implement EBPs with adherence to fidelity is mixed. Only SAMHSA funding documents contained clear criteria for applicants to describe their oversight mechanisms. Some organizations strive to meet fidelity through allocating

dedicated resources and staffing. In contrast, respondents in another organization were not aware of what intervention fidelity meant. Funders can institute a clear definition of EBP for their programs, request greater specification of implementation details in their grant applications, allocate resources for organization capacity building to implement to fidelity, and strengthen their own oversight mechanisms to monitor EBP adherence. In fact, Metz and Albers (2014) highlight similar key considerations for federal funders supporting high-fidelity implementation within human service organizations addressing adolescent health issues. The author's recommendations included careful assessment of "the thing" funders want implemented, sufficient time and resources for planning and installing, infrastructure to support connections between program developers and implementation sites, and the use of data systems to guide decision-making.

Lastly, the support system for YEH serving organizations, including intermediary organizations, can use the current study's findings to better understand and guide their training and consultations. Technical assistance organizations can identify distinct groups of organizations (e.g., non-adopting resisters, etc.) to provide individualized support and education. For example, a recent study on a housing first technical assistance and training program demonstrated increased attitudes towards EBPs among administrators and staff and increased fidelity to the intervention over time (Watson et al., 2018). Furthermore, intermediary organizations can help facilitate support connections between "high influencing" peer organizations, who serve as EBP champions, to promote shared learning of implementation best practices. In fact, some organizations in the current study participate in cohorts of peers who discuss implementation challenges and promote best

practices. CBOs may be attracted to cohort-based pilots to evaluate their implementation and receive peer feedback.

Conclusion

The current study employed a multiple case study to explore the role of external pressures on adoption of EBPs. The most significant pressure for EBPs came from federal and state/county funders; however, challenges with oversight and supervision, the incompatible EBP options for adoption on funder approved lists, and high implementation costs were identified as barriers to EBP adoption and implementation. Peers are a particularly strong support for vetting interventions based on their "on the ground" implementation experience. Additionally, conference venues and professional development groups, and higher education/research institutions play an important role as sources for learning about EBPs. Lastly, the study found that about half of the organizations in the sample are meeting their EBPs adherence requirements and support using EBPs in their organization, while the remaining organizations were classified as different types of non-adopters. These distinct subgroups of adopters can inform the development of implementation strategies that address contextual barriers to adoption or reduce the risk for implementation failure.

Overall, the findings from the current study can inform funders, policymakers, researchers, and intermediary organizations who seek to advance EBP adoption within the YEH service system. The current study adds to the paucity of literature on a group of human service organizations working with vulnerable and disadvantaged youth

populations. Their organizational health and stability is vital for completing their tasks; however, their success depends on important external support systems and resources.

Table 1. Peer Nomination Survey Results for Study Inclusion: Type of Nomination, Location of Nominator, and Nominator Role

Peer Nominations of Agencies	**# of nominations**
Type of Nomination	
Nominated Peer	7
Self-Nominated	6
Geographic Region of Nominators	**# of nominators**
Western	4
Mid-west	1
Southern	2
Nominator Role in Organization	
Director	4
Administrator	2
Mid-Level Management	3

Table 2. Organizational Characteristics

Type of Agency	*N* = 13
Non-profit	11
Public agency	2
# of Staff (FTE)	
25-49	3
50-99	3
100-249	4
Over 250	3
Service Setting	
Urban/Metro	7
Suburban/Non-metro	0
Rural	1
Combinations	5
Location	
State A	6
State B	2
State C	2
State D	1
State E	1
State F	1
Age of Organization (years)	
15-25	2
25-35	2
35-45	3
45-55	5
N/A	1

Table 3. Focus Group/Interview Respondent Demographics Across All Organizations

Gender	*N* = 30
Female	21
Male	7
Non-binary / third gender	1
Unknown	1
Age	
25-34	7
35-54	17
55-65	3
Over 65	1
Declined to state/Unknown	2
Ethnicity	
Black or African American	6
European-American	20
Hispanic or Latinx	2
Multi-racial	1
Unknown	1
Highest Education	
High School Diploma/GED	2
Bachelor's degree	7
Master's degree	16
Doctorate degree	2
Declined to state/unknown	3
Discipline of study	
Social Work	11
Psychology or Counseling	7
Public Affairs / Public Administration / Policy	1
Communication Studies	1
Criminal Justice	2
Education	1
Marketing and Business Management	1
US History	1
Declined to state/unknown	5
Role	
Director	6
Program Director	3
Program Manager	7
Clinical Manager/Supervisor	6
Administrator	5

Therapist	2
Case Worker	1

Table 4. Number of Funding Documents Reporting EBP Implementation Details for each Funding Source

Type	Funding Source and # of Funding Documents Shared by Organizations	Implementation Details Reported in Each Funding Document				
		EBP Team	EBP Fidelity	EBP Training	EBP Super-vision	TA*
Federal	Administration for Children, Youth, Families (n = 7)	3	0	5	0	7
	Substance Abuse and Mental Health Service Administration (n = 5)	2	2	3	2	2
	Housing and Urban Development (n = 1)	0	0	0	0	0
	Department of Education (n = 1)	0	0	0	0	0
State	Attorney General Office Victims of Crime (n = 1)	0	0	1	0	1
	Office of Emergency Services (n = 1)	0	0	0	0	0
	Department of Health & Human Services (n = 1)	0	0	1	0	0
	Department of Health Care Services (n = 1)	0	0	1	0	0
Local	Department of Behavioral Health (n = 2)	0	0	1	0	0
	Alcohol, Drug, and Mental Health Board (n = 1)	0	0	0	0	0
	Unspecified County Department (n = 1)	1	1	1	0	0
	City Government (n = 1)	0	1	0	1	1
Private	Nonprofit Organization (n = 2)	0	0	1	1	0
	Private Philanthropy (n = 1)	0	0	0	0	0

*Technical assistance

Table 5. Number and Percentage of EBPs Used by Organizations Compared to Percentage of Organizations Reporting EBP Use in the 2021 National Needs Assessment

	Number and Percentage of Organizations Using EBP (n = 13)	**2021 NNA* Number and Percentage of Organizations Using EBP (n = 137)**
1. Motivational Interviewing**	12 (92%)	109 (77%)
2. Cognitive-Behavioral Therapy	7 (54%)	66 (46%)
3. Eye Movement Desensitization and Reprocessing	5 (38%)	3 (2%)
4. Dialectic Behavior Therapy	4 (31%)	24 (17%)
5. Seeking Safety**	4 (31%)	16 (11%)
6. Incredible Years	3 (23%)	0%
7. Individual Placement and Support	3 (23%)	0%
8. Parent-Child Interaction Therapy	3 (23%)	0%
9. Solutions Focused Therapy	3 (23%)	0%
10. Botvin Life Skills**	2 (15%)	7 (5%)
11. Housing First	2 (15%)	0%
12. Internal Family Systems	2 (15%)	0%
13. Let's Talk	2 (15%)	11 (8%)
14. Multisystemic Therapy**	2 (15%)	12 (8%)
15. Safe Care	2 (15%)	7 (5%)
16. Seven Challenges**	2 (15%)	0%
17. Wraparound	2 (15%)	38 (27%)
18. Circle of Security	2 (15%)	0%
19. Cognitive-Behavioral Therapy Psychosis	1 (8%)	0%
20. Cognitive Behavioral Interventions in School Based Therapy	1 (8%)	0%
21. Adolescent Community Reinforcement Approach**	1 (8%)	3 (2%)
22. Aggression Replacement Therapy/Training	1 (8%)	10 (7%)
23. Brazelton Touchpoints	1 (8%)	0%
24. Child Parent Psychotherapy	1 (8%)	0%
25. Collaborative Problem Solving	1 (8%)	4 (3%)
26. Functional Family Therapy**	1 (8%)	9 (6%)
27. Health Families America	1 (8%)	0%
28. Integrative Treatment of Complex Trauma	1 (8%)	0%
29. Jobs for America's Graduates	1 (8%)	0%
30. Love and Logic	1 (8%)	0%

31. Making Proud Choices!	1 (8%)	15 (11%)
32. MATCH-ADTC	1 (8%)	0%
33. Navigate	1 (8%)	0%
34. Parents as Teachers	1 (8%)	0%
35. Parent Child Attunement Therapy	1 (8%)	0%
36. Ready to Rent	1 (8%)	0%
37. Recognize, Intervene, Support, Empower (RISE)	1 (8%)	0%
38. Rox	1 (8%)	0%
39. Safe Talk/Assist	1 (8%)	0%
40. Signs of Suicide	1 (8%)	0%
41. Somatic Experiencing Therapy	1 (8%)	0%
42. Strength Based Outreach and Advocacy**	1 (8%)	0%
43. Strength Model Case Management	1 (8%)	0%
44. Transition to Independence Model	1 (8%)	0%
45. Trauma Affect Regulation (TARGET)	1 (8%)	0%
46. Trauma Focused Cognitive Behavioral Therapy	1 (8%)	39 (27%)
47. Triple P	1 (8%)	0%

*National Needs Assessment (Kull et al., 2021).

**EBP has published research with behavioral health outcomes

Table 6. Organization-Level Means and Standard Deviations on External Pressures, EBP Attitudes, and Opinion Leadership from Quantitative Surveys

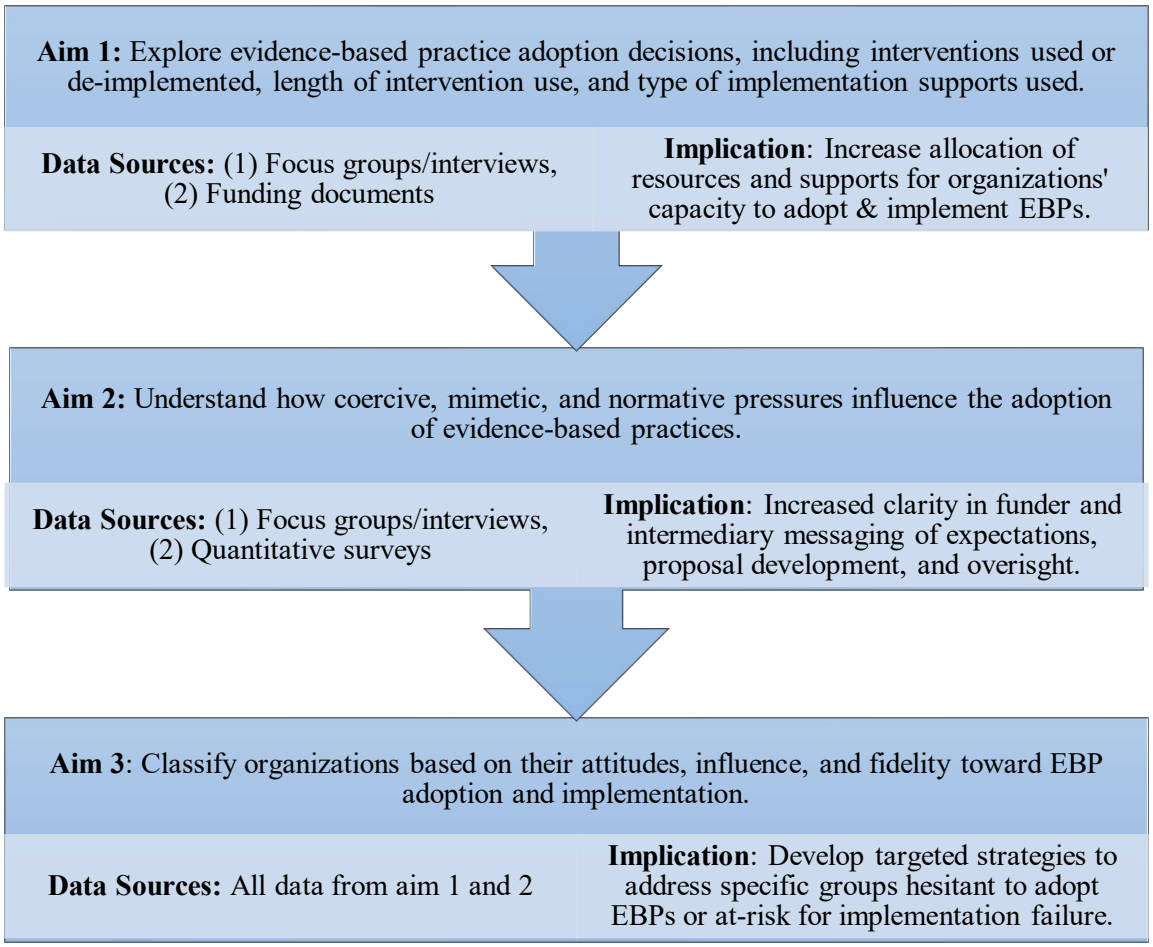
Organization (# of participants completing survey*)	**External Pressures (Total Score)**	**Coercive Pressure Subscale**	**Mimetic Pressure Subscale**	**Normative Pressure Subscale**	**EBPAS (Total Score)**	**Opinion Leadership**
1 (n = 1)	3.50 (--)	3.57 (--)	4.00 (--)	3.17 (--)	2.80 (--)	2.14 (--)
2 (n = 1)	3.38 (--)	3.57 (--)	3.00 (--)	3.33 (--)	3.47 (--)	3.71 (--)
3 (n = 1)	3.13 (--)	4.00 (--)	1.00 (--)	3.17 (--)	4.07 (--)	4.29 (--)
4 (n = 2)	2.69 (--)	2.86 (--)	2.33 (--)	2.67 (--)	3.13 (.28)	3.86 (--)
5 (n = 1)	3.69 (--)	3.29 (--)	4.33 (--)	3.83 (--)	3.07 (--)	3.86 (--)
6 (n = 1)	2.88 (--)	2.86 (--)	3.00 (--)	2.83 (--)	3.36 (--)	2.86 (--)
7 (n = 1)	3.13 (--)	3.43 (--)	2.33 (--)	3.17 (--)	3.13 (--)	3.71 (--)
8 (n = 1)	3.38 (--)	3.29 (--)	3.67 (--)	3.33 (--)	3.83 (--)	4.43 (--)
9 (n = 3)	3.67 (.60)	3.86 (1.0)	3.78 (.69)	3.39 (.19)	3.41 (.43)	4.48 (.51)
10 (n = 7)	3.14 (.86)	2.86 (.92)	2.93 (.60)	3.57 (1.22)	3.64 (.42)	3.97 (.77)
11 (n = 2)	3.31 (.44)	3.64 (.71)	3.17 (.71)	3.00 (.00)	3.07 (.38)	4.21 (.10)
12 (n = 1)	3.69 (--)	4.00 (--)	4.00 (--)	3.17 (--)	3.47 (--)	4.71 (--)
13 (n = 2)	3.53 (.75)	3.50 (1.52)	4.00 (.47)	3.30 (.62)	2.97 (.15)	4.43 (.20)

*Six focus group respondents were excluded due to missing data on quantitative surveys.

Table 7. Number of Agencies Reporting EBP Fidelity, Attitudes, Influence Typology and Classification of Organizations

Fidelity	Attitudes	Influence	Classification
Unclear or Low (n = 6)	Negative (n = 3)	Active (n = 0)	Non-Adopting Active Resister (n = 0)
		Passive (n = 3)	**Non-Adopting Passive Resister** (n = 3)
	Positive (n = 3)	Passive (n = 1)	**Non-Adopting Passive Supporter** (n = 1)
		Active (n = 2)	**Non-Adopting Active Supporter** (n = 2)
Moderate to High (n = 6)	Negative (n = 0)	Active (n = 0)	Adopting Active Resister (n = 0)
		Passive (n = 0)	Adopting Passive Resister (n = 0)
	Positive (n = 6)	Passive (n = 1)	**Adopting Passive Supporter** (n = 1)
		Active (n = 5)	**Adopting Active Supporter** (n = 5)

Figure 1. Research Aims



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Appendix A. Nomination Form for the Intermediary Organization

Thank you for assisting this study with identifying Runaway and Homeless Youth serving organizations using evidence-based practices (EBPs). Completion of this nomination form should take you no more than 15 - 25 minutes. This information will be used by researchers to recruit organizations for interviews about their experiences adopting and implementing EBPs. The goal is to identify potential strategies that can help RHY organizations use EBPs. This study is being conducted by researchers at Ohio State University. If you have any questions, please contact martin.3805@buckeyemail.osu.edu.

Instructions: Please list organizations that use one or more EBPs based on your current awareness of providers in the field, including those operating with and without funding from the Family and Youth Services Bureau (FYSB). If possible, please list between 10 to 15 organizations total. Lastly, please provide an organization contact (if known) and indicate if the organization is a current or past member of Youth Collaboratory, and the needs that their EBPs address (*check all that apply*).

1) Organization name: _____
   Contact name: _____
   Phone: _____ Email: _____
   Is this organization a current or past member of Youth Collaboratory: □ Yes □ No
   Type of EBP(s) used (*check all that apply*):
   □ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education
   □ Substance use intervention & prevention □ Teen pregnancy prevention & supports
   □ Transition to adulthood □ Other: _____
2) Organization name: _____
   Contact name: _____
   Phone: _____ Email: _____
   Is this organization a current or past member of Youth Collaboratory: □ Yes □ No
   Type of EBP(s) used (*check all that apply*):
   □ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____
3) Organization name: _____
   Contact name: _____

Phone: _____ Email: _____
Is this organization a current or past member of Youth Collaboratory: □ Yes □ No
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____

4) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Is this organization a current or past member of Youth Collaboratory: □ Yes □ No
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____

5) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Is this organization a current or past member of Youth Collaboratory: □ Yes □ No
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____

6) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Is this organization a current or past member of Youth Collaboratory: □ Yes □ No
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____

7) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Is this organization a current or past member of Youth Collaboratory: □ Yes □ No
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____

8) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Is this organization a current or past member of Youth Collaboratory: □ Yes □ No
Type of EBP(s) used (*check all that apply*):

□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____

9) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Is this organization a current or past member of Youth Collaboratory: □ Yes □ No
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____

10) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Is this organization a current or past member of Youth Collaboratory: □ Yes □ No
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____

Appendix B. Nomination Form for Peer Organizations

The purpose of this survey is to identify Runaway and Homeless Youth serving organizations using evidence-based practices (EBPs). The survey will take you approximately **five to ten (5 - 10) minutes to complete**.

Instructions: Please list up to 15 Runaway and Homeless Youth serving organizations that use one or more EBPs (for example: Cognitive Behavioral Therapy, Motivational Interviewing, Wraparound, etc.). You may complete this form with other members of your organization or independently. Please consider any local or national organizations. Self-nominating your own organization is also acceptable. If possible, please provide any contact information for the organization and indicate the type the EBP(s) used by the nominated organization (*check all that apply*).

This information will be used by researchers to recruit organizations for interviews about their experiences adopting and implementing EBPs. The goal is to identify potential strategies that can help other organizations use EBPs in their setting. This study is being conducted by researchers at Ohio State University. If you have any questions, please contact martin.3805@buckeyemail.osu.edu.

Your name: _____
Your Organization:
_____
Your role: □ Director □ Administrator □ Manager □ Direct service staff
Are you completing this survey with other members of your organization? □ Yes □ No

1) Organization name: _____
   Contact name: _____
   Phone: _____ Email: _____
   Type of EBP(s) used (*check all that apply*):
   □ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____
2) Organization name: _____
   Contact name: _____
   Phone: _____ Email: _____
   Type of EBP(s) used (*check all that apply*):

□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____

3) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____

4) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____

5) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____

6) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____
□ Transition to adulthood □ Other:_____

7) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____
□ Transition to adulthood □ Other:_____

8) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Type of EBP(s) used (*check all that apply*):

□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____
□ Transition to adulthood □ Other:_____

9) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other: _____
□ Transition to adulthood □ Other:_____

10) Organization name: _____
Contact name: _____
Phone: _____ Email: _____
Type of EBP(s) used (*check all that apply*):
□ Case management □ Disruptive behavior □ Mental health & trauma □ Parenting education □ Substance use intervention & prevention □ Teen pregnancy prevention & supports □ Transition to adulthood □ Other:_____

Appendix C. Survey Distribution Email for Peer Nominations

[Email header] Invitation to participate in a brief survey: Nominate organizations implementing evidence-based practices

[Email body] The Runaway and Homeless Youth National Needs Assessment revealed that the majority of organizations are using multiple evidence-based practices (EBPs). Organizations report implementing a wide range of EBPs, including Motivational Interviewing, Cognitive Behavioral Therapy, Nurturing Parent Program, Seeking Safety, Wraparound and many others. These are diverse intervention models with unique benefits, requirements, and potential challenges. In fact, the National Needs Assessment reported that 55% of grantee organizations are interested in receiving technical assistance to strengthen their EBP implementation.

Given the complexity of implementing EBPs, researchers at Ohio State University are interested in learning about the experiences of Runaway and Homeless Youth organizations who are currently using EBPs. The types of questions that will be explored include:

- What successes and challenges are organizations experiencing when adopting and implementing EBPs?
- What intervention characteristics do providers view as acceptable and appropriate for their service population and their organization?
- What types of adaptations are being made to EBPs?
- What strategies or external supports help organizations maintain their model fidelity?

In an effort to identify example organizations using EBPs, the research team invites you to nominate peer organizations within the Runaway and Homeless Youth service field (both locally and nationally). Self-nominations are also welcome. Below is a link to a very brief, mobile-friendly, survey where you can list organizations that are implementing one or more EBPs. **The survey will take approximately five to ten (5 - 15) minutes to complete** (depending on the number of organizations you list).

[insert Qualtrics survey link]

This information will be used by researchers to recruit organizations for follow-up interviews and surveys about their experiences and perspectives adopting and implementing EBPs. The goal is to identify potential strategies that can help other organizations use EBPs in their setting. **Participation is completely voluntary, and you**

may discontinue at any time. The nominations will be stored in a secure, password protected drive that only the research team will have access to and will be archived for 5 years after project completion. **If you have any questions about the survey**, please contact Jared Martin at martin.3805@osu.edu

Appendix D. Survey Distribution Email for Intermediary Agency Nominations

[Email header] Request for nominations for organizations using evidence-based practices

[Email Body] Dear [First Name],
I am following up with you about the possibility of receiving nominations of organizations using evidence-based practices (EBP) for youth experiencing homelessness and housing stability. These nominations will be used to inform recruitment of organizations for subsequent interviews and surveys to learn about their experiences and perspectives with adopting and implementing EBPs. The goal of this study is to identify potential strategies that can support other organizations with their adoption and implementation of EBPs.

I was wondering if you could please complete a brief electronic survey asking for up to 10 to 15 organizations who are using one or more EBPs. You are welcome to complete the survey together with other members of your team. The survey asks for the name of the RHY organization and, if known, their contact information and the type of evidence-based practice(s) used by the organization.

The survey link can be found below. Please know that your participation is completely voluntary. The nominations will be stored in a secure, password protected drive that only the research team will have access to. The data will be archived for 5 years after project completion.

[insert Qualtrics survey link]

If you have any questions, please respond to this email by contacting Jared Martin at martin.3805@buckeyemail.osu.edu or phone at 707-502-4310. **If you do not wish to participate**, please respond to this email indicating your preference. This study is being conducted by Jared for his doctoral dissertation.

Thank you for your time and support,

Jared K. Martin, MA
Ph.D. Candidate
College of Education and Human Ecology
The Ohio State University

Appendix E. Recruitment Email

[Email header] You are Invited to Participate in a Research Study about Evidence-Based Practices for Youth

Dear [First Name],

I am reaching out to you because your organization was identified as providing one or more evidence-based practices for youth and young adults experiencing homelessness and housing instability. I am a researcher at Ohio State University interested in learning about your experiences and perspectives with adopting and implementing evidence-based practices. The findings from this study will help guide the development of strategies that support other youth-serving organizations with their use of evidence-based practices.

I was wondering if you, and one or two members of your leadership team involved in implementing evidence-based practices, might be willing to participate in a 45 - 60-minute group interview via Zoom. The focus of the discussion will be on how your organization decided to adopt specific evidence-based practices and your experiences delivering these practices. At the conclusion of the interview, there will be a 15-minute electronic survey for you and your team to complete independently.

If you agree to participate, we respectfully request your organization send us electronic copies of any current and past funding cycle contracts/grant applications related to evidence-based practices prior to the group discussion. This information will help the research team contextualize evidence-based practices within your unique service setting. All grants/contracts will only be viewed by the study team and deleted five years after project completion.

Participating organizations will have a $50.00 gift card donated to the organization for youth served by their programs.

Your participation is completely voluntary and responses will be kept confidential. Please know your responses will be used to evaluate your organization. I have attached a copy of the informed consent details for your review. These detail procedures, risk, and confidentiality protections the study team is taking.

<u>If you would like your organization to participate</u> in this study, please replying to this email. **<u>If you do not wish to participate</u>**, please respond to this email indicating your preference. This study is being conducted by Jared for his doctoral dissertation.

We look forward to hearing from you at your earliest convenience.

Thank you,

Jared K. Martin, MA
Ph.D. Candidate
College of Education and Human Ecology
The Ohio State University

Appendix F. Initial Consent Email

The Ohio State University Consent to Participate in Research

Study Title:	Adoption and Implementation of Evidence-Based Practices for Youth and Young Adults Experiencing Homelessness
Researcher:	Jared Martin, MA, PhD Candidate; Natasha Slesnick, PhD
Sponsor:	N/A

This is a consent form for research participation. It contains important information about this study and what to expect if you decide to participate.

Your participation is voluntary.

Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate. If you decide to participate, you will be asked to sign this form and will receive a copy of the form.

Purpose:
The purpose of this study is to understand how organizations serving youth experiencing homelessness and housing instability decide to adopt specific evidence-based practices, including their attitudes and experiences during the adoption and implementation process. Recognizing that many factors can affect the adoption and implementation of evidence-based practices, we wish to learn more about your organization through a focus group with your leadership team (e.g., directors, administrators, managers, and clinical supervisors, and any key front-line staff) and a survey administered at the end of the focus group. Lastly, we hope to confidentially review your current and past contracts/grant applications, which will help us contextualize the use of evidence-based practice within your unique service setting. This information can guide the development of strategies that support other organizations with their use of evidence-based practices.

Procedures/Tasks:
If you decide to participate, we ask that you and other members of your leadership team complete a 45 to 60-minute focus group over Zoom and a 15 to 20-minute electronic survey at the end of the interview. A research team member will ask questions about your

perspectives on, and motives for, adopting evidence-based practices, how different factors may influence those perspectives and motives (e.g., accreditation standards, community partnerships, policy reform efforts, professional development), and your experiences implementing the evidence-based practice. Prior to the interview, we request the ability to confidentially review your current and past contracts/grant applications, including any current and past FYSB grantee applications (if available). We request these grant documents be submitted electronically to the study team. Focus groups will be audio recorded, transcribed, and saved on a secure, password protected folder. Transcripts will be de-identified and responses will be reported in aggregate. Only the study team will have access to the data and all files will be deleted after 5 years after project completion.

Duration:
You may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your future relationship with The Ohio State University.

Risks and Benefits:

There are no direct benefits to you by participating in this interview. However, you are helping us identify potential barriers and facilitators to adopting and implementing evidence-based practices that could be addressed in the future. Potential risks may occur if your responses were ever revealed, but we are taking several steps to keep your views and experiences confidential. Although names will not be published and only de-identified data may be shared with others, participants and/or agencies still risk being re-identified if shared data is somehow linked back to them. A breach of confidentiality could potentially result in a loss of professional standing or even damage to the agency if certain information were revealed in an uncontrolled way. While we ask other group participants to keep the discussion in the group confidential, we cannot guarantee this. Please keep this in mind when choosing what to share in the group setting.

Confidentiality:

We will work to make sure that no one sees your survey responses without approval. But, because we are using the Internet, there is a chance that someone could access your online responses without permission. In some cases, this information could be used to identify you. Your data will be protected with a code to reduce the risk that other people can view the responses. Personal information regarding your participation in this study may be disclosed if required by state law. Also, your records may be reviewed by the following groups (as applicable to the research):

- Office for Human Research Protections or other federal, state, or international regulatory agencies;
- The Ohio State University Institutional Review Board or Office of Responsible Research Practices;
- Authorized Ohio State University staff not involved in the study may be aware that you are participating in a research study and have access to your information; and
- The sponsor, if any, or agency (including the Food and Drug Administration for FDA-regulated research) supporting the study.

Future Research:
Your de-identified information may be used or shared with other researchers without your additional informed consent.

Incentives:
A $50 gift card will be donated to your organization for goods and services for youth served by your programs. Gift cards will be from a list of OSU-approved vendors (e.g., Amazon, Target, Best Buy, Sephora, Starbucks, Chipotle, Bed Bath & Beyond, Barnes & Noble, Apple, and Door Dash). Gift cards will be emailed to the preferred organizational contact, who will be responsible for overseeing the distribution of the gift card. By law, payments to participants are considered taxable income.

Participant Rights:
You may refuse to participate in this study without penalty or loss of benefits to which you are otherwise entitled. If you are a student or employee at Ohio State, your decision will not affect your grades or employment status.

If you choose to participate in the study, you may discontinue participation at any time without penalty or loss of benefits. By signing this form, you do not give up any personal legal rights you may have as a participant in this study.

An Institutional Review Board responsible for human subjects research at The Ohio State University reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of research participants.

Contacts and Questions:

For questions, concerns, or complaints about the study, or you feel you have been harmed as a result of study participation, you may contact **Jared Martin by email at martin.3805@buckeyemail.osu.edu or by phone at 707-502-4310.**

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact the Office of Responsible Research Practices at 1-800-678-6251.

Appendix G. Phone Recruitment Script

Hi, may I speak with [name of key organization leader]?
Good morning/afternoon. My name is Jared Martin, and I am graduate student at the Ohio State University in the Department of Human Sciences. How are you today?
I'm calling about a research study examining the adoption and implementation of evidence-based practices for youth experiencing homelessness. The goal of this study is to help identify factors that could help other youth-serving organizations improve their adoption and implementation efforts.

I was wondering if you, and one or two members of your team involved in organizational decision-making might be willing to participate in a 45-60-minute group phone interview (involving just you and the members of your organization's team) to learn more about your perspectives and experiences adopting and implementing evidence-based practices. Following the focus group there will be a brief electronic survey that will take no more than 15-20 minutes.
Our conversation will take place over web-conferencing software (e.g. zoom), and would involve only you and the members of your organization's team. Your participation is completely voluntary and our discussion will also be kept confidential. I know your time is precious, so to thank you, your organization will receive a $50 gift card.
[If NO]

- Well, thanks anyway for your time and I wish you the best. Take Care.

[If YES]

- Fantastic! Thank you! What's the best way of scheduling a day and time for our conversation? {identify preferred process e.g. schedule over the phone, contact administrative assistant, email possible dates/times}
- What's the best way to contact you to confirm our appointment as it gets closer?
- If you have any questions or concerns please feel free to reach out to martin.3805@osu.edu or over the phone at 707-502-4310.
- Thanks again for your willingness to participate and I look forward to our conversation

Appendix H. Focus Group Informed Consent Script

Hello, my name is Jared Martin. I am a graduate student at the Ohio State University in the Department of Human Sciences, and I am undertaking research that will be used in my dissertation. I would like to better understand evidence-based practices in your organization, particularly what influenced your decisions to adopt specific practices and your experiences implementing those practices. Given your leadership role in the organization, I am particularly interested in your perspectives about how different system-level activities/initiatives (such as accreditation standards, policy reform efforts, performance expectations, resource/funding competition, etc.) influence your thinking and decisions around evidence-based practices. There are no right or wrong answers to these questions.

The goal of this study is to help identify factors that could help other youth-serving organizations improve their adoption and implementation efforts.

The focus group will take up to 45 minutes of your time. *I would like to make an audio recording of our discussion, so that I can have an accurate record of the information that you provide to me. I will transcribe that recording using a transcription service provider, and will keep the transcripts confidential and securely in my possession. I will erase the recording after I transcribe it.*

With your permission, our group discussion will be recorded so that we will have an accurate record of the information discussed. At the end of the group discussion, there will be a 15-minute electronic survey that each interviewee will complete independently. Questions will expand on some of the interview questions, including organizational details and your attitudes and experiences towards adopting evidence-based practices. The survey link will be emailed to each of you directly.

There is a risk of a breach of confidentiality, but we are taking several steps to keep everything you say in the strictest of confidence. We will not link your name to anything you say in our reports or any publications. Your name and participation in this study will not be revealed to anyone outside of our research team. Your de-identified responses may be shared with other researchers in the future. All recordings and notes will be maintained in password protected folders, and once the study is concluded, audio-recordings will be erased, and other files will be disposed. *We will work to make sure that no one sees your survey responses without approval. But, because we are using the Internet, there is a chance that someone could access your online responses without permission. In some cases, this information could be used to identify you. Your data will*

be protected with a code to reduce the risk that other people can view the responses. Although names will not be published and only de-identified data may be shared with others, participants and/or agencies still risk being re-identified if shared data is somehow linked back to them. A breach of confidentiality could potentially result in a loss of professional standing or even damage to the agency if certain information were revealed in an uncontrolled way.

Your participation in this focus group is completely voluntary. If you decide not to participate, withdraw from the study, or decline to answer any questions, there will be no penalty or loss of benefits. Neither your participation nor the information you share will be used to evaluate you or your agency's performance. *While we ask other group participants to keep the discussion in the group confidential, we cannot guarantee this. Please keep this in mind when choosing what to share in the group setting.*

To thank you for your time, one $50 electronic gift card will be donated to youth served by your organization. Gift cards will be from a list of OSU-approved vendors (e.g., Amazon, Target, Best Buy, Sephora, Starbucks, Chipotle, Bed Bath & Beyond, Barnes & Noble, Apple, and Door Dash) at the conclusion of the focus group/surveys. Gift cards will be emailed to the preferred organizational contact, who will be responsible for overseeing the distribution of the gift card. If you wish to receive a report summarizing what we learn from this study, please let me know. You can expect to receive a brief report at the end of the study.

If you have any additional questions concerning this research or your participation in it, please feel free to contact me, my dissertation supervisor or our university research office at any time.

Jared Martin
PhD Candidate, Department of Human Sciences
The Ohio State University
Columbus, OH 43210
USA
Phone: 707-502-4310
Email: martin.3805@buckeyemail.osu.edu

The faculty supervisor for this research project is:

Dr. Natasha Slesnick
Department of Human Sciences
The Ohio State University
Columbus, OH 43210
USA
Phone: 614-247-8469
Email: slesnick.5@osu.edu

You may contact her with questions or if you feel you have been harmed as a result of your participation.

For questions about your rights as someone taking part in this study, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-614-688-4792 or 1-800-678-6251. You may call this number to discuss concerns or complaints about the study with someone who is not part of the research team.

Do you have any questions?

Do you agree to participate?

[If yes, proceed with interview]

[If no, do not proceed]

Appendix I. Focus Group Protocol

I. Introduction

a. Could you please introduce yourself and your role in the organization?

II. EBP adoption:

a. What evidence-based models, curriculum, or treatments does your organization currently offer and *roughly* when was each intervention/model adopted?

b. How did your organization learn about the EBPs you've adopted?

c. How did your organization decide to adopt them?

III. External Influences: Recognizing that organizations may be motivated to adopt EBPs for many different reasons, I'm interested in learning about your views on the following possible influences on the field and on your organization:

Funding

a. To what extent do federal, state, or local funders place expectations to use EBPs? How about private foundations or other philanthropic agencies?
    i. To what extent have these expectations influenced your organization's decisions to use EBPs?

b. Are there any financial or other incentives that influenced your decision to adopt EBP(s)?
    i. How does the EBP affect your organization's ability to receive these incentives?

Peers

c. To what extent are other peer organizations implementing the same EBPs you're currently using?
    i. How much has their use of a model informed your decision to implement it?

d. To what extent does offering your EBP(s) provide a competitive advantage for your organization compared to other organizations in your area or field?

Professional development/support and standards

e. Are there any local, state, or national performance measures, standards, or regulations that influenced the decision to adopt any EBPs?

f. What kind of information exchanges do you have with others outside your organization that highlight research evidence or promote EBPs?
    i. To what extent have these information exchanges informed your adoption or implementation of EBPs?

IV. **Implementation**:

a. For your current EBPs, are there any site-based or staffing certifications involved?
    i. What other training or supervision requirements are involved?

b. What types of fidelity requirements do these models have?
    i. How do you assess fidelity?

c. To what extent have there been changes or alterations made to these EBPs?

d. Within your organization's history, have there been any cases of an EBP getting de-implemented or replaced by something else?

e. Has your organization received any external support from a technical assistance organization or program developer regarding adoption or implementation of EBPs?
    i. If yes, how did your organization make that connection? What type of work did they support?
    ii. If no, are there any external supports you wish you could've received?

V. Wrap-Up

a. What would you like to share with the broader field, including practitioners, funders, or researchers, about EBPs for youth and young adults experiencing homelessness?

b. Is there anything else that you think I should know about your experiences adopting and implementing EBPs?

Thank you for your time!

Appendix J. Quantitative Survey

Please tell us a little about yourself and your organization:

Name of organization: _____

Does your organization provide services/programs to populations other than youth and young adults experiencing housing instability and homelessness? □ Yes □ No

a) If yes, please describe: _____

How many years have you worked at this organization: _____
How many years have you worked in social services/mental health total: _____

What is your role:
□ Director
□ Administrator
□ Manager or supervisor (Non-clinical)
□ Clinical supervisor/manager
□ Caseworker/Advocate
□ Therapist/Counselor
□ Other: _____

Highest level of education:
□ Associate's degree
□ Bachelor's degree
□ Master's degree
□ PhD
□ Other: _____

What is your age group?
□ 18-24
□ 25-34
□ 35-54
□ 55-65
□ Over 65
□ Prefer not to say

What is your gender?
□ Male
□ Female
□ Non-binary
□ Other: _____
□ Prefer not to say

What is your ethnicity?
□ Asian or Pacific Islander
□ Black or African American
□ Caucasian
□ Hispanic or Latinx
□ Native American or Alaska Native
□ Multi-racial
□ Other: _____
□ Prefer not to say

How many staff (1.0 FTE) did this agency have?

□ Fewer than 10 FTEs
□ Between 10 and 24 FTEs
□ Between 25 and 49 FTEs
□ Between 50 and 99 FTEs
□ Between 100 and 249 FTEs
□ Between 250 and 499 FTEs
□ Between 500 and 749 FTEs
□ Between 750 and 999

Of these staff, approximately what percentage is non-Caucasian in racial and/or ethnic background?

Non-clinical staff providing services to youth	□ 0-10% □ 11-20% □ 21-30% □ 31-40% □ 41-50% □ 51-60% □ 61-70% □ 71-80% □ 81-90% □ 91-100%
Clinical staff providing therapeutic services to youth	□ 0-10% □ 11-20% □ 21-30% □ 31-40% □ 41-50% □ 51-60% □ 61-70% □ 71-80% □ 81-90% □ 91-100%
Supervisors or Managers	□ 0-10% □ 11-20% □ 21-30% □ 31-40% □ 41-50% □ 51-60% □ 61-70% □ 71-80% □ 81-90% □ 91-100%
Administrators	□ 0-10% □ 11-20% □ 21-30% □ 31-40% □ 41-50% □ 51-60% □ 61-70% □ 71-80% □ 81-90% □ 91-100%

Approximately what percentage of this agency's clients are non-Caucasian in racial and/or ethnic background?
□ 0-10% □ 11-20% □ 21-30% □ 31-40% □ 41-50% □ 51-60%
□ 61-70% □ 71-80% □ 81-90% □ 91-100%

Does this agency primarily serve clients in rural, suburban non-metropolitan, or metropolitan areas (check all that apply)
□ Rural
□ Suburban, non-metropolitan
□ Urban, metropolitan

These questions concern your agency's current funding and major revenue:

Approximately how much of your agency's income in the last fiscal year came from…..	% (*please make sure that totals add to 100%)*
Government contracts for serving youth and families	
Government contracts for other services	
Private fees for services rendered (e.g., client-paid services, or services that are reimbursed through insurance)	
Foundation grants	
Donations from individuals and/or corporations	
Other earned income	
Other source(s) (please list)	

With what other public or private entities does your agency contract to support its programs? (*check all that apply*)
□ No contracts
□ Public child welfare systems
□ Private child and family serving agencies
□ Government housing and community development agencies
□ Public juvenile justice agencies
□ Family/juvenile courts
□ Public mental health service authorities
□ Private mental health providers
□ Public drug/alcohol service authorities
□ Private drug/alcohol service providers
□ Police department

□ Public or private schools
□ Public welfare offices (income assistance)
□ Health care clinics or hospitals
□ Other: _____

The following questions ask about your feelings about using new types of therapy, interventions, or treatments. Manualized therapy, treatment, or intervention refers to any intervention that has specific guidelines and/or components that are outlined in a manual and/or that are to be followed in a structured or predetermined way.

Please indicate the extent to which you agree with each item using the following scale.

	(0) Not at all	(1) To a slight extent	(2) To a moderate extent	(3) To a great extent	(4) To a very great extent
1. I like to use (or I like for my agency to use) new types of interventions to help our youth.	☐	☐	☐	☐	☐
2. I am willing to try (or I am willing to approve our staff to use) new types of interventions even if I/they have to follow a manual.	☐	☐	☐	☐	☐
3. I know better than academic researchers how to care for youth.	☐	☐	☐	☐	☐
4. I am willing to use (I am willing to approve the use of) new and different types of interventions developed by researchers.	☐	☐	☐	☐	☐
5. Research based interventions/treatments are not clinically useful.	☐	☐	☐	☐	☐
6. Clinical experience is more important than using	☐	☐	☐	☐	☐

manualized interventions/therapies.					
7. I would not use (or approve the use of) manualized interventions/therapies.	☐	☐	☐	☐	☐
8. I would try (or I would approve the use of) a new intervention even if it were very different from what I am (our staff are) used to doing.	☐	☐	☐	☐	☐
For questions 9 – 15: if you (or your staff) received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:					
9. It was intuitively appealing?	☐	☐	☐	☐	☐
10. It "made sense" to you?	☐	☐	☐	☐	☐
11. It was required by your supervisor?	☐	☐	☐	☐	☐
12. It was required by a funding agency?	☐	☐	☐	☐	☐
13. It was required by your state?	☐	☐	☐	☐	☐
14. It was being used by colleagues who were happy with it?	☐	☐	☐	☐	☐
15. You felt you had enough training to use it correctly?	☐	☐	☐	☐	☐

Please rate how much influence the following situations have had on your agency's decisions to adopted new programs for the young people you serve (including but not limited to evidence-based practices).

	No influence at all	A little influence	Some influence	A strong influence	A very strong influence
Performance expectations embedded in contracts with local public systems (e.g., child welfare, juvenile justice, mental/behavioral health)	☐	☐	☐	☐	☐
Performance expectations embedded in private foundation funding	☐	☐	☐	☐	☐
Performance expectations in federal funding applications (i.e., FYSB, HUD)	☐	☐	☐	☐	☐
Results of site monitoring/reviews	☐	☐	☐	☐	☐
State regulations	☐	☐	☐	☐	☐
Court requirements	☐	☐	☐	☐	☐
Lawsuits involving your agency	☐	☐	☐	☐	☐
Trying to keep ahead of other agencies (maintain competitiveness)	☐	☐	☐	☐	☐
Another agency <u>within</u> your immediate area reported success using the same or similar program	☐	☐	☐	☐	☐
Another agency <u>outside</u> your immediate area reported success using the same or similar program	☐	☐	☐	☐	☐
Higher education coursework you or your staff completed	☐	☐	☐	☐	☐

A conference presentation or training you or your staff attended	☐	☐	☐	☐	☐
Advice or information from a professional membership association	☐	☐	☐	☐	☐
Advice or information from a training/technical assistance provider	☐	☐	☐	☐	☐
Advice or information from university researchers or agency-university partnerships	☐	☐	☐	☐	☐
Staying abreast of new practices using articles, online resources, and webinars	☐	☐	☐	☐	☐

To what extent does your agency **currently compete** with the following types of organizations for funding, staff, and/or clients?

	(1) No	(2) A little	(3) Some	(4) Frequent	(5) Constant
a. Other local youth-serving organizations	☐	☐	☐	☐	☐
b. Other local homeless serving agencies	☐	☐	☐	☐	☐
c. Public child welfare	☐	☐	☐	☐	☐
d. Behavioral health treatment providers (i.e., mental health service providers and/or substance use)	☐	☐	☐	☐	☐
e. Juvenile justice agencies	☐	☐	☐	☐	☐
f. Schools	☐	☐	☐	☐	☐
g. Healthcare clinics or hospitals	☐	☐	☐	☐	☐
h. Other local or state associations of providers	☐	☐	☐	☐	☐

To what extent does your agency **currently collaborate** with the following types of organizations around data sharing, staff training, joint service delivery, and/or resource allocation?

	(1) No	(2) A little	(3) Some	(4) Frequent	(5) Constant
a. Other local youth-serving organizations	☐	☐	☐	☐	☐
b. Other local homeless serving agencies	☐	☐	☐	☐	☐
c. Public child welfare	☐	☐	☐	☐	☐
d. Behavioral health treatment providers (i.e., mental health service providers and/or substance use)	☐	☐	☐	☐	☐
e. Juvenile justice agencies	☐	☐	☐	☐	☐
f. Schools	☐	☐	☐	☐	☐
g. Healthcare clinics or hospitals	☐	☐	☐	☐	☐
h. Other local or state associations of providers	☐	☐	☐	☐	☐

Please rate yourself on the following questions related to your interactions with peer organizations (locally, statewide, or nationally) regarding your different programs for youth.

	(1)	(2)	(3)	(4)	(5)
In general, do you talk to your peers at other organizations about your programs?	Never ☐	☐	☐	☐	Very Often ☐
When you talk to your peers at other organizations about different programs do you:	give very little information. ☐	☐	☐	☐	give a great deal of information. ☐
During the past six months, how many people in general have you talked about evidence-based practices?	talked to no one. ☐	☐	☐	☐	talked to a number of people. ☐
Compared with your peer organizations, how likely are you to be asked about your programs?	Not at all likely to be asked. ☐	☐	☐	☐	Very likely to be asked. ☐
In a discussion of programs for youth homelessness would you be most likely to:	Listen to your peers' opinions. ☐	☐	☐	☐	Convince your peers of your opinions. ☐
In a discussion of programs, which of the following happens most often?	Your peers tell you about their programs. ☐	☐	☐	☐	You tell others about your programs. ☐
Overall, in all your discussions with peers, are you:	Not used as a source of advice ☐	☐	☐	☐	Often used as a source of advice ☐

Appendix K. Qualitative Codebook

Construct	Definition
A. **Respondent role / background**	
B. **Organizational details / programs used**	
1. Evidence-based practice/model(s) used	"The Thing" being implemented addresses a clinical or service need of children, youth, or families; has published research evidence supporting effectiveness; and either has a manual or staff training for local providers.
2. Organization history of EBP use	Organization/practitioner experience using EBPs, what the organization was like prior to EBP adoption, or any experience de-implementing or replacing EBPs.
3. Screening/Assessment	A specific screening or assessment method for identifying clinical problems that is used by the organization
4. Organizational context	Interviewee describes organizational traits (example: "we have a Research & Development department" or "we value using data") or processes ("we started our selection process with a literature review). Also internal issues, like general staff turnover.
5. Community context	Examples: community needs, homelessness rates, lack of services in regional areas, etc.
C. **Intervention Characteristics**	
1. Relative advantage	The EBP is better than other available EBPs or current practice.
2. Compatibility	The EBP fits with workflows, systems, and processes, and resources.
3. Intervention cost	The EBP purchase and operating costs.
4. Mission alignment	Implementing and delivering the EBP is in line with the overarching commitment, purpose, or goals in the program.
5. Relative priority	The extent that implementing and delivering the innovation is important compared to other activities/services.
6. Intervention complexity	The degree that the EBP is complicated/easy, which may be reflected by its scope or by number of steps involved implementing it.

7. Intervention Trialability	EBP has been tested or piloted on a small scale and/or undone
8. Intervention adaptability	EBP is modifiable, tailorable, or refinable to fit the local context or needs
9. Intervention Design	EBP is well designed and packaged, including how it is assembled, bundled, and presented.
D. **Outer Setting/Context -** factors existing outside the boundaries of the entity or entities leading the implementation of one or more evidence-based interventions	
1. Coercive pressure	Expectations or mandates from funders, policy, or other bodies that the organization depends on to implement an EBP.
2. Mimetic influence/peer pressure	Competing with and/or imitating peer entities drives adoption and/or delivery of the EBP.
3. Normative pressure	Professionalization of the field through standards and norms for work, such as licensing bodies, codes of conduct from professional societies, higher education institutions, or intermediary organizations.
4. Critical Incident	Large-scale and/or unanticipated events disrupt implementation and/or delivery of the innovation (e.g. COVID-19 Pandemic)
E. **Implementation**	
1. Staff training	Training for the organization to learn how to deliver the EBP.
2. Fidelity/Program Monitoring	Monitoring of intervention delivery and other oversight mechanisms of program quality.
3. Adaptations	Modifying the EBP for optimal fit and integration into work processes
4. Technical Assistance	Consultations or trainings with outside organizations, researchers, developers on how to improve their implementation efforts
5. Program Evaluation of Clinical/Service Outcomes	Using data to understand how effective a program is in achieving measurable goals/outcomes.
6. Client satisfaction	
F. **Barriers, Facilitators, Lessons Learned**	
1. Barrier	Hindrance to the adoption of EBP
2. Facilitator	Promotion of the adoption of EBP
3. Lesson Learned	We've learned from our experience, now we do, or recommend others do, X, Y, Z based on that experience.