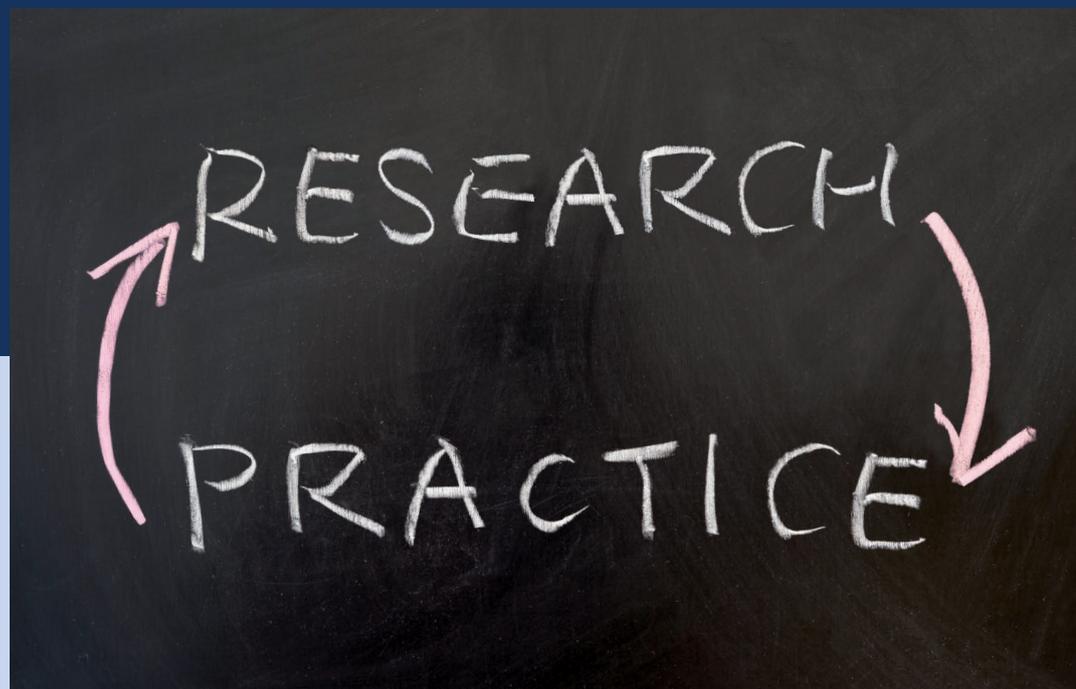


# Implementation Research, Practice, and Policy

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Dean L. Fixsen  
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# Implementation Science

## A Brief Overview and a Look Ahead

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**Abstract.** The field of implementation research is remarkable in many ways and, even as a young discipline, it has expanded well beyond the expectations of even its most optimistic supporters and stakeholders. In this overview we provide a selective rather than systematic review to serve as a relevant introduction to the field of implementation science. We highlight central concepts, strategies, frameworks, and research outcomes. These highlights draw heavily on the seminal systematic reviews from Brownson, Colditz, and Proctor (2012), Fixsen, Naoom, Blase, Friedman, and Wallace (2005), and Greenhalgh, Robert, MacFarlane, Bate, and Kyriakidou (2004) and on a thorough comparative review of implementation frameworks conducted by Meyers, Durlak, and Wandersman (2012). Looking ahead to future implementation research, we consider research challenges related to the scaling up of programs, striking a good balance between treatment integrity and local adaptation, measuring implementation quality, and program sustainability.

**Keywords:** implementation research, implementation practice, implementation strategies, implementation frameworks

In a practical sense, the central issues in implementation research are the “what,” “how,” and “who” of implementation. *What* shall be implemented, *how* will the task be carried out, and *who* shall do the work of implementation? In response to the question about “what,” we stress the importance of “effective interventions” which mostly refers to evidence-based programs or practices across several disciplines and professions (Biglan & Ogden, 2008). A useful distinction can be made between evidence-based practices and evidence-based programs. Practices are often considered to be simple procedures that can be adopted for use by individual practitioners. Programs on the other hand are collections of practices which are standardized and may integrate several intervention practices. Even if we emphasize evidence-based programs in this introduction, programs and practices share a number of challenges and requirements when it comes to implementation (Kessler & Glasgow, 2011). The question of “how” is not that easily answered and good ideas have to be derived from implementation frameworks and from research on facilitators and obstacles to effective transfer of knowledge. And finally the “who” refers to competent change agents and facilitators or, in our nomenclature, purveyors and implementation teams. It requires skilled people to do the work of implementation effectively and efficiently in complex human service environments.

### Implementation Defined

*Implementation* is “a specified set of activities designed to put into practice an activity or program of known

dimensions” (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005, p. 5). Implementation activities help practitioners become increasingly skillful, consistent, and committed in their use of an innovation (Klein & Sorra, 1996), help organizations change to support the innovative and evidence-based services (Klein, 2004), and help assure leadership for changing practices and organizational supports (Marzano, Waters, & McNulty, 2005). But it would be a mistake to consider implementation as a onetime event; it should rather be conceived of as an ongoing process from exploration to full implementation. Kitson, Harvey, and McCormack (1998) summarize that successful implementation in its simplest form requires that the evidence is high, the context receptive to change, and the change supported by appropriate facilitation.

The concept of *implementation science* has been defined as “The scientific study of methods to promote the systematic uptake of clinical research findings and other evidence-based practices into routine practice . . .” (ICE-BeRG, 2006). From its beginnings (Fairweather, Sanders, & Tornatzky, 1974; Pressman & Wildavsky, 1973), implementation science has grown out of experiences with the “science to service gap.” Proponents of implementation science have been concerned with the limited success of transferring research-based practices to ordinary service settings (Palinkas & Soydan, 2012). Over the past decades, diffusion and dissemination strategies (Brownson, Colditz, & Proctor, 2012) have resulted in about 14% use of evidence-based programs after about 17 years (Balas & Boren, 2000; Green, 2008). The poor outcomes from these necessary but insufficient approaches have led some to call for a moratorium on funding research to develop more

evidence-based programs until we learn to successfully use the ones we already have available (Kessler & Glasgow, 2011).

The growing awareness of a science to service gap has inspired research efforts and numerous papers on implementation facilitators and obstacles. Thus, the persistent challenges of putting research knowledge into practice have contributed in important ways to the emergence of the field of implementation research (Institute of Medicine, 2001; Rossi & Wright, 1984). The development of more organized approaches to implementation practice, science, and policy is timely. As pointed out by Goldman et al. (2001): "There is uncomfortable irony in moving forward to implement evidence-based practices in the absence of an evidence base to guide implementation practice" (p. 1593). Some of the research leading to a more evidence-based approach to implementation is summarized in the next section.

## Implementation Research Outcomes

Implementation outcomes are conceptually and empirically distinct from those of service and treatment effectiveness outcomes. Of course, the ultimate outcome of evidence-based interventions and evidence-based implementation is socially significant improvements in consumer well-being. Identifying implementation outcomes has required opening the "black box" of implementation processes (Sullivan, Blevins, & Kauth, 2008) to identify the necessary ingredients apparently related to supporting successful and sustainable uses of evidence-based interventions. Implementation processes hidden within the "black box" also are referred to as mediating or change mechanisms. Sullivan et al. (2008) identified two main implementation components; facilitation of training (including participant selection, training content and process, consultation and coaching) and facilitation of implementation (including evaluation approach, administrative support, and systems intervention). Another attempt at analyzing mediating mechanisms is Berkel et al.'s (2011) theoretical model for the study of treatment program implementation and effectiveness. Berkel et al. (2011) emphasize how both practitioners and clients contribute to positive outcomes. First, treatment *integrity* indicates to what extent treatment components are delivered as intended, for instance how much of the program is disseminated and how much time is spent on each component. Additionally, indicators of *competence or quality* are indicated by clinical process skills and a clear and enthusiastic presentation of the program (e.g., interactive teaching). The quality of delivery may influence client engagement and response, as indicated by showing up and actively participating in the sessions, and by doing homework and express satisfaction with treatment. Another mediating mechanism is adaptation which, contrary to program drift, is positive contributions to the program made by the therapist. This may include taking into account the participants' cultural or local distinctiveness, but without violating the underlying theory and principles of the program.

But still there is insufficient empirical evidence for evidence-based implementation and we still need to know more about what the "black box" contains. That is, what are the processes or change mechanisms that bring about the successful implementation of evidence-based interventions and other innovations.

## Facilitators and Obstacles

A considerable proportion of the literature has focused on facilitators and obstacles of change by asking: "what promotes and what slows down implementation with high fidelity and good outcomes?" Barriers and incentives to practice change are associated with characteristics of the innovation itself, the provider, the practitioner adopting the practice, the client or consumer, and the inner and outer context of the service delivery organization (Durlak & DuPre, 2008; Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004; Grohl & Wensing, 2004; Rogers, 1995). In their review of effective implementation, Durlak and DuPre (2008) found the organizational capacity of the service delivery organization and the provider's external support through training and technical assistance to be of particular importance. Key attributes of *new practice* may include relative advantage, compatibility with current norms and value, low complexity, triability, observable benefits, and flexibility in the setting (Greenhalgh et al., 2004; Rogers, 1995). Attributes of the *practitioners* may include tolerance for ambiguity, openness to change, motivation, confidence, skill, social values, and learning style (Rogers, 1995). Attributes of the innovative systems include decentralized decision-making, diverse professionals with specialized knowledge, lack of formality, good internal communication, and technical support for change.

Managers and administrators are important because they can address organizational barriers to change (Kauth, Sullivan, Cully, & Blevins, 2011). In one perspective, studies seem to indicate that "everything matters" (Durlak & DuPre, 2008), and that the collective and interactive influences of a range of implementation variables are prerequisites of practice change. Other studies have tried to determine the relative importance of specific implementation components in relation to outcomes. One example is Mihalic and Irwin's (2003) evaluation of the implementation of programs in the Blueprint series for violence prevention (Elliott, 1998), in which regression analysis showed that the quality of technical support, ideal program characteristics, limited staff turnover, and support from the local community were among the most important facilitators. Several strategies have been explored in efforts to bring innovations to a broader audience, and next we present some of these.

## Implementation Strategies

Implementation strategies are ways of dealing with the contingencies of various service systems and practice settings,

and descriptions of concrete implementation activities (Proctor et al., 2009). The well-known distinction between diffusion and dissemination on the one hand and implementation on the other highlights the difference between passive and active approaches to knowledge transfer (Greenhalgh et al., 2004). A review and synthesis of the implementation evaluation literature (Fixsen et al., 2005) concluded that diffusion and dissemination are not sufficient to reliably produce and sustain positive benefits to consumers. In addition to the active-passive dimension, implementation strategies may be categorized as “top-down” or “bottom up.” In a top-down linear model (Best et al., 2008) new interventions are disseminated from a central source (e.g., the government or program developers) to the local level or sites. This strategy may be used by governments and NGOs in order to promote better, more accessible, and cost-effective services to clients or users (Palinkas & Soydan, 2012). The possible downside of the top-down strategy appears when it fails to address local needs and concerns, and it may mobilize counterforces at the local level if it is considered to be a threat to professional autonomy (Ferrer-Wreder, Stattin, Lorente, Tubman, & Adamson, 2004; Palinkas & Soydan, 2012). A bottom-up or decentralized approach signals that new interventions are initiated by individuals and stakeholders at the community level (Price & Lorion, 1989) and may therefore increase their sense of ownership. While bottom-up approaches may increase the likelihood of increased commitment among practitioners (e.g., Sherman, 2009; Sullivan et al., 2008), they also may reduce the chances of the intervention being used as intended in practice (Ogden, Amlund-Hagen, Askeland, & Christensen, 2009; U.S. Department of Education, 2011; Vernez, Karam, Mariano, & DeMartini, 2006). The message from research is clearly in favor of combining the top-down and bottom-up approaches in such a way that the “knowledge to action” process becomes a two-way street in which “evidence-based-practice” and “practice-based evidence” are combined. Successful implementation seems to depend on striking a good balance between the two (Fixsen, Blase, Metz, & Van Dyke, 2013; Ogden et al., 2009) with top-down leadership and systems support for bottom-up practice and organization change. A more elaborated and refined approach to the analysis of implementation is communicated in frameworks of implementation. In the following section, implementation frameworks help to make sense of these lists of variables found to be influential in closing the science to service gap.

## Implementation Frameworks

A comprehensive conceptual model should by definition summarize current empirical knowledge and include clearly defined constructs, a measurement model for these key constructs, and an analytical model hypothesizing links among measured constructs (ICEBeRG, 2006). Several conceptual models or implementation frameworks have been presented in the literature during the last decade. Each framework has

guided research in one or more human service domains and has turned out to have some empirical support.

Meyers, Durlak, and Wandersman (2012) provided an excellent review of extant implementation frameworks. They reviewed the literature and found frequent references to 25 frameworks. They conducted a systematic review of each framework and found 14 dimensions that were common to many of the frameworks. The 14 common dimensions were grouped into six areas: (1) assessment strategies (conducting a needs and resources assessment; conducting a fit assessment; conducting a capacity/readiness assessment); (2) decisions about adaptation (possibility for adaptation); (3) capacity-building strategies (obtaining explicit buy-in from critical stakeholders and fostering a supportive community/organizational climate; building general/organizational capacity; staff recruitment/maintenance; effective pre-innovation staff training); (4) creating a structure for implementation (creating implementation teams; developing an implementation plan); (5) ongoing implementation support strategies (technical assistance/coaching/supervision; process evaluation; supportive feedback mechanism); and (6) improving future applications (learning from experience). The lists of potentially important implementation variables begin to make sense when they are grouped into frameworks and common dimensions.

## Active Implementation Framework

One of the frameworks in the Meyers, Durlak, & Wandersman review is the active implementation framework based on the findings from a major review and synthesis of the implementation evaluation literature (Fixsen et al., 2005). The active implementation framework integrates the multilevel approach to change. First, the active implementation framework summarizes the importance of knowing WHAT the intervention is prior to attempting to use it in practice. Researchers assess the rigor with which evaluations of evidence-based programs have been conducted (e.g., two or more rigorous randomized control trials; Elliott, 1998). Implementers assess the clarity with which the practice or program is described and operationalized so it can be taught and used in practice (e.g., usable intervention criteria; Fixsen et al., 2013). Second, the active implementation framework describes the common features of successful attempts to make full and effective use of interventions in practice. These implementation drivers describe HOW interventions are supported in practice. The implementation drivers include developing staff competencies (best practices for recruiting and selecting practitioners and for training, supervision/coaching, and performance/fidelity assessment), making organization changes to support the intervention and implementation drivers (best practices for facilitative administration, decision support data systems, and systems interventions), and leadership (best practices for technical/managerial leadership and for adaptive/transformational leadership).

The active implementation framework integrates the multistage approach to change. The progression of the implementation process is captured by the stages of implementation identified as: (1) exploration and adoption, (2) program installation, (3) initial implementation, and (4) full implementation. Rather than being a linear process, the stages are assumed to interact and impact one another in complex ways (e.g., after years of full implementation, the exploration stage may be revisited after a major change in leadership or system supports). Finally, the active implementation framework describes WHO does the work of implementation, a capacity missing in human service systems. *Purveyors* are people who bring about significant practice change and are referred to as change agents, facilitators, or implementation teams. They are individuals or groups who know the implementation drivers and stages well and actively work to implement programs or practices to achieve the intended outcomes (Fixsen et al., 2005, p. 14). The multilevel and multistage work of implementation is seen as integrated and purposeful; hence, the name active implementation frameworks. Some have argued that omitting one or more elements may weaken the overall intervention and the outcome (Kauth et al., 2011).

## Research on Implementation Stages and Components

Fixsen et al. (2005) conclude their research synthesis by stating that the best evidence points to what does not work with respect to implementation (p. 70). By themselves, diffusion of information, dissemination of information (research literature, mailings, practice guidelines), and training (no matter how well done) are ineffective implementation methods. In fact, the authors found that successful implementation efforts designed to achieve beneficial outcomes for consumers required a longer term multilevel approach. The strongest research support was found for skill-based training, coaching, and assessment of practitioner performance or fidelity. There was good evidence for the importance of practitioner selection, but the evidence was sparse and unfocused with regard to program evaluation, facilitative administrative practices, and system intervention methods. The critical role of leadership was universally acknowledged but seldom measured or modified. Even though their importance is indisputable, there was little research evidence related to organizational and system influences on implementation.

According to the research findings, programs should be fully operational before they are tested in controlled outcome studies (Durlak & DuPre, 2008). Evaluating programs before they mature may lead to poor results, the underestimation of the effectiveness, and doing disservice to the program. Also, programs should be fully implemented with fidelity before modifications are made. Panzano et al. (2004) found the "overall implementation effectiveness was negatively related to the extent to which the program had been modified from its prescribed form."

And, external system factors can facilitate or hinder the use of evidence-based programs with fidelity and good outcomes (Glisson et al., 2010). But the most noticeable gap found in the research literature concerned the interaction effects among implementation factors and their relative influences over time (Greenhalgh et al., 2004).

In sum, the research literature indicates that an active, long-term, multilevel implementation approach is far more effective than passive forms of dissemination in order to promote and sustain the use of evidence-based interventions in real-world practice. There is far more research on the implementation drivers pertaining to the individual competency dimension than on the organization level or leadership components. There is a need for more research on the interactions among the implementation drivers, and the extent to which program modifications impact outcome evaluations that are carried out before evidence-based interventions are fully operational.

An encouraging theme is that implementation principles appear to be content neutral. Thus, a separate implementation science is not required for mental health, or child welfare, or education, or health, or business. A quick look at the references for this article supports the idea that there are universal principles derived from research and practice in all fields and that apply to all fields. Thus, all fields of endeavor can contribute to and derive benefits from a common science of implementation. This is welcome given the Durlak and DuPre (2008) review of implementation research that found extensive and persuasive evidence confirming that implementation variables impact outcomes. In the next section we discuss implementation research as it is evolving.

## Implementation Research

Implementation research ideally is based on conceptual models and aims at supporting the movement of evidence-based knowledge into routine use. In this sense implementation research is applied research: it has a purpose and the variables of interest are directly related to that purpose. This is in contrast to basic research that values the pursuit of knowledge guided by the intellectual curiosity of scientists and may or may not lead to practical applications. The purpose of applied implementation work is to accomplish the full and effective use of evidence-based innovations in typical practice settings in order to produce promised improvements in outcomes for children, families, individuals, communities, and societies. The mission-driven focus of implementation has been called "making it happen" compared to "letting it happen" (diffusion) or "helping it happen" (dissemination) approaches (Greenhalgh et al., 2004; Hall & Hord, 1987).

The difficulties inherent in implementation science and practice have been recognized from the beginning. Implementation work and, therefore, implementation research is done in "an environment full of personnel rules, social stressors, union stewards, anxious administrators, political pressures, interprofessional rivalry, staff turnover, and

diamond-hard inertia.” (Fisher, 1983; p. 249). Van Meter and Van Horn (1975) concluded that these difficulties “discouraged detailed study of the process of policy implementation. The problems of implementation are overwhelmingly complex and scholars have frequently been deterred by methodological considerations. . . . a comprehensive analysis of implementation requires that attention be given to multiple actions over an extended period of time.” (p. 450–451). Glasgow, Lichtenstein, and Marcus (2003) acknowledge these difficulties and state, “We need to embrace and study the complexity of the world, rather than attempting to ignore or reduce it by studying only isolated (and often unrepresentative) situations.” (p. 1264).

Embracing these complexities is difficult for implementation researchers. Accounting for simultaneous multilevel, top-down, bottom-up, and multivariate influences presents methodological challenges for researchers as well as practical challenges for purveyors and implementation teams. Fortunately, over the past few decades implementation researchers have identified variables that directly influence the use of evidence-based programs in practice. The field has been dominated by case studies, qualitative research, and retrospective assessments of implementation factors. Recently, quantitative, prospective projects are appearing as researchers operationalize implementation variables (Fixsen, Panzano, Naoom, & Blase, 2008), develop and assess measures related to those variables (Ogden et al., 2012), and deliberately manipulate complex implementation-specific variables as part of research designs (Glisson et al., 2010).

## The Way Ahead

Several suggestions have been made for the improvement of future implementation research. Research challenges are related to the scaling up of programs, striking a good balance between treatment integrity and local adaptation, the challenges of measuring implementation quality and program sustainability.

## Implementation Theory

Given the scattered findings from implementation research and evaluation, the need for *theory-driven* analytic procedures in quantitative and qualitative studies is apparent. The implementation frameworks summarized by Meyers et al. (2012) are a step toward the kind of mid-range theory described by the ICEBeRG (2006). A mid-range theory summarizes what currently is known and helps to guide future research and practice. Investigations based on theory are more likely to advance understanding of factors and the interactions among factors that determine implementation outcomes. The implementation frameworks can be tested in practice to contribute to the development of an empirically-based mid-range theory of implementation.

## Measurement and Methods

Another important issue relates to the *methodological challenges* encountered when doing implementation research. First, there is the need to operationalize implementation components and develop new measures of implementation. Even if the concept of implementation is not new, the idea of developing ways of measuring it certainly is. Consequently, there is a great need for the development of instruments which operationalize and standardize the measurement and analyses of implementation processes and outcomes (Fixsen et al., 2008; Ogden et al., 2012). As pointed out by Durlak and DuPre (2008): “science cannot study what it cannot measure accurately and cannot measure what it does not define” (p. 342). In their recommendations for future research, Greenhalgh et al. (2004) mention the importance of using common definitions, measures and tools, and standardized approaches to measuring key variables and confounders.

Second, research designs for implementation research present challenges. Implementation research may involve larger units of analysis (e.g., organizations, communities) over longer periods of time (e.g., 5–10 years). The importance of readiness and availability of resources to support implementation of evidence-based programs and other innovations also complicate research designs. Attempting to account for multilevel, multistage influences soon leads to the problem of “too many variables and too few cases” (Goggin, 1986). Glasgow, Magid, Beck, Ritzwoller, and Estabrooks (2005) and Speroff and O’Connor (2004) summarized problems associated with using randomized group designs in complex implementation research applications. They recommended practical clinical trials that employ within-subject designs such as multiple-baseline designs. In these cases, the “subjects” may be units of practitioners, organizations, systems, or even countries. These designs require fewer “subjects,” provide evidence of functional relationships between experimental variables and outcomes, and, if the implementation intervention turns out to be effective, every “subject” eventually receives the intervention. The disadvantage is that interventions need to be powerful enough to produce visible and consistent changes in outcomes so effectiveness can be detected. Some of the more subtle, statistically significant, intervention outcomes may be lost when using within-subject designs.

## Adaptation and Fidelity

There is substantial disagreement among researchers about how much adaptation is allowed without compromising the intervention. On the one hand, some researchers strongly advocate the need for local adaptation in order to match interventions to local conditions (Castro, Barrera, & Martinez, 2004; Dodge, 2001), and even reinvention of programs (Price, 2002), while warning against “entering the zone of drastic mutation” (Ferrer-Wreder et al., 2004). Elliott and

Mihalic (2004) on the other hand assert “the need for and effectiveness of local adaptation of prevention programs is greatly overstated. . .” (p. 51) and that modifying a program too much may actually decrease program effectiveness. They question the need for adaptation of most violence prevention programs and indicate that lack of adherence might lead to program drift characterized by simplification of the intervention, the development of private strategies, and consequently to a dilution of the program. Some recent evaluations contradict the assumption that local adaptations are necessary for the successful implementation of interventions at different sites (Panzano et al., 2004). Finding the right mix of fidelity and adaptation is discussed at length by Durlak and DuPre (2008) and they concluded that the debate is framed inappropriately in either-or terms. The prime focus should be on finding the right mix of fidelity and adaptation to reliably produce the intended outcomes.

### Program Sustainability

A major threat to most evidence-based programs and practices is program drift or program dilution which occurs when services are delivered with lower dosage, less intensity, and with inferior quality than the original model. Sustaining program integrity and effectiveness over time and across intervention sites and generations of practitioners challenges program developers, purveyors, and practitioners alike (Forgatch & DeGarmo, 2011). As mentioned by Fixsen et al. (2005), programs and service delivery sites may experience shifts in the inner and outer context as when staff and leaders leave and are replaced, and when funding streams and program requirements change. New social problems arise and partners come and go. Political alliances may only be temporary, and champions move on to other causes. One solution to the challenge of program maintenance is the development of implementation capacity in the form of implementation teams. “Self-sustaining implementation sites” or “multi-allegiance centers” can help assure ongoing implementation supports (e.g., training, coaching, facilitative administration, fidelity assessments) for several programs and also add new programs and practices to those already in place (Fixsen et al., 2013; Ogden et al., 2009). One study showed that the absence of organizational support and staff turnover were the most commonly reported implementation challenges to the sustained implementation of Dialectic Behavior Therapy in routine health care settings in the UK (Swales, Taylor, & Hibbs, 2012). The survival curve demonstrated that DBT programs ran an increased risk of failure in the second and the fifth years after training in the UK. Due to the research findings that implementation can deteriorate over time, Fixsen and colleagues (2005, 2013) have called for continuous systematic monitoring and feedback systems in order to capture the variability that has been observed in levels of implementation supports and intervention outcomes over time (see also Durlak & DuPre, 2008). Implementation teams can promote sustainability by

responding constructively to variability and clearing the way for continuous improvement.

### Going to Scale

The goal of scaling is to realize the goal of the evidence-based movement: to provide socially significant benefits for whole populations. Given the complex relationships between evidence-based interventions and evidence-based approaches to implementation, scaling up interventions requires scaling up implementation capacity. Contrary to expectations, large-scale implementation can occur with a high degree of fidelity and good outcomes (Elliott & Mihalic, 2004; Glennan, Bodilly, Galegher, & Kerr, 2004; Ogden et al., 2009). However, the process of moving to broad scale use is fraught with challenges (Kellam & Langevin, 2003). At scale, interventions need to serve a more heterogeneous population employing service providers with various backgrounds working within highly variable and sometimes insufficient service infrastructures that operate with variable resources and attention to implementation supports to assure program fidelity. Welsh, Sullivan, and Olds (2010) expected attenuation of effects to occur when early prevention trials were scaled up and, across three studies, they found a fair amount of variability in scale up discounts, ranging from a low 25% and a high of 50%. Implementation capacity in the form of purveyors and implementation teams can help deal with the many problems that arise and help to assure continued access to community resources to fund the large scale training, supervision, and other expenditures related to the implementation and running of the intervention. In sum, the challenges of scaling up are many and persistent. Yet, the needs of children, families, individuals, communities, and society demand attention to scaling up the promised benefits of evidence-based programs.

### Interaction of Implementation Components

The most striking gap in the research literature concerns interaction effects among implementation factors and their relative influence over time (Fixsen et al., 2005). Most studies seem to focus on a limited number of implementation components and fail to address their interactions and contextual and contingent features. Greenhalgh et al. (2004) state, “The paradox is that context and confounders lie at the very heart of diffusion, dissemination and implementation of complex interventions.” In fact, they question if the impact of implementation components can be isolated and independently measured. Thus, interaction effects should be expected and accounted for in studies of implementation.

There also is a great need to take into account the wider context of service delivery organizations and their staff as well as the incentives or sanctions for changing practice (Goldman et al., 2001; Kitson et al., 1998). Today we know more about “what works” than how to motivate practitioners to apply interventions and practices in a systematic

and accountable way. We also know more about characteristics of individuals who are willing to adopt new practices than we know about what characterize practice organizations or agencies which are open to change. Summarizing the research on obstacles, it is not difficult to understand why the process of implementing evidence-based programs and practices has been so slow. Great demands are put on sustained funding, organizational adaptations, extensive training, coaching, and practice evaluation and on the challenges of implementing new ways of working alongside regular practice. The general time pressure and competition from other prioritized tasks may also slow down the implementation process. In the practice field, the debate on evidence-based programs also have had an impact on attitudes toward EBPs with arguments that they are too rigid, reduce the professional autonomy of practitioners, and occupy too much of the available resources and devaluates other approaches.

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