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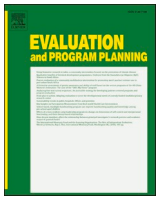

Building capacity to create community change (BC^4): A model to support successful program planning and implementation

Roxann McNeish Taormina [a,*], Tom Massey [a], Connie Walker-Egea [a], Cathy Sowell [a], Khary K. Rigg [b], Christopher Simmons [c], Quynh Tran [a]

[a] Department of Child & Family Studies, University of South Florida, USA
[b] Department of Mental Health Law & Policy, University of South Florida, USA
[c] School of Social Work, University of South Florida, USA

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ABSTRACT

Community-based interventions (CBIs) are increasingly used to address health problems and are usually implemented by organizations outside and/or inside the community. CBIs are complex and organizations need to have, or be able to build the capacity needed to implement CBIs effectively. The importance of organizational capacity building is well established in the literature, but less attention is focused on how to build capacity, particularly for prevention-focused and mental health CBIs. As part of the longitudinal process evaluation of a national initiative to promote the mental health and wellbeing of men and boys in the United States, this study developed a capacity-building model to identify areas and associated factors that were integral to grantee organizations' ability to build capacity to create change in their communities. The findings identified five domains used to comprise the Building Capacity to Create Community Change model, which contributed to organizational capacity building and as a result, implementation progress: Administrative Support, Leadership, Vision and Mission, Partnership Development, and Community Engagement. Strength in each domain increased grantees' capacity to impact the lives of participants and progress towards the goal of creating community change.

Community-based interventions (CBIs) are increasingly used to address health problems. The goals of CBIs include both improving individual outcomes and creating community changes (Durlak & DuPre, 2008; Rigg, Engelman, & Ramirez, 2018). A CBI generally refers to an intervention implemented in a community-based setting (Merzel & D'Afflitti, 2003), usually by various organizations outside and/or inside the community. However, there are other models of CBIs such as those where implementers can treat the community as the target, the resource, and/or the agent for the interventions instead of simply considering it as the setting for the projects (McLeroy, Norton, Kegler, Burdine, & Sumaya, 2003). That is, CBIs can focus on the goal of improving the health of the community (target), utilize the community's internal assets to address problems (resource), and strengthen the natural capacities of communities to meet the needs of community members (agent). These models highlight the complexity of CBIs in relation to both outcomes and the role of implementers. Additionally, McLeroy et al. (2003) suggest that these models identify building community capacity as an outcome of CBIs. These authors, as well as others (Goodman et al., 1998), further suggest that community capacity building may be a health promotion pathway in and of itself.

Many studies have focused on the strengths and importance of capacity building, highlighting its potential to create and help sustain community change. Various scholars have conceptualized and defined this concept. One of the earliest definitions of community capacity was developed during a symposium consisting of researchers in multiple disciplines (e.g., community psychology, health education, and sociology) (Goodman et al., 1998). These scholars proposed that community capacity is: "(1) the characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems and (2) the cultivation and use of transferable knowledge, skills, systems, and resources that affect community- and individual-level changes consistent with public health-related goals and objectives" (p.259). Another capacity-building framework posits that strategies for building community capacity involve efforts to strengthen organizational development and organizations are mechanisms for creating community capacity (Chaskin, 2001). Community capacity and

* Correspondence to: 13301 Bruce B Downs Blvd, MHC 2417, Tampa, FL 33612, USA.
E-mail address: mcneish@usf.edu (R. McNeish Taormina).

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organizational capacity are thus inextricably related, as organizations/agencies are most often the implementers of CBIs (Griffin et al., 2005). Building organizational capacity is therefore an integral task in building a community's capacity to implement a CBI and create change.

Throughout the years, many community projects have developed different models for capacity building that exemplifies a socioecological approach encompassing multi-level capacities. For example, The Alberta Heart Health Project constructed a conceptual model for capacity building for heart health promotion that consisted of three primary and interacting dimensions: leadership, policymaking, and infrastructure (Dressendorfer et al., 2005). Another project aiming to assist parents with intellectual disabilities also proposed a similar model with additional components (McConnell, Matthews, Llewellyn, Mildon, & Hindmarsh, 2008). The researchers suggested that in order to achieve capacity building, communities should address several conditions: leadership and managerial support, access to knowledge and information, peer networking, and adaptation to community context. Other researchers also specified the different intervention levels for capacity building. For their community project, Chan, Lam, and Cheng (2009) proposed a capacity-building model that incorporated different levels of interventions, including the organization level that targets social service agencies to improve research and training; and the community level that targets neighborhoods to mobilize different communal stakeholders for cooperative efforts against violence.

1. Organizational capacity

Building organizational capacity is important because it affects an agency's ability to create and sustain change Child Welfare Capacity Building Collaborative. (n.d.). Capacity building also supports an organization's ability to establish a local vision and mission and develop the skills and strategies needed to carry out this mission in the future (National Council of Nonprofits, 2017; Community Toolbox, 2016). Strengthening organizational factors is also useful for effectively implementing health-promoting CBIs to have long-lasting impacts (Griffith et al., 2010; Griffith et al., 2008; Peterson & Zimmerman, 2004). Various models have been developed to highlight the importance of organizational capacity building and associated factors to consider. One such model is the Organizational Empowerment model, which focuses on factors that can contribute to creating change at three organizational levels; *intra*organizational, *inter*organizational, and *extra*organizational. Intraorganizational capacity focuses on an organization's internal structure and functioning; interorganizational capacity includes collaborative partnerships among multiple organizations; and extraorganizational capacity demonstrates the influences the organization has on its surrounding community. These authors suggest that in order to build extraorganizational capacity and for the work of the organization to be impactful, organizations must have strong intraorganizational and interorganizational capacities.

CBIs can be implemented by a single organization that already exists in the community, such as a health department or a nonprofit. They can also be implemented collaboratively among multiple organizations where partnerships are established to create a network of community agencies that work towards a common goal (True, Rigg, & Butler, 2015). In either case, building or empowering organizational capacity will help catalyze effective CBI implementation (Bertram, Blase, & Fixsen, 2015; Durlak & DuPre, 2008). However, it is important to note that organizational capacity and structure can have positive or negative impacts on the implementation of CBIs (Durlak & DuPre, 2008). For example, it is generally more challenging for larger organizations that do not have ongoing interaction with the community to implement CBIs, compared to smaller organizations that may have more community relationships and may even be led by community members (McNeish, Rigg, Tran, & Hodges, 2019). On the other hand, smaller organizations may have less staff and fiscal capacity to adequately support CBIs that larger organizations usually possess.

While quite a few capacity-building models and frameworks exist, there has been less attention on *how* to build capacity to create community change, particularly in the context of implementing prevention and mental health-related CBIs (O'Farrelly, Lovett, Guerin, Doyle, & Victory, 2017). Similarly, there have been many studies on organizational capacity building, but few in the context of implementing CBIs and even less focused on implementing mental health-focused CBIs. Most literature on capacity building in mental health pertains to increased efforts to build capacity to train mental health professionals, and global mental health research (Fricchione et al., 2012; Murray et al., 2011; Shaji, 2013; Thornicroft, Cooper, Bortel, Kakuma, & Lund, 2012).

1.1. Current study

To contribute to the extant literature about capacity building, the current paper utilized findings from a longitudinal evaluation of a five-year mental health prevention CBI (described below) involving 16 grantees across the United States (U.S.) to construct an organizational capacity-building model. The model was designed to identify areas and associated factors that were integral to grantee organizations building capacity to create change in their communities. Simmons, Reynolds, and Swinburn (2011) proposed the following structure for any scholar to conceptualize capacity building: "capacity building should be defined as the identification and leveraging (or similar verb) of <insert identified characteristics> for the purpose of <insert rationale; context dependent> " (p.198). In this study, capacity building is therefore defined as identifying and strengthening organizational/agency factors for the purpose of facilitating successful planning and implementation of CBIs that promote mental health and wellbeing in communities across the U.S.

2. Method

2.1. Project background

The Making Connections Initiative (MCI) is a national effort funded by the Movember Foundation aimed at promoting the mental health and wellbeing of men and boys in the U.S. In 2015, Movember funded 16 grantees across the U.S. to develop community-driven prevention efforts for men and boys. This five-year initiative, coordinated by the Prevention Institute, supported the planning and implementation of prevention strategies intended to transform the community conditions that influence mental health and wellbeing for vulnerable male populations, including men and boys of color and veterans. The MCI provided grantees and their selected community partners the opportunity to plan, identify, and develop mental health promotion activities that would best serve a targeted male population in their community. During the first year of funding, grantees focused on planning for their local prevention programs. Grantees also engaged in various processes with the goal of creating an actionable plan for their community program, including partnering, visioning, and needs assessment. Resources needed varied by community, but the general results of the needs assessments found these needs to be safe and culturally connected spaces to meet and/or play, positive connections with others, and resources that promoted personal and/or community changes. Grantees implemented various programs to address these needs, using strategies that fell into six overall categories: creating spaces to gather and feel safe (emotionally and physically); creating social networks; building and improving participants' capacity to help themself and others (e.g., financial training, positive masculinity training, etc.); promoting civic/community action; promoting advocacy efforts (self and community); and creating opportunities for leadership and leadership development.

Grantees not only varied by program design, but also in organization size and structure, geographic location, and population of focus. The evaluation team divided the grantees into two groups: 1) public agencies and 2) nonprofit organizations. The six public agency grantees (which

were mostly public health departments) varied considerably in size, mission, and scope; the 10 nonprofit grantees also varied in organizational size, mission, and scope. For example, one Midwest region grantee is a diversified nonprofit health provider with seven member institutions that offers a full range of in-patient and outpatient healthcare services, social service programs, and research. By comparison, one Western region grantee is a small grassroots nonprofit organization focused on health, advocacy, and cultural enrichment for a specific cultural group. The nonprofit group also included grantees that functioned as intermediary organizations for their communities by providing linkages across people and groups.

The Department of Child and Family Studies at the University of South Florida (USF) conducted the cross-site national evaluation of the MCI. Considering that community change takes time and some impacts may not be realized or accomplished within the timeframe of the MCI, the evaluation team identified grantee's building capacity to create community change as a project goal and tracked progress over the five grant years. One challenge to understanding the process of community-level implementation was that funded grantees varied considerably in the population of focus and program scope. Therefore, the evaluation was designed as an explanatory case study in which each grantee site served as both a unit of analysis and contributed to cross-site findings. The case study approach offers a useful framework for understanding program implementation within and across sites by integrating data from multiple cases and data sources (Yin, 2003), and allowing comparison of findings from multiple cases (Eisenhardt & Graebner, 2007; Yin, 2003). This design provided the opportunity to understand how capacity was built under varying approaches and to identify patterns that may support generalizing cross-grantee strategies (Eisenhardt & Graebner, 2007; Yin, 2003).

During the planning year, building capacity (i.e., fostering organizational characteristics) to create change in grantee communities was operationalized as their ability to submit a clearly outlined actionable implementation plan on time. In the subsequent years, the evaluation team defined success as grantees improving their capacity to create change in their communities by progressing towards their stated project goals and towards the overall goal of the MCI.

2.2. Data collection

To develop an in-depth understanding of grantee context and progress toward the project goals, evaluation activities focused on qualitative data collection. Data was collected from multiple sources for each of the grantees, including: 1) ongoing document review (e.g., formal contracts, memoranda of understanding, meeting agenda minutes, project reports), 2) semi-structured telephone interviews with all grantees conducted at least bi-monthly during year one and monthly in the implementation years, and 3) annual site visits with grantees that included individual and/or group interviews with grantee staff, community partners, and program participants, as well as direct observation of program activities.

2.3. Data analysis

Thematic analysis was the primary data analytic method (Braun & Clarke, 2006), and the process was ongoing and iterative throughout the project. This involved reviewing and coding transcribed interview recordings, interviews and observation notes, and documents by multiple investigators (i.e., evaluation team members) to identify themes within and across grantee sites. Using multiple investigators is an analytic strategy that allows multiple perspectives, which increases the possibility of new insights. Data from the various sources were first organized and coded by site (by the evaluation liaisons assigned to that site), prior to the cross-site thematic analysis.

Site-specific thematic analysis was conducted simultaneously with other analytic strategies, namely triangulation and sequencing. Data triangulation was used to compare data from one source (e.g., observation notes) with other sources (e.g., interviews), which is crucial to strengthening the findings' validity and reliability (LeCompte & Schensul, 1999). Analytic sequencing is a strategy that focuses first on grantee-specific analyses by the assigned liaison team (two members of the evaluation team) and continues with cross-site analyses involving the entire team, prompting discussion and validation. Sequencing allowed evaluation team members to familiarize themselves with the data trends to identify themes for each grantee prior to attempting cross-site comparisons of emerging themes (Eisenhardt, 1989). The entire team participated in the iterative analysis of grantee-specific themes to identify cross-site themes from the data, which became the model domains.

3. Results

Results indicated five overarching domains that contributed to positive progress in capacity building: Administrative Support, Leadership, Vision and Mission, Partnership Development, and Community Engagement. The domains were used to develop the capacity building model (discussed in further detail later in the paper) by which grantees were assessed in the implementation years. The model domains were examined for relevancy, consistency, and how each impacted implementation progress over the five project years. The cross-site distillation of findings for each domain is directly linked to data and the observed role of how each supported successful implementation progress during the project years and grantee's ability to build capacity for creating community change. A summary of the strategies associated with each

Table 1
Summary Findings of The Five Outcome Domains.

Domain	Summary of Findings
Administrative Support	• Executive-level involvement is critical to successful planning and implementation. • Specific staff assignments support effective planning and implementation. • Project staff members need a wide range of skills and experience. • Staff must fully understand and be committed to the mission and goals of the initiative.
Leadership	• A leader's personal vision and commitment help create initiative momentum. • A well-rounded leader who effectively uses various styles (below) was most beneficial to implementation. • Values-based leadership supports staff, community, and partner agency engagement. • Relationship-oriented leadership skills support teamwork and coalition development. • Task-oriented leadership skills support grant management and progress of activities. • A shared leadership structure, with opportunities for leadership development, promotes project commitment.
Vision and Mission	• Shared vision and mission is a process rather than a product. • Needs assessment data should shape vision and mission. • Community member involvement in vision and mission development improves capacity for community impact. • Programs can create a local identity (i.e., a brand) for the initiative through vision and mission development. • Developing a theory of change helps maintain project focus and implementation progress.
Partnership Development	• Building trust is foundational to partner development. • Role clarity strengthens partnerships. • Partnership expands initiative capacity. • Shared governance/decision-making structures are most beneficial to partnership and engagement.
Community Engagement	• Community engagement builds trust with community members. • Community engagement supports a deeper understanding of community needs. • Community engagement empowers the population of focus.

domain is included in Table 1 and more information about the capacities built is detailed in the results below. The data further indicated that when grantees demonstrated strengths in all or most outcome domains this contributed to implementation progress, while challenges delayed and/or impeded progress and negatively affected their capacity to meet stated goals.

3.1. Administrative support

The Administrative Support domain included both structures and processes that facilitated day-to-day grant administration and project management. This could include but was not limited to budget administration, program planning (including evaluation), recordkeeping, meeting scheduling and facilitation, community outreach, staffing, and staff orientation and training. Sometimes referred to as facilitative administration (Bertram et al., 2015), administrative support provided a foundation for the initiative by supporting task identification, prioritization, and delegation as needed.

Having strong administrative support contributed to successful program planning and implementation by fostering staff commitment, increasing capacity to meet project goals and deadlines, enhancing evaluative capacity, and establishing the initiative as central to the mission of the funded organization. Strong administration improved staff's ability to prioritize MCI goals and activities, as well as enabled staff to generate more attention and efforts for the program. This was facilitated by dedicating adequate staff time to MCI activities, which also allowed grantees to submit reports and other program documents on time and/or consistently.

Grantees with administrative support were able to effectively plan, execute and capture activities, including participant engagement in each activity and program outcomes. Most grantees had multiple activities happening at the same time, so having support and strength in this area enabled focused attention to each activity, as well as data collection. Administrative support allowed grantees to ensure that evaluation procedures were not just in place, but also carried out according to plan. Prior planning was integral to supporting evaluation efforts, which was challenged if there was limited staff or staff time.

Staff skills and abilities were just as important as having sufficient staff time dedicated to the initiative. It was also important that staff be committed to the initiative's mission and goals, but findings additionally revealed that staff needed a variety of skills to be successful. Prior program planning experience for organizational staff leading the project proved to be more necessary for implementation progress than specific knowledge about mental health. However, for staff directly interacting with participants or leading activities, authenticity, showing genuine care for those involved, and relatability were reported by participants to promote engagement. Findings also revealed that having front-line staff that represented the focus population benefitted initial and continued engagement.

An important anchor and facilitator to implementation progress was establishing MCI as important to the funded organization. This was achieved by having organizational leadership involved, or at least aware of and supportive of the mission of MCI. Data showed that this was critical to the success of the initiative, so much so that projects failed when upper-level/executive leadership were not involved, unaware, or not supportive of the initiative. Grantee organizational leadership involvement ranged from participation in MCI meetings and activities on an ongoing basis, to only receiving periodic updates on the MCI activities. The most successful grantees had someone in leadership who attended some or most MCI meetings to remain aware of MCI progress and challenges. Leadership attendance at meetings, either between the grantee staff and MCI partners or with just the project staff, was beneficial as both sustained their ongoing involvement. This involvement was of particular importance during the planning and early implementation years of MCI and whenever there was a leadership change.

3.2. Leadership

For the purpose of this evaluation, leadership was defined as a process by which an individual influenced a group of individuals to achieve a common goal (Northouse, 2016). Leadership roles could be either assigned or emergent. In collaborative alliances and team-based efforts, it is common for group members to assume leadership roles regardless of their title or formal assignment. Grantee implementation partners (which included community agencies and community members – some of whom represented the focus population) assumed active leadership roles. However, data indicated that in the planning year, the role of formally assigned leaders was critical to establishing the initiative and facilitating planning year activities. Because of the importance of assigned leaders during the planning year, the evaluation findings related to the two types of assigned leaders typically associated with MCI: 1) the grantee organization's primary MCI contact, and 2) the individual assigned as the local program or project director for MCI.

Grantee leaders used different leadership styles, all of which supported program implementation to varying extents. Values-based leadership encouraged partnership and coalition building; relationship-oriented leadership fostered teamwork; and task-oriented leadership allowed grantees to better manage the program. A well-rounded leader who effectively used various styles, rather than one who did well with one particular style, was most beneficial to implementation. It was also helpful to have a leader with a personal vision that helped create initiative momentum by establishing project direction. This helped move activities forward and kept the focus on the outlined goals. On the other hand, when a leader's vision was different or did not align with the initiative goals, this created project drift (drifting from the stated goals of the project) and challenged program progress. For example, for a few grantees who also served other groups besides the initiative's targeted population of men and boys, if the MCI leaders did not modify their personal vision to include or focus specifically on males, then their program activities ended up lacking a gendered approach.

Having a leader who valued shared or distributed leadership was one of the strongest facilitators of capacity building and overall progress. A shared/distributive leadership structure helped grantees weather leadership and other organizational changes, as well as promoted project commitment and sustainability. Grantees usually distributed leadership responsibilities among their partners and/or to their focus population. Partners were often involved in leading different aspects of program implementation (e.g., training on a topic, performance of a service, or informing how and what activities occurred), while participants usually received leadership training to assist other participants (e.g., as mentors, peer leaders). However, many youth-focused grantees provided leadership opportunities to youth during all aspects of implementation, which was particularly beneficial when working with these youth and young adults. Along with increasing commitment, this also empowered youth to get involved in other community efforts and taught them tangible and transferable skills. Some grantee organizations were able to hire youth as staff due to the qualities they displayed in their leadership role. On the other hand, having a centralized leadership structure among partners strained relationships and impeded implementation progress. Similarly, grantees that did not provide leadership opportunities for participants (especially for youth) were unable to sustain engagement.

3.3. Vision and mission

These two concepts are related, although it is useful that they are distinguished. For the purpose of this evaluation, vision and mission were defined as expressions of purpose and goal. Mission was an expression of purpose specific to the MCI– a statement that explained why the initiative existed in the funded community. Vision was an expression of what the MCI intended to achieve over time – this could be a broad statement that captured what improved mental health and wellbeing for the men and boys of each grantee community would look

like in the future, but vision could also be expressed as a visual such as a theory of change.

The process of collaborating to develop a shared vision and mission was more valued by the grantees than the resulting vision and mission statements themselves, as it helped develop trust and understanding of MCI goals among community partners and members. This was facilitated by having both being informed by needs assessments or other available data and having stakeholders involved in these processes during project planning. Survey and interview data demonstrated that the primary grantee organization's openness to input regarding project direction and goals increased community stakeholders' trust. Community stakeholders/partners also reported increased commitment to the project and to the focus population when they were able to hear directly from the men and boys what was most needed. For example, one grantee's process of forming a shared vision allowed for the identification of a gender-specific approach, namely sports, to address the needs of their focus population. This grantee's development of a basketball program helped triple the enrollment of participants within a year.

Data also indicated that the planning period was also the opportune time to ensure that organizational leaders were aware and supportive of the vision and mission of the project. Their involvement with the community stakeholders in the development of both proved to be ideal, however, this was not always possible, especially in larger organizations. Though this did not compensate for organizational leadership involvement, it was found to be helpful to project implementation and sustainability when grant staff ensured that the project's vision and mission aligned with the organization's larger goals and/or mission and vision. Two grantees were large health systems, but one had increased community engagement as part of its vision while the other did not. MCI goals aligned with the vision of this organization; leadership was supportive of the work and the program progressed well. Leadership at the other organization supported the work as well, but there were more challenges with implementation as the organization's vision was not as aligned with MCI goals. The initiative was not sustained in this organization, other than the few program elements that aligned with its overall mission.

A clear vision and mission promoted cohesion among stakeholders by establishing a clear course of action for the program. Having a theory of change was a very helpful tool for grantees in ensuring that activities remained focused and progressed toward the project goals. Utilizing the theory of change on a regular basis not only served as a guidepost for implementation, but also enabled necessary program adaptations and need-based changes without drifting from the primary MCI goals. Grantees that utilized their theory of change were less likely to drift from the main goals of their project and the initiative and stayed more aligned with planned activities and tasks. On the other hand, a lack of clear vision and mission was a barrier to grantee organizations establishing goals related to MCI and tailoring program activities to those goals. This led to confusion among community partners and delayed implementation. Furthermore, findings indicated that clarity enabled the grantee organizations to brand their program, distinguishing it from others in the organization and/or in the community. Data showed that this was integral to implementation progress because it facilitated strategic partnering (McNeish, Rigg, Tran, & Hodges, 2019) and engagement of community members. Mission and vision clarity was important for all grantees, but was of particular importance to grantees with similar programs to MCI. One grantee had another male-focused initiative under which MCI was subsumed though their goals were distinctive. The grantee did not create or clarify the mission and vision of MCI and as such, MCI became unrecognizable to the extent that the partners could not distinguish the programs. MCI implementation had to be withdrawn.

3.4. Partnership development

Partners were defined as formal agencies and organizations that shared the vision and mission of MCI and participated in a community coalition with the goal of implementing the project in the identified community. Initially, most grantees identified organizations that they had previously collaborated with, but as the initiative progressed over time, grantees identified other or different partners to support implementation and achieve the project goals.

Partnerships were integral to building capacity to reach the community and develop a responsive program. When grantee organizations formed strong partnerships, this expanded their capacity to understand community needs, strategically utilize partners' strengths, and establish additional beneficial partnerships with other community entities. The foundation for building strong partnerships was building trust between the grantee and the partner organization, and building trust among the partner organizations (if it did not already exist from previous relationships). Having trust among partners brought organizations representing different sectors in the community together to create an alliance around a shared purpose.

Trust was built in a variety of ways, all of which centered around open communication and shared decision-making. Shared decision-making helped solidify that the initiative was for the benefit of the partners and community and not just the grantee organization. Some grantees furthered trust building by involving partners in budgeting and resource allocation decisions. The resulting culture of shared ownership and leadership among partners increased their commitment to the initiative, evidenced by partners being patient and remaining dedicated to MCI through implementation challenges and delays. Trust among partners also helped build the capacity of MCI to reach and engage members of the focus population. Partners were often facilitators of connections to men and boys in the community, particularly for larger organizations that did not work directly/closely with the community or community members. Grantees that were strategic, by partnering with organizations that were well known in the community and worked with the focus population, were more successful at engaging the population of focus and progressing through implementation.

Another factor that was beneficial to the MCI partnerships and the project as a whole was having clear partner roles. This helped avoid duplication of efforts, but also helped partners keep their responsibilities manageable and attainable. When partners had clear roles, there was more accountability and timely completion of tasks. Many partners had multiple competing responsibilities from their jobs and in their lives, and had limited time to dedicate to coalition participation. Role clarity improved the overall functioning of the partnership, which bolstered its capacity to progress through implementation (see (McNeish, Rigg, Tran, & Hodges, 2019) for additional factors related to partnership).

3.5. Community engagement

Community engagement was defined as getting the input and active participation of the community members-at-large (such as community partners) and members of the population of focus. Partnership development was considered a separate outcome domain focused on engagement with formal agency partners, but some agency partners served a dual role as community members. This occurred when: 1) the agency partner operated in the community, 2) the agency's primary mission was community benefit, and 3) agency staff and leadership were comprised primarily of community members and advocates. Most MCI partnerships included community members who represented the focus population, though they may have also been representing an organization.

Relationship building was essential to reaching, engaging, and sustaining the participation of community members in MCI and increasing the project's capacity to create positive change. Participants reported that their relationship with grant staff and other participants was one of the most important contributing factors to their participation and engagement. Trust building, again, was foundational to building this relationship. Similar to building partnerships, grantee organizational staff that worked directly with participants facilitated open

communication and provided opportunities for participants to provide input or help design programming. For grantees that did have the focus population as part of the partnership, this was primarily done via the creation of an advisory board. Youth-serving grantees primarily created these boards. These boards provided the opportunity to include various stakeholder input in the MCI planning and implementation process.

Including community voices contributed positively to a grantee's capacity to create community change, as it enabled the organization to have a deeper understanding of what the community needed. Valuing and facilitating community involvement also empowered the focus population to continue providing input, remain engaged in MCI, help recuit participants and engage in other civic community efforts. Members reported developing increased investment and commitment, as well as an increased sense of connection and ownership of the MCI (McNeish, Albizu-Jacob, & Memmoli, 2021). These factors improved the capacity of the program to progress well through implementation.

3.6. The organizational capacity-building model

The Building Capacity to Create Community Change (BC^4) model was constructed to illustrate how these five domains relate to each other and the contribution of each to implementation progress towards achieving the initiative goals (see Fig. 1). Taken together, the five domains provided a means to both identify and strengthen grantee capacity. The domains were organized into two categories: 1) organizational factors and 2) coalition-building strategies. Longitudinal ongoing analyses indicated that these findings were robust and broadly representative of experiences across the 16 grantees, regardless of organizational structure, geographic location, community context, or population demographics.

The domains of Administrative Support and Leadership were categorized as organizational factors because they occurred **within the grantee organizations** and contributed directly to the management and administration of MCI in each grantee community. Regardless of whether the grantee was a public agency, a provider-intermediary nonprofit, or a community-driven nonprofit, data indicated that both administrative support and leadership contributed substantially to how well grantees were able to accomplish their goals and objectives. In Fig. 1, the Administrative Support and Leadership domains are positioned on the outer rim of the model to suggest that these organizational factors were foundational and, to some degree, a precondition of building the capacity of projects to successfully progress. Analyses further suggested that Administrative Support underpinned and strengthened a grantee's Leadership capacity, although this relationship appeared to be more iterative than linear. In combination, both enabled grantees to successfully pursue the coalition-building strategies that are presented at the center of the model.

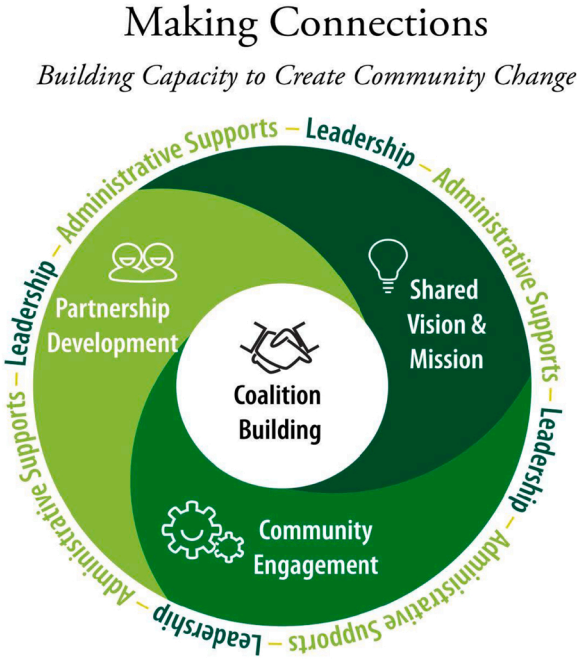

Fig. 1. BC^4: A Model to Support Successful Program Planning and Implementation.

The Vision and Mission, Partnership Development, and Community Engagement domains were categorized as coalition-building strategies because these organizational efforts were focused **outside of grantee organizations** and contributed directly to how MCI was situated within the community. In Fig. 1, Vision and Mission, Partnership Development, and Community Engagement are positioned as interlocking around the center of the model to suggest that these three domains should be cohesive in their functionality and that they were central to the process of establishing local community support and action for the initiative. Data demonstrated this is an essential component for mobilizing action and increasing community impact.

4. Discussion

Findings from the planning year of the MCI identified five outcome domains that were believed to substantially contribute to grantees developing organizational capacity to create community change. During the implementation years, these findings were tested against emerging data and refined to create the BC^4 model. Data consistently indicated that strength in factors outlined for each domain increased grantees' capacity to impact the lives of participants by facilitating progress through MCI implementation. It is important to note that while we present our findings generally for the benefit of any organization and program, this is not to diminish the contextual understanding of working with men and boys. Rather, understanding that those specific contextual factors are beyond the scope and capacity of this paper, the focus remained on the five domains found to be robust representations of capacity-building factors across the 16 variable grantees and programs.

Findings from the current study are also consistent with the existing research, namely the organizational empowerment framework, found to help build strong capacity for organizations to succeed. The organizational factors in the BC^4 model (Administrative Support and Leadership) parallel the intraorganizational component of the organizational empowerment framework, which emphasizes the importance of strengthening characteristics within the organization in order to lay a proper foundation (Peterson & Zimmerman, 2004). The coalition-building factors (Vision/Mission, Partnership, and Community Engagement) are similar to the framework's interorganizational characteristics that connect implementing organizations with the communities being served. Similarly, the Organizational Capacity Public Health Equity Action framework proposes two main components, internal context and enabling external environment, which mirror our organizational and coalition-building factors, respectively (Cohen et al., 2013). Each individual factor in the BC^4 model also emerged in other models of capacity building. For example, leadership and managerial/administrative support were identified as integral in the Alberta Heart Health Project's and the Healthy Start's capacity models (Dressendorfer, Raine, Dyck, Plotnitoff, Collins-Nakai et al., 2005; McConnell et al., 2008). There are several frameworks that consider leadership as central to program implementation (Bertram et al., 2015; Durlak & DuPree, 2008; National Implementation Research Network. n.d.) and much has also been written about the various types of leadership styles and those that best support program implementation (Bertram et al., 2015; Green, Miller, & Aarons, 2013; National Implementation Research Network. n.d.). Generally, the literature consistently supports the importance of flexibility in utilizing and balancing multiple leadership styles based on current needs to ensure organizational success and positive

programmatic progress (Bertram et al., 2015; Pepper, 2010; Schmid, 2008).

Mission and vision development is very important when implementing CBIs, as this provides organizations an opportunity to develop plans that align with intended program outcomes. Other researchers similarly found that having community member input in developing a shared mission and vision strengthens the development process and the resulting statements (Rigg, Cook, & Murphy, 2014). Many studies have also similarly identified mission and vision as being integral to building organizational capacity (Fredericksen & London, 2000; Taiwo, Lawal, & Agwu, 2016). These statements can also be effective tools in creating a shared understanding of an initiative in the community and in garnering community participation to achieve program goals. Organizations may not think about mission and vision as a way of branding their program, but this is an essential function of creating both. They distinguish programs and help to set them apart, serving as an aid in engagement. As in for-profit marketing, mission and vision statements can be utilized as tools to engage consumers (participants) as well as investors (funders). Therefore, both should be given focused attention and thought, and updated as priorities change.

The importance of forming coalitions or partnerships and engaging with community organizations, stakeholders, and community members is also emphasized in multiple capacity-building models. McConnell et al. (2008) model highlighted the significant role of peer networking. Similarly, Chan et al. (2009) multi-level intervention model emphasizes targeting social service agencies at the organization level and stakeholders in neighborhoods at the community level, which are comparable to our Partnership Development and Community Engagement domains, respectively. Community engagement is a principled approach to implementing CBIs that underpins successful program implementation. Without adequate investment of time and resources, or authentic willingness to truly partner with communities to create change that (hopefully) they identify as being needed, it is unlikely that any initiative will succeed.

Notably, although each domain contains specific strategies that directly contribute to capacity building, the evaluation team recommends treating these domains holistically rather than as discrete categories. From this perspective, the domains could be seen as intricately related to each other and functioning together to support the initiative's success, which is supported by extant research. The literature indicates that there are four overall approaches to building capacity for improved health practices: top-down organizational approach, bottom-up organizational approach, partnerships approach, and community organizing approach (Crisp, Swerissen, & Duckett, 2000). Although each approach originated as distinct models, they are argued to be interconnected and, therefore, changes in one will impact the others. These four approaches are reflected in each domain of the BC^4 model, indicating its comprehensiveness. Similarly, our study findings indicate that while the BC^4 model domains individually contribute to capacity building, it is best to view the model holistically.

Furthermore, the program implementation literature suggests that to be effective, the functions of program implementation must be both integrated and compensatory (Bertram et al., 2015; Blase & Fixsen, 2013). Extending this rationale to the BC^4 model domains, each can be thought of as dynamic and requiring the ability to adapt and respond to changes in context or environment. As such, it is important that the domains function as an **integrated** whole rather than as independent units in order to provide consistency and sustainability for initiatives over time. In addition, these domains should be considered **compensatory** in that strengths in some domains can, to some extent, offset weaknesses in others. For example, a grantee may be strong at developing agency partnerships, but less adept or experienced in community engagement. The strength in partnership development may serve to offset the lack of experience in community engagement, particularly if agency partners are able to fill this gap by taking a lead in community engagement. However, the caution to this compensatory relationship among the domains is that each has to be attended to in some way. The absence of capacity in any one domain cannot be fully offset by strengths in the other domains.

5. Lessons learned

While the BC^4 model focuses on organizations, programs can also utilize this model, as well as funders and planners. The BC^4 model provides a source that any organization can utilize to develop its implementation capacity, as well as to assess barriers and facilitators while preparing for or during implementation. Planners can utilize the model to identify the needed capacity for bolstering program progress and success, as well as areas that may need technical or other assistance. Funders can use the model in the same way and additionally to identify organizations that may not have the capacity to implement projects successfully. Existing programs can utilize the model during implementation to identify strengths or barriers that they may otherwise think are unique or contextual, and areas that may need additional support. Programs can also use the model post-implementation to help identify factors that contributed to challenges and successes. Considering the wide applications of the BC^4 model, the evaluation team plans to create a tool, such as a checklist from the findings of this model, to assist organizations in identifying areas that may strengthen or challenge their organizational capacity for program implementation.

CRediT authorship contribution statement

Roxann McNeish: Conceptualization, methodology, formal analysis, investigation, writing, supervision, project administration and funding acquisition. **Tom Massey**: methodology, formal analysis, investigation, writing, supervision. **Connie Walker**: methodology, formal analysis, investigation, writing. **Cathy Sowell**: formal analysis, investigation, writing. **Khary K. Rigg**: formal analysis, investigation, writing. **Chris Simmons**: formal analysis, investigation, writing. **Quynh Tran**: investigation, writing.

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Dr. Roxann McNeish is a Research Assistant Professor in the Department of Child & Family Studies at the University of South Florida (USF). She holds a Ph.D. in Public Health and a Master of Social Work and Master of Public Health from USF. Her overall research interests focus on behavioral health policy, services, and their impacts on individuals and families, particularly vulnerable and minority populations

Dr. Oliver Massey is an Associate Professor and Division Director in the Department of Child and Family Studies, College of Behavioral & Community Sciences at the University of South Florida. He also serves as Director of the Translational Research and Evaluation Concentration of the Master of Science in Child & Adolescent Behavioral Health program. His specialties include applied research and evaluation of community-based services for individuals with mental illness. Of special interest is the evaluation of the organization and effectiveness of behavioral health services in public schools. He also has extensive consultation experiences with local community and state agencies.

Dr. Connie Walker-Egea is a Senior Social and Behavioral Researcher in the Department of Child & Family Studies, College of Behavioral and Community Sciences at USF. Dr. Walker-Egea's primary interests are program evaluation and the development of data collection instruments. She has conducted program evaluation and research in a variety of settings and has considerable experience with data collection using quantitative and qualitative methods, conducting data analysis, and designing surveys and research instruments. Dr. Walker-Egea has been involved in coordinating data collection efforts, providing technical assistance, and conducting evaluations of projects focused on education and mental and behavioral health.

Cathy Sowell is a licensed clinical social worker and faculty member at the University of South Florida, Child and Family Studies, and co-director of the Child and Family Behavioral Health division. She directs the Children's Mental Health Graduate Certificate Program and is a focus area lead instructor for the Child and Adolescent Behavioral Health master's program. She provides technical assistance, consultation, and evaluation in the interconnected fields of mental health, child welfare, early childhood, and related social service systems and organizations to help design, implement, evaluate, improve, and sustain community-based services and supports for individuals, children and families.

Dr. Khary K. Rigg is an Associate Professor in the Department of Mental Health Law & Policy at USF. He holds a Ph.D. in medical sociology from the University of Miami and completed a postdoctoral fellowship in health services research from the University of Pennsylvania Perelman School of Medicine. His research interests include community-based behavioral health interventions and substance use prevention/treatment.

Dr. Christopher Simmons is Associate Director of the School of Social Work at the University of South Florida. As a Licensed Clinical Social Worker for over 15 years, he has extensive experience in behavioral assessment, intervention, and evaluation. Much of his research has focused on cognitive development of students in training. More recently, he has begun focusing on mental health and well-being among at-risk populations. As a PI or Co-investigator on university, foundation, and federal grants, he has expertise in recruiting and tracking participants, administering projects, collaborating with other researchers, and disseminating research through presentations and publications.

Quynh Tran is a Graduate Research Assistant in the Department of Child & Family Studies at the University of South Florida. She holds a bachelor's degree in psychology and is currently pursuing concurrent Master of Public Health and Master of Social Work degrees. Her research interests include mental health and well-being of racial and ethnic minority populations and community wellness.