

Barriers to and Facilitators in the Implementation of Cognitive-Behavioral Therapy for Youth Anxiety in the Community

Vanesa A. Ringle, B.A., Kendra L. Read, M.A., Julie M. Edmunds, Ph.D., Douglas M. Brodman, M.A., Philip C. Kendall, Ph.D., A.B.P.P., Frances Barg, Ph.D., Rinad S. Beidas, Ph.D.

Objective: The study examined, from the perspective of therapists, the barriers to and facilitators in implementing cognitive-behavioral therapy (CBT) for anxious youths in community settings.

Methods: Fifty therapists (43% of the original training sample of 115 providers) participated in a follow-up interview two years after training and consultation. They reported on barriers to and facilitators in implementation of CBT for youths with anxiety.

Results: Qualitative analyses identified numerous barriers and facilitators, including client factors (for example, motivated clients facilitated the use of CBT, whereas clients with

complex issues and numerous psychosocial stressors hindered its use), intervention factors (the structure of CBT helped facilitate its use for some providers, whereas others reported feeling constrained by such structure), and organizational factors (for example, the absence of support within one's institution served as a barrier, whereas supervision supporting the use of CBT facilitated implementation).

Conclusions: Findings of this implementation trial align with conceptual implementation frameworks and may guide the tailoring of future implementation efforts in order to overcome barriers and maximize facilitators.

Psychiatric Services 2015; 66:938–945; doi: 10.1176/appi.ps.201400134

One in five youths in the United States will receive a psychiatric diagnosis (1), and of these, less than 20% will receive services (2). Those who do typically will not receive evidence-based practices (3), described as “the integration of the best available research with clinical expertise” (4). A major challenge facing the mental health field is the implementation of evidence-based practices in community settings. Various implementation efforts have had disappointing results to date (5). Gathering perspectives of frontline providers may lead to better understanding barriers to and facilitators in implementation of evidence-based practices. Generally, providers report multidimensional perceptions of the use of evidence-based practices (6) and identify specific barriers (such as use of training manuals [7]) and facilitators (for example, modular treatment [8,9]). Understanding stakeholder perspectives allows for more effective future implementation efforts.

Implementation science frameworks can guide understanding of provider perspectives, and these frameworks suggest that factors that influence implementation occur at multiple levels, including individual, organizational, intervention, and system levels (10–13). Individual-level factors typically refer to the characteristics of providers implementing an evidence-

based practice. Organizational factors refer to characteristics of the setting (including culture and climate) where implementation occurs. Intervention factors refer to characteristics of the innovation being implemented. System-level factors refer to characteristics of the system within which providers and organizations are situated (10–13).

Barriers and facilitators at each level have been identified in the implementation of various psychosocial interventions. Preliminary evidence suggests that provider-level and organizational barriers and facilitators may be predictors of implementation outcomes (14). Qualitative interviews with stakeholders indicate that intervention factors (such as costs of evidence-based practices), organizational factors (such as staffing), and system factors (such as funding) are important barriers to and facilitators in implementation across interventions and settings (15,16). These barriers and facilitators are related to implementation outcomes in important ways. For example, provider (demographic characteristics and attitudes) and organizational (specifically, organizational climate) factors are associated with provider fidelity (17). In addition, other studies have found that organizational social context is associated with improved child outcomes (18,19). Gaining a more complete understanding of these

multilevel barriers and facilitators will move implementation science forward.

In a recent implementation trial (20), therapists were trained in the provision of cognitive-behavioral therapy (CBT) for youth anxiety (21,22) (for further description, please see the procedures section). Although CBT is widely considered to be an evidence-based practice for youth anxiety, many community settings and providers have yet to implement it or do not fully engage in all treatment components (17,23). In an effectiveness trial, providers did not conduct exposures as frequently as indicated in the treatment protocol (23). In another study, providers across several settings (including schools and community mental health clinics) reported high penetration of CBT for youth anxiety but also reported using other treatment strategies in concert with CBT and providing fewer sessions than would be expected (17,24), suggesting that implementation was not as successful as it could have been. To understand findings suggesting sub-optimal implementation of CBT for youth anxiety, this study examined provider-reported barriers to and facilitators in the implementation of CBT for anxious youths in community settings. The study used a modified grounded-theory approach two years after providers participated in training and consultation. No a priori hypotheses were specified, given the exploratory nature of the research question.

METHODS

Participants

Fifty providers participated in the two-year follow-up study, representing 43% of participants in the original implementation trial (20). Via e-mail, we invited those who participated in the original trial to participate in this project. Sixty-five providers (57%) did not respond to repeated e-mail contact (at least three e-mails); thus they did not participate in this study. Compared with those who participated in this study, participants from the original trial who declined or did not respond to the study invitation were more likely to be Hispanic or Latino ($\chi^2 = 4.73$, $df = 2$, $p < .05$). No differences were found in regard to other demographic characteristics, including gender, age, degree, licensure, clinical experience, identification with CBT, supervision hours, and prior workshop attendance.

In this study, participants were primarily female ($N = 46$, 92%), ages ranged from 23 to 75, and the mean \pm SD age was 35.09 ± 10.85 . Providers self-identified as Caucasian ($N = 37$, 74%), African American ($N = 4$, 8%), Asian ($N = 4$, 8%), and other ($N = 2$, 4%). Race-ethnicity data were missing for 6% of participants ($N = 3$). Sixty-four percent ($N = 32$) had a master's degree, 18% ($N = 9$) were enrolled in a graduate program, 6% ($N = 3$) had a doctorate in philosophy, 4% ($N = 2$) had a medical degree, 4% ($N = 2$) had a doctorate in psychology, and 4% ($N = 2$) had a doctorate in education. Providers reported previous clinical experience ranging from 0 to 372 months (69.59 ± 86.85) and high identification with CBT, as rated on a Likert scale (4.77 ± 2.02 ; range 1–7). Providers reported

receiving up to 5.5 hours of supervision per week (1.29 ± 1.33) and attending up to 600 hours of workshops in the previous two years (15.97 ± 19.54).

Participants in this study represented the following training conditions in the implementation trial: routine, didactic training ($N = 22$, 44%), computer training ($N = 15$, 30%), and augmented, experiential training ($N = 13$, 26%). No significant difference was found in training condition between participants and nonparticipants. Participants enrolled in the study completed a range of 0 to 11 study consultation sessions (8.24 ± 2.26) in the implementation trial. Of note, participants completed significantly more consultation sessions than individuals who did not partake in this study (8.24 sessions versus 6.31 sessions; $t = -3.39$, $df = 113$, $p < .01$). No differences in levels of skill or adherence were found between the participants and nonparticipants at baseline, posttraining, or postconsultation in the implementation trial.

Eighty-four percent of participants ($N = 42$) reported providing therapy to young clients. Of those who reported seeing clients, 0 to 100% reported seeing clients between ages 7 and 17 (mean \pm SD $45\% \pm 32\%$), in the previous year and in the following treatment settings: outpatient or community mental health center ($N = 18$, 43%), school ($N = 17$, 40%), hospital ($N = 6$, 14%), university-based clinic ($N = 6$, 14%), private practice ($N = 4$, 9%), home-based practice ($N = 2$, 5%), and residential treatment ($N = 1$, 2%). These were not mutually exclusive categories (24% of clinicians providing therapy for youths reported working in multiple settings). At the time of follow-up, participants reported a caseload of up to 75 child clients per week (13.95 ± 15.65 per week). Providers reported implementing at least some components of CBT with 5%–100% of anxious youth clients ($89\% \pm 1\%$). Of the 50 providers who participated in the follow-up interviews, 43 (86%) reported barriers and facilitators. Of those, 35 (81%) also reported providing therapy to youth clients in the past year.

Measures

Provider Demographics and Attitudes Questionnaire. The 15-item Provider Demographics and Attitudes Questionnaire (25) gathers demographic information and assesses opinions toward use of CBT for treatment of youth anxiety, including how strongly, measured on a Likert scale, the clinician identifies with CBT, and assesses previous experience with the Coping Cat program (21,22).

Qualitative interview. Interview questions were based on similar questions used in other interview guides (26,27) and were designed to elicit information about participant experiences with implementing CBT for youth anxiety and participant perceptions of barriers to and facilitators in implementation from the time of training until the interview. The interview also included questions about the provider's primary treatment setting, the number of anxious youths treated over the past year, and the number of anxious youths

TABLE 1. Barriers to and facilitators in using a cognitive-behavioral therapy (CBT) intervention to reduce youth anxiety, by most frequently endorsed themes among 43 providers

Factor	N	%
Client		
Barriers	41	95
Stressors and comorbidities	37	86
Motivation	25	58
Age	24	56
Facilitators	15	35
Motivation	9	21
Functioning	5	12
Parent support	4	9
Intervention		
Barriers	32	74
Structure	23	53
Exposures	12	28
Length	9	21
Facilitators	36	84
Treatment components	24	56
Structure	22	51
CBT effectiveness	9	21
Organizational		
Barriers	31	72
Setting	25	58
Lack of support	15	35
No child clients	5	12
Facilitators	36	84
Support	35	81
Setting	5	12
Autonomy	3	7

treated with CBT or different interventions over the past year. An investigator (JME) and one research assistant served as interviewers. [The interview guide is available as an online supplement to this article.]

Procedure

Details regarding implementation strategies (training and consultation) used in the implementation trial can be found elsewhere (20). All procedures were approved by the Temple University Institutional Review Board. Community providers signed up for one of six training dates, each of which was randomly assigned to one of three training conditions: routine training (six-hour didactic workshop), computer training (six-hour self-paced computer training), or augmented training (six-hour experiential workshop). After training, all providers, regardless of treatment condition, participated in three months of weekly consultation sessions conducted via virtual conferencing. A detailed account of consultation content and procedures can be found in the previously published consultation study (28).

For this study, all participants in the original study (N=115) were invited to participate in a 45- to 60-minute follow-up interview. Interviews were conducted individually with consenting participants between October 2011 and April 2012 via telephone or Skype and were digitally recorded. Therapists received a \$10 gift card for participation.

Data Analysis

Digital recordings of the follow-up interviews were transcribed. Transcripts were analyzed in an iterative process according to procedures similar to those used in previous studies (26,27,29,30) and with a modified grounded-theory approach. Through a close reading of eight transcripts, the investigators developed and defined a set of codes applied to the data (grounded theory). A priori codes derived from the original research questions and previous literature (specifically, barriers and facilitators) were also applied. Rater consensus was calculated with Cohen's kappa in a subset of 20% of transcripts with rater overlap; agreement was excellent ($\kappa=.84-.99$) (31). Barriers (specifically, anything that impeded or complicated implementation of CBT for youth anxiety) and facilitators (anything that facilitated implementation) were further examined.

Through an inductive process, two raters (VAR and RSB) independently read through the barrier and facilitator codes to identify themes. Each reviewer produced memos, including examples and commentary, to reach consensus regarding newly derived, emergent themes (29,30). On further analysis, three ecological categories emerged. Raters grouped all related barrier and facilitator themes into one of the three categories and tallied the number of providers who reported different themes, categories, and overall barriers and facilitators.

RESULTS

We identified client-level, intervention-level, and organizational factors that hindered or facilitated the implementation of CBT for youth anxiety. Most providers reported client-level barriers, followed by intervention-level and organizational barriers. Providers equally endorsed intervention-level and organizational facilitators but endorsed client-level facilitators much less frequently. Table 1 includes provider counts and proportions for themes and categories. Table 2 includes representative quotations.

Client Factors

Barriers. Multiple psychosocial stressors and comorbidities, such as parental instability, poverty, and disruptive behavior disorders, emerged as the most concerning client-level barriers. Client age was reported as an important barrier. Some providers reported that younger children were more challenging to work with. Others reported that the intervention was less likely to resonate with adolescents. Providers also reported that low client motivation affected the treatment process—an issue for any intervention.

Facilitators. Client motivation appeared to be an important facilitator to the implementation of CBT for youth anxiety, albeit nonspecific to this particular evidence-based practice. Providers reported that clients' motivation greatly influenced willingness to comply with and respond to the intervention. Providers also reported that client functioning was important and that it was necessary for a child to have

a certain level of functioning with regard to intellectual abilities or ability to understand the distinctions between cognitions, feelings, and behavior.

Intervention Factors

Barriers. Although CBT for youth anxiety is a structured treatment that can be implemented flexibly (32), its structure still posed a challenge to providers. One provider reported finding the structure helpful, particularly in the beginning of learning the treatment, but acknowledged the need for flexibility. The structure of the treatment also requires providers to prepare materials in advance, which was a barrier. Exposure to feared stimuli, one of the primary components of CBT for youth anxiety, also emerged as a common barrier to implementation. Some clinicians reported not being able to use exposures in their specific settings, whereas others were reluctant to expose clients to feared stimuli.

Facilitators. Although some providers reported the intervention's structure as a barrier, others reported it to be a facilitator. Overall, providers felt that the structure served as a guide and made the intervention clear, organized, and easy to implement. Providers also reported that intervention components, such as the CBT model, concrete coping strategies, and psychoeducation, facilitated implementation.

Organizational Factors

Barriers. Providers reported various issues related to their setting. For example, it was difficult for providers in schools to implement the intervention as intended because they had less time for each session than called for in the intervention. Some providers also reported that they needed more internal support in their work setting than they were receiving.

Facilitators. Providers frequently reported support at work as a facilitator to CBT implementation. Support was often reported in the form of supervision. Providers in both school and residential settings reported that their setting was a facilitator because they had access to youths throughout the day and did not have to rely on others to bring clients to their CBT session. An interesting theme at the organizational level pertained to the level of autonomy reported by providers. This sense of autonomy was described across a number of settings (including private practice and clinics) and contributed to therapists' perception that they could apply a new treatment with youths for whom they thought it appropriate.

DISCUSSION

This study was the first, to our knowledge, to use qualitative methods to examine barriers to and facilitators in the implementation of CBT for youth anxiety in community

settings. Barriers to and facilitators in the implementation of CBT occurred at multiple ecological levels, including the client, intervention, and organizational levels. Contrary to the current focus on organizational barriers in implementation science theory, most providers in this study reported client-level factors. Specifically, therapists endorsed many barriers and few facilitators at the client level. This result suggests that providers' concerns about implementing evidence-based practices remain at a level that is most proximal to their in-session behavior with clients. The intervention's ability to be responsive to individual client differences appears to be a critical factor that impedes clinician implementation of CBT for youth anxiety.

At the client level, providers indicated that an anxiety diagnosis was often made alongside many other considerations, given that youths and their families often present complex cases. Empirical findings support this perception, given that comorbidity rates are often high across psychological disorders, particularly for anxiety disorders (33,34). Compared with youths in the general population, anxious youths in the community often present with multiple comorbid diagnoses, lower socioeconomic status, and a background from more disadvantaged neighborhoods (23,35,36). Therefore, future training and consultation for providers working in community settings should include practical tips on how to address issues relevant for youths from urban communities. Providers in this study originally received expert consultation on adapting CBT with fidelity (20); however, the findings suggest that more support and focus on adaptation may be needed (37) and that such support should be ongoing in order to address unique challenges as they arise (28).

The intervention's overall structure was reported as both a barrier and a facilitator because it helped guide therapists through each stage, although some felt hesitant to deviate from the protocol, indicating a need to emphasize and illustrate the flexible nature of manual-based interventions (32). Providers in this study found exposures difficult to implement. This difficulty is corroborated by previous work surveying providers about their use of exposures in treatment of posttraumatic stress disorder (38). Given that exposure tasks are a critical component of CBT for youth anxiety (39), future implementation efforts should be prepared to address misconceptions about the utility of exposure for youths with complex presentations, to offer innovative solutions to the challenges community providers face when trying to complete them, and to spend time using techniques such as motivational interviewing to help reluctant providers prepare for implementation of exposures.

At the organizational level, support was consistently identified as a strong influence in the implementation of CBT for youth anxiety. Providers reported that when they had internal support, it was easier to implement CBT for youth anxiety than when they did not have that support. Ongoing support has been identified as an important strategy to improve adoption of evidence-based practices (28,40).

TABLE 2. Qualitative theme examples among providers of a cognitive-behavioral therapy for youths with anxiety

Factor and theme	Example
Client barriers	
Stressors and comorbidities	<p>"I don't really think that CBT works well with people [who] have multiple stressors because there [are] so many aspects going on that it's really hard to pinpoint one or two goals to work on. And I feel like even if you identify a goal, if there are so many stressors, by the next week there's another goal. So I don't feel like it works that well."</p> <p>"I'd say it is probably less effective because there's just constant crisis to the family. So it's hard to and it's a slower process because the crises need to be worked on as they happen, so you can't get to what your plan is every session."</p> <p>"I think the only thing is that the population that I have been working with [in] my career is primarily [the] low-income, Medicaid population, and [with] the intensity of some of their [other] issues, the anxiety doesn't always seem to be the biggest, most salient issue to treat; the trauma and other issues come first."</p> <p>"[For] a lot of clients that I see, their main diagnoses are oppositional defiant disorder (ODD) and attention-deficit hyperactivity disorder (ADHD). And some of them are diagnosed with posttraumatic stress disorder, some of them are diagnosed with anxiety, some of them are diagnosed with depression, but the majority of the clients I see are ODD and ADHD. So I would say [that for] the ones [who] are diagnosed with ODD, it's quite difficult because they don't want to do any type of work in school. So when I try to use CBT and do these different activities with them, they don't have the patience or the compliance to really be able to sit through an entire session."</p>
Motivation	"Well certainly the . . . patient willingness to participate. . . . We also treat a number of adolescents, and as those kids get older, they seem less willing to . . . practice, especially the physical stuff like the breathing exercises or progressive muscle relaxation. I don't know if they just felt awkward, but they seem less willing to [do] that, so . . . just my trying to explain what we were doing and [their] kind of accepting the modality was the most difficult thing."
Age	<p>"You know it's just hard to get it across [with] young children. I find that really hard." Another provider commented, "With the older youth [kind of] being more urban and hip-hop-ish. They don't [want to] do stuff that's corny, or . . . it's considered childish or not cool."</p> <p>"It works very well with 3rd, 4th and 5th graders, so . . . 9, 10, and 11 year-olds, but [at] 6, 7, and 8 it's more difficult—because they're not always aware of what the negative or anxious thoughts are. And they have a more difficult time labeling them."</p>
Client facilitators	
Motivation	"I guess from before when the client appears to be motivated and [wants] to work towards it, it works really well. . . . You know if the client wants to, they respond to it really well . . . so I guess, again, the motivation part."
Functioning	"Well I would say it's easier obviously if you have someone with reasonable functioning who can process and who can differentiate between their thoughts and their feelings."
Intervention barriers	
Structure	"Well personally, especially in the beginning, I do like it because it gives me a sense of what I should be doing, and it's very helpful. However, I think it can be hurtful if—I have to remind myself not to rely on that so much and that sometimes you need to alter things."
Exposures	"So I didn't really get to that with a lot of my kids. . . . I don't think that I was able to do any of the actual exposures. . . . But I think that is really an important piece of the process as long as you have done the base work for it, kind of prepping kids for that, but I don't think that I actually got to do that work with any of my kids [because they] fell off before we were able to get to that point. They either stopped coming or they weren't coming consistently enough for me to feel ok about doing an exposure with them and maybe not seeing them next week. I felt like it was really important if you were to start doing that work to know for sure that they were going to be there the next week for us to process it and . . . you know, I'm thinking that was kind of an obstacle for them."
Intervention facilitators	
Treatment components	"For the people I worked with, it was really developing coping skills, . . . and so I think that recognizing signs of anxiety and trying to problem solve around addressing those [problems] worked best. . . . The first part, the psychoeducation and the recognition of what was going on with them, was helpful."
Structure	<p>"I think in terms of being helpful, again, I like when you explain it to [students] how their thoughts are connected to how they feel and connected to how they behave, how it is all connected, I think a light bulb goes off. So I think it really kind of helps them take control of that and see how they are in control and they have power, and I think that that could really make some positive changes for some kids."</p> <p>"For me, I love the fact that it was mapped out and felt organized—like right around the fourth session, you should have the family involvement, that kind of thing. I like the guidance that it gave me. It was clear, it mapped out for me, and I had the materials right there for me."</p> <p>"I think the structure is beautiful. . . . It was very clear when it was laid out . . . the first session you should be doing this, second session you should be doing this. . . . That helped me have a map."</p>

continued

TABLE 2, *continued*

Factor and theme	Example
Organizational barriers	
Setting	"My thoughts are changed. . . . When I first received the training, I thought I would be able to incorporate it more easily into my specific job, in a school-based setting. But I tried to do that, and it wasn't always as successful as I wanted it to be. And then I felt like if I were to have the specified time, you know, one hour each week with the client, I would be able to do it much better. So really just the chaotic nature of the job that I have really impeded [my] being able to successfully do the sessions consecutively."
Lack of support	"The support, the supervision, was lacking, so that made it more difficult to do a new practice that I wasn't familiar with. And there was not anything specific like policies or financial issues . . . , except for maybe buying of rewards and things like that. . . . I was financially struggling with that. I did a lot of that on my own. So that was a challenge."
Organizational facilitators	
Support	"[Management] definitely support[s] it. . . . Through supervision, they encourage the use of CBT, they provide written materials for my training purposes, they also teach and help role play different therapy situations, and then they also bring in speakers to provide . . . training opportunities or group supervision where we will watch videotape and discuss different CBT strategies." "Our supervisor actually went through the training as well. So she was really clear about [our] being able to talk about the training, and how things are going, and got supervision through her . . . That was really helpful." "My supervisor has been appreciative and supportive of my work with kids with anxiety, so that's increased how many kids I've worked with who have anxiety. [My supervisor] has been meeting with parents. . . . She will talk to parents about my work with the child and suggest that I have sessions with the child."
Setting	"I think [CBT is easier to implement], even in the short time that I have been in my new position, because I have a greater aspect [of] the kids because I see them every day; even if I don't see them for treatment every day, they are in school every day, so it's a lot easier to implement it." Another provider described her students as a "captive audience," saying, "Because they're at school, they can't go anywhere. I don't have to rely on the parents bringing them on time, keeping the appointment, forgetting to pick them up, or picking them up late." "I think because I work with kids who are in residential care, all of the policies and procedures support their treatment and their therapy. So their attendance is not an issue, their participation generally I have no problems with; we also have kind of a wraparound model where we use all the other supports—the group therapy, the family therapy, the psychoeducational skills group—as adjunctive therapies to the individual work, and that supports the CBT process."
Autonomy	"Considering 90% of my work is self-employed, I get to do whatever I want. [But also at] the fee-for-service [facility], we are all CBT-geared, so I am pretty much my own boss. So I make up my own policies." "In my full-time job . . . I have a lot of flexibility to decide types of programs or methods I would like to use with kids. In my private practice, I have no boss, I get to use whatever I want." "In terms of the administration, the nice thing is . . . I'm supported in whatever I do. So it is kind of nice, and I can really be very creative in what I do with students, and no one objects."

Many providers already receive supervision in the community, although the content of this supervision is largely unknown (41). The potential for already existing and available supervision to provide support for the implementation of evidence-based practices is an important area for future research (42).

The factors identified in this study are consistent with various implementation frameworks, such as the exploration, preparation, implementation, and sustainment framework (10). This framework delineates the importance of inner context factors (organizational and client-level factors), innovation characteristics (intervention factors), and fit between innovation and the organization. Other frameworks supported by this study include the consolidated framework for implementation research (11) and the mental health system ecological model (13).

Despite a number of strengths, this study was not without limitations. The retrospective report likely limited participants' memories of their experience of barriers and facilitators over

the previous two years. In addition, not all participants from the initial study were available or willing to be interviewed for this follow-up study. Differences were found between those who participated in the follow-up and those who did not with regard to race-ethnicity and participation in consultation during the training study, which calls into question whether the findings are representative of the full sample. There is also a possibility of response bias, in that the experiences of those who responded and those who did not may have differed on the basis of other variables, such as providers' implementation rates; that is, clinicians who responded may have implemented the CBT intervention more than those who did not respond. In addition, client data that may have an impact on treatment, such as medication use, were not collected. Finally, the generalizability of this sample beyond providers in a large Northeastern city who volunteer to receive training in an evidence-based practice is unknown.

CONCLUSIONS

This study provides important insights into barriers and facilitators experienced by providers when implementing CBT for youth anxiety in community settings. Client, intervention, and organizational themes were identified as important. Findings revealed the varied perspectives of providers; what served as a barrier for some providers served as a facilitator for others (such as the structure of CBT). Future investigations should examine the complex interplay among multilevel factors to determine whether training should be tailored for providers according to their unique set of multilevel factors. Further, the findings of this study provide important information that should be considered in future implementation trials of evidence-based practices. In particular, future implementation trials of CBT for youth anxiety should consider the need to provide adequate support to providers over time to help them flexibly adapt CBT for use with clients who present complex cases in varied settings and to maintain fidelity to treatment principles.

AUTHOR AND ARTICLE INFORMATION

Ms. Ringle is with the Department of Psychology, University of Miami, Coral Gables, Florida (e-mail: vanesa.ringle@gmail.com). Ms. Read, Mr. Brodman, and Dr. Kendall are with the Department of Psychology, Temple University, Philadelphia. Dr. Edmunds is with Judge Baker Children's Center, Boston. Dr. Barg is with the Department of Family Medicine and Community Health and Dr. Beidas is with the Department of Psychiatry, both at the University of Pennsylvania Perelman School of Medicine, Philadelphia.

Dr. Kendall receives royalties from Guilford Press and Workbook Publishing. Dr. Beidas receives royalties from Oxford University Press and has served as a consultant for Kinark Child and Family Services. The other authors report no financial relationships with commercial interests.

Funding for this research project was supported by the following grants from the National Institute of Mental Health (NIMH): MH083333 and MH099179 (Dr. Beidas) and MH086438 (Dr. Kendall). In addition, the preparation of this article was supported in part by the Implementation Research Institute (IRI) at the George Warren Brown School of Social Work, Washington University in St. Louis; by NIMH award R25 MH080916; and by the Quality Enhancement Research Initiative, U.S. Department of Veterans Affairs contract, Veterans Health Administration, Office of Research & Development, Health Services Research & Development Service. Dr. Beidas was an IRI fellow 2012–2014.

Received March 26, 2014; revisions received September 7 and November 15, 2014; accepted January 5, 2015; published online May 15, 2015.

REFERENCES

- Merikangas KR, He JP, Brody D, et al: Prevalence and treatment of mental disorders among US children in the 2001–2004 NHANES. *Pediatrics* 125:75–81, 2010
- Report of Healthy Development: A Summit on Young Children's Mental Health. Washington, DC, Society for Research in Child Development, April 1, 2009. Available at www.apa.org/pi/families/summit-report.pdf
- Achieving the Promise: Transforming Mental Health Care in America. Pub no SMA-03-3832. Rockville, Md, Department of Health and Human Services, President's New Freedom Commission on Mental Health, 2003
- Policy Statement on Evidence-Based Practice in Psychology. Washington, DC, American Psychological Association, August 2005. Available at www.apapracticentral.org/ce/courses/ebp-statement.pdf
- McHugh RK, Barlow DH: The dissemination and implementation of evidence-based psychological treatments: a review of current efforts. *American Psychologist* 65:73–84, 2010
- Aarons GA, Cafri G, Lugo L, et al: Expanding the domains of attitudes towards evidence-based practice: the Evidence Based Practice Attitude Scale–50. *Administration and Policy in Mental Health and Mental Health Services Research* 39:331–340, 2012
- Borntrager CF, Chorpita BF, Higa-McMillan C, et al: Provider attitudes toward evidence-based practices: are the concerns with the evidence or with the manuals? *Psychiatric Services* 60:677–681, 2009
- Jensen-Doss A, Hawley KM: Understanding barriers to evidence-based assessment: clinician attitudes toward standardized assessment tools. *Journal of Clinical Child and Adolescent Psychology* 39:885–896, 2010
- Nakamura BJ, Higa-McMillan CK, Okamura KH, et al: Knowledge of and attitudes towards evidence-based practices in community child mental health practitioners. *Administration and Policy in Mental Health and Mental Health Services Research* 38:287–300, 2011
- Aarons GA, Hurlburt M, Horwitz SM: Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research* 38:4–23, 2011
- Damschroder LJ, Aron DC, Keith RE, et al: Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science* 4:50, 2009
- Fixsen DL, Blase KA, Naoom SF, et al: Core implementation components. *Research on Social Work Practice* 19:531–540, 2009
- Southam-Gerow MA, Rodriguez A, Chorpita BF, et al: Dissemination and implementation of evidence based treatments for youth: challenges and recommendations. *Professional Psychology: Research and Practice* 43:527–534, 2012
- Proctor E, Silmere H, Raghavan R, et al: Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research* 38:65–76, 2011
- Aarons GA, Wells RS, Zagursky K, et al: Implementing evidence-based practice in community mental health agencies: a multiple stakeholder analysis. *American Journal of Public Health* 99:2087–2095, 2009
- Langley AK, Nadeem E, Kataoka SH, et al: Evidence-based mental health programs in schools: barriers and facilitators of successful implementation. *School Mental Health* 2:105–113, 2010
- Beidas RS, Edmunds J, Ditty M, et al: Are inner context factors related to implementation outcomes in cognitive-behavioral therapy for youth anxiety? *Administration and Policy in Mental Health and Mental Health Services Research* 41:788–799, 2014
- Glisson C, Green P: Organizational climate, services, and outcomes in child welfare systems. *Child Abuse and Neglect* 35:582–591, 2011
- Glisson C, Hemmelgarn A, Green P, et al: Randomized trial of the Availability, Responsiveness and Continuity (ARC) organizational intervention for improving youth outcomes in community mental health programs. *Journal of the American Academy of Child and Adolescent Psychiatry* 52:493–500, 2013
- Beidas RS, Edmunds JM, Marcus SC, et al: Training and consultation to promote implementation of an empirically supported treatment: a randomized trial. *Psychiatric Services* 63:660–665, 2012
- Kendall PC, Hedtke K: *Cognitive-Behavioral Therapy for Anxious Children: Therapist Manual*. Ardmore, Pa, Workbook Publishing, 2006

22. Kendall PC, Hedtke K: Coping Cat Workbook. Ardmore, Pa, Workbook Publishing, 2006
23. Southam-Gerow MA, Weisz JR, Chu BC, et al: Does cognitive behavioral therapy for youth anxiety outperform usual care in community clinics? An initial effectiveness test. *Journal of the American Academy of Child and Adolescent Psychiatry* 49: 1043–1052, 2010
24. Beidas RS, Mychailyszyn MP, Edmunds JM, et al: Training school mental health providers to deliver cognitive-behavioral therapy. *School Mental Health* 4:197–206, 2012
25. Beidas R, Barmish A, Kendall P: Training as usual: can clinician behavior change following reading a manual and attending a brief workshop on cognitive behavioral therapy for youth anxiety? *Behavior Clinician* 32:97–101, 2009
26. Beidas RS, Edmunds JM, Cannuscio CC, et al: Therapists perspectives on the effective elements of consultation following training. *Administration and Policy in Mental Health and Mental Health Services Research* 40:507–517, 2013
27. Stirman SW, Miller CJ, Toder K, et al: Development of a framework and coding system for modifications and adaptations of evidence-based interventions. *Implementation Science* 8:65, 2013
28. Edmunds JM, Beidas RS, Kendall PC: Dissemination and implementation of evidence-based practices: training and consultation as implementation strategies. *Clinical Psychology: Science and Practice* 20:152–165, 2013
29. Hill CE, Knox S, Thompson BJ, et al: Consensual qualitative research: an update. Milwaukee, Wis, Marquette University e-Publications, 2005. Available at epublications.marquette.edu/cgi/viewcontent.cgi?article=1017&context=edu_fac
30. Hill CE, Thompson BJ, Williams EN: A guide to conducting consensual qualitative research. *Counseling Psychologist* 25:517–572, 1997
31. Landis JR, Koch GG: The measurement of observer agreement for categorical data. *Biometrics* 33:159–174, 1977
32. Kendall PC, Beidas RS: Smoothing the trail for dissemination of evidence-based practices for youth: flexibility within fidelity. *Professional Psychology: Research and Practice* 38:13–20, 2007
33. Kendall PC, Compton SN, Walkup JT, et al: Clinical characteristics of anxiety disordered youth. *Journal of Anxiety Disorders* 24: 360–365, 2010
34. Verduin TL, Kendall PC: Differential occurrence of comorbidity within childhood anxiety disorders. *Journal of Clinical Child and Adolescent Psychology* 32:290–295, 2003
35. Ehrenreich-May J, Southam-Gerow MA, Hourigan SE, et al: Characteristics of anxious and depressed youth seen in two different clinical contexts. *Administration and Policy in Mental Health and Mental Health Services Research* 38:398–411, 2011
36. Beidas RS, Suarez L, Simpson D, et al: Contextual factors and anxiety in minority and European American youth presenting for treatment across two urban university clinics. *Journal of Anxiety Disorders* 26:544–554, 2012
37. Stirman SW, Gutiérrez-Colina A, Toder K, et al: Clinicians' perspectives on cognitive therapy in community mental health settings: implications for training and implementation. *Administration and Policy in Mental Health and Mental Health Services Research* 40: 274–285, 2013
38. Becker CB, Zayfert C, Anderson E: A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. *Behaviour Research and Therapy* 42:277–292, 2004
39. Kendall PC, Robin JA, Hedtke KA, et al: Considering CBT with anxious youth? Think exposures. *Cognitive and Behavioral Practice* 12:136–148, 2006
40. Nadeem E, Gleacher A, Beidas RS: Consultation as an implementation strategy for evidence-based practices across multiple contexts: unpacking the black box. *Administration and Policy in Mental Health and Mental Health Services Research* 40:439–450, 2013
41. Accurso EC, Taylor RM, Garland AF: Evidence-based practices addressed in community-based children's mental health clinical supervision. *Training and Education in Professional Psychology* 5: 88–96, 2011
42. Dorsey S, Pullmann MD, Deblinger E, et al: Improving practice in community-based settings: a randomized trial of supervision—study protocol. *Implementation Science* 8:89, 2013