Implementing Trauma-Responsive Screening and Assessment: Lessons Learned from a Statewide Demonstration Study in Child Welfare

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Implementing Trauma-Responsive Screening and Assessment: Lessons Learned from a Statewide Demonstration Study in Child Welfare

Winters, Collins-Camargo and Antle

Abstract

Research has demonstrated children entering out-of-home care have trauma exposure and behavioral health needs. As a part of a trauma-informed system, the literature recommends universal screening and functional assessment; however, child welfare and behavioral health agencies struggle with timely identification and response to these needs. Implementation of large practice change initiatives involving collaboration within these agencies can be challenging. This paper reports on themes identified through analysis of focus group data regarding the implementation of such an initiative. Results are presented in the categories of worker perceived value, training, support, screening, and assessment practice. Lessons learned are discussed.

Introduction

Children in out-of-home care (OOHC) are known to have been exposed to significant amounts of trauma, and as a result of this, and the trauma associated with removal from their homes, have behavioral health needs that must be addressed (Casanueva, Ringeisen, Wilson, Smith, & Dolan, 2011; Griffin et al., 2011). Many of the identified challenges for youth accessing behavioral health services, however, have been associated with the child welfare and behavioral health systems' response to those needs (Cooper & Vick, 2009).

Without a systematic approach to identifying behavioral health needs, youth may not be referred for assessment and treatment until behavioral health problems escalate (Conradi, Wherry, & Kisiel, 2011). The domino effect of difficult to handle behaviors and placement disruption may further inhibit referral for services (Hyde & Kammerer, 2009), creating an inaccessible and fragmented service delivery system for youth in OOHC (Davis, Jivanjee, & Koroloff , 2010). Further, behavioral health providers have indicated they often do not receive adequate information regarding trauma history when a child is referred to them (McMahon & Forehand, 2005). The results of federal Child and Family Services Reviews illuminate that many states do not provide adequate physical and behavioral health services to these children (McCarthy, Marshall, Irvine, & Jay, 2004). There is a need for jurisdictions to implement a systematic approach to addressing these issues and responding to the socioemotional and behavioral needs of children in OOHC (USDHHS, 2012). This paper reports on themes identified through analysis of focus group data regarding a large-scale statewide initiative to implement standardized behavioral health and trauma screening and assessment for youth in OOHC.

Trauma-responsive Screening and Assessment

The field has been progressing in the development of trauma-informed child welfare and behavioral health systems (Ko et al., 2008). The literature has established that trauma-informed screening and functional assessment are critical tools for identifying and responding to the behavioral health needs of children in OOHC (e.g. Lang et al., 2017; Conradi et al, 2011; USDHHS, 2014). In the Substance Abuse and Mental Health Services Administration's (SAMSHSA) trauma-informed approach to care, standardized screening and assessment is one of the required domains (USDHHS, 2014).

Beginning in 2011, the USDHHS Children's Bureau funded three cohorts of demonstration projects that involved implementation of universal trauma and behavioral health screening and, for some, implementation of related interventions such as the use of screening to trigger referral for functional assessment and use of that data in treatment selection and case planning (Federal Funding Opportunity Announcement numbers: HHS-2011-ACF-ACYF -CO-0169; HHS-2012-ACF-ACYF-CO-0279; and HHS-2013-ACF-ACYF-CO-0637). Eighteen sites were funded to implement both standardized

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screening and assessment to inform treatment and case decision making. This paper focuses on a component of the process evaluation of one of those projects: Project SAFESPACE. In this project, public child welfare workers conducted standardized screening of all children entering out-of-home care. Data entered into the agency management information system were calculated to trigger referral to behavioral health agencies for functional assessment. The standardized functional assessment was intended to inform treatment modality selection by the behavioral health provider, and the results were shared with the child welfare worker to inform case planning and decision making. Functional assessment was to be repeated at 90-day intervals during treatment to assess progress. Hence, this project required statewide practice change on the part of both child welfare workers and behavioral health clinicians. Implementation of innovation of that magnitude required attention to the use of implementation science.

Implementation Science

The field now understands that in order to achieve programmatic outcomes we must pair the innovation with strategies to support its implementation with fidelity within an enabling context (Blase & Fixsen, 2013). Implementation science is defined as “the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice” (Eccles & Mittman, 2006, p. 1). Some have described phases of implementation: exploration, preparation/adoption, implementation, and sustainment. Within each phase, implementation requires examination of both the outer context, such as interorganizational linkages and information exchange, and the inner context, such as readiness for change, innovation-values fit, and fidelity support (Aarons, Hurlburt, & Horwitz, 2011). When implementing practice change in child welfare the Children’s Bureau encourages the importance of testing, learning, adaptation, and application of lessons learned (Framework Workgroup, 2014). Proctor (2012) suggested that when studying implementation, outcomes of interest include acceptability, adoption, appropriateness, feasibility, fidelity, penetration, cost, and sustainability.

The literature has offered a variety of implementation frameworks, including the Active Implementation Frameworks (Fixsen, Blase, Naoom, & Wallace, 2009), The Availability, Responsiveness and Continuity Organizational and Community Intervention Model (ARC; Glisson et al., 2012), The Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009), the Exploration Preparation Implementation and Sustainment (EPIS; Aarons, Hurlburt, & Horwitz, 2011), and the Getting to Outcomes framework (GTO; Wandersman et al., 2008). While there is a great deal to be learned from reviewing the approach taken by each, based on a scoping review of these implementation frameworks it has been recommended that the field move toward approaches that flexibly apply implementation core strategies (Albers, Mildon, Lyon, & Shlonsky, 2017). There is benefit to identifying the common elements or factors that are critical to programs to be implemented (Barth et al., 2011; Lyon, Lau McCauley, Stoep, & Chorpita, 2014).

Research has begun to identify and evaluate implementation strategies or systematic processes designed to promote installation and integration of innovative processes into a service delivery system. Powell et al. (2015) conducted a review and catalogued 73 implementation strategies such as data warehousing, quality monitoring systems, providing feedback to clinicians and administrators, practice reminders, and supervision. Bunger et al. (2017) tracked 45 unique implementation strategies that vary over the stages of implementation which may be valuable in understanding the most useful approaches during each of these phases. In a study published regarding implementation of a screening intervention similar to that in the current study, it was found that when implementing multiple related practice changes concurrently, multiple implementation strategies aimed at different levels in the organization was demonstrated to be important to support successful implementation of multiple and significant practice changes (Brookman-Frazee et al., 2018).

When assessing implementation of child welfare initiatives, qualitative and quantitative approaches are important to understand the process as well as the outcomes of the effort (Aarons, Green, Palinkas, Self-Brown, Whitaker

et al., 2012). When processes involving multiple agencies within the child welfare system, such as the project involved in this study, attention to the collaborative process must be considered when designing implementation support strategies (Aarons et al., 2014). Frontline staff engaged in service delivery are considered key stakeholders from whom to gather implementation-related perspectives (Akin, 2016; Greenhalgh, 2017). Flaspohler, Duffy, Wandersman, Stillman, and Maras (2008) distinguish between organizational capacity more generally and innovation-specific capacity related to what is uniquely needed in terms of skills and resources to implement practice change.

The purpose of this paper is to examine the results of focus groups conducted with child welfare workers as a part of the process evaluation of this project. These findings are reported through the lens of lessons learned related to: (a) perceived value of the intervention, (b) training received and future needs, (c) implementation support received and needed from supervisors and middle managers, (d) screening practice, and (e) assessment practice. It is intended that this study contribute to the growing literature on implementation of universal screening and functional assessment as a component of a trauma-responsive child welfare system.

Methods

Study Overview

Project SAFESPACE implemented universal, standardized screening for trauma and behavioral health needs by child welfare workers upon entry into out-of-home care and standardized functional assessment and periodic measurement of progress by behavioral health providers (see Winters, Collins-Camargo, Antle & Verbist, 2020 for more information). The 5-year project was implemented in nine service regions located in a southern state. At the end of the project, the research team conducted focus groups to explore intervention and implementation lessons learned from the project. Focus groups were conducted in five of the nine service regions.

Procedures

Focus groups were conducted with participating child welfare frontline staff and supervisors. The group process was used to elicit a range of participant experiences with the project (Cresswell, 1998; Morgan, 1997). Researchers employed a semi-structured interview guide using a priori codes of value, training, support, screening practice, and assessment practice. Interviews were conducted by the Principal Investigator with research staff present as notetakers. The PI asked questions and probes form the semi-structured interview guide designed to elicit information that would be useful in understand how implementation could be better supported or what adjustments needed to be made, as well as additional prompts to elicit more detail (e.g., “tell me more”). Notetakers captured information from each focus group, either through direct quotes or summaries. The PI and notetakers met to review artifacts for accuracy. Institutional Review Board approval was obtained for the study, and participants provided informed consent to participate.

The specific questions asked in the groups included the following:

- What do you see as the value or benefit of standardized screening and assessment?
- How did the training help you feel prepared to administer the screening? Are there areas you need more training or support to feel confident in this practice?
- What has gone well with the screening process? What have been the challenges? What are recommended changes?
- How does this screening fit with your current practice? How has this enhanced your practice?
- How have your supervisors supported you in this process? How has administration supported this process?
- What has gone well with the assessment process? What have been the challenges? What are recommended changes?
- How have you used the assessment reports (e.g., sharing results with parents/community partners)?
- What differences or impacts of the process on quality of services or collaboration between child welfare workers/behavioral health providers have you noticed?

Participants

There were a total of 54 participants from five different service regions providing geographic representation across the state. There were 45 workers (83%) and 9 supervisors (17%) in the sample. There were two participants who were African American (4%) and the remaining 52 (96%) were Caucasian. There were 8 males (15%) and 46 females (85%). The breakdown of number of participants by region was as follows: Region 1 = 9 workers; Region 2 = 3 supervisors and 5 workers; Region 3 = 5 workers; Region 4 = 2 supervisors and 9 workers; Region 5 = 4 supervisors and 17 workers.

Data Analysis

Written field notes (n = 5 artifacts) were de-identified. A priori and emerging codes were assigned to chunks of interview texts through directed content analyses (Hsieh & Shannon, 2005). Constant comparative method was used to analyze field notes (Charmaz, 2006; Strauss & Corbin, 1990). Qualitative analysis software was not used. Cutting and sorting using word processing software enabled open coding and the identification of themes and subthemes. Copies of original field note files and files at each stage of the analysis were saved to enable comparison. Open coding was conducted with field notes from each individual focus group and subsequent analysis files. The research team met to discuss discrepancies with themes, and themes as presented here, were agreed upon by all authors. See Figure 1 for a schema of a priori codes and subsequent themes.

Findings

Analysis of focus group data generated themes from each a priori code of (a) perceived value of the intervention, (b) training received and future needs, (c) implementation support received and needed from supervisors and middle managers, (d) screening practice, and (e) assessment practice. Each a priori code with subsequent themes is elucidated below. A minimum of four observations were required for a theme to be created. Themes below are presented in order of frequency with the number of observations noted for each theme. Where applicable, direct excerpts from notetakers are provided that capture the sentiment of what the participants were discussing. Direct excepts are indented after a description of the theme.

Perceived Value of the Intervention

Themes from this a priori code included engagement and treatment of youth and families, identification of trauma and behavioral health related needs, service linkage, and case planning.

Engagement and treatment of youth and families (n = 30 observations)

Participants shared that the Child and Adolescent Needs and Strengths (CANS) screening and assessment tools are more thorough than the previous tool used by the organization to inform placement referrals and allow for more engagement with families. Workers felt the way questions were outlined allowed them to gain insights into the true experiences of youth.

> [Screening and Assessment] asks specific questions, rather than broad questions. Gives you a chance to find things more specific and gives you a chance to be more intentional towards [the families].

Case planning (n = 9 observations)

Participants said the screening and assessment tool supported case planning with youth, especially those placed in foster homes. Participants also discussed the utility of the tool in court proceedings when justifying placement decisions.

> [Screening and Assessment tools] are easy to read or give to the judge to show child's history and needs instead of giving a long document to flip through.

Identification of trauma and behavioral health related needs (n = 5 observations)

Participants also felt the screening and assessment process identifies information about trauma that is beneficial for placement decisions.

> Some of the trauma such as exposure environmental things that we wouldn't have thought about before. Allows [the child welfare worker to] visualize what areas need to be targeted and make more appropriate referrals

One participant described how the screening instrument assisted with a positive court outcome.

> [The screening instrument was] used for the juvenile offender population to take. The traumatic experiences were explained to the court and why services would be beneficial. This resulted in diversion.

Service linkage (n = 4 observations)

Participants expressed the screening and assessment tools supported service linkage and communication with others about a case. This, in turn, allows for quicker access to services.

> After completing questions, [child welfare workers] can get kids into services faster. We identified kids that we didn't think needed services. Now kids in [child welfare custody] are identified for services and connected quicker. Previously wouldn't have known [of need for services].

Training Received and Future Needs

Themes from this a priori code included practice techniques, use of technology, and follow up training. Overall, participants felt the training was effective and that they were adequately trained on the intervention and screening practice. Participants described the training as good and informative and left with a positive outlook about the project.

Use of technology (n = 12 observations): Multiple participants supported the use of video tutorials with simulations for how to ask questions. Other participants said such a video could be accessed as a booster training if they forget aspects of how to implement the screening tool.

Follow up training (n = 7 observations): Participants relayed that a refresher training offered once a year would be helpful. The refresher training can target new workers and workers who have not used the instruments before. The content can focus on process components and timeframes related to aspects of screening and assessment practice.

Practice techniques (n = 6 observations): Participants expressed wanting to learn the most effective ways to ask questions of youth and families. Moreover, participants expressed wanting to learn ways to elicit the most relevant information from youth and families. Participants felt role plays were helpful and needed in learning social work and clinical skills.

Implementation Support Received and Needed from Supervisors and Middle Managers

Themes from this a priori code included support from supervisors and support from administrators.

Support from supervisors (n = 11 observations): Participants said support in screening and assessment practice from supervisors is important. Participants said supervisors send email reminders and give reminders in person, as well as take on some data entry for workers. Other participants expressed supervisors have been good with answering questions and provide support even when they do not fully have the answers.

Support from administration (n = 7 observations): Participants also expressed support from administration was needed, however does not always "trickle down" or "translate" well. Other participants said their regional teams were knowledgeable and helpful, specifically the continuous quality improvement support seemed essential at encouraging and connecting regions together with regard to information sharing. Some participants indicated that they needed regional manager efforts through boundary spanning to address issues related to their work with behavioral health agencies.

Screening Practice

Themes from this a priori code included issues with youth screened, timing, engagement and treatment of youth and families, technology, inadequate or incomplete screens, and fidelity.

Timing (n = 18 observations)

Some participants expressed concerns with the timing of when the screening tool needs to be completed (within ten days of removal of the child from home), indicating the quality is impacted if the relationship with the youth and family is not yet established. Other participants expressed concerns about the effectiveness of the screening tool when there is an emergency placement issued by the court.

> A lot of times, [after]court [proceedings] you just come back [to the office] with a kid. You end up with a kid in the office and you're trying to find a placement.

> As an investigator, screening kids is kind of harsh; as workers we are asking personal in-depth questions of kids that they are not building a relationship with.

Fidelity (n = 11 observations)

Some participants gave examples of how the screening tool may be completed incorrectly, such as having older youth complete the tool themselves and other workers not asking questions in a way that elicits useful information. Others expressed concerns about the screening tool being more time consuming.

> It's stressful. It replaced the [previous screening

instrument]. The screener is a lot more time consuming. Not the screener itself but the process around (e.g. printing, writing, sending multiple places).

Youth screened (n = 10 observations)

Participants expressed challenges in completing the screen with youth who have developmental delays, newborns, and younger children. Other participants expressed challenges in completing the screen with youth who were referred to child welfare for neglect.

> [I] have difficulty with screeners being used on neglected kids rather than kids suffering abuse/ trauma. Parents who file a petition to surrender kids because they don't want to parent anymore. Kids are usually angry and confused, shutdown as a result.

Technology (n = 7 observations)

Participants identified some challenges with the management information system (MIS) in which screening data is entered and calculated and assessment reports are received, suggesting is it may be difficult to navigate and creates barriers in successfully accessing or completing the tools. However, other participants expressed the benefits of being able to complete the screening instrument on a tablet, indicating it is less overwhelming than a paper form.

> Once tablets get internet access [we] can stop being overwhelmed with paper. We can show up at school with the tablet instead of a packet that looks overwhelming.

Engagement and treatment of youth and families (n = 6 observations)

Participants indicated they experienced challenges engaging youth and families that they have not had contact with before. Others expressed concerns engaging youth and families in questions that are considered sensitive.

> Engaging with kids. Sometimes [kids] don't want to answer traumatic/sensitive questions, they are fine answering questions about their habits.

Inadequate or incomplete screens (n = 6 observations)

Some participants felt the screening tool was inadequate, which creates an incomplete screen. More specifically, participants expressed wanting open ended boxes on the screen to elaborate or explain more detail about responses from youth. Other participants expressed wanting a space to describe the worker's observations, suggesting these would be additive to the screening process.

> Sometimes the questions are not what the child is describing or are touching on what the child is going through. There isn't space needed for what we are observing.

Assessment Practice

Themes from this a priori code included provider capacity, information exchange, technology concerns, inadequate or incomplete assessment, and fidelity.

Fidelity (n = 25 observations)

Participants indicated they were sometimes not receiving assessment reports from providers or receiving them too late, which impacted case planning. Other participants expressed concerns about not understanding how to access or incorporate the assessment into case planning, while others stated the assessment seemed to have no impact on the services youth receive.

> Kids are getting [the] same treatment as before, and the frequency [of treatment] seems as if it's the same as before.

Inadequate or incomplete assessment (n = 16 observations)

Some participants expressed concerns about receiving assessments without sufficiently detailed information or without treatment recommendations from behavioral health providers. Other participants expressed concerns about the accuracy of the assessment.

> A little more thorough [assessment is needed] to let [child welfare] workers know what's going on; [writing] not applicable does not help. It seems like providers are just marking boxes.

Technology concerns (n = 10 observations)

Participants expressed concerns related to the MIS in which the assessment report is received and made accessible to the worker. Other participants expressed confusion about the alert (reminder) system.

> Difficult when workers go to review [the Assessment Report] and it shows task is not completed, not sure how to get cleared.

Information exchange (n = 9 observations)

While some participants suggested there were no problems with information exchange between the child welfare worker and provider, others expressed concerns about timely feedback or the provider not receiving accurate information from the family.

> We [child welfare workers] don't hear back or get timely follow-up/feedback.

Provider capacity (n = 8 observations)

Participants described that some youth needs were beyond that of what some provider agencies have the capacity to provide. Other participants elaborated on this and suggested provider capacity may be impacted based on the service availability in certain regions.

> Providers may not have the services available in certain counties, so no treatment is recommended.

Discussion

This paper outlines themes associated with the implementation of standardized, universal screening and assessment of children entering out-of-home care from the perspective of child welfare workers. While the field has clearly called for use of these interventions to systematically identify and treat trauma and behavioral health needs of these children, implementation of this sort of largescale practice change can be challenging. As such, the lessons learned from Project SAFESPACE may indeed be relevant to other jurisdictions interested in rolling out similar initiatives. The focus groups conducted in this project were focused on exploring matters of concern related to perceptions of worker buy-in regarding the intervention and the effectiveness of key implementation supports. Themes in the areas of value, training, support, screening practice, and assessment practice are reported which may be useful in the development of such interventions and their implementation in other child welfare systems.

Value. In regard to child welfare practice change, Proctor et al. (2011) remind us of the importance of acceptability and appropriateness as implementation goals. Workers need to find the practice fits within what they understand to be their work and to make a valuable contribution to it. An implementation study of a project similar to the current one found that worker buy-in was critical to sustainment (Akin, Dunderley, Brook, & Bruns, 2019), so measuring their perceptions of the value of an innovation seems vital to success. Previous research has suggested worker buy-in to child welfare reform is associated with the connection between the change and their sense of purpose in the work (Fuller, Braun, & Chiu, 2018). Some of the aspects of these interventions are consistent with others in the literature. For example, use of standardized tools such as those used here has been found to lead to higher quality treatment planning (Andershed & Andershed, 2016). Workers participating clearly appreciate the benefit in engagement as well as the detailed information yielded from these interventions for their use in assessment and case planning, although it is clear that additional work is needed for some workers to have the skills to use screening and assessment data in case planning and treatment selection.

Training. The literature acknowledges that training related to the new practice to be implemented is an implementation driver (Fixsen et al., 2009). Other researchers have examined training as a part of the implementation of trauma-informed interventions in child welfare. Kerns et al. (2016) evaluated training of child welfare workers on trauma screening, finding knowledge and skill improvement associated with 3-hour and full day training, but workers varied in the extent to which they felt comfortable implementing screening in practice. Avoiding didactic approaches to focus on behaviorally specific skill building is necessary (Ricciardi, 2005). In the current study, while perceptions of the training were generally positive, some had questions of the "how-to" type and desired additional follow up training, often suggesting use of YouTube videos or tutorials to boost their knowledge and competency.

Support. While necessary, training alone is insufficient to support implementation of a project with fidelity, and as a result some initiatives to change child welfare practice have not reached full potential (Mildon & Shlonsky, 2011; Aarons et al., 2011). Supervisory support and ongoing coaching are important for implementation of new practices (Beidas & Kendall, 2010; Jones, 2015; Mildon & Shlonsky, 2011). Akin (2016) studied worker perceptions of coaching techniques related to child welfare practice change, identifying four themes: supporting through strength-oriented feedback, skill building through active learning, problem solving regarding use and adaptation of the practice, and accountability to promote fidelity. Historically child welfare has relied more on training—a "spray and pray" approach to innovation installation (National Child Welfare Workforce Institute, 2014). Supervisory coaching is not, however, a follow up to training but a uniquely valued support for implementation (Akin, 2016; Fixsen et al., 2009). Current study participants clearly valued coaching from

supervisors and middle management staff. They also indicated the importance of regional staff assisting with addressing the challenges associated with interagency information exchange and collaboration.

While the literature frequently discusses fidelity as a part of and even an outcome of implementation (e.g. Proctor et al., 2009), measurement of fidelity is less common. In reviewing programs rated on the California Evidence-Based Clearinghouse, Rolls Reutz, Kerns, Sedivy, and Mitchell (2020) found that over 30% did not conduct fidelity assessment, and the authors emphasized this is a significant gap in implementation research. McLeod, Southam-Gerow, Tully, Rodriguez, and Smith (2013) suggest there are four elements of treatment fidelity: adherence to intervention protocols, worker competence in the delivery of the intervention, differentiation (in that the intervention is not blended with other interventions), and relational factors such as the interaction between the worker and client or between collaborating partners. Through this fidelity lens, the themes related to screening and assessment practice can be examined.

Screening practice. Lessons learned from five states implementing standardized screening extolled the value of a number of implementation supports including leadership support, training and ongoing coaching, and facilitating data systems such as those used in this project (Lang et al., 2017). Clearly, our data suggest some concerns related to fidelity of the screening process which we were then able to address subsequently. In addition, these focus groups revealed important concerns regarding the intervention itself such as the match between the screener instruments and certain types of youth and the timeframe in which screening was to occur. They found the process useful within the context of engaging youth and families. Such themes are invaluable as agencies move through the adaptation process to refine the intervention and its related implementation supports.

Assessment Practice. Participants in this study also identified a number of concerns associated with the assessment process. One of the most significant issues was lack of fidelity to this intervention, in that some child welfare workers complained that were not receiving assessment reports, did not have confidence they were being completed, or that they did not find the assessment comprehensive enough for them to use in case planning. Information exchange and collaboration between the child welfare and behavioral health systems was a significant goal of this project, and improvement was observed (Winters et al., 2020). Such collaboration has been associated with improved provision of appropriate services through the use of standardized tools (He, Lim, Lecklitner, Olson, & Traube, 2015). A concern related to behavioral health provider capacity was identified which was important information that could drive future professional development and organizational capacity building. While general capacity to implement trauma-responsive interventions and readiness for change was measured initially (Winters et al., 2020) sufficient effort had not been put into behavioral health agency capacity to provide an array of treatment modalities which standardized assessment revealed was necessary.

Technological facilitation of practice change. Facilitative administrative and decision-support data systems have been deemed important to implementation of practice change (Mildon & Shlonsky, 2011; Fixsen et al., 2009). When using technology to support an innovation, functionality of both the tool and the data generated are important (Collins-Camargo, Strolin-Goltzman, & Akin, 2019; Weiner et al., 2019). Focus group participants clearly expressed the value of using technology to support their practice and were keen on addressing issues related to functionality in terms of the screener to facilitate referral to behavioral health and the assessment report being housed in their management information system. They further asked for more use of technology to help refresh their knowledge and skills after training. This is consistent with prior work suggesting that technology supports can serve to promote fidelity by helping workers to see the intervention is acceptable appropriate and feasible (Proctor et al., 2011).

Limitations

While offering potentially valuable information for other jurisdictions, limitations associated with this study must be acknowledged. The study was implemented in one state, and data were collected from a convenience sample of child welfare staff from five of nine service regions; therefore, it cannot be assumed these results are fully generalizable to the broader child welfare field. The concerns expressed by the

workers were in response to the implementation decisions made in this particular project and also may be influenced by other factors impacting the child welfare agency involved at the time related to workload and other internal and external pressures.

This study reports only on the perceptions of the child welfare staff—not that of the behavioral health clinicians conducting functional assessment and treatment, nor the children and families served. Certainly, these voices have significant relevance, and future research could benefit from their inclusion. While behavioral health clinician focus groups were conducted, the number and location of groups conducted and participants involved were significantly fewer, so the decision was made that to include them here might unintentionally amplify those voices. There were also very different implementation challenges reported by the multiple behavioral health organizations involved in focus groups than those identified by the child welfare agency groups. By focusing on the child welfare data, we are able to provide clearer direction for the implementation of interventions in the child welfare setting. Finally, the focus groups conducted were not recorded and transcribed, so our analysis was limited to extensive notes taken by the evaluation team, thereby limiting the richness of the data. Some participant statements had to be excluded from the analysis because there was not sufficient context provided to interpret their meaning.

Implications for Practice, Policy, and Research

The focus groups at the center of this paper were conducted during the transition period of moving from a federally-funded demonstration project to sustainment within routine agency practice and were used to gather information for managers on needed adaption. This paper builds on implementation studies conducted by this and two similar projects that focused on the installation and initial implementation phases (Akin, Strolin-Goltzman, & Collins-Camargo, 2017). Some of the challenges experienced then related to training, support, and intervention fidelity remained when the current data were collected near the end of the project.

The involvement of stakeholders such as frontline workers and managers in discussing needed adaptation in response to implementation data is a rarely documented but important process in need of more focus (Lengnick-Hall et al., 2019). It is easy to see how the themes identified in this study could guide adaption of the innovation as well as additional implementation supports to be utilized. Our data suggest ways in which frontline workers found implementation of this intervention valuable to their work in ways that were detailed in the results narrative.

There are implications of these findings for administrative practice and policy as well. Prior research regarding this sort of intervention has suggested the importance of establishing facilitative administration strategies to support the frontline work, including training, coaching, policies and procedures, as well as quality improvement measurement and adaptation that support implementing interventions with fidelity (Akin et al., 2019). Managers ultimately must determine how to invest limited resources both in the selection of interventions to improve practice and also in implementation strategies to promote fidelity to them. It may not be possible to devote too much effort to implementation supports for complex and interagency innovations, so decisions must be strategic to maximize these limited resources.

Implications for research include the need for us to better understand the relative impact of various implementation strategies which have been identified such as training, technology, supervision, and use of data to promote fidelity. It is likely not feasible to support the wide array of strategies described by Powell et al. (2015) and Bunger et al. (2017); therefore, such research could evaluate the comparative contribution of various strategies on implementation and outcomes. There may also be differential impacts on satisfaction, fidelity, and effectiveness of interventions based on these strategies that could be explored. There is also additional research needed on the collaboration between, and differences in the usefulness of, implementation strategies for different settings such as child welfare and behavioral health. While the area of implementation science seems to be a burgeoning field of its own, the impact of specific efforts is generally unknown.

Conclusion

Research has demonstrated the relationship between trauma exposure and adverse mental health outcomes (Chang, Jiang, Mkandawire, & Shen, 2019) and disruptive emotional problems and behaviors (Gerrity & Folcarelli, 2008). Given the amount of trauma experienced by children in OOHC it is clear that child welfare systems must address these concerns through standardized identification and response to trauma and behavioral health needs. This study has examined child welfare worker perceptions of the value of such an intervention and what went well and needs improvement in regard to implementing the process with fidelity. This provides useful lessons learned related to implementation of similar interventions in other jurisdictions.

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Figure 1: ***Schema of a priori codes and themes.***