**Rapid Realist Review using the Consolidated Framework for Implementation Research (CFIR) to inform the Implementation Delivery Platform for the ‘Engager’ intervention**

Studies were identified from the search conducted previously for the Engager Realist Review1. This broad search encompassed collaborative and integrated care in the fields of criminal justice, mental health, substance use, and vulnerable groups. We updated the search by combining the original search terms with implementation-related search terms identified during screening conducted for the intervention development review. The precision of the search terms was tested by screening sample sets of results which had been retrieved using varying combinations and truncations of the search terms.

In discussion with the wider research team involved in intervention development and evaluation, we selected the Consolidated Framework for Implementation Research (CFIR)2 as a framework for structuring our identification and synthesis of evidence that would inform the development of the intervention delivery platform (IDP) and incorporate considerations both of the wider context and on relationships and individual capacities. This discussion also enabled us to reach agreement on the areas of the IDP which the review could most usefully inform, given the expertise in the research team and stakeholder group, and the contributions of concurrent project workstreams. The CFIR constructs focused on in the review were intervention characteristics, outer setting, inner setting, characteristics of individuals, and process. We treated the selected CFIR constructs as initial programme theories (propositions about how activities can achieve intended effects3 about aspects of implementation which we would refine using the identified evidence.

Our aim was not to be comprehensive, but to identify, appraise, extract and synthesise sufficient evidence in relation to each CFIR construct to inform the design of the IDP for the implementation of the trial’s intervention. The review was intended to be of direct relevance to the design of the IDP components, but was not restricted to including evidence only about these components.

In relation to the areas of the CFIR constructs identified as priorities for this review, we included all sources that described or evaluated the implementation of a novel intervention in the fields of offender health care, care of vulnerable groups (including substance use), or common mental health problems. We developed a tool to structure this screening process, although a lack of detail in abstracts largely prevented us from classifying sources by CFIR constructs at this stage. Sources eligible for inclusion included (but were not limited to) editorials, opinion pieces, commentaries, comparative effectiveness studies, process evaluations, qualitative research, and systematic reviews. We intended this breadth to capture researchers’ and stakeholders’ experiential knowledge about implementation.

For consistency with the Engager intervention, we defined ‘novel intervention’ as a set of activities that is introduced by an external agency and delivered either by that agency’s staff or existing staff within an organisation. This definition narrowed the number of types of interventions that could be included, but maintained the breadth of fields (beyond offender health care) from which the review could draw evidence.

Two researchers (MP and SLB) screened titles and abstracts, with full-texts being obtained if it was not clear whether or not a source should be included. A random sample (10%) of screening decisions was conducted by a second reviewer (KB) with any disagreements resolved by discussion.

The expression of the synthesis is directed at informing critical judgements about how it can inform the development of an implementation strategy, and further strengthen and specify the components of what we called the Implementation Delivery Platform (IDP). Decisions already had been made that the IDP included a manual and training. The flow of sources through the review is shown in Figure 1. Information about the 29 included sources is shown in Table 1. The results are presented in relation to the CFIR framework: intervention characteristics; outer and inner settings; implementation climate and characteristic of individuals.

***Intervention characteristics***

Interventions were presented and packaged in a variety of formats, with four potentially complementary mechanisms identified (see Table 2). Whilst one study presented a broad evaluation of an implementation package as a whole4 this cannot be related to individual implementation components. One reflection-on-practice about the implementation of a mental health intervention stated that ‘detailed practitioner workbooks and research articles were mostly ignored’5 (p.618).

In reflecting on findings and the experience of researching implementation, the authors of process evaluations suggested other potentially important mechanisms relating to intervention presentation. Young6 suggests that practitioners and managers predominantly view novel interventions as ‘more of’ usual care, rather than a qualitative step-change in how tasks and care are organised and delivered. In this view, education about an intervention (and its presentation) would need to identify and emphasise the ways in which it differed substantively from usual care.A different process evaluation suggested that this process of differentiation was facilitated when an intervention can be implemented in a time and space (e.g. half-day clinics) that is separate from usual practice, and when it can be preceded by a defined practice-wide meeting at which a formal ‘kick-off’ takes place4.

Only one process evaluation described a collaborative approach to the tailoring of intervention presentation to local contexts4. The authors argue that this provided a forum in which concerns could be expressed and locally-specific refinements made to materials so that they were tailored to different professionals’ and clinics’ readiness to change. In this analysis, a diverse group of stakeholders were empowered to take ownership of the intervention and engage in constructive debate about adaptations that would make it ‘workable’ in the local context.

 ***Boundary-spanning***

Roles which incorporated boundary-spanning were supported by the following processes. ***A summary of how these were proposed to work is stated in bold italics:***

***Development of working relationships between people in different organisations*** – through:

a. exposure to different teams and professional experiences by practitioners spending time working at sites other than their main place of employment 66.

b. team meetings, focusing on the needs of service users, that involved practitioners from different organisations7.

c. building on existing working relationships – when there is this base, formal structures for communication can be useful8.

***Iterative and locally-developed adaptation of the intervention*** – through intervention practitioners working closely with other practitioners to work out how to integrate intervention delivery with existing service delivery.9,4 This process, which needed to include regular two-way communication with practitioners, could also develop trust between practitioners and research staff.4

***Facilitative organisational context***

a. inter-organisational agreement about roles and responsibilities so that practitioners understand where their responsibilities begin and end.8

b. assigning work in a way that reflects the focus of an intervention – for example, assigning by location (institution or community) or requiring ‘clocking in’ at certain locations, is likely to inhibit a user-centred approach.9

c. inter-organisational agreement about service-user confidentiality procedures, so that information-sharing is not unduly restricted.9

***Shared vision***

Many different stages of developing a shared vision were reported in the included studies, but none were clear about the extent to which each stage was needed in an implementation strategy. However, the way in which each of these stages builds on the last suggests strongly that if the conditions of the preceding stage are not yet met then subsequent stages are unlikely to be successful in developing a shared vision.

*Preparatory, ‘pre-implementation’ work*– the extent and content of preparatory’ work that will be required depends on the extent of ‘fit’ between the environment and intervention. One reflection on practice identified three areas that may need to be addressed: i) differences in priorities between practitioners and researchers; ii) the extent of differences in ways of working between ‘partner’ organisations; and iii) the extent to which changes in the wider funding and regulatory environment impacted on the priorities of organisations.10 The tone for preparatory work could be positively set by visible commitment at a senior level to the goals and ethos of a proposed intervention.11 One intervention held pre-implementation half-day workshops to foster the development of collaborative working in new teams – in reflecting on practice, the authors argued that these workshops also facilitated ‘ownership’ of the intervention and clarified practitioners’ and managers’ appreciation of the distinct contributions they could make.12 A review and a case study both argued that leaders’ role in ‘selling’ the intervention to staff was important for motivating staff to engage with its delivery.13,14

***Involvement of all stakeholders in planning delivery***

There was unanimity in reflections on practice,15,16 a process evaluation,6 and a case study13 that input into the design of implementation needed to be sought from everybody. This included people who had a clinical, administrative, managerial, or strategic role.15,16,13 It was posited that this approach helped to foster widespread understanding and ownership of the intervention,13 create a supportive professional network for embedding the intervention,15 and provide a way for tangible responses to feedback to be delivered.6 Geographically-dispersed sites could engage in this process using a wiki-based manual which incorporated learning from local sites.17 A comparative process evaluation observed lower levels of implementation at a site where a top-down, less collaborative management style was used.18 One review reported descriptive findings from a number of studies which suggested that successful implementation occurred where leaders acted decisively to make the personnel, administrative and procedural changes necessary for the delivery of change.14

***Recognition of the knowledge, views and professional culture of practitioners and managers***

Interventions, even when collaboratively-developed, can often be perceived as external and imposed by those who were not personally-involved. The starting point of developing a shared vision therefore needs to be the knowledge, views and professional culture of practitioners and managers. 8,19,20 Competing priorities may mean that the focus of an intervention is not viewed as a priority by practitioners and managers,8 but this does not mean that an open and facilitative approach introducing and discussing issues arising from the proposed implementation of a novel intervention cannot be discussed.19 Misunderstandings, and at times conflicts, can be rooted in different professional and organisational cultures – working through these differences is part of the process of developing shared vision.20 Participants in one study found that a focus on improving outcomes for service users facilitated collaborative decision-making.21

***Information sharing***

The majority of studies reported the introduction and use of web-based systems. 21,22,23 These are not reported here as discussion during intervention development clearly identified web-based systems as unviable in prisons at the present time due to restrictions on electronic information transfer. Other studies simply reported descriptions of using individual working relationships,24 structured records,15,19 and regular 90-minute meetings involving all stakeholders11 as important for supporting implementation.

***Webs of social networks***

The description of one intervention specified how the intervention itself was intended to create and sustain favourable conditions for intervention delivery.9 This approach was intended to embed conditions, which would themselves sustain an environment conducive to the delivery of the intervention. A reflective piece on a different intervention identified the importance of ‘time and space’ for groups of stakeholders to meet and build the relationships that would support intervention delivery.10 However, it was acknowledged that there was rarely a mutually convenient meeting time for *all* stakeholders, meaning that realistically not all stakeholders would be present at every meeting. Nevertheless, it was reported that this approach still enabled social networks to be developed.

***Formal and informal communication***

Participants in intervention delivery perceived formal communication structures, such as a weekly multi-disciplinary team meeting, as necessary for the intervention to be delivered as planned.24 Participants’ perceptions were that formal communication structures were a necessary starting point where routes of communication were not established.20 This points to implementation requiring a subtle balance of formal and informal communication. Initially, this is likely to require the use of formal communication routes. However, as implementation progresses and face-to-face working relationships develop between individual practitioners, informal communication that is sustained by collegial social ties was consistently reported to play a major role in *sustaining* intervention delivery.8

Co-locating practitioners,25 ‘shadowing’ colleagues,20 and activities which increased the personal visibility of staff who needed to work together to deliver an intervention, 20,24 were all reported to be workable ways of increasing informal communication and social ties. However, none were measured or reported to offer any particular advantages over another.

***Culture***

Process evaluations and reflections on practice consistently identified the importance of awareness of the local culture and how it provides a more or less conducive environment for implementation. Culture can manifest in approaches to team-working or communication strategies,26 levels of decision-making and authorisation,8 or degree of openness towards different ways of working and the testing of novel interventions.18 The principle of introducing intervention staff gradually into the working life of a service was argued to provide the strongest starting point for gaining insight into local culture and how to work collaboratively with it.9,25 Reflection on practice suggests that demonstrating familiarity with the work setting and communicating efficiently are important for establishing and maintaining credibility.25

***Implementation climate***

It was consistently identified how the ‘implementation climate’ was not something that could be changed, but rather a context in which interactions to support implementation could take place. ***Feedback processes*** between those responsible for intervention delivery, management and evaluation needed to include implementation issues.18 They provided the means for multiple mechanisms to support implementation to become active, including:

***Belief that feedback would be listened to and acted upon***18,4,6 which fostered an upward spiral of sharing data, self-monitoring of progress, and interaction between stakeholders.

***Competitiveness between sites*** to improve process and health outcomes that were being measured - this was achieved by sharing quality improvement data across sites that were simultaneously implementing,22 although it could also be confined to the level of strategic monitoring.20

***Curiosity about others’ practice*** and how problems were addressed - this could be facilitated in team meetings,4 Action Learning Sets12 or, where teams were geographically-dispersed, through a wiki-based manual that provided a ‘window’ on to the work of teams at other sites.17

***Recognition of the value of outcomes data for informing practice***, which in itself was argued to ***empower teams*** to judiciously adapt their practice and facilitate implementation. Consistent with this was a change in view from data collection being in order to ‘feed the bureaucratic machine’ to its collection and use being an inherently useful part of practice.17

Contexts which may place constraints on how the above mechanisms may work included: differences in professions between how health, family networks, and/or rehabilitation are conceptualized;27 the multiple responsibilities and allegiances within a system, and therefore risk of conflicting priorities, which practitioners and managers may have;10 and, externally imposed resource-constraints that significantly limit the time, resources or people available to implement an intervention.8

*Access to information and knowledge about the intervention and how to incorporate it*

Sources described rather than evaluated the ways in which access to information and knowledge about an intervention were delivered. They included: workbooks with detailed guidance, re-enforced by supervision;28 laminated explanatory materials;29 practice support materials, educational materials for patients, training materials;16 job descriptions and scopes of practice;16 and decision support systems to enable accurate administration of structured clinical assessments and facilitate access to evidence-based guidelines.16

***Education about an intervention***

The included sources used the reflections of intervention participants or the study’s authors about the impact of different ways of organising and delivering educational material. Sources tended towards descriptions of what was done and included scant information on how people responded to educational events and/or their impact.

Included sources reported on a variety of ways of delivering educational material, including face-to-face group learning and webinars, but did not differentiate between the impact of these. On the basis of the reflections and analyses in the included sources, the following characteristics were identified as being important:

***Inclusive*** of all those who would be involved in the delivery of the intervention, whether at an operational or managerial level. Professionals who were not *directly* involved may still need to take part so that they understand, for example, new roles and referral pathways.30

***In-depth*** learning about the underlying model and/or approach.27,30,22

***Tailored*** to address the learning needs of groups at different sites8,11,30,22 or with different professional backgrounds.21

***Boosted*** at key junctures, with a quarterly ‘refresher’ session for practitioners27,13,6 and, for managers, shortly before implementation at a new site.22

***Facilitated by the work environment*** - through monitoring and supervision27,6 or addressing organisational barriers such as work flows that maintained a physical/mental health division rather than integration.30

***Process (Engagement)***

*Engaging individuals who can act as leaders*

Sources consistently identified the importance of leaders (who did not necessarily have to be senior) in providing direction and motivation for others to play their role in implementing an intervention.12,10,31,11,17,18,22 Sources also reported the negative effects of rapid change where leadership was lacking - this led to people being unsure of their role in implementation.26 Reflections on practice identified a number of ways in which researchers thought that people could best be engaged in a leadership role:

a. Through creation of a ***community of practice*** of leaders across different sites. This social network would provide ***motivation, support,*** and a forum for ***learning and sharing experiences,*** and ***developing personal skills, knowledge and confidence***.12

b. By creating a cross-site process for implementation progress ***feedback and review*** - the aim being not simply to monitor progress, but to ***provide a forum*** for cross-site reflection and learning.22

c. Through ***consistency between an organisation’s and an intervention’s goals*** - for example, leaders cannot achieve or maintain credibility if their support for the delivery of an intervention is overwhelmed by other organisational drivers of behaviour (for example, evaluations of practitioner performance10 or economic costs27)

**Table 1: Included study characteristics and areas of Consolidated Framework for Implementation Research (CFIR) addressed**

| **Author (year)** | **Country** | **Area of practice** | **Study type** | **Participants** | **Data collection** | **Areas of CFIR reported**  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  | **IC** | **OS** | **IS** | **CI** | **P** |
| Abrahamson & Raine (2009) 8  | UK (London) | Elderly people in the community | Qualitative | Health care professionals n=13; Social care professionals n=76; Voluntary workers n=20 | Semi-structured interviews and focus groups |  |  |  |  |  |
| Allen et al. (2005) 28 | UK (Wales) | Challenging behaviour and intellectual disabilities | Reflection on practice | 250 nursing staff | Epidemiological survey |  |  |  |  |  |
| Brenner et al. (2011) 29 | USA (Colorado) | Suicide among veterans | Process evaluation | 69 mental health professionals | Vignettes, questionnaires and focus groups (n=NR) |  |  |  |  |  |
| Callahan et al. (2011) 10 | USA (Indianapolis) | Mental health / other vulnerable groups | Reflection on practice | NR | NR |  |  |  |  |  |
| Coupe et al. (2014) 21 | UK (Bristol, Manchester and London) | Mental health (primary care) | Qualitative | Case managers n= 6; Trial research team members n=5; GPs n=15 | Interviews |  |  |  |  |  |
| Curran et al. (2012) 31 | USA (Seattle, Los Angeles, San Diego and Little Rock) | Anxiety disorders | Process evaluation | 47 clinic staff members (18 primary care providers, 13 nurses, 8 clinic administrators and 8 clinic staff) and 14 study-trained anxiety clinical specialists (ACSs) | Semi-structured interviews  |  |  |  |  |  |
| Dodds et al. (2004) 11 | USA (Miami) | Mental health and HIV | Description of service | NR | NR |  |  |  |  |  |
| Edwards et al. (2001) 27 | USA | Offenders | Reflection on experience / audit of implementation | NR | NR |  |  |  |  |  |
| Elizur (2012) 15 | Israel | Family-oriented care | Historical narrative | Key CRC/DRC figures for interviews; case study family with 3 children (9, 16 and 11 years) and divorced parents | 14 interviews, case study, author’s field notes, previous evaluation reports |  |  |  |  |  |
| Fortney et al. (2009) 16 | NR | Depression | Description of implementation steps | NR | NR |  |  |  |  |  |
| Frazer et al. (2006) 19 | UK (Yorkshire) | Depression | Description of development and implementation | 13 Primary Care Graduate Mental Health Workers (PCGMHWs), GPs and service users (N=NR) | Questionnaires  |  |  |  |  |  |
| Fuggle et al. (2014) 17 | UK (Cambridge & Islington) | Mental health | Reflection on practice | NR | NR |  |  |  |  |  |
| Hall & Higgins (2006) 7 | UK | Other vulnerable groups – people with learning disabilities | Implementation process reflection | NR | NR |  |  |  |  |  |
| Herman et al. (2007) 9 | USA (New York & New Jersey) | Homelessness and mental illness | Reflection on evaluations | Initial trial = 96 men randomised to intervention or treatment as usual | E.g. in initial trial (results reported in detail elsewhere) main outcome = average number of homeless nights (n = 96) and measure of extended periods of homelessness, as well as Positive and Negative Syndrome scale for Psychiatric Symptoms (n = 76) (Kay et al., 1992) |  |  |  |  |  |
| Katon et al. (2006) 5 | USA | Mental health | Reflection on practice | 49 primary care sites | ‘Stakeholder groups’ |  |  |  |  |  |
| Kirchner et al. (2004) 26 | USA (South East) | Mental health / substance use | Process evaluation | Primary care physicians (n=3), physician assistants (n=2), nursing staff (n=7), administrative staff (n=5), APNs (n=2), social worker (n=1) | Interviews (11 from one site, 9 from the other) |  |  |  |  |  |
| Knowles et al. (2013) 30 | UK (North West England) | Mental health / co-morbidities | Qualitative | Psychological Well-Being Practitioners (case managers); Practice Nurses | Interviews T1: Case managers n=6; Practice Nurses n=12. T2: Case managers n=5; Practice Nurses n= |  |  |  |  |  |
| Lalayants (2013) 20 | USA (New York) | Child protection | Qualitative | CPS workers (n=30); CPS supervisors (n=30); consultants in mental health, substance abuse and domestic violence disciplines (n=21); team coordinators and borough managers (n=10) | Semi-structured interviews (n=91); field notes taken during and after each interview |  |  |  |  |  |
| Main et al. (2009) 18 | USA | Mental health | Process evaluation | Physician or non-physician practice champions (2 for each practice = 32) | Field notes of learning sessions (3 groups); semi-structured telephone interviews (n=32); email communications; small group discussions |  |  |  |  |  |
| Murray et al. (2013) 13 | USA (North Carolina) | Children’s mental health | Reflection on practice | NR | NR |  |  |  |  |  |
| Oishi et al. (2003) 24 | USA | Mental health | Qualitative | Depression Clinical Specialists (DCSs) | Interviews with DCSs (n=11); focus groups (n=2, ‘including all DCSs in the trial’) |  |  |  |  |  |
| Solberg et al. (2013) 22 | USA (Minnesota) | Mental health | Process evaluation | NR | NR |  |  |  |  |  |
| Syson & Bond (2010) 12 | UK (Salford) | Vulnerable groups | Description of implementation processes | NR | NR |  |  |  |  |  |
| Tapp et al. (2014) 4 | USA | Physical health (asthma) | Process evaluation | Patients (n=140); clinic staff (n=NR) | Survey (patients); focus groups (clinic staff) |  |  |  |  |  |
| Torrey et al. (2011) 14 | NR | Substance use / mental health | Review | NR | NR |  |  |  |  |  |
| Vanneste et al. (2013) 23 | Belgium | Integrated care (older people) | Survey | Nurses, physiotherapists, SALT, dietitians, podiatrists, social workers, physicians, dentists, pharmacists | Survey (282/661 (43%) survey response rate) |  |  |  |  |  |
| Vogel et al. (2012) 25 | USA | Mental health | Reflection on practice | NR | NR |  |  |  |  |  |
| Whitebird et al. (2014) 32 | USA (Minnesota) | Mental health | Process evaluation | Care managers, project leads, registered nurses, licensed social workers / psychologists | Participation and outcome data from 99 clinics (21 different medical groups), implementation assessed at 42 clinics (14 different medical groups), interviews and observations of practice (n=NR) |  |  |  |  |  |
| Young (2004) 6 | USA (East) | Offenders | Process evaluation | Programme staff | ‘Structured discussion groups and “ride alongs”’ (n=40); ‘sessions with central office and regional administrators’ (n=17); ‘numerous other meetings and informal discussions’ |  |  |  |  |  |

**Key:**

NR = not reported / not applicable

**CFIR: IC** = Intervention Characteristics; **OS** = Outer Setting; **IS** = Inner Setting; **CI** = Characteristics of the Individual; **P** = Process

**Table 2: Intervention characteristics and inferred mechanisms**

|  |  |  |
| --- | --- | --- |
| **Format** | **Intervention characteristics** | **Inferred mechanism(s)** |
| Educational support or reminder materials about the intervention | Slide sets22Written29 or video vignettes5,13Posters listing key principles5Manual13,6 (Young6 reported manual contents included details about service user progression through each phase of the intervention and specification of timeframes, deliverables and roles, e.g. ‘between 15 and 30 days before release, the community case manager must complete the Individualised Service Plan form based on at least two meetings with the youth, a family member, and relevant provider representatives’,6 p.8 | People learn in a variety of ways, meaning that educational materials need to be delivered in multiple formats; expressing the intervention in a way that aligns as closely as possible with existing practitioner experiences and service design will facilitate understanding of how to deliver it. |
| Educational strategies | For practitioners:Classroom tuition, self-directed learning, in-situ interactive instruction(28 – broad description only of these strategy types)For service users:Patient brochures22Workbook for collaboratively working through therapy with health professional19 Educational materials (e.g. video) and activities (e.g. role play) for service users’ significant others13 | Service users and their significant others are an essential part of the implementation process – implementation can only occur if they understand the intervention content and goals, and are supported to take an active role in the intervention. |
| Written ‘work support’ materials | Checklists, example workflows, treatment plan templates, sample job descriptions5,13,22 | ‘Helping hands’ in intervention delivery – both reminder and facilitator. |
| Decision-support tools | Evidence-based guidelines22Gap analysis to identify gaps in implementation strategy22Decision-tree29 | Concise, portable and directly-usable tools that incorporate knowledge in a form that is geared to practical application. |

**Figure 1: Flow of sources through the review**

**Intervention development review [2]**

Handsearching n= approx.5728

Group-focused database searches n=5326

Citation chasing n=636

Other searches n=79

TOTAL n=11769 (inc. unobtainable n=18)

**Sources flagged for potential inclusion (1)**

n=534

**Total sources for potential inclusion**

n=1183

(inc. unobtainable n=6)

**Full-text sources obtained**

n=172

**Sources included for delivery platform**

n=29

**Sources for potential inclusion (2)**

n=649

**Delivery platform review**

*Group-focused database searches:*

Vulnerable groups n=168

Substance use n=138

Common mental health problems n=273

Prisoners n=70

**Excluded at title/abstract stage**

n=1011

(inc. duplicates n=9)

 **Excluded at full-text stage**

n=143

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