THE INFLUENCE OF DISSEMINATION TECHNIQUES
ON DIFFERENT EVALUATION STAKEHOLDERS

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The Influences of Dissemination Techniques
on Different Evaluation Stakeholders

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ABSTRACT OF THE THESIS

The Influence of Dissemination Techniques on Different Evaluation Stakeholders
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Evaluation research should be influential, helping to guide behavior, shape policy, and inform decision-making activities. For evaluation research to wield its influence, findings must be communicated in a way that enhances the knowledge of relevant stakeholders. However, previous research on dissemination has only begun to shed light on the effects of various dissemination techniques across multiple stakeholder groups. This study extends this knowledge on dissemination by describing the path dissemination takes, assessing the influence of, and preference for, different dissemination techniques, and how reported influence and preferences differ between stakeholder groups. This study also examines individuals’ beliefs regarding the evaluation and following the dissemination of findings.

Representatives from San Diego County mental health treatment programs (n = 77), Behavioral Health Services division of the Health and Human Services Agency (CMH; n = 4), and the Health Services Research Center (HSRC; n = 4) were interviewed to assess the influence of varying dissemination techniques used to communicate evaluation research findings. The dissemination techniques included an 88-page comprehensive report, a 36-page shortened report, two single paged summaries of findings, and oral presentation of findings during regularly held meetings. Multiple regression analyses for nested (clustered) data were used to assess the overall influence of, and preferences for, each dissemination technique. Additionally, these analyses were used to assess potential differences in influences and preferences corresponding to stakeholder group membership, and stakeholder involvement in the evaluation.

Results suggest representatives from CMH report significantly more involvement in the evaluation than program representatives (\( \hat{\beta} = 1.77, z = 8.87, p < .0005 \)). Additionally, the influence of meetings was significantly greater than the influence of the documents, \( t(16) = -3.93, p = .001 \), which did not differ significantly by stakeholder group, \( t(16) = 0.95, p = .358 \). Findings also suggest the reported appeal of the shortened comprehensive report was significantly greater than the appeal of the full-length comprehensive report. When asked about preferences for dissemination techniques, participants rated the 36-page shortened report significantly more appealing than the 88-page comprehensive report, \( t(7) = -8.52, p < .0005 \), which did not differ significantly by stakeholder group using family-wise alpha protection, \( t(7) = -3.95, p = .008 \).

Findings from this study suggest that, regardless of participant type, meetings supplemented by shortened reports are the best method of dissemination for maximizing
influence of findings. These results are consistent with research on passive diffusion, which has been shown to be ineffective and unlikely to result in influence. Should influence of evaluation research be the primary objective, an active dissemination approach is needed.
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CHAPTER 1

INTRODUCTION

The ultimate goal of evaluation research is social betterment (Christie, 2007; Henry & Mark, 2003; Mark & Henry, 2004; Mark, Henry, & Julnes, 1999; Shaddish, Cook, & Leviton, 1991). Evaluation not only facilitates a greater understanding of how a program works, who the program reaches, and the outcomes a program elicits, but helps provide information necessary to modify a program to help better reach its mission.

However, in order for evaluators’ findings to be used effectively to improve a program, evaluation findings must be disseminated in a way that enhances the knowledge of relevant audiences. Effective dissemination techniques help relevant stakeholders to buy-in to the evaluation findings, and put the findings to their intended use. Reciprocally, ineffective communication may lead to a lack of use, or even a misuse of evaluation results (Shaddish et al., 1991).

To enhance the knowledge of relevant stakeholders, dissemination techniques must be tailored for their corresponding audience. Although many researchers have stressed the importance of tailoring the dissemination strategy to suit the target audience (Di Noia, Schwinn, Dastur, & Schinke, 2003; Fitzpatrick, Sanders, & Worthen, 2003; Lawrenz, Gullickson, & Toal, 2007; Owens, 2001; Patton, 1997; Rosenbaum, 2005; Rossi, Lipsey, & Freeman, 2004), there has been a lack of research specifying which dissemination techniques are best given a particular stakeholder group. Knowing which dissemination techniques lead
to a greater influence of evaluation findings is crucial should an evaluator wish to actually achieve the ultimate goal of social betterment.

The purpose of this thesis is to extend the knowledge on dissemination of evaluation research. Specifically, this thesis uses a specific evaluation research context to investigate the effectiveness of different dissemination techniques by examining which strategies are reported as being most influential, and whether the influence of evaluation research depends on stakeholder group. Additionally, this thesis also investigates the reported preferences for different dissemination techniques, again assessing whether preferences depend on stakeholder group.

This thesis will explore the abovementioned topics within the context of an evaluation task recently asked of University of California San Diego’s Health Services Research Center (HSRC) by San Diego County Mental Health (CMH). San Diego County Mental Health asked HSRC to evaluate outcome measures used to assess client symptoms treated by mental health treatment programs. After evaluating these measures, HSRC was faced with the challenge of disseminating their findings to both CMH and the treatment programs expected to use these outcome measures. University of California San Diego’s Health Services Research Center’s goal in dissemination was that the most valid, most clinically useful, and easily administered measures were chosen for implementation. After much deliberation, outcome measures were chosen for implementation, excluding HSRC’s top recommendation.

As a means of addressing the abovementioned topics regarding dissemination strategies and influence of evaluation research, staff at CMH involved in choosing the outcome measures, as well as program managers/directors, clinicians, case managers, and program staff involved in future implementation of these outcome measures, were asked a
series of questions specific to each dissemination technique. Specifically, these questions assessed the reported influence of evaluation research contingent upon each dissemination method. Additionally, staff at HSRC involved in disseminating the research findings was interviewed to learn why each of the dissemination methods was used, as well as who the intended audiences of each method were. Lastly, participants were surveyed on their preferred methods of receiving information as a means of assessing any stakeholder group differences.

Previous evaluations on dissemination techniques have not only shed light on the effects of various dissemination techniques across multiple stakeholder groups, but they have helped stakeholders find greater use of evaluation findings. Greater understanding of the influence of, and preference for, various dissemination techniques is necessary to perfect HSRC’s, and other evaluator’s, dissemination techniques. Tailoring HSRC’s dissemination techniques accordingly to their intended audiences will facilitate greater influence of their findings, making their services more valuable. Additionally, CMH could increase adherence and improve attitudes towards policies should they also tailor their dissemination techniques accordingly.
CHAPTER 2

LITERATURE REVIEW

GAUGING THE IMPACT OF EVALUATION RESEARCH

Evaluation research is distinct from other basic scientific research. Before the field of evaluation identified and adopted its own standards, basic scientific researchers took responsibility solely for designing studies, collecting data, and publishing findings. Basic scientific research was intended to discover basic principles, while remaining value-free, and the responsibility of translating research findings into practice was ignored. The impact or usefulness of findings is a much higher priority for evaluation research. Evaluation research’s original vision was to contribute to long-term program effectiveness and improved decision making (Patton, 1997). *The Program Evaluation Standards* published by the Joint Committee on Standards for Educational Evaluation (1994) challenges evaluation researchers to take responsibility for use by requiring evaluation research serve the practical information needs of intended users.

Evaluation Use

In 1967, Suchman proposed that the success of an evaluation project will be largely dependent upon its usefulness to the administrator in improving services. The effect evaluation has on that which is being evaluated has been termed evaluation use (Christie, 2007). Throughout the years, the notion of evaluation use has shifted from a narrow,
utilitarian perspective to a more multifaceted construct (Cummings, 1997). Traditionally, evaluation use implied a direct instrumental use—that evaluation findings would lead to immediate and specific actions such as program continuation, expansion, revision or termination (Caracelli, 2000). By the early 1990s, evaluation use as a concept included at least four different kinds of use—instrumental, conceptual, strategic, and process use.

As discussed by Shaddish and colleagues (1991) instrumental use of evaluation findings is most similar to that of the traditional perspective of evaluation use, wherein evaluation findings are overtly used to make decisions. Conceptual use is when evaluation findings help to better understand a program and the issues related to it. Weiss (1977) referred to this as enlightenment, and refers to a general learning that occurs as a result of evaluation. Strategic use, or symbolic use (Mark & Henry, 2004), is when evaluation findings are used strategically to persuade others, or to gain particular outcomes. The notion of strategic use is not necessarily concerned with an outcome or effect of an evaluation, but primarily with the initial intent for conducting the evaluation. The fourth kind of use, process use, was introduced by Patton (1997) to describe the ways within which being involved in the evaluation process can be useful aside from the findings themselves. Specifically, process use includes enhancing shared understandings, supporting and reinforcing the program through intervention-oriented evaluation, increasing participants’ engagement, sense of ownership, and self determination, and program or organizational development (Patton).

**Evaluation Influence**

However multifaceted the perspective of evaluation use has become throughout the years, many still argue against the term *use* for being too results-oriented. For example,
Chelimsky (1997) and Cook (1997) have argued that use may not be a requirement of many evaluation studies. Henry (2002) questions whether use should be the defining goal of evaluation, as it may blind us from the broader goal of social betterment. In 2000, Kirkhart proposed a re-conceptualization of evaluation impact from use to influence as a means of broadening the framework for evaluation impact. Kirkhart defines influence as the “capacity or power of persons or things to produce effects on others by intangible or indirect means” (p. 7). Her integrated theory of influence is based on the notion that influence is comprised of three dimensions; the source, intention, and timing of influence.

**SOURCE OF INFLUENCE**

According to Kirkhart (2000), the source of influence is the starting point of the process of change. Sources of influence arise from either the evaluation process or the evaluation results. Results based sources of influence are similar to the traditional perspective of evaluation use—conceptual, symbolic, and instrumental. Process based sources of influence are more in line with Kirkhart’s re-conceptualization of evaluation impact, emerging during the act of being engaged in the evaluation process. The focus of process use is on an increased understanding among stakeholders, changes in their sense of worth or value, and the development of new relationships among stakeholders.

**INTENTION OF INFLUENCE**

Kirkhart’s (2000) second dimension of influence, intention of influence, is defined as “the extent to which evaluation influence is purposefully directed, consciously recognized, and planfully anticipated” (p. 11). Although intention may be a difficult construct to measure, Kirkhart identifies three general aspects of intention. These aspects include the type
of influence, the target of influence, and the sources of influence (being people, processes, and findings). Kirkhart also identifies other characteristics of intention, being dimension (intended, unintended), explicitness (manifest, latent), orientation (results oriented, process oriented), and direction (positive, negative).

**TIME OF INFLUENCE**

The final dimension of Kirkhart’s (2000) model is the timing of influence. Kirkhart proposed three categories for the time of influence—immediate, which takes place during the study, end of cycle, and long-term.

The Joint Committee on Standards for Educational Evaluation (1994) prioritizes the impact of evaluations, proposing evaluators design and conduct evaluations so that they will be informative, timely, and influential. Despite the noted priority on evaluation impact there is relatively little literature on evaluation influence in comparison to evaluation use (Christie, 2007). Henry and Gordon (2004) suggest that little research “unpacks how evaluations wield their influence” (p. 4). Regardless of whether we term evaluation impact as use or as influence, there is no debating that the impact of an evaluation is critical, particularly when striving towards social betterment. It has become clear that evaluation influence is the mechanism through which evaluation leads to the ultimate goal of social betterment (Lawrenz et al., 2007). However, for evaluation influence to elicit social betterment, people must interact in some way with the evaluation process or the evaluation results.
COMMUNICATING EVALUATION RESEARCH FINDINGS

With practitioners’ busy schedules and the overwhelming amount of output produced through research, an unawareness of, and/or a lack of easy access to, the latest research findings can act as a barrier to the spread of knowledge. Consequently, there has been a movement in the field of scientific publishing towards open access to research results (Hardisty & Haaga, 2008). There is a huge body of knowledge available for discovery, most of which is published in scientific journals. The open access movement suggests that communication of research findings could be improved through increasing accessibility of these scientific journals. The open access movement seeks to make research articles and scientific journals readily available to anyone, any time, free of charge, over the internet.

Despite open access to research findings, the gap between what we know to be true and effective from research and what is actually applied in practice remains. In 1995, the General Accounting Office proposed the problem was not in access to research and evaluation findings, but that “available information is not organized and communicated effectively” (p. 39). Many theorists suggest evaluation research and evaluation research reports be designed in a manner which leads to clear communication of findings, easily understood by relevant stakeholders.

There are many terms used to describe the strategies used to communicate evaluation research findings. Rossi and colleagues (2004) refer to the set of activities through which knowledge about evaluation findings is made available to the range of relevant audiences as dissemination. However, terms such as transfer, diffusion, and dissemination have often been used interchangeably. Consequently, a more thorough discussion of these terms is warranted.
Passive Diffusion of Evaluation Research

The open access movement implies an influence of passive diffusion. In fact, much of the literature on innovation implementation prioritizes diffusion independently to that of dissemination (Frambach & Schillewaert, 2002; Klein, Conn, & Sorra, 2001, Mendel, Meredith, Schoenbaum, Sherbourne, & Wells, 2008). Diffusion is a relatively passive process wherein new knowledge is communicated through certain channels over time among the members of a social system (E. M. Rogers, 1995).

Much of the research analyzing the effectiveness of passive diffusion can be found in the field of health promotion. Examples of passive diffusion as described by the Cochrane Collaboration Effective Practice and Organization of Care (EPOC) Review Group (Grimshaw et al., 2001) included attending conferences, reading medical journals, and mailing clinical practice guidelines. Other examples of passive diffusion as described by Ellis and colleagues (2005) include audit and feedback, and postal delivery.

A growing knowledge of evaluation research implementation has suggested that passive diffusion of innovative research is largely ineffective and unlikely to result in influence (Gotham, 2004; Grimshaw et al., 2001; Kerner, Rimer, & Emmons, 2005; Lomas, 1991; Stirman, Crits-Christoph, & DeRubeis, 2004). Practitioners have continued to express an uncertainty about where and how they should access the best information (Saul et al., 2008). Some even suggest that the volume of available information can lead to information overload (Col, 2005). Even when practitioners have access to various sources of information, there is still confusion regarding which sources of information are credible, and which ones are most relevant to their work (Saul et al., 2008). Some practitioners even express the lack of time to seek out information that is not targeted directly to them (Saul et al.). Weiss
(1987) has noted that policymakers are very busy people, with “little time available for reading,” with no “time to study and analyze” (p. 275). These findings suggest that it is simply not enough for evaluation researchers to rely on diffusion of evaluation findings should influence of findings be a primary objective. Rather, the more active approach of dissemination is necessary.

**Dissemination of Evaluation Research**

Recognition of the failure to translate research findings to widespread use via passive diffusion has led to research designed to help the dissemination of knowledge transfer to a widespread audience. Providing access to evaluation results is the role of dissemination (Lawrenz et al., 2007). Perhaps keeping the abovementioned utility Standards of Evaluation in mind, Hutchinson and Huberman (1993) defined dissemination as “the transfer of knowledge with and across settings, with the expectation that the knowledge will be ‘used’ conceptually or instrumentally” (p. 6). Owens (2001) expanded on the notion of active dissemination even further by defining dissemination as “the process of knowing your clients and systematically providing them, either directly or in partnership with other organizations, with knowledge, strategies, products, and support that can enable them to better solve their problems and enhance their delivery of effective technical education” (pp. ii-iii).

Active dissemination has often been thought of as the answer to bridging the gap between what we know to be true and effective from research, and what is actually applied in practice (Aarons, 2004; Ellis et al., 2005; Gotham, 2006; Haines & Donald, 1998; Hardisty & Haaga, 2008; Leung, 1992; Lipton, 1992; Mendel et al., 2008; Saul et al., 2008; Wandersman et al., 2008). To apply evaluation research findings into practice, individuals must feel
compelled to do so. According to McGuire’s (1968) model of persuasion for attitude and behavior change, five steps exist following the presentation of a message (e.g., evaluation research findings) that are crucial for persuasion. These five steps include attention, comprehension, yielding, retention, and behavior. McGuire reasoned individuals could not be persuaded by messages they take no notice of. Consequently, attention to a message is crucial. The subsequent step in McGuire’s model is comprehension. Once individuals pay attention to a message, they must be able to understand the message in order for the message to influence their attitudes. The next step in McGuire’s model is yielding, wherein individuals accept the message. In this step, McGuire believes attitude change occurs. However, the amount of time attitude change lasts concerns McGuire’s stage of retention. McGuire recognizes the fact that attitudes may change. If attitudes were permanent, we could not hope to change them via persuasion. Finally, McGuire proposed behavior as the final step in his model of persuasion, for persuasion often has the ultimate goal of action. This is indeed the case for bridging the gap between science and practice. As evaluation researchers, we hope our messages will facilitate use in applied settings.

McGuire’s (1968) model is important for understanding the process of translating research findings into practice. Other methods for communicating evaluation research findings work to influence different parts of McGuire’s persuasion process. For example, the open access movement and passive diffusion models of communication help intended audiences to reach McGuire’s attention step of persuasion at most. These models of communication focus on making evaluation research findings more accessible and preventing individuals from taking no notice of their findings, but do nothing to ensure individuals comprehend the message, yield to the message, retain the message, or change behavior.
Where these communication methods fall short within McGuire’s model of persuasion, active dissemination persists. Active dissemination focuses on later steps within McGuire’s model of persuasion, facilitating comprehension, yielding, retention, and behavior change. 

Active dissemination of evaluation research findings differs from that of passive diffusion in that it is a targeted process designed to engage stakeholders—often in the absence of request mechanisms such as the internet, or libraries of scientific publications. Patton (1997) describes it as “inherently participatory and collaborative in actively involving primary intended users” (p. 100). Examples of active dissemination are also widely found in the health promotion literature and include media education campaigns, train-the-trainer models, role modeling and workshops, telephone outreach, lectures, group discussions, and more.

Marlenga, Pickett, and Berg’s (2002) evaluation of enhanced dissemination of the North American Guidelines for Children’s Agricultural Tasks provides a great example of how active dissemination can facilitate utility of evaluation research. The North American Guidelines for Children’s Agricultural Tasks (NAGCAT) were developed to enhance farm parent’s understanding of developmentally appropriate and safe farm work for children aged 7-16 years old. The purpose of their study was to evaluate the influence of the standard dissemination strategy of the guidelines, in comparison to an enhanced dissemination strategy of the guidelines, in regards to parents’ knowledge of and adherence to the guidelines.

Farms across Canada and the United States were randomly assigned to the standard dissemination strategy of the guidelines, or an enhanced dissemination strategy of the guidelines. Specifically, the standard dissemination strategy comprised of mailed copies of the guidelines from the NAGCAT Parent Resource personalized to each farm and corresponding children, along with a signed cover letter. The enhanced dissemination
strategy was a more active approach, and was comprised of much more—a signed letter
describing the project mailed along with a copy of a video on child development, a fact sheet
on child development tailored to the age of children on the farm, a brief, scripted telephone
call to confirm receipt of video and fact sheets, copies of guidelines from the NAGCAT
Parent Resource specific to the participating farm, a brief, scripted telephone call to confirm
receipt of the guidelines and to encourage their active use, and a final letter of encouragement
with a toll-free telephone number for questions.

Results of their study demonstrate parents of the enhanced dissemination strategy
group report significantly greater knowledge of the content of the NAGCAT at both a 6- and
15-month follow up than their standard dissemination strategy counterpart. Additionally,
parents of the enhanced dissemination strategy group report significantly greater active
adherence to NAGCAT in the assignment of work to children than the standard
dissemination strategy group.

The results of Marlenga and colleagues’ (2002) evaluation demonstrate how an
enhanced dissemination strategy, primarily a more active dissemination approach, has greater
influence on stakeholders. Their evaluation also provides evaluators with a variety of
dissemination methods applicable to a wide variety of circumstances. However, their
enhanced dissemination strategy consisted of many different dissemination techniques. It is
unclear as to which methods were of most influence, which methods were of little relevance,
or if the combined package of dissemination methods mediated influence. Consequently,
more information on the influence of particular dissemination methods on stakeholders
would be beneficial.
These active dissemination techniques are believed to facilitate the translation of research into practice. The theory behind this is effective practices are not being applied in the field as a result of a lack of access to evaluations and evaluation findings due to misguided dissemination techniques, particularly a lack of communication and cooperation between researchers and their intended audiences. If evaluation results in a cumbersome report that is too lengthy for relevant stakeholders or uses scientific jargon, it is unlikely the report will be read, and unlikely the evaluation will be influential. Correspondingly, innovation development, implementation, and evaluation are lengthy, costly, endeavors. If practitioners and policymakers fail to recognize evidence for effectiveness from these efforts, they risk creating an endless cycle of reinventing the wheel, or reinventing something less effective (Emshoff et al., 2003). Consequently, it is not only crucial researchers and evaluators actively disseminate their findings as a means of encouraging knowledge transfer, but they must also tailor their dissemination techniques for their relevant audiences. Tailoring their dissemination techniques accordingly not only enhances their audiences’ knowledge of the research and its findings, but may also mediate implementation of effective innovations.

**TAILORING DISSEMINATION TECHNIQUES**

It has been noted that basic scientific researchers “get caught in a ‘one-size-fits-all’ process of dissemination” (Lomas, 1997, p. 3). They are familiar with research methodology, and writing scientific publications, but fail to tailor the format of the dissemination to an audience outside of the research field. In addition to making the information available to relevant audiences, the goal of dissemination is to ensure that the information is
comprehensible. Many researchers have stressed the importance for the dissemination strategy implemented to suit the target audience (Cleary, Walter, & Luscombe, 2007; Di Noia et al., 2003; Fitzpatrick et al., 2003; Lawrenz et al., 2007; Owens, 2001; Patton, 1997; Rosenbaum, 2005; Rossi et al., 2004). Upon evaluating the National Science Foundation’s Advanced Technological Education Program, Western Michigan University’s Evaluation Center has suggested in numerous documents that dissemination practices could be improved if dissemination strategies were targeted to specific audiences (Lawrenz et al., 2007; Owens, 2001). Additionally, Di Noia and her colleagues (2003) have suggested dissemination materials be tailored to the differing prevention needs of relevant stakeholders upon disseminating adolescent drug abuse prevention programs. They suggest doing so may enhance the relevance and appeal of the content for varying stakeholders. Rosenbaum (2005) also proposes the importance that work be “packaged” (p. 167) and explained in ways that make it appealing and accessible.

The rationale for tailoring dissemination strategies reflects theory and practicality. Theory has proposed that professionals and other consumers of information prefer sources that address their particular realities, circumstances, and needs (Gold et al., 1991; Smith, Steckler, McCormick, & McLeroy, 1995). Practically, dissemination strategies tailored for particular audiences can contain more pertinent information if designed with that specific stakeholder group in mind. However, little is known about which dissemination techniques are best for any given stakeholder group.
METHODS FOR EFFECTIVE DISSEMINATION

Although the literature on dissemination stresses the importance of tailoring dissemination strategies for particular audiences and stakeholders, there is a noted lack of research on which dissemination strategies are best (Christie, 2007; Di Noia et al., 2003; Lawrenz et al., 2007; Waddell, 2002). Rosenbaum (2005) suggests that as long as materials are written in plain language, they may be judged equally well by varying audience, but further proposes findings be presented in varied formats, including written, oral, graphic—via the internet, brochures, and so forth. He recognizes that the cognitive processes involved in learning suggest that not all individuals learn similarly, and by varying presentation formats, one can increase understanding of the information. In Mendel and colleagues’ (2008) paper on building evidence on dissemination and implementation in health services research, the importance of tailoring dissemination strategies to particular settings is noted as a critical step in the “transportability of interventions” (p. 29), but do not provide any guidance on exactly how to tailor the dissemination strategy, which strategies are ideal, or even suggest different possible methods of dissemination.

Although there has been a noted lack of research on how to tailor one’s dissemination for varying stakeholders, there are some studies and narratives on the impact of varying dissemination methods. One such study is Lawrenz and colleagues’ (2007) paper on dissemination. Their paper on dissemination provided a reflective case narrative of the influence of various dissemination techniques employed in the process of evaluating the National Science Foundation’s (NSF) Advanced Technology Education (ATE) program. Specifically, they discussed five strategies used to disseminate findings. The first of which,
and perhaps the most traditional dissemination approach, was a full report. Their full report was a very typical primary dissemination technique (Rossi et al., 2004) which contained detailed data, graphs, and recommendations. The authors found that very few NSF staff read the report. Consequently, the authors employed several secondary dissemination techniques, including an executive summary of findings, an oral presentation with power-point slides, a fact sheet, and an online preliminary stat sheet—each designed to meet the needs of their targeted stakeholder groups.

Each of these secondary dissemination methods was designed to communicate results in ways that met the needs of relevant parties, which include NSF staff, ATE project managers, Congress and more. The executive summary contained highlights, or a summary, of the full report, and was reported to be much more widely influential than the full report. The power-point presentation was designed to enhance an oral presentation of the full report. It contained a subset of the information, or the most interesting findings, of the full report. Advanced Technology Education project managers found the slides to be quite interesting and used these presentations at professional meetings. The fact sheet was three pages of key indicators the NSF could use to prepare reports for Congress. National Science Foundation said they “loved the fact sheet” (Lawrenz et al., 2007, p. 283), and Congress must have also thought highly of it because they continued to increase funding to ATE. However, the local ATE projects made very little use of the fact sheet. Finally, the online preliminary stat sheet was an innovative technique ATE project managers could use as they responded to an online web based survey. As the project managers provided their information to the survey, they could sign in and view the project’s data. Some ATE project managers found this capability useful; however, NSF made little use of it.
Lawrenz and colleagues (2007) also used a variety of dissemination techniques for communicating the findings of 13 ATE project site visits. The authors’ original plan was to combine the site visit information into a case study of the ATE program. However, at the advice of the evaluation advisory panel and the NSF, the information from the site visit reports were reorganized into a set of issue papers aligned with nine important aspects of the ATE program. Along with these nine issue papers, the authors made use of five other dissemination techniques: a National Visiting Committee (NVC) Handbook, an overview brochure, a trifold brochure, a video conference, and an electronic synthesis.

The initial nine issue papers were a series of documents synthesizing site visit reports and survey data, along with existing research. Upon request, the NVC Handbook consisted of step-by-step instructions for conducting site visits. The NSF was not interested in the handbook, but the evaluation field was. In fact, the handbook was used by the Centers for Disease Control for developing a new evaluation technique. The overview brochure covered seven of the nine issues, and was created with the intent of building interest in the issue papers. The brochures did in fact raise interest, which was made evident when the authors were invited to publish the issue papers. The NSF staff also made use of the brochures, as well as distributed them to other governmental agencies. The trifold brochure, which is perhaps the most condensed dissemination of the site visit information, was developed at the suggestion of the NSF staff. The trifold brochure was well received by the field, was used by NSF, and was the most popular dissemination technique for the ATE project managers.

Lawrenz and colleagues (2007), ATE project managers, NSF staff, and other ATE program evaluators created a videoconference, discussing one of the nine topics from the issue papers. The NSF staff and ATE project managers found the videoconference to be useful, but other
members of ATE and evaluation communities found little use of it. Finally, Lawrenz and colleagues created an electronic synthesis of all reports, documents, products, and so forth, into an electronic hyperlinked website. This dissemination technique was the most expensive technique, and perhaps the most innovative. However, to this day it has not received much use.

Although Lawrenz and colleagues’ (2007) narrative presents dissemination techniques tailored specifically for their unique stakeholders, perhaps not as generalizable to a wide array of evaluation circumstances, the different preferences for various dissemination methods held amongst stakeholder groups exemplify the need for evaluators to modify their dissemination strategy to suit their corresponding audience. Also noteworthy was the contrasting preferences for dissemination reported by NSF in comparison to the ATE project managers. National Science Foundation’s role was much more executive on a program level, whereas ATE project managers had a more applied, hands-on role in implementing services at a project level. It is plausible other stakeholder groups who take an executive role on a program level will prefer similar dissemination techniques as the methods preferred by NSF. Similarly, perhaps stakeholder groups who take a front-line project level role will prefer dissemination techniques similar to those preferred by ATE project managers. Currently, there is not enough information available in the dissemination literature to make such conclusions regarding different dissemination methods.

**Evaluating the Influence of Dissemination**

Lawrenz and colleagues’ (2007) narrative strongly influenced this current study. More information on the influence of various dissemination methods on varying stakeholder
groups may help guide evaluators’ future dissemination efforts. Knowing which techniques have the greatest influence on particular stakeholder groups enable suitable tailoring of dissemination methods. As a means towards a greater understanding of the most influential dissemination techniques for varying stakeholder groups, this study explores the influence of dissemination within the context of a particular evaluation research project involving University of California San Diego’s Health Services Research Center (HSRC) and San Diego County’s Adult Behavioral Health Division of the Health and Human Services Agency, referred to as CMH (County Mental Health) for the remainder of this paper.

**The Contextual Underpinnings of This Study**

In 2002, HSRC was contracted to work in collaboration with CMH to evaluate the effectiveness of their adult and older adult mental health services. Although the relationship between HSRC and CMH has evolved throughout the years, the basic services requested of HSRC consists of the measurement, collection, analysis, and reporting of health outcomes data to a variety of stakeholder groups.

**UNIVERSITY OF CALIFORNIA SAN DIEGO’S (UCSD) HEALTH SERVICES RESEARCH CENTER (HSRC)**

The HSRC is a small nonprofit organization within UCSD’s Department of Family and Preventive Medicine that provides a variety of research services to academia, corporations, and individuals worldwide. Spearheaded by the direction of Theodore Ganiats, chair of UCSD’s Department of Family and Preventive Medicine, HSRC specializes in the evaluation of health outcomes on a local, national, and global level. The HSRC is comprised of university faculty, staff, and students, as well as San Diego County Mental Health Services
consumers, each with significant academic and practical training within the fields of psychology, public health, anthropology, biology, and computer science.

**WHO/WHAT IS SAN DIEGO COUNTY MENTAL HEALTH (CMH)?**

For ease of communication, this thesis describes an evaluation research collaboration between HSRC and “CMH.” However, a more detailed description of the group I refer to as “CMH” is necessary.

Since 2002, HSRC has worked under the direct supervision/guidance of Quality Assurance/Quality Improvement (QA/QI)—a small group of individuals working under the Mental Health Services facet of the Behavioral Health Division of San Diego County’s Health and Human Services Agency (HHSA; seen in Figure 1). The Behavioral Health Division of San Diego County’s HHSA provides mental health, alcohol, and other drug services for children, youth, families, adults, and older adults. Services include prevention, intervention, and treatment services for individuals with the intention of promoting recovery and social well being. The Mental Health Services QA/QI group maintains an active process designed to identify areas of possible system improvement in these prevention, intervention, and treatment services. They meet regularly to review service program data, develop QA/QI related policies, and are responsible for reporting findings across the appropriate channels within the Behavioral Health Division, and upwards to California’s Department of Mental Health.
Outcome Measures Evaluation
Research Project

As the contract between HSRC and CMH commenced, the concept of mental health recovery was growing in dominance over the traditional, symptom based approach to managing mental illness. Consequently, CMH wanted to move the County of San Diego towards a recovery oriented model of service delivery. To aid in doing so, HSRC was asked to review and recommend outcome measures to assess client recovery for the use in adult outpatient facilities across San Diego County. After reviewing several outcome measures, HSRC began to disseminate their findings and recommendations for implementation to CMH. Similar to Lawrenz and colleagues’ (2007) and Marlenga and colleagues’ (2002) papers discussed above, HSRC employed a number of different dissemination techniques, including a full report, executive summaries, key findings, fact sheets, oral presentations, and email correspondence. County Mental Health and HSRC then further disseminated these findings to treatment program managers, clinicians, case managers, and other treatment program staff. Ultimately, several measures were chosen for implementation across San Diego County, excluding HSRC’s top recommendation.

The goal of HSRC’s dissemination was to ensure the best outcome measures were chosen for implementation. It is therefore important to understand how the various dissemination strategies influenced stakeholders’ attitudes towards the outcome measures. Similar to the role of the NSF and ATE project managers in Lawrenz and colleagues’ (2007) paper, CMH’s role was executive in nature across all treatment programs in San Diego County, while the role of treatment program managers, clinicians, and staff were more applied, and hands-on, at the treatment program level. It is therefore likely the varying roles
of these stakeholder groups may influence preference for particular dissemination strategies as they did in Lawrenz and colleagues’ paper.
CHAPTER 3

PRESENT STUDY AIMS AND HYPOTHESES

This study investigates the influence of both HSRC and CMH’s dissemination techniques within the context of the outcome measures evaluation. There are several broad aims of this study, all geared towards achieving an enhanced understanding of the influence of varying dissemination strategies.

**Aim 1**

The first aim of this study is to provide a narrative of the dissemination techniques used by HSRC and CMH. This narrative is not only intended to record the different dissemination methodologies employed, but also describe which stakeholder groups were the audience of the varying techniques, and why each technique was employed.

**Aim 2**

The second aim of this study is to model the path dissemination takes. As mentioned above, HSRC originally disseminated their findings to CMH. Later, CMH and HSRC disseminated findings to representatives of several of the treatment programs. Ultimately, outcome measures were chosen for implementation. However, between the original dissemination of findings from HSRC to CMH, then final dissemination from CMH/HSRC to program representatives, secondary dissemination was relayed to several stakeholder groups. Metaphorically, this relay of information between groups can be likened to the
childhood game of telephone. The message, as transferred from the original source to the final recipient, mutates throughout the relay across informants. After HSRC originally disseminated their findings to members of CMH, these individuals may have further disseminated this information to other members of CMH. The path this dissemination took throughout stakeholders may have influenced stakeholders’ knowledge of, and ultimate sentiments for, the outcome measures. It is therefore important to understand this path for future dissemination efforts.

**AIM 3**

The third aim of this study is to investigate stakeholder access to the varying dissemination techniques. As mentioned earlier, for an evaluation to be influential, stakeholders must have some form of interaction with the evaluation—either through being informed of the evaluation and/or its findings, or simply by being involved in the evaluation itself. If there were any barriers to one’s access to dissemination, or breakdowns in communication, attitudes towards implementing these outcome measures are likely to be affected. For example, if dissemination of outcome measures failed to reach a particular treatment program, individuals expected to implement these outcome measures at that treatment program may feel negatively about having to do so (which may further hamper the implementation of these outcome measures).

**H1:** All else being equal, there is a positive relationship between individuals’ access to information and positive beliefs towards the selection and implementation of the outcome measures.
**AIM 4**

The fourth aim of this study is to explore which dissemination techniques are associated with greatest influence of evaluation findings. It is plausible certain dissemination techniques may be associated with greater influence of evaluation findings for one stakeholder group in comparison to other stakeholder groups. This study aims to assess these group differences as well. This aim is particularly relevant for greater understanding of dissemination. An enhanced understanding of which dissemination techniques lead to greater influence of findings for a particular stakeholder group may help guide future dissemination efforts.

H2: CMH representatives will express greater influence of findings corresponding to the reports than the oral presentations at meetings.

H3: Program representatives will express greater influence of findings corresponding to the oral presentations at meetings than reports.

It is also plausible certain factors may moderate the extent to which any particular dissemination method is associated with greater influence of evaluation findings. Past research has suggested that one way to improve translation of findings is to increase stakeholder involvement (Col, 2005; Lipton, 1992; Saul et al., 2008; Zeldin, Petrokubi, & MacNeil, 2008). Based on these findings, I expect individuals who were more involved in the process of choosing outcome measures will report greater influence of evaluation findings. For example, a report describing the outcome measures may be more associated with greater influence of evaluation findings for individuals who completely read this report in comparison to individuals who merely skimmed through the document.

H4: The reported influence corresponding to reports will be greater the more individuals read the report.
H5: The reported influence corresponding to oral presentations will be greater the more meetings individuals attend.

**AIM 5**

The final aim of this study is to report stakeholder preferences for dissemination techniques. As mentioned above, it is plausible certain stakeholder groups will have varying preferences for particular dissemination techniques. Knowing this information in advance will again guide future dissemination efforts.

According to Weiss and Bucuvalas (1980), policymakers value high quality research. Specifically, policymakers value high quality research “because it increases the power of research as ammunition in intraorganizational argument. To change minds and mobilize support, it is valuable to have research evidence of sufficient merit to withstand methodological criticism and convince others of one’s case” (p. 253). However, Weiss (1987) has also noted that policymakers do not have a lot of time to study and analyze long reports. Rather, she noted that policymakers prefer summaries of findings. Following Weiss and Bucuvalas’ (1980) observations, I hypothesize CMH will report a preference for reports as a means of receiving information of evaluation findings. More specifically, because Weiss and Bucuvalas’ observations reveal policymakers prefer summaries, I hypothesize CMH will report highest preference for the shortest report HSRC has used to disseminate their evaluation findings. However, because the representatives at the treatment programs are not in a position wherein they need to mobilize support and convince others, as CMH is in, I do not believe they will report a preference for reports. Rather, I predict representatives at the treatment programs will report a preference for receiving information regarding evaluation findings through oral presentations at meetings.
H6: CMH representatives will report greatest preference for reports than any other dissemination method.

H6a: This preference will be greater the shorter the report.

H7: Program representatives will report greatest preference for oral presentations than any other dissemination method.

The goal of social betterment fits in well with HSRC’s goal of evaluating outcome measures for CMH. As mentioned above, the goal of HSRC’s dissemination was to ensure the best outcomes measures were chosen for implementation. Using the best outcome measures available enhances CMH’s knowledge as to which treatment programs lead to ideal outcomes, such as recovery, and which programs are not as effective. County Mental Health is then able to make informed decisions to improve the less effective programs, and model new programs after the programs shown to lead to ideal outcomes—ultimately leading towards social betterment. If the ultimate goal is for the best outcome measures to be chosen so that CMH can make informed decisions for program modification and approach social betterment, it is crucial dissemination of evaluation findings are influential.
CHAPTER 4

METHODOLOGIES

PARTICIPANTS

The individual participants of this study were nested within higher order organizations, resulting in program level, and individual level participants.

Programs

In total, 47 adult and older adult outpatient CMH treatment programs were originally considered for implementing the chosen outcome measures in the near future. These programs vary in the number of clients they serve, whether they are case management only, full service partnerships, or traditional outpatient programs, the number of staff employed, and location across San Diego County. Of these programs, those chosen to be required to use the outcome measures were asked to participate in this current research study.

Individuals

Four representatives from each of the mental health treatment programs, CMH, and HSRC were asked to participate in this study. These four representatives include the program manager/directors of each program, corresponding clinicians, and staff members from each program. For programs consisting of case management only, the program manager/directors and case managers from each of these programs were asked to participate. Additionally, several CMH staff members were heavily involved in the selection of outcome measures.
Specifically, Marshall Lewis, MD (DFAPA, Clinical Director; Behavioral Health Division), Piedad Garcia, EdD, LCSW (Assistant Deputy Director; Systems of Care, Adult/Older Adult Mental Health Services), Candace Milow (Quality Improvement and Performance Monitoring Mental Health Services Chief), and Kathy Anderson (Principle Administrative Analyst, Quality Improvement and Performance Monitoring) made the executive decision of choosing the outcome measures to be implemented, and will consequently be asked to participate in this study. Lastly, several individuals at HSRC involved in evaluating the outcome measures and disseminating the findings were also asked to participate.

**RECRUITMENT**

Two strategies for recruiting participants were employed. First, a letter informing treatment program representatives of this research study, its proposed objectives, participation logistics, and requests for their program’s participation were mailed to all program managers/directors from CMH. This letter also notified program managers/directors to expect a telephone call further requesting their participation in this study.

This telephone call was the second strategy used to recruit participants. During this telephone call, the researcher confirmed receipt of the aforementioned letter, and reminded the program manager/director of this study, its objectives, and participation logistics. It is also during this telephone call the researcher scheduled a time for the treatment program representatives to participate in the study. The researcher obtained each program representative’s email address (when applicable) for later email confirmation of their scheduled participation time.

All program representatives were given a $25 gift certificate for their participation.
INSTRUMENTS

As a means of addressing this study’s aims, HSRC representatives were asked to participate in an interview (Appendix A), and CMH and program representatives were asked to participate in an interviewer administered survey (Appendices B and C). The interviewer-administered surveys were piloted on several evaluation stakeholders prior to official data collection.

Assessing Aim 1

To investigate the first aim of this study, HSRC representatives were interviewed on the varying dissemination techniques employed, and their intended stakeholder audience. Specifically, HSRC representatives were asked a series of open ended questions providing a narrative of each of the dissemination techniques used, why each technique was used, and who the intended stakeholders of each of the techniques were.

Assessing Aim 2

As a means of exploring the path dissemination takes throughout an organization and across treatment programs, each participant was interviewed on how they received access to each dissemination method, from whom they received access, if they shared information of findings to others, and if so, who these individuals were. Several of the questions used to assess the path dissemination takes can be seen in Table 1.

Assessing Aim 3

This aim intends to address stakeholder access to the varying methods of dissemination, and its correlation with program representatives’ beliefs towards the selection
Table 1. Survey Items Assessing Path of Dissemination

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item text</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1.2</td>
<td>From whom did you receive this document?</td>
</tr>
<tr>
<td>M1.19</td>
<td>Did you share this document with any of your coworkers?</td>
</tr>
<tr>
<td>M1.19a</td>
<td>Who did you share this document with? What are their positions here?</td>
</tr>
</tbody>
</table>

and implementation of the chosen measures. As noted above, it is not enough for evaluators to assume findings will diffuse across relevant stakeholders. Stakeholders must interact in some way with the findings in order for them to be influential. To measure stakeholder access to dissemination, each participant was shown each of the documents HSRC created to disseminate findings. The participants were interviewed on whether they had access to each of the documents shown, who they received access from, and to what extent they read the shown documents. Because HSRC disseminated findings orally at meetings, participants were also interviewed on whether they attended each of these meetings. If applicable, participants were also interviewed on their reasons for not attending these meetings in order to assess potential barriers to accessing findings. The HSRC also invited program clinicians to participate in focus groups to discuss the outcome measures. Consequently, program clinicians were interviewed on their participation in these focus groups.

An overall “Involvement” score representing participants’ access to, and involvement with, evaluation findings was calculated for each participant. This score was calculated by aggregating one’s access to each of the dissemination methods, and extent of involvement with each of those dissemination methods (how thoroughly participants read a particular document, number of meetings they attended, etc.). Several of the questions comprising this “Involvement” score can be seen in Table 2. For CMH representatives, this “Involvement”
Table 2. Survey Items Assessing Extent of Involvement

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item text</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1.1</td>
<td>Did you have access to this document?</td>
</tr>
<tr>
<td>M1.3</td>
<td>Please tell me which statement best describes the extent to which you reviewed this document.</td>
</tr>
<tr>
<td>Mtg1</td>
<td>Have you attended any meetings with HSRC to discuss outcome measures?</td>
</tr>
<tr>
<td>Mtg2</td>
<td>Approximately, how many of these meetings have you attended?</td>
</tr>
</tbody>
</table>

score was comprised of the following questions from their respective survey: M1.1, M1.3, M2.1, M2.3, M3.1, M3.3, M4.1, M4.3, Mtg1, Mtg2, and MtgCMH4. For program representatives, this “Involvement” score was comprised of the following questions from their respective survey: B9, B12, B15, M1.1, M1.3, M2.1, M2.3, M3.1, M3.3, M4.1, and M4.3.

The association between this program representatives’ “Involvement” score and a “Beliefs Towards Selection and Implementation of Measures” (BTS&IM) score was also assessed. For each of the survey items comprising the BTS&IM score, participants were asked to report the extent to which they agree with the statements, using a 7-point Likert scale, wherein 0 represents “Disagree very strongly,” and 6 represents “Agree very strongly.” The questions comprising the BTS&IM score from Program Representatives’ “Reported Influence of Dissemination Methods” survey can be seen in Table 3.

Assessing Aim 4

This aim intends to assess the reported influence of evaluation findings corresponding with each dissemination method. This aim also intends to assess group differences in
Table 3. Survey Items Assessing Beliefs Towards Selection and Implementation of Measures

<table>
<thead>
<tr>
<th>Item</th>
<th>Item text</th>
</tr>
</thead>
<tbody>
<tr>
<td>BTS&amp;IM</td>
<td>I believe CMH took my and this treatment program’s perspective into consideration when selecting the outcome measures.</td>
</tr>
<tr>
<td>BTS&amp;IM</td>
<td>I feel CMH chose the most appropriate outcome measures.</td>
</tr>
<tr>
<td>BTS&amp;IM</td>
<td>I anticipate the chosen outcome measures will become one of this program’s routine assessments.</td>
</tr>
<tr>
<td>BTS&amp;IM</td>
<td>I see a need for measuring outcomes.</td>
</tr>
<tr>
<td>BTS&amp;IM</td>
<td>I believe the chosen outcome measures are capable of assessing changes in clients’ symptoms.</td>
</tr>
<tr>
<td>BTS&amp;IM</td>
<td>I believe the chosen outcome measures are capable of assessing clients’ progression towards recovery.</td>
</tr>
</tbody>
</table>

reported influence of evaluation findings corresponding with each dissemination method. A series of survey items were developed in order to assess participants’ reported influence of evaluation findings. For each of the survey items, participants were again asked to state the extent to which they agree with the statement, using a 7-point Likert scale, wherein 0 represents “Disagree very strongly,” and 6 represents “Agree very strongly.”

As described above, evaluation influence is theoretically an extension of the multifaceted construct of evaluation use. Generally, evaluation influence is an umbrella term for each of the varying kinds of use, and refers to the potential impact of persons or things through tangible or intangible means. In order to assess the larger construct of influence of evaluation findings as expressed through the varying dissemination methods, a series of questions were designed to address the subfacets of *instrumental, conceptual, strategic*, and *process use*. The questions concerning instrumental, conceptual, and strategic use were asked in regards to each of the varying dissemination methods. Because process use refers to
the extent to which being involved in an evaluation is influential aside from the findings themselves, the questions regarding process use were asked in regards to the evaluation process itself (as opposed to each of the dissemination methods).

*Instrumental* use describes the extent to which evaluation findings are directly used to make decisions. Although CMH made the executive decision of choosing the outcome measures to be implemented, all stakeholder groups were told the executive decision would be based upon their opinions regarding each of the outcome measures. All stakeholder groups believed they were in a position to make direct use of evaluation findings. Consequently, all stakeholder groups were surveyed on instrumental use. Some of the survey items intended to address instrumental use can be seen in Table 4.

<table>
<thead>
<tr>
<th>Table 4. Survey Items Assessing Instrumental Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item #</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>M1.10</td>
</tr>
<tr>
<td>M1.11</td>
</tr>
</tbody>
</table>

*Conceptual use* refers to a greater understanding of the evaluation and any of its issues. All stakeholder groups were assessed on this subfacet in relation to each of the dissemination methods. Some of the survey items intended to address conceptual use can be seen in Table 5.

*Strategic use* refers to the extent to which findings are used to persuade others or obtain particular outcomes. All stakeholder groups were assessed on this subfacet in relation to each of the dissemination methods. The survey items intended to address strategic use can be seen in Table 6.
Table 5. Survey Items Assessing Conceptual Use

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mtg3</td>
<td>These meetings expanded my knowledge of measuring outcomes.</td>
</tr>
<tr>
<td>Mtg4</td>
<td>These meetings expanded my understanding of each outcome measure.</td>
</tr>
<tr>
<td>Mtg5</td>
<td>These meetings informed me of the issues associated with the outcome measures.</td>
</tr>
</tbody>
</table>

Table 6. Survey Items Assessing Strategic Use

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item text</th>
</tr>
</thead>
<tbody>
<tr>
<td>M4.12</td>
<td>I used this document to persuade others of preferred outcome measures.</td>
</tr>
<tr>
<td>M4.13</td>
<td>I used this document to gain a particular outcome.</td>
</tr>
</tbody>
</table>

*Process use* refers to the extent to which being involved in the evaluation process is influential aside from the evaluation findings themselves. All stakeholder groups were assessed on this subfacet. However, these survey items were not linked to each of the dissemination methods. Rather, these items were asked in relation to being involved in the evaluation process. The survey items intended to address process use can be seen in Table 7.

Table 7. Survey Items Assessing Process Use

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item text</th>
</tr>
</thead>
<tbody>
<tr>
<td>PUse1</td>
<td>Being involved in choosing outcome measures enhanced my knowledge of outcome measures.</td>
</tr>
<tr>
<td>PUse2</td>
<td>My involvement in this evaluation influenced my opinion regarding the outcome measures.</td>
</tr>
<tr>
<td>PUse3</td>
<td>My involvement in this evaluation helped me decide which outcome measures were best.</td>
</tr>
<tr>
<td>PUse4</td>
<td>My involvement in this evaluation helped me understand the issues associated with each outcome measure.</td>
</tr>
</tbody>
</table>
Responses on each of the survey items concerning Instrumental, Conceptual, and Strategic use were aggregated to obtain an “Influence” score specific to each of the dissemination techniques. Regression analyses with Stata’s cluster subcommand were used to assess differences in these “Influence” scores depending upon dissemination method. To assess potential differences in influence depending upon stakeholder group membership, a variable identifying group membership was included in these analyses. An “Overall Influence” score was also calculated to assess the overall influence of HSRC’s dissemination of evaluation findings. Responses for survey items concerning Instrumental, Conceptual, Strategic, and Process use across all dissemination techniques were aggregated to obtain the Overall Influence score. Differences in overall influence between stakeholder groups were assessed using regression analyses, clustering participants by facility.

**Assessing Aim 5**

In order to assess each stakeholder group’s preference for dissemination methods, an “Appeal” score was calculated for each method of dissemination. The survey items intended to assess method Appeal can be seen in Table 8. For each of the survey items, participants were again asked to state the extent to which they agree with the statement, using a 7-point Likert scale, wherein 0 represents “Disagree very strongly,” and 6 represents “Agree very strongly.”

Additionally, all participants were asked a series of open-ended questions wherein they chose which dissemination methods were most useful, which were most informative, and finally, which was their preferred method for receiving information. Some of these questions can be seen in Table 9. Regression analyses with Stata’s cluster suboption were
### Table 8. Survey Items Assessing Appeal

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item text</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1.13</td>
<td>The information in this document was written in a straightforward manner.</td>
</tr>
<tr>
<td>M1.14</td>
<td>This document was easy to read.</td>
</tr>
<tr>
<td>M1.15</td>
<td>This document was an appropriate length.</td>
</tr>
<tr>
<td>M1.16</td>
<td>This document was user-friendly.</td>
</tr>
</tbody>
</table>

### Table 9. Survey Items Assessing Preferences

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item text</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>I want you to think about all of the documents you had access to, all of the meetings you have attended, and (IF APPLICABLE) the focus group you have participated in. Out of these three options, did you find the documents, meetings, or focus groups to be most useful?</td>
</tr>
<tr>
<td>P4</td>
<td>When thinking about all of the documents you had access to, all of the meetings you have attended, and (IF APPLICABLE) the focus group you have participated in, which was the most informative?</td>
</tr>
<tr>
<td>P6</td>
<td>What is your preferred method for receiving information from CMH/HSRC?</td>
</tr>
</tbody>
</table>

again used to assess potential group differences in preferences as indicated by the final question of the survey.

### Statistical Analyses

The data collected in this thesis fall into a nested/multilevel structure. Specifically, there are two levels of data, with individual participants nested within organizations. The micro-level consists of all individual participants, while the macro level consists of higher level groupings, such as the treatment programs they work for. When analyzing multilevel data, it is crucial to account for the dependence of data within groups. If researchers focus solely on the micro level, ignoring any higher-level groupings, standard errors will be
underestimated resulting in inaccurate significance tests. If researchers focus solely on the macro level, all variability within each group is aggregated to a single mean, and any between-group variability found will appear greater than if within-group variability was included (Byrne, 2006). In order to prevent inaccurate standard error estimates, Stata’s cluster command was used (Froot, 1989; W. H. Rogers, 1993; Williams, 2000; Woolridge, 2002). This cluster command allows users to specify a variable that indicates which group each individual belongs to while running any given analysis, such as multiple regression or ANOVA. This cluster command also calculates the intraclass correlation coefficient (ICC), indicating the correlation between levels of data.

**Statistical Power**

Although the entire population of treatment programs expected to implement the outcome measures were asked to participate in this study, several power analyses were conducted beforehand to determine the total number of participants per treatment program to sample. All power analyses were conducted using G*Power power analysis software.

A power analysis of a between factors repeated measures ANOVA, with 47 groups (corresponding to each of the 47 treatment programs considered for implementation) and six repetitions (corresponding to each of the six dissemination methods), was used to assess dissemination-method-specific differences in individuals’ level of influence. Another power analysis of a between-within factors interaction repeated measures ANOVA, with 47 groups and six repetitions was used to assess potential moderating effects of extent of involvement of influence on differences in dissemination-method-specific differences in individuals’ level of influence. Specifically, both of these power analyses were run with \( \alpha = .05 \), using small,
medium, and large effect sizes of .10, .25, and .45 respectively, with small, medium, and large correlations among measures, .1, .3, and .5 respectively (Cohen, 1977, 1988). Results from these power analyses can be seen in Tables 10 and 11.

Table 10. Between Factors Repeated Measures ANOVA: Estimated Sample Sizes by Power, Effect Size, and Correlation Among Methods

<table>
<thead>
<tr>
<th>Estimated power (1 - β)</th>
<th>Effect size (f)</th>
<th>.10</th>
<th>.25</th>
<th>.40</th>
<th>.10</th>
<th>.25</th>
<th>.40</th>
<th>.10</th>
<th>.25</th>
<th>.40</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>799</td>
<td>188</td>
<td>94</td>
<td>1,269</td>
<td>235</td>
<td>141</td>
<td>1,739</td>
<td>329</td>
<td>141</td>
</tr>
<tr>
<td>.80</td>
<td>.85</td>
<td>846</td>
<td>188</td>
<td>94</td>
<td>1,410</td>
<td>282</td>
<td>141</td>
<td>1,927</td>
<td>376</td>
<td>141</td>
</tr>
<tr>
<td>.90</td>
<td></td>
<td>940</td>
<td>188</td>
<td>94</td>
<td>1,551</td>
<td>282</td>
<td>141</td>
<td>2,162</td>
<td>376</td>
<td>141</td>
</tr>
<tr>
<td>.95</td>
<td></td>
<td>1,081</td>
<td>235</td>
<td>141</td>
<td>1,786</td>
<td>329</td>
<td>141</td>
<td>2,491</td>
<td>423</td>
<td>141</td>
</tr>
</tbody>
</table>

Because there is no previous research allowing the estimation of the magnitude of the relationships between the influence of each of the dissemination methods, the sample size suggestions corresponding to small correlations among methods are appropriate for both analyses assessed in aim 4. Specifically, given a moderate effect size of .25 with adequate power of at least .80, the minimum total sample size is \( n = 188 \) individuals, or four participants per group.

To assess aim 3 and aim 5, multiple regression models were used to determine the association between one’s level of involvement and attitudes towards the outcome measures, as well as the potential group differences in preferences. An omnibus \( R^2 \) multiple regression
Table 11. Between-Within Factors Interaction Repeated Measures ANOVA: Estimated Sample Sizes by Power, Effect Size, and Correlation Among Methods

<table>
<thead>
<tr>
<th>Effect size ($f$)</th>
<th>.80</th>
<th>.85</th>
<th>.90</th>
<th>.95</th>
<th>Correlation between methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>.10</td>
<td>940</td>
<td>1,034</td>
<td>1,128</td>
<td>1,269</td>
<td>.10</td>
</tr>
<tr>
<td>.25</td>
<td>188</td>
<td>188</td>
<td>235</td>
<td>235</td>
<td>.30</td>
</tr>
<tr>
<td>.40</td>
<td>94</td>
<td>94</td>
<td>141</td>
<td>141</td>
<td>.50</td>
</tr>
<tr>
<td>.10</td>
<td>752</td>
<td>799</td>
<td>893</td>
<td>987</td>
<td>.10</td>
</tr>
<tr>
<td>.25</td>
<td>141</td>
<td>188</td>
<td>188</td>
<td>188</td>
<td>.30</td>
</tr>
<tr>
<td>.40</td>
<td>94</td>
<td>94</td>
<td>94</td>
<td>94</td>
<td>.50</td>
</tr>
<tr>
<td>.10</td>
<td>517</td>
<td>564</td>
<td>658</td>
<td>705</td>
<td>.10</td>
</tr>
<tr>
<td>.25</td>
<td>141</td>
<td>141</td>
<td>141</td>
<td>141</td>
<td>.30</td>
</tr>
<tr>
<td>.40</td>
<td>94</td>
<td>94</td>
<td>94</td>
<td>94</td>
<td>.50</td>
</tr>
</tbody>
</table>

power analysis using one predictor was assessed, using Cohen’s (1977, 1988) size conventions for small, medium, and large effect sizes for omnibus multiple regression analyses, which are .02, .15, and .35, respectively. However, this power analysis does not take the multilevel nature of these data into account. In multilevel data structures, even a relatively small ICC can have adverse effects on power, requiring larger sample sizes. Using the Donner and Klar (2000) formula for the variance inflation factor (VIF), which is also referred to as the design effect (Murray, 1998), we can determine adjusted sample size requirements in the presence of clustering. If an unclustered design for a randomized controlled trial requires $n$ patients per group to detect the desired effect size with adequate power and $\alpha = .05$, then the VIF allows us to adjust the sample size for a positive ICC. If we sample $m$ individuals per cluster, then we must inflate the sample size by a factor of $(1 + [m - 1] ICC)$. According to Cohen’s (1977, 1988) size conventions for ICCs, small ICCs are .05, medium are .10, and large are .15. Using these size conventions, the VIFs when $m = 4$ are
1.15, 1.3, and 1.45 for small, medium, and large ICCs, respectively. The results from the power analyses for aim 3 and aim 5, adjusted with the VIFs, are shown in Table 12.

Table 12. Omnibus $R^2$ Multiple Regression With One Predictor: Estimated Sample Sizes by Power, Effect Size, and Correlation Among Methods Adjusted With the Variance Inflation Factor

<table>
<thead>
<tr>
<th>Effect size ($f$)</th>
<th>.80</th>
<th>.85</th>
<th>.90</th>
<th>.95</th>
<th>Intraclass correlation coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>.02</td>
<td>454.25</td>
<td>518.65</td>
<td>607.2</td>
<td>749.8</td>
<td>.05</td>
</tr>
<tr>
<td>.15</td>
<td>63.25</td>
<td>71.3</td>
<td>83.95</td>
<td>102.35</td>
<td>.05</td>
</tr>
<tr>
<td>.35</td>
<td>28.75</td>
<td>32.2</td>
<td>37.95</td>
<td>46.0</td>
<td>.05</td>
</tr>
<tr>
<td>.02</td>
<td>513.5</td>
<td>586.3</td>
<td>686.4</td>
<td>847.6</td>
<td>.10</td>
</tr>
<tr>
<td>.15</td>
<td>71.5</td>
<td>80.6</td>
<td>94.9</td>
<td>115.7</td>
<td>.10</td>
</tr>
<tr>
<td>.35</td>
<td>32.5</td>
<td>36.4</td>
<td>42.9</td>
<td>52.0</td>
<td>.10</td>
</tr>
<tr>
<td>.02</td>
<td>572.75</td>
<td>653.95</td>
<td>765.6</td>
<td>945.4</td>
<td>.15</td>
</tr>
<tr>
<td>.15</td>
<td>79.75</td>
<td>89.9</td>
<td>105.85</td>
<td>129.05</td>
<td>.15</td>
</tr>
<tr>
<td>.35</td>
<td>36.25</td>
<td>40.6</td>
<td>47.85</td>
<td>58.0</td>
<td>.15</td>
</tr>
</tbody>
</table>

Results from this power analysis suggest that 188 individuals, 4 participants per group, is more than sufficient to detect moderate effect sizes with adequate power of at least .8. Specifically, this analysis suggests that to detect moderate effect sizes with power of at least .8, sample sizes of approximately $n = 64, 72, \text{ and } 80$ for small, medium, and large ICCs, respectively, are required.
CHAPTER 5

RESULTS

The following presentation of results opens with a discussion of this study’s resulting participants from the treatment programs, CMH, and HSRC. Participation from the treatment programs is discussed at both the program level, and individual level.

Following the description of study participation, results of the analyses are addressed accordingly to each of the study aims. Whenever appropriate, analyses will be reported separately for each dissemination method, then aggregated across the entire evaluation.

PARTICIPANTS

Three stakeholder groups were asked to participate in this study, which includes Program Representatives, CMH Representatives, and HSRC Representatives.

Program Representatives

At the time of this study, CMH decided only 26 of the 47 outpatient mental health treatment programs would be expected to implement the chosen outcome measures. Of these 26 programs, 21 agreed to participate in this study. Participants from each these programs reported serving 99 to 1,200 clients ($M = 454.73$, $Med = 400$, $s = 310.91$) with severe mental illness. Approximately 45.5% of program representatives reported the most common primary diagnosis of their clients was schizophrenia, 24.7% reported major depressive disorder, 16% reported bipolar disorder, 6.2% schizoaffective disorder, and the remaining 7.6% reported
The majority of participating programs were in San Diego County’s Central region (57.1%), while approximately 10% were in the East region, 10% were in the North Central region, 10% were in the North Coastal region, 10% were in the North Inland region, and 4.8% were in the South region (see Table 13).

Most of the programs participating in this study had representation from four staff members (71.4%), while 14.3% had three staff members participating, 4.8% had two staff members participating, and 4.8% had five staff members participating, for a total of 77 program representatives participating in this study. Of these participants, 62 (80.5%) were female, and 15 (19.5%) were male. Fifty-seven (74%) participants earned a Master’s degree, nine (11.7%) earned a Bachelor’s degree, seven (9%) earned a Doctoral degree, three (3.9%) earned an Associate’s degree, and one (1.3%) completed some college.

Of these 77 participating program representatives, 22.1% were Psychosocial Rehabilitation Specialists, 15.6% were Case Managers, 14.3% were Program Managers/Coordinators, 13% were Licensed Mental Health Clinicians, 7.8% were Directors, 7.8% were Interns, 6.6% were Psychiatric Social Workers, 5.2% were Counselors, 3.9% were Registered Nurses, and the remaining 3.9% worked under another job title (see Figure 2).

**County Mental Health (CMH) Representatives**

Four representatives from CMH also participated in this study. Of these four participants, one was male. Two of these participants earned Master’s degrees, one earned a doctoral degree (PhD), and another earned a professional degree (MD). One of these participants was the Clinical Director of San Diego County’s Health and Human Services
### Table 13. Reported Number of Clients Served and Most Common Primary Diagnoses per Program

<table>
<thead>
<tr>
<th>Program</th>
<th># Clients</th>
<th>Most common primary diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Areta Crowell Center</td>
<td>397-516</td>
<td>Schizoaffective/Bipolar/Major Depressive Disorder</td>
</tr>
<tr>
<td>Center Star ACT</td>
<td>99-111</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Central Case Management</td>
<td>300</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Family Health Center Hillcrest</td>
<td>250</td>
<td>Axis II</td>
</tr>
<tr>
<td>Family Health Center Logan Heights</td>
<td>200-750</td>
<td>Major Depressive Disorder</td>
</tr>
<tr>
<td>Jane Westin Wellness &amp; Recovery Center</td>
<td>540</td>
<td>Schizophrenia/Schizoaffective/Bipolar/Major Depressive Disorder</td>
</tr>
<tr>
<td>Project Enable</td>
<td>300</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Providence Community Services</td>
<td>130-400</td>
<td>Bipolar Disorder</td>
</tr>
<tr>
<td>South East Mental Health Center</td>
<td>420</td>
<td>Major Depressive Disorder</td>
</tr>
<tr>
<td>Telecare Access</td>
<td>110</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Telecare ACT</td>
<td>110-215</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>UCSD Outpatient Psychiatric Services</td>
<td>1,000</td>
<td>Major Depressive Disorder</td>
</tr>
<tr>
<td>East Region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heartland Center</td>
<td>234-320</td>
<td>Bipolar</td>
</tr>
<tr>
<td>East County Mental Health Center</td>
<td>960</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>North Central Region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Douglas Young Clinic</td>
<td>400</td>
<td>Major Depressive Disorder</td>
</tr>
<tr>
<td>North Central Mental Health Center</td>
<td>1,100</td>
<td>Major Depressive Disorder</td>
</tr>
<tr>
<td>North Coastal Region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Coastal Mental Health Center</td>
<td>1,000</td>
<td>Schizophrenia/Bipolar</td>
</tr>
<tr>
<td>Vista Case Management</td>
<td>280</td>
<td>Schizophrenia/Schizoaffective Disorder</td>
</tr>
<tr>
<td>North Inland Region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BPSR Kinesis</td>
<td>500</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Heritage Clinic East</td>
<td>250-1,000</td>
<td>Schizophrenia/Bipolar</td>
</tr>
<tr>
<td>South Region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maria Sardiñas Center</td>
<td>504</td>
<td>Major Depressive Disorder</td>
</tr>
</tbody>
</table>
Figure 2. Job titles of participating program representatives.

Agency, two of these participants were directors of distinct facets of the Behavioral Health Division of the Health and Human Services Agency, and one participant was an Administrative Assistant for the Behavioral Health Division of San Diego County’s Health and Human Services Agency. These participants have worked for San Diego County Health and Human Services Agency between 2 and 25 years ($M = 9.75$ years, $Med = 6$ years, $s = 10.37$ years).

Health Services Research Center (HSRC) Representatives

Four representatives from UCSD’s Health Services Research Center participated in this study. Of these four participants, one was female. Three of these participants have
earned a doctoral degree (PhD) in clinical psychology, and one of these participants was completing a Master’s degree. All participants were heavily involved in the evaluation and dissemination of outcome measures.

**RESEARCH AIMS**

Altogether, there were five research aims of this study. The first was to provide a narrative of the dissemination techniques used. The second was to model the path of dissemination. The third was to investigate stakeholder access to dissemination. The fourth was to assess the influence of dissemination techniques. The fifth was to report stakeholder preferences for dissemination techniques.

**Aim 1: Dissemination Techniques**

Health Services Research Center representatives were interviewed to learn which dissemination methodologies were employed, who the intended audiences of the varying techniques were, and why each technique was employed. All HSRC representatives were in agreement as to which dissemination methods were used, and who their intended audiences were. Overall, there were five main methods HSRC used to disseminate evaluation findings to County and treatment program representatives. These included two comprehensive reports of findings (Full Length and Shortened Report), two single-paged summaries of findings (Full Length and Shortened Summary), and oral presentation and discussions of findings, with supporting documents, during regularly held Outcomes Committee Meetings. Health Services Research Center representatives were not in agreement regarding why each technique was employed.
METHOD 1: FULL LENGTH REPORT

When asked to evaluate outcome measures for future implementation, HSRC initially presented their findings via an 88-page report to members of CMH’s Quality Improvement and Performance Monitoring (QI) team. The report opened with an introduction to measuring outcomes with recovery based measures, continued with a one-page summary of 12 recovery based outcome measures, then provided a more detailed description of each measure, including the instrument itself. This report was sent to the QI team members via email, who then reviewed the document before forwarding it to a group of treatment program representatives, also via email. The treatment program representatives included in this email were instructed to share/review the document with other program representatives in preparation for Outcomes Committee meetings (further discussed below).

METHOD 2: SHORTENED REPORT

As the evaluation of recovery based outcome measures progressed, certain outcome measures were deemed impractical, and HSRC narrowed their focus to five outcome measures with the greatest potential for future implementation. As a result, HSRC drafted a second report of findings. This second report was 36 pages long, formatted similarly to the previously mentioned report of findings, but included descriptions of only five recovery based outcome measures. As with the previous report, this document was first sent via email to QI members for initial review, then forwarded to treatment program representatives, also via email, to be shared/reviewed in preparation for Outcomes Committee meetings.
METHOD 3: FULL LENGTH SUMMARY

To aid discussions comparing the initial 12 outcome measures considered for implementation, HSRC created a full length summary of measures to be printed and distributed during the Outcomes Committee meetings. This summary listed all 12 outcome measures, each measure’s strengths, weaknesses, and length of time of administration.

METHOD 4: SHORTENED SUMMARY

As the evaluation progressed and all stakeholders narrowed their focus to the five potential outcome measures, HSRC created a shortened summary of measures to be printed and distributed during the Outcomes Committee meetings also to aid discussions comparing the measures. Similar to the Full Length Summary, the Shortened Summary page listed the five outcome measures, each measure’s strengths, weaknesses, and length of time of administration (see Figure 3).

OUTCOMES COMMITTEE MEETINGS

Both the Full Length Report and the Shortened Report were sent to QI for initial review, who then forwarded the documents to a group of treatment program representatives. Recipients of this email, who included treatment program directors and managers, were asked to review/share the documents with other treatment program representatives in preparation for Outcomes Committee meetings. These Outcomes Committee meetings were held approximately monthly at CMH offices. Email recipients were asked to either attend, or appoint another program representative to attend, these meetings.

During these meetings, HSRC staff would present the findings as documented in the various reports to CMH and treatment program representatives. All attendees of these
**Clinic Perception of Progress**
Functional Assessment Rating Scale (FARS)
Illness Management and Recovery (IMR) Scale

**Client Perception of Individual Recovery**
Recovery Markers Questionnaire (RMQ)
Illness Management and Recovery (IMR) Scale

**Recovery Orientation of the System**
Recovery Self-Assessment (RSA)
Recovery Oriented System Indicators (ROSI-ADP)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Time</th>
</tr>
</thead>
</table>
| FARS    | Clinically useful for treatment planning.  
Comprehensive, many different domains.  
Parallel with CFARS in children’s system.  
Incorporated into new Anassad MIS. | Only gathers information from therapists.  
Training supplied online might not be enough to insure reliability.  
Although it measures strengths, perhaps still too problem-oriented.  
(Can supplement with recovery based measure and add more strength items.) | 5-10 min. |
| RMQ     | Provides opportunity for comprehensive assessment.  
Agencies can find out where consumers are in the recovery process.  
Well researched and validated.  
Minimizes provider burden. | Only gathers information from consumers. | 5-10 min. |
| IMR     | Strong face validity.  
Brief and easily administered.  
Includes objective descriptors for the ratings.  
Provides both consumer and clinician ratings.  
Clinician measure may be used alone. | Validation process is in the early phases.  
Predictive validity of the scales still needs to be assessed.  
May need to be done as interview with many clients.  
Consumer measure may not be as good as other instruments. | 10 min. |
| RSA     | Strong link to theory.  
Participatory process of development.  
Strong face validity and internal consistency on factors.  
Easy to administer and score. | May be more prone to socially desirable responses.  
Consumer measure dependent on individual knowledge of agency practices. | 5-10 min. |
| ROSI    | Rigorous development grounded in consumer experiences.  
Administrative-Data Profile creates no burden of questionnaires. | Limited depth of assessment of recovery orientation of the service systems. | N/A |

Figure 3. Shortened summary.
meetings were encouraged to discuss the practical considerations of implementing each outcome measure in their treatment programs, with their respective clientele. After several months of discussing potential outcome measures, a group of regular attendees formed, referred to as the Outcomes Committee. This Outcomes Committee eventually discussed the possibility of pilot testing several of the measures. As a result, several treatment program representatives agreed to have their program pilot test the measures, after which pilot test results were discussed at later held Outcomes Committee meetings.

After approximately one year since the inception of the Outcomes Committee meetings, the Outcomes Committee chose three recovery based outcome measures for implementation.

**Aim 2: Dissemination’s Path**

As a means of exploring the path dissemination takes throughout an organization and across treatment programs, each participant was asked a series of questions on how they received access to each dissemination method, from whom they received access, if they shared information of findings to others, and if so, who these individuals were.

As mentioned earlier, HSRC first disseminated evaluation findings with a Full Length Report. Three of the four CMH representatives participating in this study reported having shared this document with their personal team of staff members, and 38.5% of program representatives reported having shared this document with other program staff—of which 40% of respondents reported sharing this document with all staff, 40% reported sharing this document with their director, and 20% reported sharing this document with clinical staff.
The HSRC then disseminated its findings with the Shortened Report. All CMH representatives reported having shared this document with other CMH staff—including all CMH staff \((n = 1)\), their director \((n = 1)\), and their personal team of staff \((n = 2)\). Half of the program representatives participating in this study reported having shared this document with other program staff, including all program staff \((28.6\%)\), clinical staff \((42.9\%)\) or the program director \((28.6\%)\).

The HSRC also disseminated its findings with two, one page, summary of findings—a full length summary and a shortened summary. One CMH representative shared the full length summary with their own team of staff, whereas three CMH representatives shared the shortened summary with all staff \((n = 1)\), directors \((n = 1)\), or my team of staff \((n = 1)\). Only 15.4\% of program representatives reported sharing the full length summary, whereas 18.2\% reported having shared the shortened summary with other program staff. Of those who shared these documents, half reported having shared the documents with program directors, and the other half reported having shared the documents with all staff.

Despite several program representatives having reported sharing various documents with other program staff members, only three of these staff members reported having received these shared documents. The intended path of dissemination, as well as the actual path of dissemination, can be seen in Figures 4 and 5. Within these figures, the mutual sharing and receiving of information between organizations is represented with double-sided arrows. As expected, the visual representation of the intended path of dissemination includes many double-sided arrows between all organizations. Unfortunately, the majority of outcomes committee members report not having shared the documents with other program staff. Even when outcomes committee members report having shared the documents with
Figure 4. Visual representation of the intended path of dissemination.

Figure 5. Visual representation of the actual path of dissemination.
other program staff, the majority of these program staff members report not having received these documents. Consequently, the visual representation of the actual path of dissemination has far fewer double-sided arrows between organizations.

**Aim 3: Access, Involvement, and Belief Towards Selection and Implementation of Measures**

The third aim of this study was to investigate stakeholder access to the dissemination of outcome measures, involvement in the evaluation, and beliefs about the selection and implementation of outcome measures. Results of this aim will be reported first by describing access to each method of dissemination, then presenting findings regarding participants’ overall involvement in the evaluation. Then results regarding the hypothesized relationship between involvement and beliefs about the selection and implementation of outcome measures will be addressed.

**METHOD 1: FULL LENGTH REPORT**

Of the 81 participants interviewed (77 program representatives and 4 CMH representatives), 17 (21%) reported having access to the full length report. Of the participants who reported having access to this document, 17.6% \( n_{\text{programrep}} = 3 \) reported having skimmed through the document, 29.4% \( n_{\text{programrep}} = 4, n_{\text{CMHrep}} = 1 \) reported having read less than half the document, 5.9% \( n_{\text{programrep}} = 1 \) reported having read half the document, 35.5% \( n_{\text{programrep}} = 3, n_{\text{CMHrep}} = 3 \) reported having read more than half the document, and 11.8% \( n_{\text{programrep}} = 2 \) reported having read the whole document. Reported access to this dissemination method differed significantly by participant type such that CMH representatives reported having access more frequently than program representatives,
$R^2 = .20, \hat{\beta} = .83, t(22) = 18.80, p < .0005$. Although more than 5% of the variance in the extent to which this report was reviewed was explained by participant type, it did not significantly differ between CMH representatives and program representatives, $R^2 = .05$, $\hat{\beta} = .73, t(11) = 1.41, p = .19$.

**Method 2: Shortened Report**

Of the 81 participants interviewed, 18 (22.2%) reported having access to the shortened report. Of the participants who reported having access to this document, 22.2% ($n_{\text{programrep}} = 4$) reported having skimmed through the document, 22.2% ($n_{\text{programrep}} = 3$, $n_{\text{CMHrep}} = 1$) reported having read less than half the document, 27.8% ($n_{\text{programrep}} = 3$, $n_{\text{CMHrep}} = 2$) reported having read more than half the document, and 27.8% ($n_{\text{programrep}} = 4$, $n_{\text{CMHrep}} = 1$) reported having read the whole document. Reported access to this dissemination method differed significantly by participant type such that CMH representatives reported having access more frequently than program representatives, $R^2 = .18, \hat{\beta} = .82, t(22) = 21.38, p < .0005$. Although approximately 4% of the variance in the extent to which this report was reviewed was explained by participant type, it did not differ significantly between CMH representatives and program representatives, $R^2 = .04, \hat{\beta} = .75, t(13) = 1.44, p = .18$.

**Method 3: Full Length Summary**

Of the 81 participants interviewed, 17 (21%) reported having access to the full length summary. Of the participants who reported having access to this document, 23.5% ($n_{\text{programrep}} = 3$, $n_{\text{CMHrep}} = 1$) reported having skimmed through the document, 5.9% ($n_{\text{CMHrep}} = 1$) reported having read half the document, 17.6% ($n_{\text{programrep}} = 2$, $n_{\text{CMHrep}} = 1$) reported having
read more than half the document, and 52.9% \( (n_{\text{programrep}} = 8, n_{\text{CMHrep}} = 1) \) reported having read the whole document. Reported access to this dissemination method differed significantly by participant type, such that CMH representatives reported having access more frequently than program representatives, \( R^2 = .20, \hat{\beta} = .83, t(22) = 20.42, p < .0005 \). Although approximately 3% of the variance in the extent to which this document was reviewed was explained by participant type, it did not differ significantly between CMH representatives and program representatives, \( R^2 = .03, \hat{\beta} = -0.67, t(12) = -1.46, p = .17 \).

**METHOD 4: SHORTENED SUMMARY**

Of the 81 participants interviewed, 17 (21%) reported having access to the shortened summary. Of these participants, 20% \( (n_{\text{programrep}} = 2, n_{\text{CMHrep}} = 1) \) reported having skimmed through the document, 6.7% \( (n_{\text{programrep}} = 1) \) reported having read less than half the document, 6.7% \( (n_{\text{programrep}} = 1) \) reported having read half the document, and 66.7% \( (n_{\text{programrep}} = 7, n_{\text{CMHrep}} = 3) \) report having read the whole document. Reported access to this dissemination method differed significantly by participant type, such that CMH representatives reported having access more frequently than program representatives, \( R^2 = .23, \hat{\beta} = .86, t(22) = 21.63, p < .0005 \). The extent to which this document was reviewed did not differ significantly between CMH representatives and program representatives, \( R^2 = .00, \hat{\beta} = .18, t(10) = 0.40, p = .70 \).

**OUTCOMES COMMITTEE MEETINGS**

Of the 81 participants interviewed, 26 (32.1%) reported having attended the outcomes committee meetings to discuss the outcome measures. Although a majority of participants
report having attended five meetings or less ($Med = 5$), program representatives reported having attended an average of 6.91 of these meetings ($s = 5.76$), and CMH representatives reported having attended an average of 7.25 of these meetings ($s = 4.86$). Reported attendance at these meetings differed significantly by participant type, such that CMH representatives reported having attended these meetings more frequently than program representatives, $R^2 = .11, \hat{\beta} = .71, t(22) = 16.24, p < .0005)$. The number of meetings attended did not differ significantly between CMH representatives and program representatives, $R^2 = .00, \hat{\beta} = .34, t(17) = 0.30, p = .77$.

**COUNTY MENTAL HEALTH OUTCOMES MEETINGS**

County Mental Health representatives held private meetings to discuss the outcome measures. Of the four CMH representatives interviewed, three (75%) reported having attended these private meetings. On average, these three CMH representatives attended four of these meetings ($M = 4, Med = 4, s = 1$).

**OVERALL INVOLVEMENT**

The distribution of program representatives' overall involvement in evaluating the outcome measures was positively skewed, with an average involvement score of 5.21 ($s = 10.14$). The distribution of CMH representatives’ overall involvement scores was relatively symmetrical, with an average involvement score of 30.5 ($s = 2.65$). Results from negative binomial regression models suggest overall involvement in evaluating the outcome measures
differed significantly between CMH representatives and program representatives, such that CMH representatives reported greater involvement, $\hat{\beta} = 1.77$, $z(22) = 8.87$, $p < .0005$.

**Beliefs Toward the Selection and Implementation of Measures and Involvement**

The distribution of BTS&IM scores was relatively symmetrical, with program representatives reporting an average score of 22.73 ($s = 5.73$). Although 2.5% of the variance in BTS&IM scores was determined by overall involvement in evaluating the outcome measures, there was not a significant relationship between BTS&IM and overall involvement scores, $R^2 = .03$, $\hat{\beta} = 0.09$, $t(21) = 1.88$, $p = .07$.

**Aim 4: Method Specific Influence by Stakeholder Group**

The fourth aim of this study was to assess the influence of dissemination techniques, and to assess stakeholder differences in influence. The influence of each dissemination technique will be presented first, along with stakeholder differences in influence within dissemination method, followed by differences between methods of dissemination.

**Influence—Method 1: Full Length Report**

For those who had access to the full length report, the distribution of instrumental use scores was slightly negatively skewed, with an average score of 6.294 ($s = 3.20$, $s_m = .78$), conceptual use was relatively symmetrical, with an average score of 23.18 ($s = 6.72$, $s_m = 1.63$), and strategic use was negatively skewed, with an average score of 3.12 ($s = 1.76$, $s_m =$
Instrumental use did not differ significantly between CMH representatives and program representatives, $R^2 = .00, \hat{\beta} = -0.06, t(11) = -0.06, p = .95$. Conceptual use did not differ significantly between CMH representatives and program representatives, $R^2 = .02, \hat{\beta} = 2.06, t(11) = 1.23, p = .25$. Strategic use did not differ significantly between CMH representatives and program representatives, $R^2 = .00, \hat{\beta} = 0.17, t(11) = 0.39, p = .71$ (Figure 6). Overall influence of Method 1 was slightly positively skewed, with an average score of 32.59 ($s = 10.77, s_m = 2.61$). Overall influence of Method 1 did not differ significantly between CMH and program representatives, $R^2 = .01, \hat{\beta} = 2.17, t(11) = 0.84, p = .43$ (Figure 7).

Figure 6. Full length report influence by influence type.
Figure 7. Overall influence of full length report: Program and CMH representatives.

**INFLUENCE—METHOD 2:**
**SHORTENED REPORT**

For those who had access to the shortened report, the distribution of instrumental use scores was relatively symmetrical, with an average score of 7.33 ($s = 2.87$, $s_m = 68$), conceptual use was also relatively symmetrical, with an average score of 24 ($s = 6.78$, $s_m = 1.60$), and strategic use was positively skewed with an average score of 3.22 ($s = 1.3$, $s_m = .45$; Figure 8). Instrumental use differed significantly between CMH representatives and program representatives, such that CMH representatives reported greater instrumental use of method 2, $R^2 = .26$, $\hat{\beta} = 3.43$, $t(13) = 4.14$, $p = .001$. Conceptual use differed significantly between CMH representatives and program representatives, such that CMH representatives
Figure 8. Shortened report influence by influence type.

reported greater conceptual use of method 2, $R^2 = .20, \hat{\beta} = 7.11, t(13) = 4.02, p = .002$.

Strategic use differed significantly between CMH representatives and program representatives, such that CMH representatives reported greater strategic use of method 2, $R^2 = .26, \hat{\beta} = 2.28, t(13) = 4.78, p < .0005$ (Figure 9). Overall influence of Method 2 was negatively skewed, with an average score of 34.78 ($s = 10.03, s_m = 2.36$). Overall influence of Method 2 differed significantly between CMH and program representatives, such that CMH representatives reported greater overall influence of Method 2, $R^2 = .30, \hat{\beta} = 12.82, t(13) = 5.15, p < .0005$ (Figure 10).
Figure 9. Shortened report influence by influence type: CMH and program representatives.

Figure 10. Overall influence of shortened report: Program and CMH representatives.
Influence—Model 3: Full Length Summary

For those who had access to the full length summary, the distribution of instrumental use scores was relatively symmetrical, with an average score of 4.59 ($s = 2.37, s_m = .58$), conceptual use was relatively symmetrical, with an average score of 22.41 ($s = 6.87, s_m = 1.67$), and strategic use also relatively symmetrical, with an average score of 2.29 ($s = 1.49, s_m = .36$). Instrumental use differed significantly between CMH representatives and program representatives, such that program representatives reported greater levels of instrumental use of method 3, $R^2 = .20, \hat{\beta} = -2.73, t(12) = -4.74, p = .001$. Conceptual use did not differ significantly between CMH representatives and program representatives, $R^2 = .04, \hat{\beta} = -3.15, t(12) = -1.70, p = .12$. Strategic use did not differ significantly between CMH representatives and program representatives, $R^2 = .00, \hat{\beta} = -.08, t(12) = -0.13, p = .90$ (Figure 11). Overall influence of Method 3 was slightly negatively skewed, with an average score of 29.29 ($s = 8.69, s_m = 2.11$). Overall influence of Method 3 did differ significantly between CMH and program representatives, such that program representatives reported greater overall influence of Method 3, $R^2 = .09, \hat{\beta} = -5.94, t(12) = -2.65, p = .02$ (Figure 12).

Influence—Method 4: Shortened Summary

For those who had access to the shortened summary, the distribution of instrumental use scores was relatively symmetrical, with an average score of 5.87 ($s = 2.95, s_m = .76$), conceptual use was slightly negatively skewed, with an average score of 23.47 ($s = 7.14, s_m = 1.84$), and strategic use was slightly positively skewed, with an average score of 2.27.
Figure 11. Full length summary influence by influence type: CMH and program representatives.

Figure 12. Overall influence of full length summary: Program and CMH representatives.
Instrumental use did not differ significantly between CMH representatives and program representatives, $R^2 = .01, \hat{\beta} = -0.5, t(10) = -0.92, p = .38$.

Conceptual use did not differ significantly between CMH representatives and program representatives, $R^2 = .00, \hat{\beta} = 0.73, t(10) = 0.33, p = .75$. Strategic use differed significantly between CMH representatives and program representatives, such that CMH representatives reported greater strategic use of method 4, $R^2 = .27, \hat{\beta} = 2.09, t(10) = 4.59, p = .001$ (Figure 14). Overall influence of Method 4 was slightly negatively skewed, with an average score of 31.8 ($s = 9.58, s_m = 2.47$). Overall influence of Method 4 did not differ significantly between CMH and program representatives, $R^2 = .01, \hat{\beta} = 2.32, t(10) = 0.87, p = .41$ (Figure 15).

![Figure 13. Shortened summary influence by influence type.](image-url)
Figure 14. Shortened summary influence by influence type: CHM and program representatives.

Figure 15. Overall influence of shortened summary: Program and CMH representatives.
OUTCOMES COMMITTEE MEETINGS

For those who attended the Outcomes Committee meetings, the distribution of instrumental use scores was relatively symmetrical, with an average score of 2.23 ($s = 1.66$, $s_m = .33$); conceptual use was also relatively symmetrical, with an average score of 28.81 ($s = 5.39$, $s_m = 1.06$); and strategic use was also relatively symmetrical, with an average score of 3.08 ($s = 1.85$, $s_m = .36$; Figure 16). Instrumental use differed significantly between CMH representatives and program representatives, such that program representatives reported greater instrumental use of the outcomes committee meetings than CMH representatives, $R^2 = .04$, $\hat{\beta} = -0.86$, $t(17) = -2.70$, $p = .02$. Conceptual use also differed significantly between CMH representatives and program representatives, such that CMH representatives reported greater conceptual use of the Outcomes Committee meetings than program representatives, $R^2 = .04$, $\hat{\beta} = 2.89$, $t(17) = 2.51$, $p = .02$ (Figure 17).

Overall influence of the Outcomes Committee meetings was relatively symmetrical, with an average score of 32.12 ($s = 7.21$, $s_m = 1.42$). Overall influence of the outcomes committee meetings differed significantly between CMH and program representatives, such that CMH representatives reported greater overall influence of the outcomes committee meetings, $R^2 = .05$, $\hat{\beta} = 4.30$, $t(17) = 2.73$, $p = .02$. Strategic use also differed significantly between CMH representatives and program representatives, such that CMH representatives reported greater strategic use of the Outcomes Committee meetings than program representatives, $R^2 = .20$, $\hat{\beta} = 2.27$, $t(17) = 5.62$, $p < .0005$ (Figure 18).
Figure 16. Outcomes meeting influence by influence type.

Figure 17. Outcomes meeting influence by influence type: CMH and program representatives.
Three of the CMH representatives attended private meetings to discuss the outcomes measures. Instrumental use of these private meetings was symmetrical with a reported average score of 9 ($s = 3, s_m = 1.73$). Conceptual use of these private meetings was relatively symmetrical with a reported average score of 27 ($s = 8.54, s_m = 4.93$). Each CMH representative who attended these private meetings reported a strategic use score of 6. Overall influence of these CMH outcomes meetings was slightly positively skewed, with an average score of 42 ($s = 10.15, s_m = 5.86$).
EVALUATION INFLUENCE

Overall instrumental, conceptual, strategic, and process use of the evaluation were very positively skewed, with average scores of 6.04 (Med = 0, s = 10.63, s_m = 1.18), 28.07 (Med = 0, s = 47.69, s_m = 5.30), 3.30 (Med = 0, s = 6.28, s_m = 0.70), and 11.42 (Med = 12, s = 8.94, s_m = 0.99), respectively (Figure 19).

Figure 19. Overall evaluation influence by influence type.

Negative binomial regression models were used to assess differences in overall instrumental, conceptual, strategic, and process use by participant type, while controlling for participants level of involvement in the evaluation. While controlling for participants level of involvement in the evaluation, instrumental use of the evaluation significantly differed between participants, such that CMH representatives reported greater instrumental use
conceptual use significantly differed between participants, such that CMH representatives reported greater conceptual use of the evaluation ($\hat{\beta} = -2.11, z = -2.25, p = .03$), strategic use of the evaluation did not significantly differ between participants ($\hat{\beta} = -0.48, z = -0.08, p = .42$), and process use significantly differed between participants, such that program representatives reported greater process use of the evaluation ($\hat{\beta} = 0.17, z = 2.10, p = .04$; Figures 20 and 21).

![Box plot of influence by influence type for program representatives.](image)

**Figure 20. Overall evaluation influence by influence type: Program representatives.**

Overall evaluation influence was greatly positively skewed, with an average score of 40.48 ($\text{Med} = 0, s = 69.13, s_m = 7.68$). A negative binomial regression model, wherein standard errors were adjusted for 22 clusters of participants, was used to assess differences in
overall evaluation influence by participant type, controlling for participants’ involvement in the evaluation. Controlling for participants’ involvement in the evaluation, overall evaluation influence significantly differed by participant type such that CMH representatives reported greater overall influence ($\hat{\beta} = -1.35$, $z = 2.10$, $p = .04$; Figure 22).

Four interaction contrasts were used to assess the participant type by method interaction on influence (Figure 23). Because the majority of participants reported not having access to the methods of dissemination, only participants who identified as being members of the Outcomes Committee were included. Specifically, the first contrast assessed the difference in influence of Methods 1 and 2 (the full length and shortened report) to Methods 3 and 4 (the summary pages) in program representatives compared to CMH representatives.
Figure 22. Overall evaluation influence: Program and CMH representatives.

Figure 23. Method influence by participant type: Outcomes Committee members.
The second contrast assessed the difference in influence of Method 1 to Method 2 in program representatives compared to CMH representatives. The third contrast assessed the difference in influence of Method 3 to Method 4, in program representatives compared to CMH representatives. The last contrast assessed the difference in influence of the outcomes meetings to the average influence of Methods 1, 2, 3, and 4 in program representatives compared to CMH representatives.

Using Dunn-Sidak’s alpha (.002) to protect for family-wise error rate, the influence of the outcomes committee meetings was significantly greater than the influence of the four documents ($\hat{\beta} = -24.15, t(16) = -3.93, p = .001$), which did not differ significantly by participant type ($\hat{\beta} = 3.33, t(16) = 0.95, p = .36$). The other comparisons, including their participant type interaction effects, were not significant.

**Aim 5: Stakeholder Preference for Dissemination Method**

The fifth aim of this study was to investigate stakeholder preferences for dissemination method. Stakeholder preferences are presented below with results to quantitative differences in method appeal, as well as participant identified preferences assessed with open-ended questions.

**Method Appeal**

The distribution of appeal scores for the full length report was slightly negatively skewed, with an average score of 3.51 ($s = 1.28, s_m = .31$). The distribution of appeal scores for the shortened report was slightly negatively skewed, with an average score of 4.43 ($s = 1.3, s_m = .31$). The distribution of appeal scores for the full length summary was slightly
negatively skewed, with an average score of 5.15 (s = .56, \( s_m = .14 \)). The distribution of appeal scores for the shortened summary was relatively symmetrical with an average scores of 4 (s = 1.27, \( s_m = .25 \)).

Similar comparisons as discussed earlier were used to test differences in appeal by method of dissemination, as well as the moderating effect of participant type. Specifically, the first contrast assessed the difference in appeal of Methods 1 and 2 (the full length and shortened report) to Methods 3 and 4 (the summary pages) in program representatives compared to CMH representatives. The second contrast assessed the difference in appeal of Method 1 to Method 2 in program representatives compared to CMH representatives. The third contrast assessed the difference in appeal of Method 3 to Method 4, in program representatives compared to CMH representatives. The last contrast assessed the difference in appeal of the outcomes meetings to the average influence of Methods 1, 2, 3, and 4 in program representatives compared to CMH representatives.

Using Dunn-Sidak’s alpha (.002) to protect for family-wise error rate, appeal of the shortened comprehensive report was significantly greater than the appeal of the full-length comprehensive report (\( \hat{b} = -1.28, t(7) = -8.52, p < .0005 \)). The other comparisons, including their participant type interaction effects, were not significant.

**Preferences for Dissemination**

Participants who had access to the methods of dissemination (\( n = 17, 2\% \) of participants) were asked to identify what they believed to be the most useful dissemination method employed. Of these participants, the majority (52.9\%) identified the outcomes committee meetings as being most useful. Approximately 35.3\% of these participants
reported the documents as being most useful, while the remaining 11.8% reported other methods of dissemination, such as a combination of methods, as being most useful. Participants were then asked to identify what they believed to be the most useful document, upon which the majority of participants (40%) reported the shortened summary report as being the most useful document. Another 40% of participants reported the full length report (20%) and both summary pages (20%) as the most useful documents, and the remaining 20% of participants reported the full length summary page (10%) and the actual outcome measures within the reports (10%) as the most useful documents.
CHAPTER 6

DISCUSSION

The importance of evaluation influence has been stressed numerous times in the evaluation literature. In 1967, Suchman proposed that the “success of an evaluation project will be largely dependent upon its usefulness to the administrator in improving services” (p. 21). However, there is a noted lack of research suggesting how evaluations wield their influence. Appropriate dissemination has often been thought of as the key to ensuring an evaluation is influential. The purpose of this study was to extend the knowledge on dissemination, as previous research has only begun to illuminate the effects of various dissemination techniques across multiple stakeholder groups.

In 1997, Patton published his *Utilization-Focused Evaluation: The New Century Text*. In it, Patton describes the challenge facing society to put evaluation findings to use, providing utilization-focused evaluations as an answer to bridging the gap between science and practice. The HSRC’s evaluation and dissemination of recovery-based outcome measures appears to have been an unwitting attempt at Patton’s utilization-focused evaluation. From its inception, HSRC’s evaluation of recovery-based outcome measures focused on the use and influence of relevant stakeholders. Ultimately, HSRC employed five dissemination techniques to communicate research findings to relevant stakeholders while facilitating use—which included a variety of documents and oral presentations during regularly held Outcomes Committee Meetings. The participation and feedback from relevant stakeholders
helped to guide all evaluation activities, and dissemination activities, from the beginning of
the evaluation, to its end.

**HEALTH SERVICES RESEARCH CENTER’S DISSEMINATION**

The first aim of this study was to learn more about the dissemination techniques
HSRC employed to communicate research findings to relevant stakeholders. Four HSRC
representatives who were most actively involved in the dissemination process were
interviewed to learn about these dissemination techniques. Results from these interviews
suggest there were four documents created to help disseminate research findings, and
findings were also discussed in meetings with an Outcomes Committee—program and CMH
representatives who were asked to review HSRC’s results and provide feedback to help with
the selection of outcome measures.

Initially, HSRC disseminated findings with a lengthy, 88-page report of findings.
Interviews with HSRC representatives revealed this document was created in an attempt to
present all findings to the stakeholders, without imposing their own judgment of the
evaluation. The HSRC believed their responsibility was to present findings, and what the
decision makers did with these findings was not their responsibility. What HSRC quickly
learned, and what is described in Patton’s (1997) book on utilization-focused evaluation, is
that no evaluation can be value-free. For HSRC’s evaluation research to have utility to all
appropriate stakeholders, they had to use additional and/or alternative methods to disseminate
their findings.

Per stakeholder feedback, HSRC began to tailor their dissemination techniques.
Upon review of the initial full-length report, CMH requested HSRC make clearer
recommendations to guide their decision of outcome measures. Consequently, HSRC shortened the full-length report to present only the findings of their top choices of outcome measures. The HSRC also created the two single-paged summary documents, weighing the strengths and benefits of each outcome measure, designed primarily to facilitate decision making. The HSRC’s role in this evaluation of outcome measures very clearly evolved from that of a basic scientific researcher to that of the evaluator. The HSRC learned their role as an evaluator was to facilitate judgment and decision making by intended users rather than acting as a distant, independent judge (Patton, 1997).

**THE PATH DISSEMINATION TRAVELS**

The second aim of this study was to learn more regarding the path dissemination takes. The HSRC originally disseminated their findings to CMH. Later, CMH and HSRC disseminated findings to representatives of several of the treatment programs, the Outcomes Committee. Ultimately, outcome measures were chosen for implementation. It was previously believed that, between the original dissemination of findings from HSRC to CMH and final dissemination from CMH/HSRC to program representatives, secondary dissemination was relayed to several stakeholder groups. In other words, HSRC and CMH hoped members of the Outcomes Committee would share evaluation findings with their program staff, and return to the Outcomes Committee with their feedback. Unfortunately, evaluation findings were very rarely shared beyond the primary members of the Outcomes Committee.

There are several reasons the evaluation findings may not have traveled further than the Outcomes Committee meetings. When interviewing the program representatives, many
of the Outcomes Committee members expressed purposefully withholding evaluation findings from other program staff members to prevent overburdening staff with extra labor. Earlier research has noted humans as very inefficient at passing knowledge from one brain to another, further noting organizational culture as the primary culprit preventing this knowledge transfer (Cantoni, Bello, & Frigerio, 2001). Organizational culture is embedded in the way people act, what they expect of each other, and how they make sense of others’ actions. According to Cantoni et al. (2001), if San Diego County’s mental health treatment programs were organizations with a knowledge-sharing culture, the sharing of ideas, insights, knowledge, and evaluation research findings would occur naturally, without feelings of being forced to do so. Because these program representatives purposefully prevented the exchange of evaluation research findings for fear of overwhelming staff/co-workers with too much work, one can assert these programs lack a knowledge-sharing culture.

Perhaps not coincidentally, several of these program representatives who withheld the evaluation research findings believed they had insufficient authority to help CMH decide which outcome measures were ultimately chosen for implementation. Past research has also noted insufficient authority to adopt procedures as being the top barrier to the dissemination and implementation of evaluation utilization (Funk, Tornquist, & Champagne, 1995). Seligman’s (1975) notable theory of learned helplessness can be translated to organizations, wherein organizational learned helplessness is induced when properties of formal organizations inadvertently condition employee failure (Martinko & Gardner, 1982). Stedry and Kay (1966) found individuals reduce their productivity when they believe it is impossible to reach imposed goals, and Watkins and Marsick (1993) noted organizational learned helplessness occurs when organizations confront an undesirable situation that persists
despite their best efforts. Under organizational learned helplessness, organizations may
develop the expectation that nothing they do will affect the outcome and may transfer this
expectation to all other tasks. As a result, they may put less effort into subsequent tasks.
Perhaps prior experiences with CMH conditioned organizational learned helplessness within
program representatives, teaching them not to expend labor in an evaluation wherein their
efforts are potentially fruitless. Unless stakeholders are motivated to participate in an
evaluation, there may be little a tailored dissemination technique may do to facilitate
influence of findings. Future evaluation and dissemination efforts should be mindful of the
potential impact of prior relational experiences between stakeholder groups.

**Evaluation Access and Involvement, and Beliefs About the Selection and Implementation of Measures**

The third aim of this study was to learn more regarding stakeholder’s access to
and involvement in the evaluation, and how this access and involvement may influence
stakeholder’s beliefs about the selection and implementation of measures. Across all
methods of dissemination, CMH participants reported significantly greater access to
dissemination method than program representatives. In fact, their overall involvement in the
evaluation was reported to be significantly greater than that of the program representatives.
The fact CMH representatives had greater access to and involvement in this evaluation than
program representatives is not surprising. The unexpected finding that many program
representatives from the outcomes committee purposefully withheld information from other
program representatives, and felt their participation in the evaluation was not to facilitate
CMH’s decision regarding the selection of outcome measures, prevented program
representatives not in the Outcomes Committee from having access to the evaluation and evaluation research findings. However, what is unexpected is the extent to which participants reviewed each of the documents, and the number of meetings participants attended, did not differ significantly between stakeholder groups. This may be an indication that individual characteristics have little influence on the extent to which an individual deeply engages in various dissemination methods. In other words, differences in the format of the dissemination method may be a stronger predictor of one’s engagement in that method than characteristics of an individual. However, the formats of the dissemination methods utilized in this evaluation were very similar across methods (i.e., four dissemination methods in document format). Future evaluation research efforts should focus on differences in stakeholder engagement between more varied dissemination methods.

When queried on their beliefs about the selection and implementation of measures, program representatives generally reported feeling positively. In other words, program representatives typically believe CMH chose the most appropriate outcome measures, believe the chosen measures are capable of assessing changes in symptoms and recovery, and believe CMH took their treatment program’s perspective into consideration when selecting the chosen outcome measures. Interestingly, these positive beliefs were not influenced by individuals’ involvement in the evaluation. Results of this study failed to support the hypothesized positive relationship between participants’ evaluation involvement and their beliefs about the selection and implementation of measures. The literature on organizational silence provides clues as to why program representatives reported positive beliefs about the selection and implementation of measures regardless of evaluation involvement. Organizational silence is a phenomenon wherein individuals purposefully withhold ideas and
opinions based on resignation, cooperation, or fear (Van Dyne, Ang, & Botero, 2003). In organizations wherein learned helplessness has been conditioned, individuals may present acquiescent silence, keeping opinions to themselves due to low self-efficacy to make a difference. If program representatives felt as though their opinions would not influence CMH’s decision for outcome measures, they may have purposefully reported generally positive beliefs about the selection and implementation of outcome measures under acquiescent silence.

The heuristic/systematic model of message reception, attitude change, and behavior change provides an alternative explanation for the generally positive beliefs about the selection and implementation of measures across participants regardless of evaluation involvement. Under this model, stakeholders who are “unmotivated (or unable to process a message)” may rely on heuristics to form their beliefs on the particular message (Crano & Prislin, 2006, p. 348). According to this heuristic/systematic model, people sometimes exert little cognitive effort in judging the validity of a message, rather basing their agreement with the message using simple decision-making rules. In this particular evaluation, program representatives were oftentimes minimally involved in the evaluation of outcome measures, even purposefully withheld information from regarding the outcome measures, which may have resulted in them being unmotivated and/or unable to process details regarding the selected measures. When later questioned on their beliefs about the selected measures, and these measures’ implementation within their treatment programs, program representatives may have relied upon heuristics, such as “County Mental Health always makes the appropriate decisions,” to form attitudes regarding the outcome measures.
THE INFLUENCE OF DISSEMINATION TECHNIQUES

The fourth aim of this study was to learn more about the influence of each method of dissemination, and how differences in method influence may be moderated by stakeholder group membership. Four hypotheses regarding the influence of dissemination techniques were proposed. County Mental Health representatives were hypothesized to report greater influence for documents than meetings, and program representatives were hypothesized to report greater influence for meetings than documents. Additionally, the influence of the documents was hypothesized to be moderated by the extent to which individuals read the documents, and the influence of meetings was hypothesized to be moderated by the number of meetings individuals attended. Results partially supported these hypotheses.

Providing support for the second hypothesis, program representatives did report significantly greater influence of Outcomes Committee meetings than the documents. However, the influence of Outcomes Committee meetings was significantly greater than the influence of the documents for all participants, regardless of stakeholder group membership. In fact, the majority of participants singled out the Outcomes Committee meetings as being the most useful part of the evaluation. However, it is important to note that the presentation and discussion of findings during these meetings were not done in isolation to the documents. All Outcomes Committee members received the documents during these meetings as reference materials. Additionally, access to these documents was rare unless participants attended the Outcomes Committee meetings. Therefore, perhaps it is the combination of meetings and documents which results in greater use or influence of findings. Interestingly, the extent to which individuals read the documents, and the number of meetings individuals attended, did not act to moderate this difference in influence.
These results are consistent with research on passive diffusion, which has been shown to be largely ineffective and unlikely to result in influence. Numerous studies have stressed the importance of using active dissemination efforts, wherein a strategic approach to dissemination of research results to change agents is developed (Cantoni et al., 2001; Lock, Kaner, Heather, McAvoy, & Gilvarry, 1999; Stryer, Tunis, Hubbard, & Clancy, 2000). Results from this study reiterate the need of using an active dissemination approach should influence of findings be the primary objective.

**STAKEHOLDER PREFERENCES FOR DISSEMINATION TECHNIQUES**

The fifth aim of this study was to learn more about stakeholder preferences for dissemination techniques. Three hypotheses were proposed regarding stakeholder preferences for dissemination techniques. Specifically, CMH representatives were hypothesized to report greater preference for documents than any other dissemination method. This preference was also hypothesized to be greater the shorter the document. Program representatives on the other hand were hypothesized to prefer meetings to any other dissemination method.

Results from this study partially support these hypotheses. Of all documents, participants chose the shortened comprehensive report as most useful—a choice that did not differ by stakeholder groups. Perhaps not coincidentally, this shortened comprehensive report was significantly more appealing than the full-length comprehensive report. Although not significant, the general direction of findings suggests participants find shorter documents more appealing than the lengthier documents. These preferences are only more pronounced in CMH representatives than program representatives.
The reported preference for the shortened comprehensive report across all participants is not surprising given previous research on the translation of research into practice. Research has repeatedly shown practitioners and policymakers report lacking the time necessary to read, study, and analyze evaluation research findings (Funk, Tornquist, Champagne, & Wiese, 1992; Miller & Messenger, 1978; Saul et al., 2008; Weiss, 1987). Although lengthy reports may contain more information than a condensed report of primary findings, these reports are likely to go unread given stakeholders’ busy schedules.

**LIMITATIONS AND FUTURE DIRECTIONS**

Although this current study helps to expand the knowledge of dissemination influence, a few limitations should be noted to improve future research on the influence of evaluation.

One unanticipated finding from this study was that many participants reported purposefully preventing the spread of dissemination of evaluation research findings in order to protect their coworkers/staff. As a result, very few participants report having been influenced by the evaluation of outcome measures. Although the pre-existing relationship and history between CMH and Program Representatives was hypothesized as the root-cause of the purposeful withholding of evaluation research findings, future research is needed to confirm this proposition. Because this barrier to the spread of dissemination was unanticipated, the root-cause guiding stakeholders’ withholding of evaluation research findings to protect their coworkers/staff was not thoroughly assessed. Future studies on the influence of evaluation research and dissemination should be mindful of this study’s shortcoming, and more thoroughly assess the relationships between stakeholders. Knowing
how the relationships between stakeholders mediate/moderate the influence of dissemination is imperative for maximizing the influence of evaluation research findings.

Another limitation of this study rests in its minimal internal validity. The influence of dissemination techniques was assessed following a naturally occurring evaluation amongst stakeholder groups, and causal inferences are difficult to make in the absence of experimental methodology. To attribute the cause of influence precisely to particular dissemination techniques, future researchers may choose to employ an experimental methodology to evaluate the influence of evaluation research. However, studying the influence of dissemination techniques under naturalistic circumstances is advantageous for supporting the generalizability of findings. It is very likely the influence of dissemination techniques found within this study would hold true under other similar evaluation research contexts, using similar dissemination techniques, amongst similar stakeholder groups. To improve the generalizability of these findings, future studies assessing the influence of evaluation research should examine whether the extent to which these findings are replicated under different evaluation research contexts (Matt, Brewer, & Sklar, 2010).

Additionally, participants were surveyed on the influence of a particular evaluation research project after all evaluation research activities and primary dissemination of findings came to an end. Some participants were surveyed months following their introduction to particular dissemination methods. As a result, some participants found it difficult to answer survey questions regarding dissemination methods they no longer remembered—and findings may be subject to faulty recall. Future studies assessing the influence of evaluation research findings may benefit from observing participant influence throughout the evaluation, while being mindful of how their presence may threaten the validity of their own findings.
Greater understanding of the influence of evaluation research can help inform future evaluation and dissemination efforts. With improved dissemination of evaluation research findings, the gap between science and practice is likely to narrow, and the ultimate goal of social betterment is more readily attained.
REFERENCES


Rosenbaum, P. (2005). From research to clinical practice: Considerations in moving research into people’s hands: Personal reflections that may be useful to others. *Developmental Neurorehabilitation, 8*(3), 165-171.


APPENDIX A

NARRATIVE OF DISSEMINATION TECHNIQUES:

HSRC REPRESENTATIVES
NARRATIVE OF DISSEMINATION TECHNIQUES:

HSRC REPRESENTATIVES

Participant ID#: ______________________________________________________________

Date of Interview: ________ / ________ / ________

month                                     date                                year

As described in the consent form, this study intends to assess the effectiveness of HSRC’s
communication techniques during the process of choosing outcome measures. In order to assess the
effectiveness of HSRC’s communication techniques, I need to learn more about which dissemination
methods were used, why they were used, and who their intended audiences were.

First, I want you to think to when you were informed CMH wanted HSRC to evaluate outcome
measures.

N1) Approximately when did CMH inform HSRC they wanted us to evaluate new outcome
measures? _____________________________________________________________________

N2) What prompted CMH to ask HSRC to evaluate new outcome measures? ___________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Now I want you to think about all of the strategies HSRC used to communicate findings.

N3) How did HSRC first communicate evaluation findings? ________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

N4) Were these findings communicated orally at a meeting or communicated in a document, or
both? _____________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
N5) Who were the intended audiences of this initial communication of evaluation findings?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

N6) What was this audience’s response to this initial communication of evaluation findings?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

N7) Did HSRC communicate these evaluation findings further, or differently? If so, please explain.
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

IF ‘NO’, INTERVIEWER MUST PROBE FOR PLAUSIBLE DISSEMINATION STRATEGIES, INCLUDING SURVEYS, KEY FINDINGS, BROCHURES, ETC. IF ANSWER IS STILL ‘NO,’ SKIP TO END.

N8) What was the next method HSRC used to communicate evaluation findings?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

N9) Were these findings communicated orally at meetings, or in a communicated in a document, or both? ________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

N10) Who were the intended audiences of this communication of evaluation findings?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
N11) What was this audience’s response to this communication of evaluation findings?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

N12) Did HSRC communicate these evaluation findings further, or differently? If so, please explain.
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

IF ‘NO’, INTERVIEWER MUST PROBE FOR PLAUSIBLE DISSEMINATION STRATEGIES, INCLUDING SURVEYS, KEY FINDINGS, BROCHURES, ETC. IF ANSWER IS STILL ‘NO,’ SKIP TO END.

N13) What was the next method HSRC used to communicate evaluation findings?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

N14) Were these findings communicated orally at meetings, or in a communicated in a document, or both? ____________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

N15) Who were the intended audiences of this communication of evaluation findings?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

N16) What was this audience’s response to this communication of evaluation findings?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
N17) Did HSRC communicate these evaluation findings further, or differently? If so, please explain.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

IF ‘NO’, INTERVIEWER MUST PROBE FOR PLAUSIBLE DISSEMINATION STRATEGIES, INCLUDING
SURVEYS, KEY FINDINGS, BROCHURES, ETC. IF ANSWER IS STILL ‘NO,’ SKIP TO END.

N18) What was the next method HSRC used to communicate evaluation findings?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

N19) Were these findings communicated orally at meetings, or in a communicated in a document, or
both? _________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

N20) Who were the intended audiences of this communication of evaluation findings?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

N21) What was this audience’s response to this communication of evaluation findings?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

N22) Did HSRC communicate these evaluation findings further, or differently? If so, please explain.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

IF ‘NO’, INTERVIEWER MUST PROBE FOR PLAUSIBLE DISSEMINATION STRATEGIES, INCLUDING
SURVEYS, KEY FINDINGS, BROCHURES, ETC. IF ANSWER IS STILL ‘NO,’ SKIP TO END.
N23) What was the next method HSRC used to communicate evaluation findings?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

N24) Were these findings communicated orally at meetings, or in a communicated in a document, or both?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

N25) Who were the intended audiences of this communication of evaluation findings?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

N26) What was this audience’s response to this communication of evaluation findings?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
APPENDIX B

REPORTED INFLUENCE OF DISSEMINATION

SURVEY: CMH REPRESENTATIVES
REPORTED INFLUENCE OF DISSEMINATION SURVEY:
CMH REPRESENTATIVES

Participant ID#:_____________________________________________________

Date of Interview: ________ / ________ / ________
month date year

As described in the consent form, this study intends to assess the effectiveness of HSRC’s communication techniques during the process of choosing outcome measures.

First, I have some background questions for you.

B1) What is your gender?
    0 = Male
    1 = Female
    2 = Other

B2) What is the highest level of education you have completed?
    0 = Some high school
    1 = High school/GED
    2 = Some college
    3 = 2-Year college degree (Associates)
    4 = 4-Year college degree (Bachelors; BA, BS)
    5 = Master’s degree
    6 = Doctoral degree
    7 = Professional Degree (MD, JD)

B3) What is your current job title? _________________________________

B4) How long have you been working as a ________? _____________________

B5) How long have you been working with County Mental Health?
    ____________________________________________________________________

B6) What prompted CMH to ask HSRC to evaluate new outcome measures?
    ____________________________________________________________________
    ____________________________________________________________________
    ____________________________________________________________________
B7) What information did you hope HSRC would provide upon evaluating the outcome measures?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

B8) What information regarding each outcome measure was most relevant upon deciding which outcome measures to implement?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

B9) HSRC’s top recommendation, the FARS, was not chosen for implementation. What did CMH dislike about the FARS?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

B10) Did HSRC provide you with all the information you had hoped for regarding the outcome measures?

0 = No, 1 = Yes

B10a) If not, what additional information did you hope HSRC would provide?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

B11) Was there anything HSRC could have done to improve your decision for which outcome measures to implement?

0 = No, 1 = Yes

B11a) If yes, what could HSRC have done?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Thank you. Now I’m going to ask you a series of questions regarding each of the reports created to describe the outcome measures.

The first questions refer to the Recovery Measures Report.

M1.1) Did you have access to this document? __________________________

IF NO, SKIP TO M2.1            0 = No, 1 = Yes

M1.2) How did you obtain this document? From...

0 = HSRC
1 = Coworker
2 = I received it at a meeting with HSRC, wherein we discussed the report
3 = Other, (please specify) _____________________________________________

M1.3) Please tell me which statement best describes the extent to which you reviewed this document

0 = I didn’t read any of the document.
1 = I skimmed through the document.
2 = I read less than 50% of the document.
3 = I read 50% of the document.
4 = I read more than 50% of the document.
5 = I read the document from front to back.

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

<table>
<thead>
<tr>
<th>M1.4)</th>
<th>This document expanded my knowledge of measuring outcomes.</th>
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<tbody>
<tr>
<td>M1.5)</td>
<td>This document enhanced my understanding of each outcome measure.</td>
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<tr>
<td>M1.6)</td>
<td>This document informed me of the issues associated with the outcome measures.</td>
</tr>
<tr>
<td>M1.7)</td>
<td>I learned about the advantages of each outcome measure from this report.</td>
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</table>
M1.18) Do you have any comments regarding this document that were not already addressed?

____________________________________________________________________________________
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M1.19) Did you share this document with any of your co-workers?

IF “No,” SKIP TO M2.1

0 = No, 1 = Yes

M1.19a) Who did you share this document with? What are their positions here?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Thank you. Now I’m going to ask you the same series of questions, but in regards to the Recovery measures Summary Report.

M2.1) **Did you have access to this document?** ________________________  
IF NO, SKIP TO M3.1  0 = No, 1 = Yes

M2.2) **How did you obtain this document?** From...  
0 = HSRC  
1 = Coworker  
2 = I received it at a meeting with HSRC, wherein we discussed the report  
3 = Other, (please specify) ________________________________

M2.3) **Please tell me which statement best describes the extent to which you reviewed this document**  
0 = I didn’t read any of the document.  
1 = I skimmed through the document.  
2 = I read less than 50% of the document.  
3 = I read 50% of the document.  
4 = I read more than 50% of the document.  
5 = I read the document from front to back.

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

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<th>0 = Disagree very strongly</th>
<th>1 = Disagree</th>
<th>2 = Somewhat disagree</th>
<th>3 = Neither disagree nor agree</th>
<th>4 = Somewhat agree</th>
<th>5 = Agree</th>
<th>6 = Agree very strongly</th>
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<td>This document enhanced my understanding of each outcome measure.</td>
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<td>M2.6)</td>
<td>This document informed me of the issues associated with the outcome measures.</td>
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<td>I learned about the advantages of each outcome measure from this report.</td>
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M2.18) Do you have any comments regarding this document that were not already addressed?
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M2.19) Did you share this document with any of your co-workers?

IF “No,” SKIP TO M3.1

0 = No, 1 = Yes

M2.19a) Who did you share this document with? What are their positions here?
____________________________________________________________________________________
____________________________________________________________________________________
Thank you. Now I'm going to ask you the same series of questions, but in regards to the Summary of Measures (v.1).

M3.1) **Did you have access to this document?**

IF NO, SKIP TO M2.1

0 = No, 1 = Yes

M3.2) **How did you obtain this document?**

From...

0 = HSRC
1 = Coworker
2 = I received it at a meeting with HSRC, wherein we discussed the report
3 = Other, (please specify) _____________________________________________

M3.3) **Please tell me which statement best describes the extent to which you reviewed this document**

0 = I didn’t read any of the document.
1 = I skimmed through the document.
2 = I read less than 50% of the document.
3 = I read 50% of the document.
4 = I read more than 50% of the document.
5 = I read the document from front to back.

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

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<th>5 = Agree</th>
<th>6 = Agree very strongly</th>
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<td>M3.8</td>
<td>I learned about the disadvantages of each outcome measure from this report.</td>
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<td>M3.9</td>
<td>In general, I learned more about outcome measures from this document.</td>
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<td>M3.10</td>
<td>I was able to identify my preferred outcome measure from this document.</td>
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<tr>
<td>M3.11</td>
<td>I used this document to choose the best outcome measures.</td>
<td></td>
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<tr>
<td>M3.12</td>
<td>I used this document to persuade others of preferred outcome measures.</td>
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<td>M3.13</td>
<td>The information in this document was written in a straightforward manner.</td>
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<td>M3.14</td>
<td>This document was easy to read.</td>
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<td>M3.15</td>
<td>This document was an appropriate length.</td>
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<td>M3.16</td>
<td>This document was user-friendly.</td>
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M3.18) Do you have any comments regarding this document that were not already addressed?
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M3.19) Did you share this document with any of your co-workers? ____________________________
IF "No," SKIP TO M4.1
0 = No, 1 = Yes

M3.19a) Who did you share this document with? What are their positions here?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Thank you. Now I’m going to ask you the same series of questions, but in regards to the Summary of Measures (v.2).

M4.1)  Did you have access to this document?  
________________________  
IF NO, SKIP TO A1 
0 = No, 1 = Yes

M4.2)  How did you obtain this document? From...  
0 = HSRC  
1 = Coworker  
2 = I received it at a meeting with HSRC, wherein we discussed the report  
3 = Other, (please specify) ____________________________________________

M4.3)  Please tell me which statement best describes the extent to which you reviewed this document  
0 = I didn’t read any of the document.  
1 = I skimmed through the document.  
2 = I read less than 50% of the document.  
3 = I read 50% of the document.  
4 = I read more than 50% of the document.  
5 = I read the document from front to back.

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

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<td><strong>M4.6)</strong></td>
<td>This document informed me of the issues associated with the outcome measures.</td>
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<tr>
<td><strong>M4.7)</strong></td>
<td>I learned about the advantages of each outcome measure from this report.</td>
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M4.18) Do you have any comments regarding this document that were not already addressed?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

M4.19) Did you share this document with any of your co-workers? ____________________________
IF “No,” SKIP TO Mtg1
0 = No, 1 = Yes

M4.19a) Who did you share this document with? What are their positions here?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Thank you. Now I’m going to ask you a series of questions regarding meetings you attended with HSRC.

Mtg1) Have you attended any meetings with HSRC to discuss outcome measures?

*IF NO, SKIP TO MtgCMH1*

0 = No, 1 = Yes

Mtg2) Approximately how many of these meetings have you attended?

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

<table>
<thead>
<tr>
<th>Mtg3)</th>
<th>These meetings expanded my knowledge of measuring outcomes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mtg4)</td>
<td>These meetings enhanced my understanding of each outcome measure.</td>
</tr>
<tr>
<td>Mtg5)</td>
<td>These meetings informed me of the issues associated with the outcome measures.</td>
</tr>
<tr>
<td>Mtg6)</td>
<td>I learned about the advantages of each outcome measure from these meetings.</td>
</tr>
<tr>
<td>Mtg7)</td>
<td>I learned about the disadvantages of each outcome measure from these meetings.</td>
</tr>
<tr>
<td>Mtg8)</td>
<td>In general, I learned more about outcome measures from attending these meetings.</td>
</tr>
<tr>
<td>Mtg9)</td>
<td>I was able to identify my preferred outcome measures from these meetings.</td>
</tr>
<tr>
<td>Mtg10)</td>
<td>I used these meetings to choose the best outcome measures.</td>
</tr>
<tr>
<td>Mtg11)</td>
<td>I used these meetings to persuade others of preferred outcome measures.</td>
</tr>
<tr>
<td>Mtg12)</td>
<td>The information discussed at these meetings was expressed in a straightforward manner.</td>
</tr>
</tbody>
</table>
Mtg13) Do you have any comments regarding this/these meeting/s that were not already addressed?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Thank you. Now I’m going to ask you a series of questions regarding meetings CMH held without HSRC to discuss outcome measures.

MtgCMH1) Did CMH have any meetings to further discuss outcome measures? ________________

IF NO, SKIP TO A1

0 = No, 1 = Yes

MtgCMH2) Who typically attended these meetings? ________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

MtgCMH3) When were these meetings typically held? ________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

MtgCMH4) Did you attend any of these meetings? ________________

IF NO, SKIP TO A1

0 = No, 1 = Yes

MtgCMH5) Approximately, how many of these meetings have you attended? ________________

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.
| MtgCMH6 | These meetings expanded my knowledge of measuring outcomes. |
| MtgCMH7 | These meetings enhanced my understanding of each outcome measure. |
| MtgCMH8 | These meetings informed me of the issues associated with the outcome measures. |
| MtgCMH9 | I learned about the advantages of each outcome measure from these meetings. |
| MtgCMH10 | I learned about the disadvantages of each outcome measure from these meetings. |
| MtgCMH11 | In general, I learned more about outcome measures from attending these meetings. |
| MtgCMH12 | I was able to identify my preferred outcome measures from these meetings. |
| MtgCMH13 | I used these meetings to choose the best outcome measures. |
| MtgCMH14 | I used these meetings to persuade others of preferred outcome measures. |
| MtgCMH15 | The information discussed at these meetings was expressed in a straightforward manner. |
Do you have any comments regarding these meetings that were not already addressed?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

<table>
<thead>
<tr>
<th>Statement</th>
<th>0 = Disagree very strongly</th>
<th>1 = Disagree</th>
<th>2 = Somewhat disagree</th>
<th>3 = Neither disagree nor agree</th>
<th>4 = Somewhat agree</th>
<th>5 = Agree</th>
<th>6 = Agree very strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being involved in choosing outcome measures enhanced my knowledge of outcome measures.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My involvement in this evaluation influenced my opinion regarding the outcome measures.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My involvement in this evaluation helped me decide which outcome measures were best.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My involvement in this evaluation helped me understand the issues associated with each outcome measure.</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you. These last questions will assess your preferred methods for receiving information from HSRC.

P1) I want you to think about all of the documents you had access to, all of the meetings you have attended with HSRC, and the meetings you have attended without HSRC. Out of these three options, did you find the documents, meetings with HSRC, or meetings without HSRC (or any combination of the three) to be most useful?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
P2) Why was/were this/these method/s most useful for you?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

P3) I want you to think about all of the documents HSRC created regarding outcome measures. Out of the Recovery Measures Report, Recovery Measures Summary Report, Summary of the Measures (v.1) and Summary of the Measures (v.2), which document (or combination of documents) was most useful for you?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

P4) When thinking about all of the documents you had access to, all of the meetings you have attended with HSRC, and all of the meetings you have attended without HSRC, which was most informative?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

P5) What is your preferred method for receiving information from HSRC?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
APPENDIX C

REPORTED INFLUENCE OF DISSEMINATION

SURVEY: PROGRAM REPRESENTATIVES
REPORTED INFLUENCE OF DISSEMINATION
SURVEY: PROGRAM REPRESENTATIVES

Participant ID#: ________________________________________________________________

Treatment Facility: _____________________________________________________________

Date of Interview: ________ / ________ / ________

As described in the consent form, this study intends to assess the effectiveness of both CMH and HSRC’s communication techniques during the process of choosing outcome measures.

First, I have some background questions for you.

B1) What is your gender?
   0 = Male
   1 = Female
   2 = Other

B2) What is the highest level of education you have completed?
   0 = Some high school
   1 = High school/GED
   2 = Some college
   3 = 2-Year college degree (Associates)
   4 = 4-Year college degree (Bachelors; BA, BS)
   5 = Master’s degree
   6 = Doctoral degree
   7 = Professional Degree (MD, JD)

B3) What is your current job title? ________________________________________________

B4) How long have you been working as a ________? ________________________________

B5) How long have you been working in this treatment facility? ________________________

B6) Approximately how many hours per week do you work? ___________________________

B7) How many individuals does this treatment facility currently treat? ________________
B8) What are the most common primary diagnoses of people seen at this facility?

B9) Have you attended any meetings at CMH to discuss outcome measures?  
IF “YES,” SKIP TO B12  
0 = No, 1 = Yes

B10) What was the reason for not attending these meetings?  
0 = I was unaware of these meetings  
1 = I was not invited to attend  
2 = I was told not to attend  
3 = I chose not to attend  
4 = A coworker went on this program’s behalf

B11) Have you ever discussed outcome measures with your co-workers in the past?  
SKIP TO B15  
0 = No, 1 = Yes

B12) Approximately how many of these meetings did you attend? 

B13) Did you discuss outcome measures with your co-workers prior to attending meetings with CMH?  
0 = No, 1 = Yes

B14) Did you discuss outcome measures with your co-workers after attending meetings with CMH?  
0 = No, 1 = Yes

B15) Did you participate in an online focus group regarding outcome measures?  
IF “YES,” SKIP TO F1  
0 = No, 1 = Yes

B16) What was the reason for not participating in this focus group?  
0 = I was unaware of this focus group  
1 = I was not invited to participate  
2 = I was told not to participate  
3 = I chose not to participate  
4 = A coworker participated on this program’s behalf

B17) Would you like to participate in future focus groups?  
0 = No, 1 = Yes
IF RESPONDENT DID NOT ATTEND THE ONLINE FOCUS GROUP, SKIP TO M1.1.

Thank you. Now I’m going to ask you some questions regarding your experience participating in this online focus group.

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>F1)</td>
<td>Participating in this focus group expanded my knowledge of measuring outcomes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F2)</td>
<td>Participating in this focus group enhanced my understanding of each outcome measure.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F3)</td>
<td>Participating in this focus group helped inform me of the issues associated with the outcome measures.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F4)</td>
<td>I learned about the advantages of each outcome measure from participating.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F5)</td>
<td>I learned about the disadvantages of each outcome measure from participating.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F6)</td>
<td>In general, I learned more about outcome measures from participating.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F7)</td>
<td>I was able to identify my preferred outcome measure from participating.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F8)</td>
<td>I persuaded others of my preferred outcome measures while participating.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F9)</td>
<td>I feel the opinions expressed during this focus group were used in deciding the final outcome measures.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F10)</td>
<td>I enjoyed participating in the focus group.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F11)</td>
<td>I believe focus groups are important to inform decisions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F12)</td>
<td>I would like to participate in future focus groups.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Thank you. Now I’m going to ask you a series of questions regarding each of the reports created to describe the outcome measures.

The first questions refer to the Recovery Measures Report.

M1.1) Did you have access to this document?
IF NO, SKIP TO M2.1
0 = No, 1 = Yes

M1.2) From whom did you receive this document?
0 = CMH
1 = HSRC
2 = Coworker
3 = I received it at a meeting with CMH
4 = Other, (please specify) 

M1.3) Please tell me which statement best describes the extent to which you reviewed this document
0 = I didn’t read any of the document.
1 = I skimmed through the document.
2 = I read less than 50% of the document.
3 = I read 50% of the document.
4 = I read more than 50% of the document.
5 = I read the document from front to back.

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

<table>
<thead>
<tr>
<th>M1.4)</th>
<th>This document expanded my knowledge of measuring outcomes.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 = Disagree very strongly 1 = Disagree 2 = Somewhat disagree</td>
</tr>
<tr>
<td></td>
<td>3 = Neither disagree nor agree 4 = Somewhat agree 5 = Agree</td>
</tr>
<tr>
<td></td>
<td>6 = Agree very strongly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M1.5)</th>
<th>This document enhanced my understanding of each outcome measure.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 = Disagree very strongly 1 = Disagree 2 = Somewhat disagree</td>
</tr>
<tr>
<td></td>
<td>3 = Neither disagree nor agree 4 = Somewhat agree 5 = Agree</td>
</tr>
<tr>
<td></td>
<td>6 = Agree very strongly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M1.6)</th>
<th>This document informed me of the issues associated with the outcome measures.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 = Disagree very strongly 1 = Disagree 2 = Somewhat disagree</td>
</tr>
<tr>
<td></td>
<td>3 = Neither disagree nor agree 4 = Somewhat agree 5 = Agree</td>
</tr>
<tr>
<td></td>
<td>6 = Agree very strongly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M1.7)</th>
<th>I learned about the advantages of each outcome measure from this report.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 = Disagree very strongly 1 = Disagree 2 = Somewhat disagree</td>
</tr>
<tr>
<td></td>
<td>3 = Neither disagree nor agree 4 = Somewhat agree 5 = Agree</td>
</tr>
<tr>
<td></td>
<td>6 = Agree very strongly</td>
</tr>
</tbody>
</table>
M1.18) **Do you have any comments regarding this document that were not already addressed?**
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

M1.19) **Did you share this document with any of your co-workers?**

0 = No, 1 = Yes

IF “No,” SKIP TO M2.1

M1.19a) **Who did you share this document with? What are their positions here?**
____________________________________________________________________________________
____________________________________________________________________________________
Thank you. Now I’m going to ask you the same series of questions, but in regards to the Recovery measures Summary Report.

M2.1) **Did you have access to this document?**

\[
\begin{array}{c}
\text{\underline{IF NO, SKIP TO M3.1}}
\end{array}
\]

\[0 = \text{No}, \ 1 = \text{Yes}\]

M2.2) **From whom did you receive this document?**

\[
\begin{array}{c}
0 = \text{CMH} \\
1 = \text{HSRC} \\
2 = \text{Coworker} \\
3 = \text{I received it at a meeting with CMH} \\
4 = \text{Other, (please specify) } \underline{\text{_________________________}}
\end{array}
\]

M2.3) **Please tell me which statement best describes the extent to which you reviewed this document**

\[
\begin{array}{c}
0 = \text{I didn’t read any of the document.} \\
1 = \text{I skimmed through the document.} \\
2 = \text{I read less than 50% of the document.} \\
3 = \text{I read 50% of the document.} \\
4 = \text{I read more than 50% of the document.} \\
5 = \text{I read the document from front to back.}
\end{array}
\]

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

\[
\begin{array}{|c|c|c|c|c|c|}
\hline
\text{M2.4)} & \text{This document expanded my knowledge of} & \text{4} & \text{3} & \text{2} & \text{1} & \text{0} \\
\hline
\text{measuring outcomes.} & \text{measuring outcomes.} & \text{Neither disagree nor agree} & \text{Somewhat agree} & \text{Disagree} & \text{Disagree very strongly} \\
\hline
\text{M2.5)} & \text{This document enhanced my understanding of} & \\
\hline
\text{each outcome measure.} & \text{Each outcome measure.} & \\
\hline
\text{M2.6)} & \text{This document informed me of the issues} & \\
\hline
\text{associated with the outcome measures.} & \text{Associated with the outcome measures.} & \\
\hline
\text{M2.7)} & \text{I learned about the advantages of each outcome} & \\
\hline
\text{measure from this report.} & \text{Advantages of each outcome} & \\
\hline
\end{array}
\]
M2.18) Do you have any comments regarding this document that were not already addressed?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

M2.19) Did you share this document with any of your co-workers? __________________________

IF “No,” SKIP TO M3.1
0 = No, 1 = Yes

M2.19a) Who did you share this document with? What are their positions here?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Thank you. Now I’m going to ask you the same series of questions, but in regards to the Summary of Measures (v.1).

M3.1) **Did you have access to this document?**

   [Blank]

   **IF NO, SKIP TO M2.1**

   0 = No, 1 = Yes

M3.2) **From whom did you receive this document?**

   0 = CMH
   1 = HSRC
   2 = Coworker
   3 = I received it at a meeting with CMH
   4 = Other, (please specify) [Blank]

M3.3) **Please tell me which statement best describes the extent to which you reviewed this document**

   0 = I didn’t read any of the document.
   1 = I skimmed through the document.
   2 = I read less than 50% of the document.
   3 = I read 50% of the document.
   4 = I read more than 50% of the document.
   5 = I read the document from front to back.

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

<table>
<thead>
<tr>
<th>M3.4)</th>
<th>This document expanded my knowledge of measuring outcomes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>M3.5)</td>
<td>This document enhanced my understanding of each outcome measure.</td>
</tr>
<tr>
<td>M3.6)</td>
<td>This document informed me of the issues associated with the outcome measures.</td>
</tr>
<tr>
<td>M3.7)</td>
<td>I learned about the advantages of each outcome measure from this report.</td>
</tr>
<tr>
<td>M3.8)</td>
<td>I learned about the disadvantages of each outcome measure from this report.</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>M3.9)</td>
<td>In general, I learned more about outcome measures from this document.</td>
</tr>
<tr>
<td>M3.10)</td>
<td>I was able to identify my preferred outcome measure from this document.</td>
</tr>
<tr>
<td>M3.11)</td>
<td>I used this document to choose the best outcome measures.</td>
</tr>
<tr>
<td>M3.12)</td>
<td>I used this document to persuade others of preferred outcome measures.</td>
</tr>
<tr>
<td>M3.13)</td>
<td>The information in this document was written in a straightforward manner.</td>
</tr>
<tr>
<td>M3.14)</td>
<td>This document was easy to read.</td>
</tr>
<tr>
<td>M3.15)</td>
<td>This document was an appropriate length.</td>
</tr>
<tr>
<td>M3.16)</td>
<td>This document was user-friendly.</td>
</tr>
</tbody>
</table>

M3.18) Do you have any comments regarding this document that were not already addressed?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

M3.19) Did you share this document with any of your co-workers? ______________________ __ 
IF “No,” SKIP TO M4.1 0 = No, 1 = Yes

M3.19a) Who did you share this document with? What are their positions here?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Thank you. Now I’m going to ask you the same series of questions, but in regards to the Summary of Measures (v.2).

M4.1) **Did you have access to this document?**

<table>
<thead>
<tr>
<th>0 = No, 1 = Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF NO, SKIP TO Mtg1</td>
</tr>
</tbody>
</table>

M4.2) **From whom did you receive this document?**

| 0 = CMH |
| 1 = HSRC |
| 2 = Coworker |
| 3 = I received it at a meeting with CMH |
| 4 = Other, (please specify) ___________________________ |

M4.3) **Please tell me which statement best describes the extent to which you reviewed this document**

| 0 = I didn’t read any of the document. |
| 1 = I skimmed through the document. |
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| 5 = I read the document from front to back. |

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

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<tr>
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<th>3 = Neither disagree nor agree</th>
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<th>5 = Agree</th>
<th>6 = Agree very strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>M4.4) This document expanded my knowledge of measuring outcomes.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>M4.5) This document enhanced my understanding of each outcome measure.</td>
<td></td>
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</tr>
<tr>
<td>M4.6) This document informed me of the issues associated with the outcome measures.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>M4.7) I learned about the advantages of each outcome measure from this report.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
M4.18) Do you have any comments regarding this document that were not already addressed?
____________________________________________________________
____________________________________________________________
____________________________________________________________

M4.19) Did you share this document with any of your co-workers? 
________________________________
IF “No,” SKIP TO Mtg1 0 = No, 1 = Yes

M4.19a) Who did you share this document with? What are their positions here?
____________________________________________________________
____________________________________________________________
____________________________________________________________
IF RESPONDENT DID NO ANY MEETINGS AT CMH, SKIP TO PUSe1. T ATTEND

Thank you. Now I’m going to ask you a series of questions regarding the meetings you attended at CMH.

For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

<table>
<thead>
<tr>
<th>Mtg1)</th>
<th>Attending this/these meeting/s expanded my knowledge of measuring outcomes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mtg2)</td>
<td>This/these meeting/s enhanced my understanding of each outcome measure.</td>
</tr>
<tr>
<td>Mtg3)</td>
<td>This/these meeting/s informed me of the issues associated with the outcome measures.</td>
</tr>
<tr>
<td>Mtg4)</td>
<td>I learned about the advantages of each outcome measure from this/these meeting/s.</td>
</tr>
<tr>
<td>Mtg5)</td>
<td>I learned about the disadvantages of each outcome measure from this/these meeting/s.</td>
</tr>
<tr>
<td>Mtg6)</td>
<td>In general, I learned more about outcome measures from attending this/these meetings.</td>
</tr>
<tr>
<td>Mtg7)</td>
<td>I was able to identify my preferred outcome measures from this/these meeting/s.</td>
</tr>
<tr>
<td>Mtg8)</td>
<td>I used this/these meeting/s to persuade others of preferred outcome measures.</td>
</tr>
<tr>
<td>Mtg9)</td>
<td>The information discussed at this/these meeting/s were expressed in a straightforward manner.</td>
</tr>
</tbody>
</table>

Mtg10) Do you have any comments regarding this/these meeting/s that were not already addressed?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
For the following questions, please tell me the extent to which you agree with the following statements, using the scale provided to you.

| PUe1 | My level of involvement in choosing outcome measures enhanced my knowledge of outcome measures. |
| PUe2 | My level of involvement in this evaluation influenced my opinion regarding the outcome measures. |
| PUe3 | My level of involvement in this evaluation helped me decide which outcome measures were best. |
| PUe4 | My level of involvement in this evaluation helped me understand the issues associated with each outcome measure. |
| BTS&M1 | I believe CMH took my and this treatment program’s perspective into consideration when selecting the outcome measures. |
| BTS&M2 | I feel CMH chose the most appropriate outcome measure. |
| BTS&M3 | I anticipate the chosen outcome measures will become one of this program’s routine assessments. |
| BTS&M4 | I see a need for measuring outcomes. |
| BTS&M5 | I believe the chosen outcome measures are capable of assessing changes in clients’ symptoms. |
| BTS&M6 | I believe the chosen outcome measures are capable of assessing clients’ progression towards recovery. |
Thank you. These last questions will assess your preferred methods for receiving information from CMH.

**IF RESPONDENT DID NOT HAVE ACCESS TO ANY OF THESE METHODS, SKIP TO P5.**

**P1) I want you to think about all of the documents you had access to, all of the meetings you have attended, and (IF APPLICABLE) the focus group you have participated in. Out of these three options, did you find the documents, meetings, or focus group (or any combination of the three) to be most useful?**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**IF THE PARTICIPANT DID NOT CHOOSE THE DOCUMENTS AS THE MOST USEFUL, SKIP TO P3.**

**P2) Which document was most useful for you?**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**P3) Why was/were this/these method/s most useful for you?**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**P4) When thinking about all of the documents you had access to, all of the meetings you have attended, and the focus group you participated in, which was most informative?**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**P5) Would you like have access to these documents, meetings, and focus groups in the future?**

0 = No, 1 = Yes

**P6) What is your preferred method for receiving information from CMH?**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________