Ready to roll: Strategies and actions to enhance organizational readiness for implementation in community mental health

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Abstract

Background: Organizational readiness for implementation (ORI) is a barrier to disseminating recovery-oriented evidence-based practices for people with severe mental illnesses. However, there is a knowledge gap regarding implementation strategies and specific actions related to those strategies that may enhance ORI across organizations. The Transtheoretical Model (TTM) is a well-established stage-based model used to support organizational change. In TTM, the first three stages—Pre-contemplation, Contemplation, and Preparation—represent the pre-implementation phase, during which ORI should be developed. This study explored ORI enhancement strategies reported as useful by different stakeholders in the field of community mental health (CMH) and tested the applicability of the TTM readiness stages as an organizing framework to direct ORI development.

Methods: The study included the following two phases: (1) a qualitative exploration of ORI enhancement actions reported by various stakeholders in the CMH field (N = 16) based on their experience in successful implementation projects and (2) a consolidation process performed by the research team to create coherent groups of actions and their overarching implementation strategies per readiness stage.

Results: A comprehensive list of strategies and related actions was created. The strategies and actions correspond with each of the first three stages of the TTM. Stakeholders differed in their methods of facilitating engagement across the organization and in their level of involvement in developing ORI.

Conclusions: This study is a first step in conceptualizing a systematic process for developing ORI using the TTM as a theoretical framework. Future studies should test the transferability and effectiveness of this repository to other implementation efforts, expend the lists per stage, and further explore differences between stakeholders’ role in ORI development.

Plain language abstract: Interventions that were proven effective in supporting the recovery of people with mental illnesses are not sufficiently available in the field of community mental health. One barrier to getting those interventions implemented is the lack of willingness and preparedness of organizations to change their practice, also referred to as organizational readiness for implementation (ORI). Little is known about how to enhance ORI to increase the availability of interventions. This study explored actions used to enhance ORI by people in different
roles who successfully implemented new recovery-oriented interventions in community mental health settings. The actions were organized into three stages of readiness development based on the Transtheoretical Model (TTM) of behavioral change. Differences were found between administrators, consultants, supervisors, and providers in the type and number of strategies they described. The results show the applicability of the TTM as an organizing framework for ORI development and provide sets of strategies and specific actions to support different readiness needs across the organization.

**Keywords**
Adoption, stages of implementation, implementation strategy, Transtheoretical Model, qualitative methods, pre-implementation, readiness, community mental health services

Many interventions have been developed and proven effective in supporting the recovery of people with severe mental illnesses (SMI). Effective recovery-oriented interventions focus on hope, empowerment, and the development of new meaning and purpose in one’s life, beyond the impact of mental illness (Farkas, 2007). However, the adoption of these evidence-based practices (EBPs) in the community mental health (CMH) field is limited. Recent estimates suggest that less than 4% of people coping with SMI have access to recovery oriented EBPs delivered in community-based services (Interdepartmental Serious Mental Illness Coordinating Committee, 2017). The low rate remains consistent despite the fact that increasing the adoption and sustainment of EBPs into CMH services in the United States has been a major priority of federal agencies since the beginning of the century (National Institute of Mental Health, 2020; President’s New Freedom Commission on Mental Health, 2003). Identifying the best implementation strategies for integrating EBPs into practice is critical to ensure that people with SMI have access to proven beneficial interventions.

One factor that influences the adoption rate of EBPs is lack of organizational readiness for change (Powell et al., 2014; Simpson & Flynn, 2007; Weiner et al., 2008). Holt and Vardaman (2013) conceptualize organizational readiness as the individual and collective sense of being primed, motivated, and capable of executing change. This definition emphasizes three distinct aspects that need to be addressed across the organization before launching a change process—informing people about the change, ensuring positive attitudes and beliefs, and developing their efficacy to succeed in making the change. This definition further specifies the concepts of collective change commitment and change efficacy suggested by Weiner (2009) in his Theory of Organizational Readiness. Although some conceptualize readiness for the change throughout the implementation process (Domlyn & Wandersman, 2019; Simpson, 2009; Stevens, 2013), our work focuses on the constructs related to the development of initial motivation prior to implementation. Separating the development of initial motivation from the sustainment of motivation is a different construct that offers a timely approach to developing ORI. This approach can reduce many barriers that often arise during implementation and sustainment due to a lack of proper engagement. To reach a collective sense of ORI, it is crucial to identify implementation strategies that promote knowledge, motivation, and self-efficacy across the organization. For example, studies have found that to increase the use of an EBP, clinicians need to have knowledge and positive attitudes toward the EBP (Becker-Haines et al., 2019; Zubkoff et al., 2016) and confidence in their organization’s ability to support them through the implementation process (von Treuer et al., 2018). However, team leaders need to become enthusiastic and committed to the change process to support their staff (Sayer et al., 2017), while administrators need to have confidence in the organizational resources and staff capacity to implement the EBP (Stadnick et al., 2017).

Lack of readiness at each of these organizational levels can cause resistance and reduce the effectiveness of the implementation process (Prochaska et al., 2001).

Despite broad consensus about the importance of readiness for implementation, there are no systematic methods to build such readiness before starting an implementation effort. Implementation strategies described in the literature (Kirchner et al., 2020; Powell, Waltz, et al., 2015) do not specify which strategies are best used with different stakeholder groups. Furthermore, recent attempts to classify implementation strategies suggest categorization by function (e.g., quality management, communication, resources; Boyd et al., 2018; Kwok et al., 2020; Waltz et al., 2015) but do not provide clarity as to their utilization along the implementation timeline. Finally, implementation strategies described in the literature often lack description of concrete actions that facilitate those strategies (Perry et al., 2019). A refined look into strategies and actions is needed, similar to how Leeman et al. (2017) define dissemination strategies as “any action or set of actions that target public health and healthcare decision-makers’, clinicians’, and other staffs’ awareness, knowledge, attitudes, and intention to adopt an intervention” (p. 4). Furthermore, identifying pre-implementation readiness development strategies and related actions, applied by different stakeholders across the organization, could provide much-needed...
specificity and a temporal aspect to the utilization of implementation strategies.

The Transtheoretical Model of Organizational Change (TTM; Prochaska et al., 2001) aligns with Holt and Vardaman’s (2013) conceptualization by offering a tailored approach to different readiness needs within the organization. The TTM suggests five stages of change that occur before, during, and after practice change. The first three stages correspond with the three readiness aspects of feeling primed, motivated, and capable of executing the change: (1) Pre-Contemplation, in which members of the organization have no awareness of the need to change their practice; (2) Contemplation, in which the benefits of changing the practice are recognized, but are still outweighed by the potential risks or costs at a personal level; (3) Preparation, in which interest and motivation to changing the practice have been established, and people are ready to create a plan or take small steps toward launching implementation activities; (4) Action, in which actual implementation takes place through various activities such as training, policy change, and procedure development; and (5) Sustainment, in which the new practice becomes integrated into routine work and maintained over time. The TTM also suggests 10 processes of change through which individuals progress from one stage to the other (Levesque et al., 2001). These processes are broad, with most related to the Action and Sustainment stages. However, identifying specific implementation strategies and actions to support advancement along the three TTM pre-implementation stages (pre-contemplation, contemplation, and preparation) is important for systematizing the development of organizational readiness for implementation.

This study had two aims: (1) to identify implementation strategies and related actions specific to pre-implementation readiness development reported as helpful by different stakeholders in the CMH field, and (2) to test the applicability of the three TTM pre-implementation stages as an organizing framework for those readiness strategies and actions. Gathering evidence from the field about useful implementation strategies, identifying a suitable framework for organizing them coherently, and identifying concrete actions associated with each strategy, might inform a systematic process for enhancing ORI to increase the uptake of EBPs.

**Methods**

To identify useful strategies and relatable actions for enhancing ORI, we conducted a qualitative exploration of pre-implementation actions used in successful EBP implementation projects in CMH agencies and consolidated them under overarching strategies. We interviewed 16 participants representing different stakeholder groups from three organizations to collect a variety of experiences. We used the TTM pre-implementation stages as a framework to organize the strategies and actions by readiness stages.

**Study sample**

We purposefully selected participants to represent a variety of stakeholder groups in terms of role, work contexts, and levels of experience. The organizations included two agencies that provide multiple CMH services and a national training and dissemination center. The two provider agencies differed in size (280 vs 1,100 employees), type (Private not for profit vs Public), geographic location (suburban/rural vs urban), and spread of the EBP within the organization (one specific unit vs several sites). The training and dissemination Center provides training and technical assistance to national and international organizations to implement recovery-oriented EBPs. Participants included administrators (n = 6) such as director or assistant director of services; supervisors (n = 4) who manage a team of employees, provide supervision on the delivery of the EBP, and hold a small caseload of clients; providers (n = 4) who deliver the intervention; and external consultants (n = 2) who provide training and consultation to CMH organizations at a national level. The participants represented a range of mental health disciplines (e.g., social work, psychology, rehabilitation counseling) and were directly involved in implementing a new recovery-oriented EBP for people with SMI during the prior 3 years. All the projects discussed were successful in reaching their implementation metrics (i.e., number of individuals trained to implement the EBP, number of recipients, sustainment over time, etc.).

**Recruitment and data collection**

The Boston University Institutional Review Board deemed the study to be non-human subjects research. Participants were recruited through direct outreach to organizations. An administrator at each agency served as the study liaison and recruited relevant participants using a brief description of the study. Contact with each participant was then made directly by the first author to coordinate the interview. The participants were not required to sign a consent form; rather the description of the study was read aloud at the beginning of each interview to verify understanding of the expectations. We used a semi-structured interview guide focused on readiness challenges experienced while introducing the EBP into the agency and strategies or activities found useful for overcoming those challenges. We asked questions such as “How were you brought into this implementation process?” “Have you encountered any barriers to effective implementation of this intervention and do you think some of them could have been prevented?” and “Did you use or experience any strategies that helped overcome these barriers?” In each question, we used prompts related to knowledge, attitudes, beliefs, and sense of efficacy about the change based on Holt & Vardaman’s definition of readiness. For example, in the question “how were you brought into the process,” the participants were prompted...
to share which information they received about the expected change, how confident they felt before starting the process, and what made them believe this will be worthwhile. Six interviews were conducted in person and 10 were conducted through videoconference. The participants received a gift card to thank them for their contribution. All the interviews were recorded, transcribed verbatim, and saved to a secure server.

Data analysis
Qualitative analysis was conducted in two phases. In the first phase, three independent coders applied a Directed Content Analysis approach (Hsieh & Shannon, 2005) guided by the TTM stages and processes of change (Prochaska et al., 2001). The working definitions that guided our identification of each ORI stage referred to the person’s condition that led to using the strategy, possible activities relevant for this stage, and the achieved outcome from applying the strategy (see Table 1). Strategies and actions were identified in the text based on Leeman et al. (2017) definition of dissemination strategies.

Using the coding software NVivo 12, the coders identified implementation actions described in the interviews and coded them by the stages of change they addressed—ORI-1 (Pre-contemplation), ORI-2 (Contemplation), ORI-3 (Preparation), and During implementation (Action/Sustainment). The actions described as pre-implementation (ORI-1, 2, 3) were then labeled with short titles. For example, a paragraph describing the organizational thought process behind resource allocation was labeled “planning for resources allocation.” To validate the coding and ensure the clarity of the labels, a fourth coder reviewed the classification.

In the second phase, we consolidated the list of actions generated previously. The consolidation involved three steps: Sorting, Refinement, and Validation. Step 1: Sorting. We used the card sorting online platform UsabilitEST (https://www.usabilitest.com/) to sort the items identified for each ORI stage into groups of actions. Each member of the research team grouped the actions independently and labeled each group with an overarching strategy name. The platform, used to develop conceptual frameworks in the business world, helped visualize the sorting process, compare responses between the researchers, and identify areas of disagreement. Step 2: Refinement. We then met to discuss the grouping framework and conceptual organization of the actions and strategies. This step included multiple discussions regarding the consolidation of repeated items, their grouping, stage-allocation, overarching strategy name, and wording of each action, until we reached a consensus. Step 3: Validation. We reviewed the quotes from the interviews and the final grouping of actions to ensure the quotes still fit with their original meaning and allocation.

The methods used in the consolidation phase were appropriate for building agreement among the small group of researchers around the three-level conceptual structure of stages-strategies-actions. The card sorting allowed each team member to thoroughly review the actions independently before engaging in discussions with the other team members. The multiple discussions allowed us to develop a more concise grouping of the actions and strategies and refine our shared conceptualization of the three-level structure.

Results
In the initial round of coding, we identified a total of 148 activities relevant to ORI enhancement. In the consolidation phase, these activities were merged into 39 actions grouped under 12 overarching strategies across the three ORI-stages, with an average of three actions exemplifying each strategy.

ORI-1: pre-contemplation strategies and actions
In the first phase of analysis, 36 items were identified as helping stakeholders across the organization acknowledge the need for change, understand its importance to the organization, and become open to consider the suggested

| Stage         | Condition                                      | Possible strategies                                                                 | Expected outcome                      |
|---------------|------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------|
| ORI-1         | Pre-Contemplation                              | Providing knowledge through exposure, inspiration, explanation of general benefits for the clients and the organization | Willingness to consider, but not to act |
| ORI-2         | Contemplation                                  | Discussing personal benefits of the change                                          | Willingness to become actively involved |
| ORI-3         | Preparation                                    | Developing belief in the success of the process                                      | Intention to act                       |
| ORC           | Implementation                                 | Training, supervision, problem solving                                              | Sustainability of the program         |
practice change. The items were consolidated into 12 actions, grouped under four implementation strategies with three exemplary actions for each (see Table 2). Strategies were the following: (1) Raising awareness about the need for practice change, for example, by sharing results of needs assessment of a wide range of stakeholders. One administrator said, “We had some focus groups with the members about what they wanted their recovery services to look like . . . they wanted us to update the services to be mostly individually based and more recovery focused.” (2) Developing enthusiasm for the change, for example, by increasing identification with the benefits of the EBP. As suggested by one supervisor: “Through supervision and through team meetings . . . we kind of just talk about why it’s effective and important for our people to participate.” (3) Encouraging leadership engagement, primarily by identifying the most relevant opinion leaders to message the need to change. As one consultant stated, “sometimes you have to know who the leader is, or you may be addressing the wrong leader. so, it might be a facility director that you’re talking to, but their state office chief is directing them to make this change.”

(4) Developing a culture of innovation sets the ground for openness to change. An exemplary action for this strategy was recruiting staff upfront who are open to innovation, as one of the supervisors explained, “We try to hire people who are excited about recovery and who have their own recovery story so that they understand the benefit of using everything at your disposal to try to help our members make progress.”

**Ori-2: contemplation strategies and actions**

We identified 37 items and consolidated them into 10 actions grouped under three implementation strategies with three or four exemplary actions per strategy (see Table 3). All items in this category were focused on helping stakeholders across the organization weigh the pros and cons of joining the project and personally connect with the need for change. Strategies were the following: (1) Highlighting personal and professional benefits of the EBP, by, for example, identifying incentives for staff participation. As one administrator shared, “We kind of sold it as if you’re an experienced clinician, it’s a prestigious thing to be . . . you would go through a special training and you would get special supervision.” (2) Addressing staff’s concerns, for example, by learning from local participants about their perception of barriers and facilitators of the change. One of the consultants described, “I try to understand what their perspective is. What is it that worries you or concerns you? What’s your worst-case scenario about this?” (3) Building a perception of self-efficacy for delivering the EBP. An exemplary action for this strategy is connecting staff with others who already deliver the EBP to appreciate the feasibility. One supervisor stated, “She [the administrator] hooked me up with some of the other workers . . . so, I was able to see the curriculum and just kind of get myself familiar with the various chapters and things.”
Table 3. Strategies and exemplary actions used in the contemplation stage.

| Strategies                                           | Exemplary actions                                                                 |
|------------------------------------------------------|------------------------------------------------------------------------------------|
| 1. Highlighting personal and professional benefits of the EBP | (a) Tapping into staff's interest and desire for professional growth (A, S, P)      |
|                                                      | (b) Identifying incentives for staff participation, such as positioning the EBP as a specialty, getting a pay increase, participating in a desired training, and so on (A) |
|                                                      | (c) Framing how the EBP will increase providers' capacity to provide better services (A, S, P) |
| 2. Addressing staff's concerns                       | (a) Learning from local participants about their perception of barriers and facilitators of the change (A, C) |
|                                                      | (b) Helping resisting staff to process their resistance or to learn more about the EBP to help them change their mind (A, S, P) |
|                                                      | (c) Keeping participation in the implementation optional (C, S)                     |
|                                                      | (d) Reassuring staff about the feasibility of the change process (A, C)            |
| 3. Building a perception of self-efficacy for delivering the EBP | (a) Acknowledging staff's skills and knowledge relevant to the new practice and to the implementation process (A, P) |
|                                                      | (b) Discussing any flexibility mentioned in the EBP's protocol and how it fits with local context or staff's skills (A, S) |
|                                                      | (c) Connecting staff with others who already deliver the EBP to appreciate the feasibility (S) |

EBP: evidence-based practices; ORI: organizational readiness for implementation; TTM: Transtheoretical Model.
Letters in brackets represent the stakeholders who reported the action: A: administrators; C: consultants; P: providers; S: supervisors.

**ORI-3: preparation strategies and actions**

The ORI-3 stage had the most strategies and actions. We identified 75 items in the first phase that were consolidated into 5 implementation strategies and 17 actions that empower members across the organization to begin the implementation process and help them plan the steps and infrastructure for moving forward (see Table 4). Strategies for this stage were the following: (1) **Ensuring policy and procedural support.** One of the administrators shared an example of how they advocated to state regulators for practice change: “We really tried to . . . negotiate that through with some people, particularly reviewers like licensing reviewers, to make them understand why we might streamline certain processes.” (2) **Adapting to local context** involves assessment of potential resources and capacity of the organization and how they may be adjusted to implement as outlined, as one of the administrators explained, “we’ll share [with intervention developers] information about how things happen here, what some of the structures that are in place; and they sort of think about how the intervention will fit.” (3) **Preparing for client recruitment,** for example, by identifying potential participants from the program’s existing caseload. One of the providers described how potential clients were identified: “they [the staff] looked at their caseloads to see who fell into the age range and if they would benefit from additional services such as groups or a more available clinician.” And an administrator added, “[we] selected the group of people who would benefit the most and likely to engage with the different program elements.” (4) **Preparing stakeholders for the change.** This strategy helped bringing different contributors to be on the same page by providing, for example, an overview of the expected change to all stakeholders. One of the administrators shared, “We trained all of the program directors and the middle-management people, but they weren’t going to be trained to practice. They just needed to be informed about what it was.” The last strategy was (5) **Developing an implementation action plan.** This strategy had the broadest scope of actions, covering different operational aspects that were planned in advance to allow a smooth transition into the Action stage of implementation. An action plan that all stakeholders agree on, or at least aware of, is the end goal for readiness development. The study participants mentioned various components that should be developed to compile the implementation action plan. These components included goal setting and planning for staffing, training, oversight infrastructure, resources, and procedures for delivering the EBP. One of the consultants explained, “It’s just a matter of setting a goal . . . what do you want to accomplish? how would things be different 18 months from now, if you made the change that your state office wants you to make?”

**Discussion**

This study adds to current efforts in the implementation science field to collect and organize implementation strategies into practical frameworks (Kirchner et al., 2020; Kwok et al., 2020; Waltz et al., 2019). By tying pre-implementation strategies and related actions to the TTM conceptual framework, we create a much-needed link between theory...
and practice. Our results also address the need to move from broad concepts to detailed actions to apply the suggested ORI strategies with precision and flexibility (Leeman et al., 2017; Proctor et al., 2013). Our study follows the dimensions suggested by Proctor et al. (2013) as guidelines for specifying strategies: (a) It focuses on a distinct goal—EBP adoption, (b) in a specific context—CMH organizations, (c) within a certain time frame—pre-implementation, (d) conducted by specified actors—administrators, consultants, supervisors, and providers, and (e) supported by a theoretical justification—the TTM stages of change. By creating clear, logical sets of stage-strategies-and actions, this study offers an approach to addressing the needs of different groups within the organization and increasing the sense of collective readiness.

Breaking down the concept of organizational readiness into smaller stages unbundles some of the construct’s complexity derived from the multi-levels and facets involved in the change process (Prochaska et al., 2001). The ability to attend to readiness needs of different groups offers a practical methodology for bridging readiness gaps within the organization. Viewing readiness development as a stage-based process that occurs prior to implementation provides the time and space for an effective cross-organizational intervention. Furthermore, the pre-action stages of the TTM align well with the readiness definition by addressing the acceptance of the change through knowledge, motivation, and self-efficacy, before moving on to execution. Such an approach can help diminish many of the commonly reported barriers to implementation including lack of knowledge, negative attitudes and beliefs about the change, and lack of adequate planning (Finch et al., 2020; Rye et al., 2019).

Through this study, we were able to demonstrate the applicability of the first three stages of the TTM to organizing pre-implementation strategies into a comprehensive process of readiness enhancement.

| Strategies                                      | Exemplary actions                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Ensuring policy and procedural support       | (a) Advocating to state regulators about changes in practice to receive their support (A) (b) Plan for adjusting the productivity measures while staff is in training (A) (c) Adjusting policies and procedures of the organization to include the delivery of the EBP (C)                                                                                     |
| 2. Adapting to local context                    | (a) Assess potential resources and capacity of the organization and how they may be adjusted to implement as outlined (A) (b) Incorporating implementation and EBP application ideas from various resources (literature, other agencies, decision makers) in order to adapt the delivery of the EBP to the agency’s structure and capacity (A, C, S, P) (c) People from “all levels” meeting together to discuss how the implementation should look like locally (A, C, S, P) |
| 3. Preparing for client recruitment             | (a) Involving referral sources prior to launching the program to make recruitment more efficient (A) (b) Identifying potential participants from the program’s existing case load (A, P)                                                                                                                                                                      |
| 4. Preparing stakeholders for the change       | (a) Consultant/developers collaborating with internal figures to explain how the EBP relates to local context (C) (b) Conducting readiness assessment at the leadership and staff level: need to change, positive expectations of the change, self-efficacy (as an organization), support, resources (C) (c) Providing overview of the expected change to all stakeholders (A, C, S) |
| 5. Developing an implementation action plan     | (a) Developing goals, measures, and metrics for assessing implementation outcomes (A, C) (b) Planning for staffing: - Decide on structure and selection process (A, S) - Identify potential staff (A, S, P) - Remove or reassign strong resisters (C) (c) Planning for skill development—Developing a training plan to address different skill levels and knowledge needs (A) (d) Developing oversight infrastructure: - Allocate resources for an implementation leader (A) - Develop a taskforce/champions that represents all who are going to be affected by the change (A, C) (e) Planning for resources allocation: - Identify resources requirements (space, time, staff, equipment, funding) and possible solutions (A, P) - Communicate with the management about the demands of the EBP (A) (f) Developing procedures for delivering the EBP (A) |

Note: EBP: evidence-based practices; ORI: organizational readiness for implementation; TTM: Transtheoretical Model. Letters in brackets represent the stakeholders who reported the action: A: administrators; C: consultants; P: providers; S: supervisors.
When considering each of the pre-implementation stages, ORI-3, which is the most proximal stage to active implementation, had more actions reported by all stakeholders compared to ORI-1 and ORI-2. However, it is clear that ORI development involves more than operational planning and that motivation building should go hand in hand with capacity building to effectively increase readiness (Scaccia et al., 2015). In our operationalization of the ORI stages, the first two stages focus on the development of knowledge, attitudes, and beliefs related to the change. The third stage focuses mostly on the participants’ self-efficacy to execute the change, using infrastructure, and capacity planning. Separating those constructs allows for higher resolution as to how each should be addressed. It is important to note that while some people in the organization will be in the preparation stage, others might still be in pre-contemplation or contemplation. The ORI stages offer a way to address different readiness needs across the organization and tailor strategies to each group that is expected to be part of the implementation effort. Moreover, the separation between the stages increase the ability to duplicate, report, and discuss these strategies and actions to ensure a more systematized readiness development process.

Another difference we found in the distribution of activities was related to the stakeholders’ reports. Most of the actions were reported by administrators, indicating their key role across all stages in facilitating readiness development. This picture aligns with a study that found significant correlations between leadership characteristics and empowering versus demoralizing organizational climates, where demoralizing climate was associated with perceived burden of EBPs (Brimhall et al., 2016). Administrators in our study were actively involved in creating a positive atmosphere for the practice change, especially during ORI-1 and ORI-2. For example, they used various methods to share evidence in support of the need for change, they emphasized the fit between organizational values and the change, and they identified incentives for staff participation. During ORI-3, the administrators invested efforts in reducing the expected burden by planning for the adjustment of productivity measures during training and by obtaining support from referral sources upfront. While administrators were focused on developing a supportive climate and resources, consultants were focused on goal setting, removing resistance, and providing information about the intervention and the implementation process as needed. Interestingly, the supervisors and the providers reported much fewer actions. Supervisors might play an important role as mediators of readiness between management and the front line. Increasing supervisors’ contribution in developing motivation and commitment to the change could not only enhance providers’ engagement but also have an impact on the ability to sustain the change through the supervisors’ ongoing support. As for the providers, it is possible that in the pre-implementation phase, they are mostly the receivers of readiness development actions, yet their role becomes more relevant during implementation when they need to apply similar strategies to engage clients with the new practice. These results also suggest that since administrators and consultants have a bigger role as key facilitators of engagement within the agency, developing frameworks for effective collaboration between these two stakeholder groups might be of great benefit for the implementation process.

The primary limitation of this study was the small sample size and the exploration of various stakeholders’ perspectives in only three organizations. Although we intentionally selected organizations with varied characteristics, we have not exhausted the scope of readiness development experiences and, as with any qualitative project, our findings may not be generalizable to other organizations. It is possible that many more strategies and actions exist that we were not able to capture in this study. Another limitation is related to the retrospective nature of the data collected. Participants were asked to reflect on how they were brought in or how they engaged others in the implementation of the EBP, 3 years after the implementation process began. This approach may have affected the accuracy and completeness of their recollection. Finally, our analysis only referred to the stakeholder who mentioned the action, but not the actors involved. We could not conclude who the commonly participating actors in each action were due to the small sample and varied contexts of the participating organizations. Future studies should aspire to collect data on all aspects related to strategies’ specifications (Proctor et al., 2013) across multiple organizations, during or as close as possible to the beginning of implementation. Longitudinal studies could be helpful in evaluating the effectiveness of ORI development using this method of organizing strategies.

The methods used for the consolidation phase were appropriate and efficient for the size of our team and for clearly conceptualizing the three-level structure of stages-strategies-actions. Nevertheless, we suggest that future studies move beyond this initial attempt into a more enhanced framework for readiness-related actions and strategies. To do so, larger groups of stakeholders should be involved in more rigorous methods for conceptual development, such as Group model building or Concept mapping (Powell, Beidas et al., 2015).

Some theoretical aspects also limited the study. The first was the TTM focus on attitudes and beliefs of individuals and some aspects of the organizational context, while overlooking two important factors affecting change processes—resources and external context (Damschroder et al., 2009; Waltz et al., 2019). These two factors are more objective than the attitudes and beliefs of individuals across the organization. Addressing discrepancies between objective measures and the subjective perception of the need and capacity to execute change might add an important dimension to ORI development. Another theoretical challenge we
encountered was the lack of clear distinction in identifying when readiness ends, and implementation begins. The TTM describes the preparation stage as when people are ready to create a plan or take small steps toward launching implementation activities. Following this definition, we operationalized the end of the pre-implementation phase as having a plan for implementation and the beginning of the Action stage as executing the plan, including skills training, supervision, staff recruitment, and so on. Our operationalization aligns with the readiness definitions used to guide this study (Holt & Vardaman, 2013; Weiner, 2009).

Despite the limitations mentioned earlier, the results of this study represent a wide variety of implementation strategies and actions applicable to the field of community mental health. The results align with recent efforts to create a useful pool of implementation strategies and compile them in various ways (Powell et al., 2012; Powell, Waltz, et al., 2015; Waltz et al., 2015, 2019). While some of the strategies identified in this study were already included in previous compilations, we also suggest several new ones derived from the field, such as “addressing staff’s concerns” or “developing enthusiasm for the change.” In addition, many have tried to operationalize the TTM (Choi & Ruona, 2011; Clark, 2013; Smathers et al., 2018) but we believe this study is among the first to generate a comprehensive list of strategies and actions that operationalize each stage.

The results of this study underscore the importance of having both academic and field experts pay more attention to the pre-implementation phase and value the richness of steps and processes it entails. Using this comprehensive list to engage all stakeholders in the change process may inform technical assistance activities. Further studies are needed to evaluate the transferability of these strategies to other implementation projects in the field and to test the effectiveness of readiness strategies in advancing members of organizations along the stages of change. Future research might also compare the strategies presented here to other implementation strategies known in the literature, such as the compilation of implementation strategies created by the Expert Recommendations for Implementing Change (ERIC) project (Powell, Waltz, et al., 2015) to clarify the extent to which TTM provides an effective categorization system for such lists as well.

Conclusion
This study exposed a variety of helpful strategies and supporting actions for developing organizational readiness for implementation as experienced by various stakeholders in the CMH field. The study also demonstrated the applicability of the TTM as a stage-based organizing system for pre-implementation strategies. This comprehensive list is a first step toward operationalizing the process of organizational readiness development to improve implementation outcomes of EBPs that support the recovery of people with SMI.

Authors’ note
We followed the SRQR reporting guidelines checklist for qualitative studies. This study was a non-human subjects’ research, therefore, we chose this checklist and not the COREQ as we found it more focused on the overall study design rather than on the interaction between the researcher and the interviewees. Initial findings were presented as a poster in December 2019 at the 12th Annual Conference on the Science of Dissemination and Implementation in Health, Arlington, VA.

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