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ORIGINAL PAPER

New Directions in Capacity Building: Incorporating Cultural Competence into the Interactive Systems Framework

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Abstract The UMBC Psychology Department's Center for Community Collaboration (CCC) provides training and support for capacity building to promote substance abuse and mental health treatment as well as adherence improvement in community agencies funded through the Ryan White Act serving persons living with HIV/AIDS. This article describes an approach to dissemination of Evidence Based Practices (EBPs) for these services that uses the Interactive Systems Framework (ISF) and incorporates a collaborative process involving trainer cultural competence, along with a comprehensive assessment of organizational needs, culture, and climate that culminates in tailored training and ongoing collaboration. This article provides: (1) an overview of the CCC's expanded ISF for the effective dissemination of two EBPs—motivational interviewing and the stages of change perspective; (2) an examination of the role of trainer cultural competence within the ISF framework, particularly attending to organizational culture and climate; and (3) case examples to demonstrate this approach for both general and innovation-specific capacity building in two community based organizations.

Keywords Capacity-building · Organizational culture · Interactive systems framework · Dissemination · Motivational interviewing · HIV

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Our Organization and Mission

This article describes an adaptation of the Interactive Systems Framework (ISF) for disseminating Evidence Based Practices (EBPs) that focuses on the cultural competence in trainer/consultant and trainee/service provider interactions. The Center for Community Collaboration (CCC) has several key guiding principles. The first is that the training process is at least as important, if not more so, than the content being presented for effective dissemination. We emphasize a parallel process in which training empowers, builds collaboration, and supports existing strengths of agency and staff so that they can do the same with clients. A second principle is that dissemination is not a one-size-fits-all process. We focus on comprehensive assessment of organizational needs, culture, and climate, which culminates in tailored training. This approach has been used for over 4 years by the CCC, which is funded by the State of Maryland Infectious Disease and Environmental Health Administration, and located in the Psychology Department at the University of Maryland, Baltimore County. Current projects funded through the Ryan White Act provide training and capacity building to community agencies to support and strengthen substance abuse and mental health services and treatment adherence for HIV positive clients. This article addresses the general lack of emphasis and understanding of the role that cultural competence plays in building organizational capacity, and describes how this dimension can be integrated more completely into the ISF system.

Target Populations Served

The Baltimore-Towson area ranks 10th in the nation for reported AIDS cases with approximately 22.8 cases per

100,000 people, contributing to the high estimated total HIV/AIDS cases in Baltimore at over 1,000 per 100,000 people (CDC 2009; Maryland Department of Health and Mental Hygiene 2010). Populations served by the health care agencies with which the CCC collaborates in this region are largely majority-minority (i.e., African American, non-Hispanic), with low SES and high rates of homelessness and HIV/AIDS. Needs assessments conducted by the CCC with these agencies in 2008–2009 indicate that 15–60 % of HIV-positive clients have mental health disorders, 15–40 % have substance use disorders, and 15–40 % have co-occurring mental health and substance use disorders (Welsh et al. 2010). It has been the experience of the CCC in working with these agencies that populations of multiply-diagnosed clients with limited resources (i.e., homeless, chronically mentally ill, substance abusers living with HIV/AIDS) are seen as particularly challenging to engage and maintain in health care services; many have been disenfranchised from treatment systems and are subsequently distrustful of treatment providers.

Treatment providers and staff members at these agencies represent different professional disciplines, ethnic backgrounds, genders, sexual orientations, education levels, regions of the country, and religions, creating an eclectic and diverse workforce. The varying backgrounds of the agency staff and their clients create a wide array of belief systems and assumptions about clients' capacity for change, as well as what constitutes effective treatment, that contribute to the various perceptions and behaviors of the agencies, the providers, and the client populations. The CCC strategy for delivering training in EBPs first addresses the needs of these various cultures with the goal of helping the agency staff to be more effective in working with clients with target problems or behaviors. Specifically, our goal is to help agencies build capacity in the areas of client retention, treatment adherence, and effective service delivery, with a particular emphasis on dissemination and implementation of EBPs for substance abuse and mental health.

The Challenges of Dissemination

There are several unique challenges involved in deploying EBPs in community agencies that provide publicly funded healthcare services. Two of the most critical are workforce development (i.e., recruiting, training, and retaining staff), and the creation and maintenance of services that meet both the needs of clients and the mandates of funders. Increasingly, funding organizations are defining quality programs and services as those using practices supported by current research and developing quality assurance indicators that require use of EBPs. These EBPs are viewed as providing a solution to the disproportionately poor outcomes that diverse and underserved populations with mental health and substance abuse problems often experience in the public healthcare systems.

However, introducing new practices and procedures requires substantial commitment and modification of established patterns of organizational structure or roles. Implementation and training must be sensitive to the culture, needs, and desires of agencies and staff to be effective (Fixsen et al. 2005; Owczarzak and Dickson-Gomez 2011).

While most agencies provide basic support and/or training for their staff, trainings are usually done in large groups, often take place outside of the agency, and are void of follow-up or follow-through. Agency staff may or may not be receptive to new ideas introduced in these often mandatory trainings, and may not be particularly clear about how to integrate the knowledge or skills into their daily workload (which may already seem overwhelming). A frequent complaint of agency staff is that they are inundated with training and forced to endure hours of didactic, under-stimulating lectures to satisfy external demands and obtain certification, licensure, or accreditation. There is often little buy-in or clarity about practical applications of the EBP for populations in their particular setting. Bunch (2007) classifies these types of issues as common training failures, and asserts that such shortcomings can be avoided by attending to elements of organizational culture.

Glisson (2007) defines organizational culture as the way things are done in an organization or the system's work norms. Subcultures also exist, based sometimes on organization subgroup norms or characteristics of staff (age, profession, or ethnicity). Organizational climate, on the other hand, is viewed as the psychological impact of the work environment on employees or their perceptions of how the organization affects them (Glisson et al. 2006; Rousseau 1988; Dennison 1996). While organizational culture may be conceived of in a relatively judgment-neutral manner, climate includes staff perceptions and may be classified along evaluative dimensions, especially as it relates to the implementation of new ideas. The climates of organizations may be classified, according to Glisson (2007), as engaged (e.g., staff perceptions of high personal accomplishment), functional (e.g., staff perceptions of adequate cooperation and assistance from others), or stressful (staff perceptions of being overworked and unable to accomplish tasks). For example, a stressful agency climate will be reflected in burn-out, high turnover of staff, and a general inability to implement new ideas, despite the most effective training.

Considered simultaneously, organizational culture and climate are related to staff work attitudes, perceptions,

behaviors, and both the quality and outcomes of services provided (Aarons and Sawitzky 2006; Anderson et al. 2004). Research demonstrates that organizational interventions are more successful when attention is paid to organizational functioning (Glisson et al. 2006; Livet et al. 2008). The CCC proposes a model in which the extent to which training and technical assistance competently address the organizational qualities of culture and climate is a key determinant in successful dissemination and implementation of EBPs.

Disseminating Motivational Interviewing and the Stages of Change

In the translation of evidence into practice, we specialize in the adaptation and dissemination of two EBPs: Motivational Interviewing (MI) and the Stages of Change (SOC) from the Transtheoretical Model of Intentional Behavior Change. Motivational Interviewing is a style of counseling and a set of brief intervention strategies that focuses on the major principles of client autonomy, evocation of change talk and commitment, and collaboration (Miller and Rollnick 2002). The Stages of Change (SOC) are rooted in the Transtheoretical Model of Intentional Behavior Change which segments and describes the multidimensional process of change and has become an important heuristic perspective by which to understand client motivation and guide intervention approaches to care (DiClemente 2003; Prochaska et al. 1992). MI and SOC principles and practices are synergistic, and both are being promoted for counseling and brief interventions for substance abuse and mental health treatment among various healthcare populations (SAMHSA/CSAT 1999, 2005; DiClemente et al. 2011). Both have demonstrated utility and effectiveness across various populations, cultures and settings (DiClemente 2003; Miller and Rollnick 2002; Prochaska et al. 1992). Intervention studies with HIV-positive samples that employ techniques based in MI and the Transtheoretical Model have demonstrated effectiveness in reducing risk behaviors (e.g., drug and alcohol use) and improving medication adherence (DiIorio et al. 2010; Fisher et al. 2006; Gilbert et al. 2008; Richardson et al. 2004; Velasquez et al. 2009). Thus, the practices related to MI and SOC can serve as essential components for comprehensive, evidence based treatment programs for persons living with HIV/AIDS, and represent important innovations for many HIV care agencies. In addition, the major principles of these EBPs make them particularly well-adapted to be integrated into the motivational considerations and tasks necessary for both organizational and individual change (see Table 1). Specifically, stage-based strategies employed in a motivational style (i.e., with an emphasis on autonomy, collaboration, and evocation) may help promote movement through critical tasks of each of the stages of change for individual behavior change as well as for organizations adopting innovations for mental health and substance abuse treatments (DiClemente and Velasquez 2002; Kruszynski et al. 2006).

Interactive Systems Framework (ISF)

The ISF is an emerging heuristic for understanding and improving the dissemination of prevention research and innovations. The ISF focuses on the components of and interactions between three systems: (1) synthesis and translation of research into useable formats for agency staff (Synthesis and Translation System); (2) building of general and innovation specific capacity for implementation

Table 1 Stages of change, stage tasks, and CCC capacity building strategies

Stages of change	Stage tasks	CCC strategies
Precontemplation: not thinking about change; satisfied with status-quo	Become aware of and interested in need for change	Conduct assessment of organization needs and capacity for EBP; seek to understand organizational climate and culture; meet with core staff and discuss concerns
Contemplation: thinking about change, but not sure	Weigh the pros and cons for change, and commit to decision to change	Collaboratively examine current organizational processes, flowcharts, feedback and recommendations
Preparation: would like to change, may be planning and trying out changes	Develop a plan for change; begin to make behavioral and environmental adjustments for change	Identify specific content areas and staff for training and capacity building activities, leadership and resources; discuss plans for training
Action: beginning to change	Observable changes take place; revise change plan as needed to support change	Engage in capacity building activities, evaluate, and address organizational climate and capacity use; problem solve implementation
Maintenance: have successfully implemented change	Long-term adjustment to change; change becomes integrated into behavior and systems	Sustained capacity use; ongoing relationship for program development, problem-solving, and EBP support; booster sessions, integrate into continuous quality improvement (CQI) processes

(Support System); and (3) current levels of general and innovation-specific capacity use (Delivery System) (Wandersman et al. 2008). In the context of the CCC's work with local agencies, the ISF is a valuable framework for understanding how one can more effectively disseminate best practices for substance abuse and mental health interventions to community-based organizations that serve people living with HIV/AIDS. It provides an overarching conceptualization for our community-centered, multi-level approach to capacity building.

Overview of CCC's ISF Enhancement

Our work with various agencies continually demonstrates that general capacity building—enhancing "general organizational functioning, openness to or willingness to try innovations," ability to carry out interventions to meet agency and funder goals, and agency staff development of relevant skill sets (Wandersman et al. 2008, p. 178)—is critical for innovation-specific capacity building. Livet et al. (2008) indicate that both general organizational functioning and process-specific (i.e., innovation-specific) capacity are necessary for successful dissemination; process-specific organizational capacity may be nested within general organizational capacity in a manner consistent with Bronfenbrenner's ecological perspective (1979). We perceive of organizational culture and climate as having similar relations, whereby organizational climate may be nested within organizational culture. Although Wandersman et al. (2008) describe individual and organizational factors, including culture and climate, as important, broad elements of dissemination and discuss the potential for these factors to interact with particular characteristics of innovations, they appear to place both climate and culture on the periphery of the interacting systems. In the work of the CCC, however, we propose that organizational climate and culture are, in fact, major determinants of an agency's ability to engage in both general and innovation-specific capacity building.

The CCC proposes an expanded emphasis on organizational culture and climate in the ISF (see Fig. 1; new components of the model are highlighted). As originally described, capacity building is a function of the interactions among all three ISF systems. The process begins with the Synthesis and Translation of EBPs and then focuses on

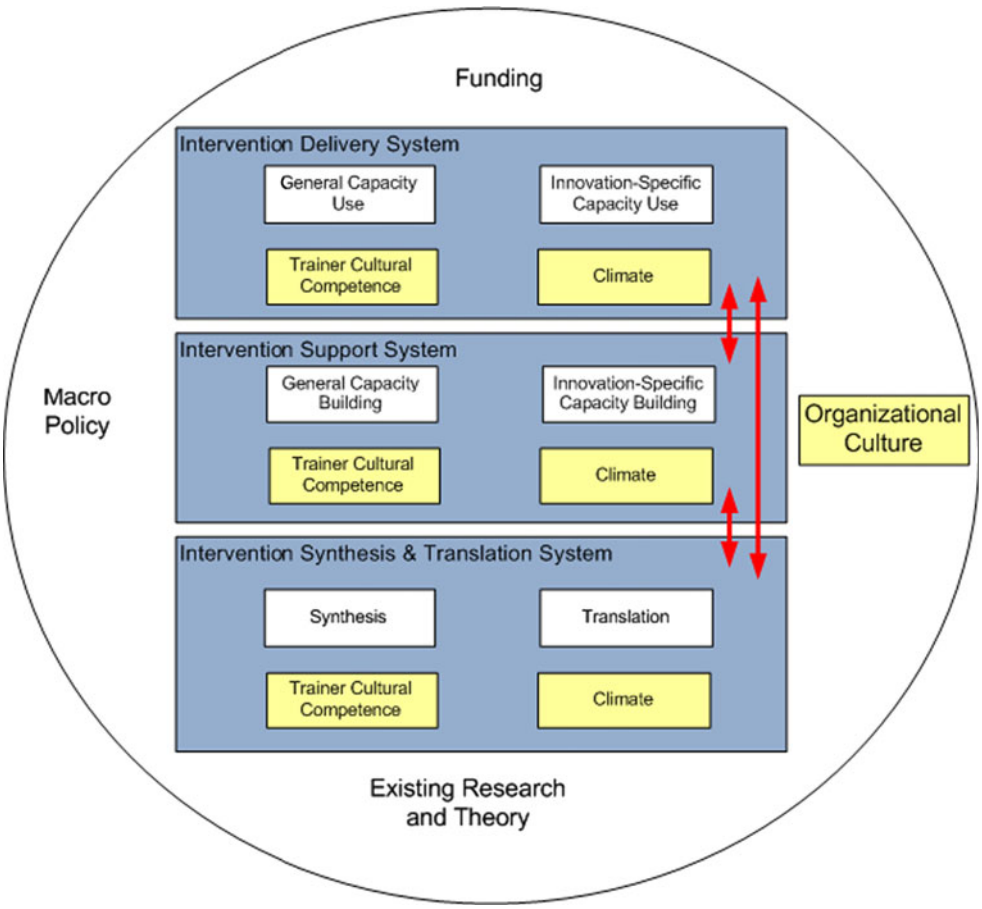

Fig. 1 The CCC's modified interactive systems framework for dissemination and implementation (Wandersman et al. 2008)

the Support System, with the goal of helping agencies to move toward sustainability of the innovation in the Delivery System. Consistent with our enhanced ISF perspective, dissemination involves treating culture as the context within which we engage individual and organizational level change. Thus, organizational culture is a broader contextual factor that influences dissemination and implementation of EBPs alongside funding, macro-policy, existing research and theory; organizational climate, meanwhile, is central to the Interactive Systems Framework and should be considered in each component of the systems (Fig. 1). In our consultation with agencies, we determine how to support the existing agency system. The success of this approach relies on what we call "trainer cultural competence" at each ISF system level to internalize both clinical knowledge and agency cultural dynamics and help shift organizational climate toward building capacity for EBPs.

Cultural competence is a continually evolving concept. Cross et al. (1989) define it as a set of congruent behaviors, attitudes, and policies that come together in a system, an agency or among professionals that enable the system, agency or professionals to work effectively in cross-cultural situations. They also emphasize that culturally competent agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of target and, especially, minority populations.

Whaley and Davis (2007) view cultural competence as a set of problem-solving skills that includes "(a) the ability to recognize and understand the dynamic interplay between the heritage and adaptation dimensions of culture in shaping human behavior; (b) the ability to use the knowledge acquired about an individual's heritage and adaptation challenges to maximize the effectiveness of assessment, diagnosis and treatment; and (c) internalization (i.e., incorporation into one's clinical problem-solving repertoire) of this process of recognition, acquisition and use of cultural dynamics so that it can be routinely applied" (p. 565). Cultural competence has been shown to increase engagement and retention rates in a variety of research, treatment, and training environments when information is presented in tailored formats and flexible interactive styles that are acceptable to and effective in reaching the targeted populations (Aktan 1999; Baer et al. 2009; Bradford 2007; Calsyn et al. 2004).

In Hudley and Taylor's (2006) model cultural competence is viewed as comprising three elements: (a) culturally effective—describes the individual's acquisition of self-knowledge, attitudes and skills; (b) culturally responsive—describes the agency's ability to provide interventions and programming that are responsive and respectful to the service population; and c) culturally engaged—describes the service population's ability to successfully navigate their ecocultural niche (cultural knowledge, cultural pride, positive sense of self, bicultural competence, and the critical awareness to challenge inequality). Consistent with these concepts, the CCC process for organizational capacity building that will be described starts with efforts to understand and respond to organizational climate expressed as individual staff perceptions of their work and its challenges and includes attending to the cultures of individual providers and agencies in an ongoing effort to understand and connect individually and collectively to the values, beliefs, and practices that influence provider receptivity to innovation.

The CCC promotes a process-oriented model of cultural competence that focuses on communication dynamics (Lopez 1997) among consultants, agency staff, and clients, and how culture and climate operate in the here and now of the current conversation. In today's multicultural world filled with multicultural individuals, this approach avoids the pitfalls of cultural stereotyping (by race or ethnicity) that can easily sabotage content-only approaches to cultural competence (Whaley and Davis 2007). Consequently, we believe that the only effective way to recognize and understand another's culture is to interact with and listen to that individual.

The process of effectively engaging agencies for training and capacity building is to a large extent dependent upon the ability of consultants/trainers to communicate understanding of the existing organizational culture and subcultures, creating a bridge through which knowledge and information can pass. The CCC emphasizes several key aspects of cultural competence when providing technical assistance for innovation-specific capacity building and use of MI and SOC, including individual and organizational self-awareness, encouraging a parallel process between trainer and agency/staff, agency and staff, and client and provider, using empathy and respect and adapting approaches and innovations to culture and climate. As both Whaley and Davis (2007) and Lopez et al. (2002) found in other contexts, a process model of training is more likely to successfully address the needs and perspectives of diverse staff.

Although the CCC does not presume an ability to change broader contextual factors (such as the funding sources or the agency culture), it is essential to understand how they influence the agency, how they can be drawn upon to support capacity building, and how these contextual elements can shift over time, providing opportunity and challenges for implementation and sustainability. We address various characteristics of individual capacity

(e.g., buy-in, understanding of the problem, skills, and perceived capacity), as well as organization-level capacity (e.g., fit with patient population, resource availability, collaboration, shared goals and leadership) (Flaspohler et al. 2008). This approach is intended to have an aggregate effect on organizational climate, thereby building general and specific capacity that will support EBP use and accommodate lasting change. Thus, trainer organizational cultural competence is added as a key component at each level of the modified ISF (Fig. 1). Our capacity building activities accommodate the unique experiences, education, disciplines, and service delivery requirements of each targeted agency and staff to ensure that appropriate cultural adaptations are being made to make the innovation and information useful to that agency's staff (Whaley and Davis 2007).

CCC Perspective on Cultural Competence in Capacity Building

The CCC's approach to providing services in a culturally competent manner starts with an awareness of our own cultural norms and how they may influence the consultation with an agency that has its own culture. We view all interactions with targeted agencies as cross-cultural interactions, accepting that our CCC cultural lens may differ from those of the community-based provider agency. Thus, we employ a parallel process that is interactive as well as motivational and instructional to help trainees work through, individually and as a group, several elements of organizational climate including resistance to change (Flaspohler et al. 2008), staff cohesion (Simpson 2002), tolerance for experimentation (Greenhalgh et al. 2004), and perceptions of staff strengths and weaknesses (Fixsen et al. 2005). Thus, while we conceptualize and approach organizational change in ways that are consistent with the motivational and change process tasks described in Table 1 (DiClemente and Velasquez 2002; Kruszynski et al. 2006), we also seek to address the change process of each individual staff member or trainee involved. We find that MI approaches which are sensitive to motivational tasks and stage of change are particularly useful for facilitating these interactions and respecting agency, provider, and patient culture.

A process-oriented approach to cultural competence is one in which the primary skill involved is reflective listening, a critical element of motivational styles of counseling (Miller and Rollnick 2002). When working with agencies, the CCC strives to allow the trainees to lead and teach us about their culture(s), i.e., learning styles, beliefs, conflicts, etc. Through empathic and compassionate listening, the CCC team begins to understand the organizational climate, including the trainees' level of buy-in, motivation and stage of change, and how it affects their ability to engage in innovative capacity building. Thus, we are able to gain an understanding of the agency's customary way of doing things and then internalize that understanding of the organization's systems of meanings, language, behavior, and overall culture (Whaley and Davis 2007).

Cultural competence also involves listening for direct and indirect emotional expressions—that is to say, it requires that we listen to the emotions of our trainees/clients and verbally reflect the perceived feelings. Emotions that are not acknowledged are acted out and can manifest in the trainings and the capacity building process as resistance (Kiefer 2005). The culturally competent consultant/trainer attends to the emotional climate of the participants, thereby creating the emotional space for new learning to occur. For people of color in particular, who represent a large proportion of our providers and clients, attending to the process and the resulting emotions which it engenders may be as important as the product of the intervention (Nichols 1976). Cultural competence for capacity building requires that adaption of strategies and interventions fit consumers' needs, for example, providing content appropriate to participants' age and experience, professional disciplines, service populations, and intended application of EBP (Ball et al. 2002).

Research demonstrates that elements of organizational climate and trainer cultural competence are related in ways that support general and innovation-specific capacity building and are critical for the successful dissemination of EBPs in HIV/AIDS care agencies. Providers working in these settings may report a desire to adopt EBPs and improve patient outcomes, meanwhile feeling critical of top-down strategies for dissemination and doubtful about the efficacy of the innovation with their service population (Owczarzak and Dickson-Gomez 2011). Based on the work of the CCC, we concur with these researchers that providers need to be treated as the experts in their work, and successful dissemination integrates provider characteristics and experiences with ongoing training and technical assistance. However, few studies to date have examined quality of technical assistance within the framework of ISF organizational functioning and dissemination (Livet et al. 2008). Jolly et al. (2003) found that community-based HIV prevention program evaluation staff preferred technical assistance providers with practical expertise, accessibility, cultural competence, communication skills, and collaboration skills. These elements are emphasized throughout the CCC's capacity building process for the dissemination of EBPs, designed to meet the needs of each agency's organizational culture and climate, described as follows.

Overview of the CCC Capacity Building Process

Assessment of Organizational Capacity

The CCC begins collaboration with each agency by assessing organizational capacity using a multi-step, interactive process that encourages and provides opportunities for active agency participation, seeking the input of front-line staff as well as administrators. The first step facilitates the development of a collaborative framework by using both verbal and written needs assessments. An initial meeting is held to gain buy-in from key staff and leadership at the targeted agency, during which we encourage the provider agency to invite as many of its staff to the meeting as they deem appropriate. The meeting includes several CCC staff presenting our approach for improving mental health and substance abuse services for HIV-positive clients. We ask provider agencies to express desired outcomes and perceptions of areas for improvement and general capacities. To further assess aspects of culture, climate, population, and process, we request that a structured, written Needs Assessment be completed by an agency director and primary administrators that includes information about the agency's structure, client population, standards of care, screening and intervention practices, training interests, and continuous quality improvement procedures.

Because initial screening for mental health and substance abuse problems represents the doorway to providing adequate services, CCC staff further assesses agency capacity and climate by conducting observations of clinical interactions with clients, interviewing various staff members, and developing flowcharts of agency processes. The CCC observes a few client intake visits and any other clinical services the agency feels would help the CCC understand client flow and organizational functioning. Information collected from both the Needs Assessment and the observations are synthesized to create a view of the agency that includes: the agency's mission, staff capability and openness, organizational structure, leadership and management style, resource availability, and organizational climate. This information is then integrated into a written report and a visual flowchart of agency processes related to substance abuse and mental health problems that highlight the client journey through the agency—from outreach to intake to treatment or referral for additional services.

Feedback

Personalized feedback is often a part of brief motivational interventions for behavior change (DiClemente et al. 2001). In a follow-up meeting with the agency, the assessment report and flowchart that represents our understanding of client process, elements of organizational structure, current capacity and strengths, and recommendations for organizational capacity-building are shared with agency leaders. Using a motivational, nonjudgmental style of presenting feedback, these reports are presented and discussed, seeking clarification and revision of findings as needed. These "fact-checking" meetings use the methods of participatory action research to support a collaborative environment in which the recommendations for implementation of EBPs are a better fit with the agency culture (Winter and Munn-Giddins 2001). This approach promotes internalization of both clinical EBP knowledge and awareness of the agency's cultural dynamics; both the CCC and the agency share an understanding of needs, and the organization begins to express ownership of the proposed trainings and procedural adaptations, thereby setting the stage for collaboration and innovation-specific capacity building.

To insure that our feedback and understanding of the agency culture and climate are accurate and ongoing, we have developed an in-house process of monitoring and assessing our work with agencies and tracking shifts in climate for innovations. We keep detailed narratives of each interaction, meeting, and training, which are reviewed periodically by trainers to help adapt our consultation model and capacity building strategies.

Training

Our capacity building efforts move from organizational assessment to training and intervention development. The collaborative process between the CCC and each agency results in the creation of staff development and capacity building activities focused on screening and interventions for substance abuse and mental health and enhancing treatment adherence among HIV + clients. During this process we identify specific content areas for trainings, and key staff (subgroups) to be included in the trainings. Meetings and trainings with various agency teams and staff members representing varied professional backgrounds and capabilities provide the CCC team with the opportunity to re-assess and intervene to promote general and innovation-specific capacity (i.e., "the knowledge and skills necessary to implement a specific innovation and the motivation to do so," Wandersman et al. 2008, p. 178).

Much of our training work is focused on enhancing capacity—e.g., re-organizing intake, screening, and assessment practices; increasing engagement and retention rates; improving staff cultural competence (both general and specific to target populations); assisting with grant writing and obtaining funding for mental health and/or substance abuse treatment; or improving the overall functioning of the agency's board of directors. Thus, for some

agencies, our work is primarily in the area of general capacity building, offering skills to address these multiple types of problems faced by agency staff. With other agencies, our work focuses more on innovation-specific capacity building (i.e., MI and stage-based interventions as EBP), assisting with the implementation of standard screening and brief interventions to identify and engage HIV care clients in need of mental health and substance abuse treatment, or methods for making effective referrals for these clients.

Training uses a process of change perspective of the Transtheoretical Model that identifies tasks of the stages of change relevant for targeted behavior change and a range of motivational strategies to facilitate completion of these tasks. Strategies used to convey content and skills include demonstration of the skills and cognitive processes, use of role-plays with actual client scenarios presented by trainees, and feedback to the trainees (i.e., demonstrating what information to attend to and what questions to ask in their own practice of the skills). For example, we demonstrate how a motivational approach can reduce perceived resistance by having the trainee role-play one of their "resistant" clients and a CCC trainer acting as the provider. Remarkably, this kind of trainer/trainee role-playing is rarely done in other training programs (Garb 2005).

Training also focuses on difficult aspects of staff members' jobs (a measure of climate), and what they see as the pros and cons of both their current approach and the suggested new practice, thus engaging them in a decision-making process. In order to influence the staff to consider or adopt a new approach, we use translation of the research literature related to the issues at hand in order to support the perception of pros or payoffs of the training concept or innovation. In the case of MI training, we use challenges and resistant behavior on the part of trainees as opportunities to demonstrate, in vivo, the utility of the empathic and reflective approach to diffuse "resistance" in a parallel process approach. When trainees see the trainers "walking the talk" by using the skills in interactions with them, the interaction creates a higher level of credibility and a climate of openness and mutual respect. Trainers must be willing to be vulnerable in demonstrating skills and be seen as equals with the trainee without sacrificing their role as an expert on the subject matter. By showing respect for trainees and providing a real-life experience of the innovation, our goal is to enhance perceived value of and capacity to utilize the innovation by the individual trainee and the agency.

Evaluation

The CCC continually gathers feedback about the effectiveness of the collaboration with agencies. We ask participants to complete anonymous evaluations following training. These questionnaires provide data with which the CCC evaluates the work and responds. Early feedback suggested that some trainings were overly didactic, which resulted in our additional emphasis on trainee participation methods that highlight the trainee as an expert on his/her client population and difficult cases and include the role-playing techniques described. In general, the evaluation data suggest that respondents have been very satisfied with the overall training experience. Agency feedback often includes themes consistent with the CCC's general capacity building training goals and that trainings be culturally and personally relevant and responsive to staff process issues; when asked to comment on what they have learned, trainees have stated, "focus more on managing my own emotions in sessions," "more self-awareness," and, "I am coming to learn how to be an effective person inside and outside of work."

With regards to MI skills and implementation as a training goal, first-time trainees often report that they are now more aware of and willing to try MI techniques, as evidenced by statements like, "I am more mindful of advice-giving or leading questions," "listening more to what the client is asking for and allowing the client to set up his/her own plan," and "there is a need to understand what the client expresses as his/her needs and go from there—not necessarily what the counselor feels." Supervisory staff often indicate an interest in employing MI principles with their own staff, for instance, noting the "importance of developing a relationship with supervisees that lends to the rest of the process" as well as "the need to maintain boundaries and the importance of keeping a regular supervision schedule." Evaluation comments also often reflect trainees' appreciation for the opportunity to improve and increase staff interaction through CCC consultation and training. Trainees have stated that trainings have "encourage[d] increased communication and feedback among co-workers," and they have appreciated, "everyone's participation…hearing their process of engagement" and "sharing of personal struggles." Other sources of data on training effectiveness include agency performance on subsequent funder site visits and the CCC's own observation of the agency's performance of the skills taught in training during follow-up visits, as well as reports about the use of the EBPs in the agencies.

Capacity Use

As agencies progress from capacity building to capacity use, we adapt our training approach to attend to sustainability of efforts. At the end of a series of trainings or collaborative activities, the CCC meets with agencies to review what support was provided and how to continue to

expand EBPs in the general and specific areas of practice. Consultation support for increasing and sustaining use of the EBPs includes structural changes to supervision, plans for program development, problem solving use of techniques and strategies, and encouraging sustained change and continued use of intervention techniques with clients.

Although action plans and specific implementation outcomes differ for different agencies, at this point in the collaboration, many agencies have made some decisions and created plans for changing practices or approaches, and are entering the action stage of change for implementing best practices and improving their capacity use for more effectively addressing mental health and substance abuse problems with their clients. After trainers have completed the more formal aspects of the consultation, the CCC attempts to create ongoing relationships with agencies to support their implementation, maintenance, and continuous quality improvement (CQI) efforts. This includes communicating readiness to provide booster trainings and consultation as requested by the agency as well as access to evidence-based materials to facilitate long-term capacity use by continuing to provide research-based information and efficacy enhancement for the use of these EBPs. Overall, the CCC's stage-based strategies for assessment, feedback, training, evaluation, and capacity use described in Table 1 are parallel in many ways to the Getting To Outcomes™ System Model described by Wandersman (2009), a useful logic model for planning outcomes-based assistance to organizations.

Agency Case Examples

Although the overall approach used by the CCC is consistent with the ISF model, we found the need to tailor our approaches significantly in light of the cultural differences and needs and types of agencies that we have been asked to assist. Descriptions of our work with two sample agencies (Agency A and B) may provide an operational view of the diversity of CCC collaboration experiences and the integration of an appreciation of culture and context, and also demonstrate what is meant by trainer cultural competence in capacity building.

Agency A

Agency A's organizational culture is that of a large, comprehensive care clinic for the homeless. It includes many departments and services and a large, diverse professional staff including physicians, nurses, social workers, case managers, and addiction counselors. They treat a very needy and low SES target population who engage through appointments as well as daily walk-ins. With regard to existing general capacity, the agency is very well organized in terms of services, leadership, and staffing.

The climate of this large Agency A may be characterized as functional in some departments and stressful in others (Glisson 2007). The climate includes a crisis-management orientation driven by staff perceptions of client needs as being very tangible/materially-driven (e.g., immediate need for identification cards, housing, etc.). Agency A's climate is also characterized by some emotional ambivalence among the staff about strong leadership, as well as by some power struggles between long-time staff and new supervisors. In the needs assessment process, Agency A identified their need for innovation-specific capacity building as training in several areas: structuring and engaging supervision, client empowerment, intra- and interdisciplinary collaboration for client care, and the incorporation of MI into agency culture.

As we collaborated with Agency A in their request for innovation-specific capacity building around MI and SOC, we were able to establish good relations with each of the agency team leaders, provide weekly consultation during Agency A's case conference meeting from an "MI coach" who was a member of the CCC team, and conduct trainings serially with different teams at the agency, tailoring each training to the skill level and experiences of the team members. Agency A's director of mental health and social work had this to say about the collaboration: "Most important was the longitudinal piece. The training lasted 3 months [and] gave time for what I call 'counter-cultural shifts' around practice issues…The shift must be put in the lexicon of the agency, creating a common language…[The training] raised my awareness of parallel process (I use this now in my own trainings) [and] of provider ambivalence and resistance" (Anonymous, personal communication, May 3, 2011). See Table 2 for a comprehensive listing of the capacity building activities conducted with Agency A in terms adapted from the taxonomy provided by Flaspohler et al. (2008).

Agency B

The organizational culture of Agency B is quite different from Agency A, being a small grassroots agency serving African American men who have sex with men (MSM).

The agency staff are mostly volunteers with few paid staff. However, Agency B is the primary vehicle for reaching and engaging an elusive population and providing significant HIV prevention interventions. They provide HIV testing, peer support groups, youth services and community outreach. They are very relationship-oriented with a dynamic leader.

At the time of the consultation, Agency B's climate could be characterized as stressful—i.e., staff members felt

Table 2 Agency case examples of CCC capacity building activities

Capacity	AGENCY A activities
General	Individual
	Staff capability: evaluated understanding, skills, and expertise
	Organizational
	Organizational Climate: provided ongoing collaboration and understanding of needs to build buy-in from staff and facilitate administrative support
	Organizational Climate: used motivational style to evoke tension for change, assess strengths and weaknesses of current practices, and promote a receptive context for change
	Resource availability: helped agency develop standardized screening and tracking forms
	Staff capacity: CCC staff member participated in agency's weekly staff meeting as active consultant on training implementation and planning
Innovation-specific	Individual
	Understanding: responded to agency administrators' concern of staff inexperience with EBPs, Motivational Interviewing (MI) and Stages of Change (SOC)
	Understanding: provided continued access to information and support for MI through on-site support, ongoing trainings ("booster sessions") and email/phone support
	Perceived capacity to implement innovation: created a manual for EBP implementation to fit agency needs and to ensure delivery method was consistent with agency style
	Buy-in: worked with agency staff to illustrate the value of using innovations such as EBP
	Organizational
	Fit and support: responded to administrative request for MI and SOC trainings suited to organizations' needs
	Support: helped develop a climate conducive to implementation of EBPs
	Support: aided in problem-solving to address perceived barriers at trainings through role plays and examples relevant to agency and staff experiences
	Technical assistance and training: tailored training material to meet the needs of agency staff with ongoing consultation and coaching
Climate	Individual
	Attended to administrators' and staff members' needs, goals, values, and perceptions during and after interactions and trainings
	Organizational
	Developed an ongoing relationship that seeks to understand and support organizational climate, goals, values, norms, and practices

Terms and structure adapted from capacity taxonomy provided by Flashpohler et al. (2008)

emotionally exhausted, overloaded, and unable to accomplish tasks (Glisson 2007). Much of the stress that the staff in Agency B perceived was a product of the lack of management systems. It was further characterized by a palpable distrust of large research institutions and technical assistance providers. The climate also included a fluctuating staff morale influenced by a rigid administrative structure, a dynamic leader, and a staff of part-time volunteers who worked with great passion but had few formal systems of support. Many staff members were also clients with high levels of commitment to the work, multiple psychosocial challenges themselves, and little or no professional training.

This agency was a good example of the need for general capacity building. Their Needs Assessment indicated the need for assistance with systems, program development, staff development and grant writing. The challenges to general capacity building included limited organizational capacity and professional training, a somewhat rigid hierarchy, and the lack of trust for those outside of the community. According to the founder/director of Agency B, "[The CCC] made me consciously aware that all capacity building services are not created equal…[They] walked us through clear cut needs assessments, strategies and templates that serve as road maps to quality programming, improvement, assurance, and evaluative measures" (Anonymous, personal communication, April 29, 2011). Our consultation included several cultural adaptations: we provided on-site assistance with intervention groups, thereby becoming a regular presence in the agency; made an effort to learn the terminology for experiences and practices that were unique to the agency clientele;

Table 3 Agency case examples of CCC capacity building activities

Capacity	ACENGY B activities
General	Individual
	Staff capability: evaluated understanding, skills, and expertise
	Organizational
	Organizational Climate: provided ongoing collaboration and understanding of needs to build buy-in from staff and facilitate administrative support change
	Organizational climate: used motivational style to evoke change talk, assess strengths and weaknesses of current practices, and promote a receptive context for change
	Organizational structure: assisted with clarification of staff roles and responsibilities; assisted with organizational strategic planning
	Resource availability: assisted with grant writing to ensure fiscal resources through additional funding
	Resource availability: provided trainings for staff on Mental Health & Substance Abuse, Communication Skills, Stages of Change, and HIV & Treatment Adherence
	Resource availability: enhanced agency infrastructure through development of strategic planning workshop and tracking forms
	Leadership: provided ongoing collaboration, understanding of needs, and buy-in from director and administrative staff
	Staff capacity: provided direct support for staff skills and CCC staff member co-facilitated a therapy group with agency staff member
	External relationships: promoted inter-organizational networking through other CCC collaborations and community relationships
Innovation-specific	Individual
	Understanding: responded to agency director's request for specific changes after the initial rapport building period
	Perceived capacity to implement innovation: modeled delivery of services to staff through group co-facilitation
	Organizational
	Support: collaborated with agency board to ensure ongoing support for training implementation
	Technical assistance and training: provided ongoing consultation and support to agency staff
Climate	Individual
	Attended to administrators' and staff members' needs, goals, values, and perceptions during and after interactions and trainings
	Organizational
	Developed an ongoing relationship that seeks to understand and support organizational climate, goals, values, norms, and practices

Terms and structure adapted from capacity taxonomy provided by Flashpohler et al. (2008)

respected the chain of command and rate of change that was acceptable to agency staff; and utilized CCC staff resources to provide assistance with clinical group management and tasks such as grant writing. See Table 3 for a comprehensive listing of the capacity building activities conducted with Agency B.

Each of these agency examples demonstrates a process of using diverse capacity building strategies to identify and fit the needs of the cultures and climates of the two organizations. One represents a focus on more innovation-specific capacity building, the other general capacity building. Together they represent the importance of honoring and working through the existing culture and attending to individual and organizational dynamics (Aarons and Sawitzky 2006). When this is done successfully, a shifted culture that is receptive to evidence-based innovations can emerge in response to positive changes in climate.

Conclusion

The ISF is a valuable tool for understanding effective dissemination of best practices for substance abuse and mental health interventions for persons living with HIV/AIDS in community-based organizations. At the CCC we enhance the ISF model to incorporate a focus on consultant/trainer cultural competence and agency climate in all three system phases as primary determinants of effective dissemination in the context of organizational culture. It is not enough to have good information or innovative practices. Effective implementation of EBPs requires that we also have an effective, interactive process for dissemination that is culturally competent and thereby responsive to staff issues and perceptions. Our process is based on the use of MI skills, strategies, and attitudes to help us understand organizational culture and recognize organizational stage

of change for both general and innovation specific capacity building. We understand that readiness for change or innovation may not translate across behaviors. Consequently, an organization like Agency B needed general capacity building (e.g., development of resources, policies and procedures, and staff cohesion) before it was ready for innovation-specific capacity building such as training in motivational interviewing and utilization of the stages of change perspective. We use the MI style, strategies, and skills throughout the training process to address climate issues that impede movement through the stages of change, such as trainee ambivalence, decision making, and buy-in that must be attended to in order for dissemination and sustained change to be successful. The case examples presented demonstrate the importance of cultural adaptations, in many forms, to support general and innovation specific capacity building. The CCC's efforts to customize and tailor their trainings and capacity building efforts represent the paradox of the evidence–based movement. Ultimately, our goal is the development of a skilled and empowered staff, as only an empowered staff can empower clients and move from creating a new pattern of agency behavior to maintained change that is sustained over time. While fidelity to EBPs is necessary and desirable, it is only through adapting the presentation and being flexible in their use that they can fit effectively into existing organizational cultures and be accepted by those charged with implementing them. This process, when collaborative, is empowering to the staff and organization and, as such, has a much better chance of creating and sustaining change and incorporating EBPs into the fabric of each agency's treatment system.

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