Supplement 1.

Boolean Search Terms

((implementation OR dissemination OR fidelity OR adherence OR diffusion OR adoption OR sustainability OR sustainment) AND (mental health OR mental illness OR mental disorders OR psychopathology OR adjustment disorders OR anxiety disorders OR agoraphobia OR panic disorder OR phobia OR posttraumatic stress disorder OR trauma OR abuse OR neglect OR generalized anxiety disorder OR obsessive compulsive disorder OR reactive attachment disorder OR separation anxiety disorder OR eating disorder OR anorexia nervosa OR bulimia OR attention deficit hyperactivity disorder OR conduct disorder OR oppositional defiant disorder OR depression OR depressive disorder OR bipolar disorder OR mania OR dysthymic disorder OR substance use disorder OR alcohol dependence OR drug dependence OR cannabis dependence OR marijuana dependence OR nicotine dependence OR intoxication OR withdrawal OR autistic disorder OR asperger's disorder OR pervasive developmental disorder OR tic disorder OR tourette's disorder OR schizophrenia OR psychotic disorder OR mental retardation OR learning disorder OR reading disorder OR dyslexia OR mathematics disorder OR disorder written expression OR developmental coordination disorder OR expressive language disorder OR mixed receptive-expressive language disorder OR phonological disorder OR stuttering OR encopresis OR enuresis OR delirium OR personality disorder) AND (child OR adolescent OR adolescence OR children OR youth OR youths) AND NOT (diffusion tensor))

Table S1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Systematic Review Checklist[1]

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	X
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	X
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	X
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	X
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	N/A
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	X
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	X
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	X
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	X
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	X
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	X

Section/topic	#	Checklist item	Reported on page #
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	N/A
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	N/A
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	N/A
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	N/A
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	N/A
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	X
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	X
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	N/A
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	N/A
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	N/A
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	N/A

Section/topic	#	Checklist item	Reported on page #
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	N/A
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	X
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	X
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	X
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	X
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	N/A

Table 2S. Summary of Studies of Evidence-Based Practice (EBP) Dissemination and Implementation in Youth Mental Health

Paper	EPIS Stage	Prevention / Treatment	Treatment/ Practice Studied	Treatment/ Practice Setting	Contextual Focus	Intervention	Research Design	Unit(s) of Analysis	n
Aarons and Sawitzky, 2006[2]	Preparation	Treatment	Multiple	Mental health clinics	Inner (organizational-culture/climate)	None	Descriptive-quantitative (provider survey)	Multiple-provider, mental health programs	301/49
	Summary: Constructive organizational culture was associated with more positive attitudes towards EBP adoption, while poor organizational climates (Defensive) was associated with perceived divergence of usual practice and EBP. Interns reported more positive attitudes towards EBPs than employees.								
Aarons *et al.*, 2009[3]	Implementation	Prevention	SafeCare	Home-based (Child welfare)	Inner (organizational; provider; fidelity)	2x2 RCT: Safecare versus care as usual x fidelity monitoring vs. no monitoring	RCT	Multi-organization, provider (organization dropped from final analyses)	153/25
	Summary: In multivariate model analyses, Safecare plus fidelity monitoring had higher staff retention rates than Safecare plus no monitoring. Older age, greater perceived job autonomy, and lower expressed intention to leave their job also positively correlated with higher staff retention rates.								
Aarons *et al.*, 2009[4]	Implementation Sustainment	Prevention	SafeCare	Child welfare	Inner (organizational; provider; fidelity; coaching)	2x2 RCT: Safecare versus care as usual x fidelity monitoring vs. no monitoring	RCT	Multiple-agencies/providers (analyses Were conducted to address clustering of providers in programs)	21/99
	Summary: Providers in programs implementing Safecare had lower levels of emotional exhaustion. Significant predictors of emotional exhaustion included age (older=less emotional exhaustion) and caseload (higher=greater emotional exhaustion).								
Aarons *et al.*, 2009[5]	Preparation Implementation	Treatment	Multiple	Mental health clinics	Outer (sociopolitical; funding; consumer), Inner (adopter; organizational; EBP fit)	None	Descriptive-qualitative (focus groups)	Single-Focus Group	6
	Summary: Analyses identified 14 factors/dimensions important for the adoption and implementation of EBPs in public mental health services. These factors include inner (adopter characteristics) and outer contexts (funding and costs) as well as characteristics of the intervention itself.								
Aarons, and Palinkas, 2007[6]	Implementation Sustainment	Prevention	SafeCare	Child welfare	Inner (organizational-leadership; EBP fit) Outcomes (family)	None	Descriptive-qualitative	Single-case managers	17
	Summary: Critical determinants of EBP implementation included acceptability to the caseworker and family, suitability to the family's needs, caseworker motivations for using the EBP, training experiences with the EBP, organizational support for implementation, and the EBP's impact on process and service outcomes.								
Aarons, 2006[7]	Preparation	Treatment	Multiple	Mental health clinics	Inner (organizational-leadership; provider)	None	Descriptive-quantitative (provider survey)	Multiple-provider, mental health programs	303/49
	Summary: Higher ratings of supervisors' transformational and transactional leadership skills were associated with positive attitudes towards EBPs. Interns and individuals with shorter job tenures had more positive attitudes towards EBPs.								

Asgary-Eden and Lee 2011[8]	Preparation Implementation	Prevention	Triple P-Positive Parenting Program	Mental health clinics	Outer (training), Inner (organizational-climate, leadership)	Impacts of a prior training effort	Descriptive-quantitative (provider and administrator survey)	Multiple -administrator, provider (analyzed separately)	113/214
Summary: 70% of the trained service providers delivered the intervention with an average adherence percentage of 86%. No variables predicted intervention use, but agency characteristics (organizational climate, staff characteristics, supervisor characteristics) predicted greater implementation fidelity.									
Asgary-Eden and Lee 2011[9]	Preparation Implementation	Prevention	Triple P-Positive Parenting Program	Mental health clinics	Intervention, Outer (sociopolitical), Inner (organizational)	Impacts of a prior training effort	Descriptive-quantitative (provider and administrator survey)	Multiple -administrator, provider (analyzed separately)	63/215
Summary: Similar to companion paper, most programs adopted the program but a significant minority did not (26%). Adherence rates were very high (86%). Perceived time limitations or lack of relevance of intervention to certain activities were associated with non-adherence.									
Barwick *et al.*, 2009[10]	Implementation	Treatment	CAFAS	Mental health clinics	Inner (organizational)	Use of a community of practice approach for improving adherence to use of the CAFAS	RCT	Single - provider (randomization was done by organization, which was not addressed in the analysis)	37/(6)
Summary: Providers working in organizations using a Community of Practice implementation model had higher rates CAFAS use; their knowledge regarding the CAFAS increased over time while those in the Practice as Usual programs decreased.									
Beidas *et al.*, 2012[11]	Implementation	Treatment	CBT for anxiety	Mental health clinicians in private practice	Outer (training)	Three different initial training workshops (routine, computerized, and routine augmented with active learning principles)	RCT	Single - provider	115
Summary: Based on the Adherence and Skill Checklist, the three workshops did not show significant differences in adherence, skill, and knowledge; however, participants preferred the in-person over the computerized training. Follow-up played a critical role with adherence and skill but was not a part of the randomized design.									
Carstens *et al.* 2009[12]	Preparation	Treatment	Multisystemic Therapy	Mental health clinics	Outer (sociopolitical; leadership; funding; interorganizational networks)	None	Descriptive-qualitative	Single-service systems	13
Summary: Alliances that adopted MST had done more system of care collaboration and planning, felt they had the financial resources to deliver MST, benefited from stronger collaborative planning activities, and described the presence of entrepreneurial leadership.									
Chapman and Schoenwald 2011[13]	Implementation	Treatment	Multisystemic Therapy	Mental health clinics	Inner (provider; fidelity)	None	Descriptive-Quantitative	Multi-organization, provider, youth and caregiver	1979/429/45
Summary: Ethnically similar caregiver-therapist pairs had higher adherence ratings, which, in turn, predicted slightly better outcomes for youth.									
Chu and Kendall, 2009[14]	Implementation	Treatment	CBT for anxiety	Mental health clinic	Inner (provider; fidelity) Outcomes (patient)	None	Descriptive-Quantitative	Single - youth (provider and clinical trial levels not addressed in analyses)	63/(16)/(3)
Summary: Greater flexibility in implementing CBT was associated with greater child involvement later phases of treatment; greater child involvement was predictive of better treatment outcomes.									

Cross *et al.*, 2010[15]	Implementation	Prevention	All Stars	Schools	Inner (organizational-climate; training; provider; turnover)	None	Descriptive-Mixed methods (primarily quantitative)	Single - school	5
	Summary: Analyses suggested that the quality of implementation varied across the 5 schools and that the 2 schools with the highest quality implementation had higher youth attendance in the program and better development of social skills.								
Di Noia *et al.* 2003[16]	Exploration	Prevention	Multiple	Schools, community agencies	Outer (Information transmission)	3 different dissemination strategies (pamphlet, CD, internet)	RCT	Single-provider	188
	Summary: Exploration impacts (accessibility of materials, self-efficacy to select/recommend an intervention, and behavioral intentions to encourage adoption of interventions) was stronger in the internet group, intermediate in the CD-ROM group, and weakest in the pamphlet group.								
Ellis *et al.*, 2010[17]	Implementation	Treatment	Multisystemic Therapy	Schools	Inner (provider; fidelity), Outcomes (parent)	None	Descriptive-Quantitative	Single- youth (provider and school levels not specified or described)	82/(?)/(?)
	Summary: Parent-reported parent/family characteristics (in particular parental psychopathology, motivation, treatment expectations, and child rearing practices) at baseline were statistically predictive of parent-reported therapist adherence to MST principles during treatment.								
Ennett *et al.*, 2011[18]	Implementation	Prevention	Multiple	Schools	Inner (organizational; provider; fidelity) Outcomes (youth)	None	Descriptive-Quantitative (staff survey)	Single - school	342
	Summary: Rates of fidelity were low overall - almost no providers were coded as fully demonstrating fidelity in all five domains. However, fidelity was high for quality of delivery and participant responsiveness; low for program differentiation; and modest for adherence and exposure (the latter representing the two core domains of fidelity).								
Epstein *et al.*, 2007[19]	Preparation Implementation	Treatment	Stimulant Medication Dosage Determination Support	Primary care clinics	Inner (provider; fidelity; coaching)	A pre-packaged and specialist-supported titration trial to determine optimal methylphenidate dose in children with ADHD	RCT	Multiple-patient, provider, practice (note patient and provider levels dropped from key analyses)	145/52/12
	Summary: Availability of the titration service increased the use of titration trials but not the monitoring of ADHD symptoms, and it did not impact ADHD symptomatology overall. However, patients who actually received this service received higher stimulant doses and experienced greater improvement in symptoms.								
Epstein *et al.*, 2008[20]	Implementation	Treatment	AAP ADHD Guidelines	Primary care clinics	Outer (training); Inner (provider; fidelity)	Quality improving intervention for improving adherence to AAP ADHD treatment guidelines.	Quasi-Experimental (pre-post)	SIngle-practices, providers (analysis at provider level only)	(19)/84
	Summary: The intervention yielded substantial improvement in guidelines use. Parent and teacher assessment rating scales use increased from 52-55% to nearly 100%. Systematic monitoring of responses to medication improved from 9% to 40%. Qualitative data suggests that adherence declined over time in some clinics.								
Fagen *et al.*, 2009[21]	Implementation	Prevention	Violence, unsafe sex, and drug prevention-- "Aban Aya Youth Project"	Schools	Inner (organizational; training; supervision)	None	Descriptive-mixed (predominantly qualitative)	Single-School	5

	Summary: Study results showed uneven implementation of this parent-centered intervention across the five schools, and this finding was largely attributed to parent educator preparation and parent educator-health educator relations. The intervention's implementation did not stabilize after one year.								
Foster and Stiffman, 2009[22]	Preparation Sustainment	Treatment	Decision Support System	Social services	Inner (organizational; provider)	System provided via personal digital assistant (PDA) or PDA plus desktop computer	Randomized Experimental/descriptive -mixed methods	Single-provider	28
	Summary: Quantitative results found that device usage increased, peaked, then declined and having the PDA and the desktop increased use. Qualitative results suggested that successful adoption of decision support systems requires 1) integration into the referral system, including workers' knowledge and experiences with referral resources; and 2) consideration of the natural flow of worker interaction and organizational constraints.								
Garner *et al.*, 2011[23]	Implementation	Treatment	Adolescent Community Reinforcement Approach (A-CRA) and Assertive Continuing Care (ACC).	Substance abuse treatment clinics	Inner (organizational)	Pay for performance (payments for receiving a rating of at least minimal competency on an audio session recording and for each adolescent receiving a targeted threshold of treatment)	RCT	Multiple - providers and agency	95/29
	Summary: Therapists in the pay for performance condition reported significantly greater intentions to achieve each of the two quality targets (to achieve monthly intervention competence and to deliver the intervention at a targeted threshold level) during the first 3 months of the experiment.								
Glisson *et al.* 2010[24]	Implementation	Treatment	MST and ARC (availability, responsiveness and continuity)	Mental health clinics	Inner (organizational-culture/climate)	Organizational intervention (ARC) that addresses services barriers, training in principles of effective service systems, and facilitates the development of flexibility, openness, and engagement among providers	RCT	Multiple - youth, providers, counties (number of providers not specified, but this level was included in analyses)	615/?/14
	Summary: At 6-month follow-up youth total problem behavior in the MST plus ARC condition was at a nonclinical level; significantly lower than in other conditions. At 18-month follow-up youth in the MST plus ARC condition entered out-of-home placements at a significantly lower rate than in the other conditions.								
Glisson *et al.*, 2008[25]	Implementation Sustainment	Treatment	Non-specific	Mental health clinics	Inner (organizational-climate/culture)	None	Descriptive-quantitative	Single-clinic directors	100
	Summary: Organizational culture best predicted new program sustainment while organizational climate and service structure best explained therapist turnover. Clinics with separate children's service units had higher turnover rates than clinics serving adults and children within the same unit.								
Goldberg *et al.*, 2004[26]	Implementation	Prevention	Life Skills Training and Strengthening Families Program	Schools	Inner (provider; fidelity)	None	Descriptive-Quantitative (using data collected as part of an RCT)	Parallel single - classroom or youths (levels of school and RCT arm not addressed; no hierarchical modeling). Precise number of participants at each level is not specified.	?/?

	Summary: For those classroom lessons that were evaluated by an observer, the implementation assessment correlation between providers and observers was .80 . Providers rated their implementation as better than observers. Only observer ratings predicted youth substance use outcomes.								
Hamilton *et al.*, 2011[27]	Implementation	Treatment	Multiple	Mental health clinics	Outer (sociopolitical, funding, leadership); Inner (organizational; EBP fit)	None	Descriptive-Qualitative	Multiple-source ethnographic (interviews, focus groups, meeting minutes, emails) in 1 clinic	(33)/1
	Summary: Because organizations were rated on access to care rather than EBP implementation by external reviewers, these assessments interfered with the implementation of EBPs.								
Hanbury *et al.* 2011[28]	Implementation	Prevention	Suicide Prevention Guidelines	Mental health clinics	Inner (organizational; provider)	Staff training to improve adherence to mandated suicide prevention guidelines	Quasi-experimental (time series)/Descriptive-mixed methods	Multiple-provider, clinical teams	93/8
	Summary: Training did not increase adherence with no change in targeted behavioral norms. Qualitative analyses indicated that the intervention, while well-received, failed to include inpatient staff, thereby reducing its impact.								
Henderson *et al.*, 2006[29]	Preparation Implementation	Prevention	The Arson Prevention Program for Children (TAPP-C)	Mental health clinics	Intervention, Outer (training), Inner (adopter).	Survey responses from mental health professionals who had participated in a TAPP-C educational event	Descriptive-quantitative (provider survey)	Single-provider	210
	Summary: Although 82% of providers chose to adopt the intervention, only 29% reported routine levels of implementation. Adoption was associated with perceived compatibility of the intervention with the provider's organization. Implementation was associated with provider sense of self-efficacy and educational exposure.								
Henderson *et al.*, 2008[30]	Preparation	Treatment	Multiple	Criminal justice programs	Outer (inter-organizational networks), Inner (organizational-leadership)	None	Descriptive-quantitative	Single-Programs	263
	Summary: Organizational structure, management's emphasis on the quality of treatment, training and resources variables as well as administrators' attitudes predicted EBP use. Connections to inter-organizational networks showed the strongest relationship with EBP use.								
Henderson *et al.*, 2009[31]	Preparation	Treatment	Multiple	Criminal justice programs	Outer (funding, inter-organizational networks), Inner (organizational-leadership)	None	Descriptive-quantitative	Multiple-program directors, state executives	420/93
	Summary: Systems integration at the state level was associated with greater EBP use, state staffing adequacy and stability accentuated the association between local training and resources for new programs and EBP use. State executives' attitudes regarding the missions and goals of corrections tended to diminish the extent to which corresponding local administrator attitudes were associated with EBP use.								
Henderson *et al.*, 2010[32]	Preparation Implementation	Prevention	The Arson Prevention Program for Children (TAPP-C)	Home-based	Outer (training; inter-organizational networks), Inner (provider)	Impacts of a prior dissemination effort	Descriptive-quantitative (provider survey)	Single-Provider	241
	Summary: Adoption was related to provider sense of self-efficacy, educational exposure to the intervention, and consultation with mental health professionals. Implementation was related to educational exposure and fire service consultation for the fire service component; mental health consultation for the mental health component.								

Henggeler *et al.*, 1997[33]	Implementation	Treatment	Multisystemic Therapy	Mental health clinics	Inner (provider; fidelity)	Implementation of MST without fidelity measures compared to care as usual (and MST with fidelity measures drawing on prior publications)	RCT	Multiple - clinics/therapists/ youth	2/4/155
	Summary: Modest outcomes were achieved when not considering fidelity to MST, especially when compared to prior MST trials that included fidelity monitoring. Parent and adolescent ratings of treatment adherence predicted low rates of rearrest; and therapist ratings of treatment adherence and treatment engagement predicted decreased self-reported index offenses and low probability of incarceration, respectively								
Henggeler *et al.*, 2002[34]	Implementation	Treatment	MST	Mental health clinics	Inner (organizational; provider; fidelity)	None	Descriptive-Quantitative	Multiple-supervisors/therapists/ youths	285/74/ 12
	Summary: Supervisor experience with MST and other EBPs was associated with therapist fidelity to MST. Supervisor focus on the analytic process/treatment principles and developing therapist competencies was associated with lower therapist fidelity.								
Henggeler *et al.*, 2008[35]	Implementation Sustainment	Treatment	Contingency Management within the context of MST	Mental health and substance abuse clinics	Outer (training); Inner (organizational; provider; fidelity; coaching)	Workshop training + intensive quality assurance vs. workshop training only	RCT	Multiple-provider/caregiver-youth	30/70
	Summary: Workshop plus intensive quality assurance was more effective than workshop only at increasing practitioner implementation of contingency management techniques in the short-term based on youth and caregiver reports, and these increases were sustained based on youth reports.								
Henggeler *et al.*, 2008[36]	Preparation Implementation	Treatment	Contingency Management	Mental health and substance abuse clinics	Outer (training), Inner (provider; organizational-climate)	Survey responses from mental health and substance abuse professionals who attended a 1-day contingency management workshop (monthly for six months).	Descriptive-quantitative (provider survey)	Multiple - provider, agency	225/44
	Summary: 58% of practitioners used CM; rates of adoption increased over the 6-month study period. Correlates of adoption included provider and organizational factors. Barriers to adoption included competing clinical priorities and lack of youth and family engagement. Fidelity of implementation of both the cognitive component and the monitoring component of CM were associated with both provider and organizational characteristics								
Herschell *et al.*, 2009[37]	Implementation	Treatment	PCIT	Mental health clinics	Outer (training)	"Experiential" versus "didactic (including role playing)" training	Experimental (non-random assignment)	Single-Provider	42
	Summary: Reading the manual resulted in statistically significant improvements in knowledge and skills, but did not result in material mastery. Both experiential and didactic methods resulted in significant increases in skills with no significant differences between these training methods.								
Hoagwood *et al.*, 2006[38]	Implementation Sustainment	Treatment	CBT	Mental health clinics	Outer (inter-organizational networks); Inner (organizational-leadership, culture)	None	Descriptive-mixed methods (primarily quantitative)	Single - therapists	not reported

	Summary: Five key factors facilitated implementation: 1) early adoption and guidance by innovative leaders; 2) attention to the "fit" between the intervention and local practices; 3) attention to front-end implementation processes (e.g., cultural adaptation, translation, training, fiscal issues); 4) attention to back-end processes early in the project (e.g., sustainability); and 5) establishing strong relationships with multiple stakeholders within the program setting.								
Holth *et al.*, 2011[39]	Implementation Sustainment	Treatment	Multiple (MST, contingency management)	Mental health and substance abuse clinics	Outer (training); Inner (organizational; provider; fideilty; coaching)	Workshop training + intensive quality assurance vs. workshop training only	RCT	Multiple-supervisor/provider	21/41
	Summary: Compared to workshop only, intensive quality assurance enhanced therapist adherence to CBT techniques but not to contingency management. Cannabis abstinence increased as a function of time in therapy and was more likely with stronger adherence to contingency management.								
Jensen-Doss *et al.*, 2009[40]	Implementation	Treatment	Multiple	Mental health clinics	Inner (adopter; organizational-climate; training)	Statewide mandate for using specific EBPs	Descriptive-quantitative (provider survey)	Single-provider	197
	Summary: Better attitudes towards EBPs were predicted by less formal education, colleagues' support for EBPs, agency and supervisor support for the EBPs, positive perception of training, and fewer institutional barriers to EBP implementation.								
Kam *et al.*, 2003[41]	Implementation	Prevention	Promoting Alternative Thinking Skills	Schools	Inner (organizational-leadership; provider; fidelity)	None	Descriptive-Quantitative	School	3
	Summary: Only the combination of high quality of implementation by teachers and high principal support was associated with significantly greater reductions in aggression and behavioral dysregulation, and significant increases in emotional competence. Neither factor alone predicted intervention effectiveness.								
Klimes-Dougan *et al.*, 2009[42]	Implementation	Prevention	Early Risers	Schools	Inner (organizational-climate/culture; provider; fidelity)	None	Descriptive-Quantitative	Single-providers	27
	Summary: Provider personality traits, beliefs, and use of flexible coping were related to various fidelity indexes. Teachers' negative perceptions of the organizational climate/culture were positively related to fidelity and child exposure to the intervention.								
Kolko *et al.*, 2012[43]	Implementation	Treatment	AF-CBT	Mental health clinics, child welfare	Outer (training)	"Learning community"-based training versus training as usual	RCT	Multi-agency (not addressed in analyses)/providers	(10)/182
	Summary: Providers who participated in the community condition rated higher on knowledge and use of skills included in the EBP. Practitioners in both groups reported significantly more negative perceptions of organizational climate during the intervention phase								
Langley *et al.*, 2010[44]	Implementation	Treatment	CBITS	Schools	Inner (organizational-leadership; provider)	None	Descriptive-Mixed methods (primarily qualitative)	School	35
	Summary: Participants reported similar barriers to implementation: limited support from administrators and teachers, logistical challenges, competing responsibilities, and parental disengagement. Sites overcoming these barriers had greater organizational structure, a social network of other clinicians implementing CBITS, and administrative support for implementation.								
Leslie *et al.*, 2004[45]	Exploration	Treatment	Training, clinical materials, and additional staff support for diagnosis and treatment of ADHD	Pediatrics practices	Intervention, Outer (Inter-organizational networks), Inner (organizational; provider; family)	Pilot Implementation	Descriptive-mixed methods	Multiple clinic/provider/patient (analyzed separately)	7/16/116

	Summary: The intervention was acceptable and feasible from all stakeholders' perspectives, but it did not adequately guide pediatricians in the assessment of complex clinical presentations or the management of limited insurance coverage and connections with specialist mental health providers.								
Liddle *et al.*, 2006[46]	Implementation	Treatment	Multi-Dimensional Family Therapy	Substance abuse day treatment clinics	Inner (organizational; training; provider; fidelity); Outcomes (patient)	Staff training and supervision	Quasi-experimental (interrupted time series)	Multiple-provider/patient (analyzed independently)	10/104
	Summary: Training and post-training phases of trial had more therapy sessions than baseline, increased focus on MDFT themes, and increased adherence. Clients rated environment as more controlled, more practical/useful, less clarity, more youth autonomy. Youths treated in training and post-training phases had higher levels of abstinence, lower rates of out of home placement, as well as externalizing and internalizing symptoms than youths treated at baseline.								
Lochman *et al.*, 2009[47]	Implementation	Prevention	Coping Power	Schools	Outer (training); Inner (provider; fidelity); Outcomes (youth)	2 different levels of training and a control condition	RCT	Multiple-school/counselor/student (school not included in modeling-some schools shared counselors)	(57)/49/531
	Summary: The higher intensity training condition resulted in better engagement with students and better child outcomes (reductions in children's externalizing behavior problems and improvement in their social and academic skills).								
McBride *et al.* 2002[48]	Implementation	Prevention	SHAHRP	Schools	Intervention, Outer (training); Inner (provider; fidelity), Outcomes (youth)	None-Description of the factors associated with implementing SHAHRP with fidelity	Descriptive-mixed (primarily qualitative)	Multiple-school/teacher/student	6/61/970
	Summary: Most teachers liked the training and higher teacher motivation was associated with a greater willingness to implement with fidelity. The inability to cover entire lessons within available time slots was a problem for many teachers. Fidelity varied by school and teachers with more training had slightly better fidelity, but fidelity was not related to student outcomes.								
Olson *et al.*, 2005[49]	Implementation	Treatment	AAP ADHD Guidelines	University pediatrics clinic	Inner (organizational; training; provider; fidelity)	Formal diagnostic protocol	Quasi-experimental (Comparison Group Pretest/Posttest Design)	Single-provider	31
	Summary: Four percent of providers adhered to guidelines pre intervention, while 82% adhered after intervention. Significant improvement was observed across each of the four criteria in the AAP guidelines, and improved adherence was noted for residents and faculty alike.								
Ozer *et al.*, 2010[50]	Implementation	Prevention	Multiple	Schools	Outer (intervention developers), Inner (provider; fidelity; adaptation)	None	Descriptive-Mixed methods (primarily qualitative)	Multiple-interdigitating qualitative analysis (classroom observations; teacher interviews; student focus groups)	163/22/188
	Summary: Teacher most frequently changed the instructional format to accommodate students and adding in "real-life" examples" Students recommended "surface" modifications to make the content more appealing to youth. Intervention developers considered most adaptations acceptable.								
Palinkas and Aarons, 2009[51]	Implementation	Treatment	SafeCare	Child welfare	Outer (interorganizational networks), Inner (organizational-leadership; provider)	None	Descriptive-Qualitative	Single-administrators	13
	Summary: Identified 6 issues important for implementation; resource availability, positive external relations, agency leadership support, motivated staff, benefits for staff, perceived benefit over costs.								

Palinkas *et al.*, 2008[52]	Implementation	Treatment	Multiple	Mental health clinics	Outer (intervention developers), Inner (provider; fidelity; adaptation)	None	Descriptive-Qualitative	Multiple-interdigitating qualitative analyses (key informant interviews [trainers/supervisors/clinicians] , participant observation)	62
	Summary: Identified 3 "intentions" for EBP implementation: implement with fidelity, abandon the EBP, and selective/partial implementation. Three pre-implementation factors emerged: lag between training and use of EBP, clinician engagement, and clinician EBP fit. Four short-term implementation factors were also identified: first impression of EBPs after initial use, competence in EBP use, clinician and researcher adaptability, and clinician-researcher relationships.								
Palinkas *et al.*, 2009[53]	Implementation	Treatment	Multiple	Mental health clinics, child welfare	Outer (Intervention developers), Inner (provider; fidelity; adaptation)	None	Descriptive-Qualitative	Multiple-interdigitating qualitative analysis (administrator/supervisor, consultant/trainer, provider interviews)	94
	Summary: Productive interactions between EBP propagators (researchers, trainers, supervisors) and EBP end users (agency directors, clinicians) require accessibility, mutual respect, a shared language, and a willingness to negotiate and compromise.								
Pankratz and Hallfors, 2004[54]	Preparation	Prevention	Multiple	Schools	Inner (organizational-leadership)	None	Descriptive-quantitative	Single-Schools	99
	Summary: The majority of school districts use evidence-based prevention curricula; they are rarely the most commonly used curricula. Evidence-based curricula are much more likely to be used at the middle school level than at the elementary or high school levels. Urbanicity, coordinator time, and coordinator experience correlated with extensive use, but only coordinator time significantly predicted extensive use								
Pankratz *et al.*, 2006[55]	Implementation	Prevention	Protecting Me/Protecting you	Schools	Inner (provider; fidelity; adaptation)	None	Descriptive-Quantitative	Single-teachers	17
	Summary: Teachers attempted to implement most sections of a lesson, but lessons were consistently and extensively adapted. Teachers were more likely to delete content than to add to it, and teachers who extensively adapted one lesson tend to adapt other lessons. Percent of lessons completed also varied across teachers.								
Pentz *et al.*, 1990[56]	Implementation	Prevention	Midwestern Prevention Project	Schools	Inner (organizational; provider; fidelity), Outcomes (participant)	Implementation versus wait list control (by school)	RCT	Multiple-schools/teachers/ students	42/65/ 5065
	Summary: All schools implemented the program. Exposure to the intervention was the strongest predictor of student outcome (minimizing increases in drug use behavior). Reinvention (adherence/adaptation) was not related to student outcome.								
Riley *et al.*, 2008[57]	Implementation	Treatment	MET/CBT5	Substance abuse treatment programs	Inner (organizational; provider; fidelity; adaptation)	None	Descriptive-Qualitative	Single-schools	9
	Summary: Programs modified the intervention without concern of potential impact on its effectiveness and use of fidelity monitoring diminishing over time. Major modifications included going from group to individual sessions, cultural adaptations, and extending treatment beyond 5 sessions.								
Robbins *et al.*, 2011[58]	Implementation	Treatment	Brief Strategic Family Therapy	Substance abuse treatment programs	Inner (provider; fidelity; adaptation), Outcomes (youth)	None (treatment arm of an RCT)	Descriptive-Quantitative	Multiple-program/clinicians, patients (partial use of multi-level modeling)	8/20/415
	Summary: Therapist adherence was associated with engagement and retention in treatment, improvements in family functioning, and reductions in adolescent drug use.								

Roberts-Gray *et al.*, 2007[59]	Implementation	Prevention	Texas Tobacco Prevention Initiative (TTPI)	Schools	Inner (organizational-leadership; training; provider)	None	Descriptive-quantitative	Single-schools	47
	Summary: The school-based leadership factor was an independent predictor of quality of adherence whereas the facilitation processes factor (implementation, plans, training, supervision, communication) predicted quantity of implementing activity.								
Rohrbach *et al.* 1993[60]	Preparation Implementation	Prevention	Adolescent Alcohol Prevention Trial	Schools	Inner (organizational-leadership; adopter)	Brief vs. intensive training x principal vs. no principal intervention	RCT	Multiple-teacher/school	60/25
	Summary: There was no difference in rates of implementation/fidelity between the brief and intensive teacher training. Principal training increased implementation/fidelity. Teachers who reported higher rates of implementation/fidelity also reported less teaching experience, stronger self-efficacy, greater enthusiasm, better preparedness, higher teaching method compatibility, and greater principal encouragement. Integrity of implementation was related to positive program outcomes.t.								
Rohrbach *et al.*, 2005[61]	Preparation	Prevention	Multiple	Schools	Outer (sociopolitical; inter-organizational networks; advocacy), Inner (organizational-leadership)	None	Descriptive-quantitative	Single-Schools	1593
	Summary: Factors associated with EBP adoption included using information from a state substance use prevention group, national substance abuse prevention groups, local needs assessment data, research about effective curricula, and allocating coordinator time to prevention activities.								
Sanders *et al.*, 2009 [62]	Preparation	Prevention	Triple P-Positive Parenting Program (PPP)	Human service settings	Inner (organizational; provider)	None	Descriptive-quantitative	Providers	611
	Summary: Practitioners were more likely to use Triple P if they received positive client feedback, experienced minor barriers to implementation, and consulted with other practitioners. They were less likely to use Triple P if they were less confident about either delivering the EBP or consulting with parents, or reported low workplace support.								
Schoenwald *et al.*, 2003[63]	Implementation	Treatment	MST	Mental health clinics	Inner (organizational-climate; provider; fidelity)	None	Descriptive-Quantitative	Multiple-program/clinicians/ patients	39/217/ 666
	Summary: Therapist adherence, organizational climate and structure at baseline directly affected immediate post treatment child outcomes, but results for specific organizational variables were mixed with some subscales working in the opposite of the hypothesized direction. Post hoc analysis suggested that organizational factors are important predictors of child outcomes only when adherence to MST protocol is low.								
Schoenwald *et al.*, 2005[64]	Implementation	Treatment	MST	Mental health clinics	Inner (provider; fidelity) Outcomes (caregiver; youth)	None	Descriptive-Quantitative	Multiple-program, clinicians, patients	45/405/ 1711
	Summary: Therapist demographic variables, professional training and experience, endorsement of the MST model, perceived difficulty and rewards of doing MST, and perceived similarity to treatments previously used did not predict adherence. Therapist perceptions that the flexible hours required to implement MST are problematic predicted lower adherence. Therapist–caregiver similarity on ethnicity and gender predicted higher adherence. Low caregiver education and African American ethnicity predicted higher adherence. With the exception of youth psychosocial functioning, indicators of severity of youth problems did not predict adherence.								
Schoenwald *et al.*, 2008[65]	Implementation	Treatment	MST	Mental health clinics	Inner (organizational-climate; provider; fidelity), Outcomes (youth)	None	Descriptive-quantitative	Multiple-clinic/provider/youth	45/429/ 1979

	Summary: Therapist adherence and organizational climate and structure yielded improved youth outcomes. One climate and two structural variables predicted changes in youth behavior, and the climate variable also predicted therapist adherence. However the climate and structure variables were not associated with therapist adherence.								
Schoenwald *et al.*, 2008[66]	Implementation	Treatment	Multiple	Mental health clinics	Inner (organizational; provider; training; supervision)	None	Descriptive-Quantitative	Single-programs	200
	Summary: For-profit organizations were more likely to implement new treatments; organizations with more licensed staff and weekly supervision were less likely. Compared to private organization directors, public organization directors found it more important that new treatments align with prevailing practices, infrastructure support, organizational mission, and internal support.								
Schoenwald *et al.*, 2009[67]	Implementation	Treatment	MST	Mental health clinics	Inner (organizational; supervision; fidelity; provider) Outcomes (youth)	None	Descriptive-Quantitative	Multiple-program, clinicians, patients	45/429/ 1979
	Summary: Supervisor focus on adherence predicted greater therapist adherence. Two supervision dimensions, adherence to the structure and process of supervision, and focus on clinician development, predicted changes in youth behavior.								
Schoenwald *et al.*, 2012[68]	Implementation	Treatment	MST	Mental health clinics	Inner (organizational-climate) Outcomes (youth)	None	Descriptive-Quantitative	Multi-program, clinicians, patients	45/429/ 1979
	Summary: Findings some support found for positive aspects of organizational climate decreasing symptoms and negative aspects increasing symptoms. However, there were a great deal of null findings as well as unexpected findings. For example, for substance abusing youth, more positive indices of climate predicted increases in externalizing and internalizing problems.								
Shapiro *et al.*, 2011[69]	Sustainment	Prevention	PPP	Multiple (mental health, schools, child welfare)	Inner (organizational; supervision; EBP fit; provider)	None	Descriptive-Quantitative	Single-providers	174
	Summary: Requirements to use PPP was related to implementation but not amount of use. The ability to discuss cases and receive consultation or supervision significantly predicted program use.								
Stevens *et al.*, 2011[70]	Preparation	Treatment	Medication guidelines	Mental health clinics	Inner (organizational; provider)	None	Descriptive-quantitative	Single - Clinic Directors	152
	Summary: Medication guideline use was related to utilizing standardized child outcome measures but not related to the employment of a child psychiatrist. Many clinic directors reported they did not use medication guidelines in their programs.								
Thaker *et al.*, 2008[71]	Implementation	Prevention	Reconnecting Youth	Schools	Inner (organizational; EBP fit; training)	None	Descriptive-mixed (predominantly qualitative)	Multiple-administrators, school staff, teachers	38
	Summary: Implementation was impacted by the EBP's structural fit with schools, particularly the need for small classes, student selection, and intensive training of interventionists. Limited financial resources, limited leadership support, as well as planned and unplanned changes hindered implementation								
Turner *et al.*, 2011[72]	Implementation	Treatment	Primary Care PPP	Primary care clinics	Outer (training materials); Inner (organizational-leadership; provider)	None	Descriptive-Quantitative	Single-providers	488
	Summary: 97% or practitioners reported using Triple P following training. Program supports and barriers impacted on practitioner self-efficacy, and higher self-efficacy was positively associated with implementation. Prior professional experience, satisfaction with training, and workplace factors were not significant predictors.								

Vismara *et al.*, 2009[73]	Implementation	Treatment	Early Start Denver Model	Early Intervention Sites	Outer (training)	In-person versus distance (via videoconference) training	Experimental (non-random assignment)	Program/Provider/Parent-Child (analyses use provider or child as unit of analyses, no multilevel modeling)	(4)/10/32
	Summary: Distance learning and live instruction were equally effective for teaching therapists to implement the model, to train parents, and to achieve improvement in child symptoms and behaviors.								
Zazzali *et al.* 2008[74]	Preparation, Implementation	Treatment	FFT	Mental health clinics	Outer (sociopolitical; interorganizational networks), Inner (organizational-leadership)	None	Descriptive-qualitative	Single-organization	14
	Summary: Factors associated with FFT's adoption included compatibility with the organization's mission and the organization's interest in EBPs. Factors facilitating FFT's implementation included fit with organizational characteristics (resources, structure, culture).								

Note: AAP=American Academy of Pediatrics; ADHD=attention-deficit/hyperactivity disorder; AF-CBT=Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT); ARC=availability, responsiveness, and continuity; CAFAS=Child And Adolescent Functional Assessment Scale; CBITS=Cognitive Behavioral Intervention for Trauma in Schools; CBT=cognitive behavioral therapy; CD=compact disc; FFT=functional family therapy; MET/CBT5=Motivational Enhancement Therapy plus Cognitive Behavioral Therapy; MST=Multisystemic Therapy; RCT=randomized controlled trial; SHAHRP= School Health and Alcohol Harm Reduction Project.

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