Medical Research Archives

European Society of Medicine

OPEN ACCESS

Published: October 31, 2023

Citation: Pisciotta C, Hill-Kane R, et al., 2023. Sustainability of a Child Mental Health Intervention in Child Welfare Services: Case study, Medical Research Archives, [online] 11(10). https://doi.org/10.18103/mra.v11i10.4524

DOI
https://doi.org/10.18103/mra.v11i10.4524

ISSN: 2375-1924

CASE REPORT

Sustainability of a Child Mental Health Intervention in Child Welfare Services: Case study

Caterina Pisciotta, MSW*
PhD candidate, City University of New York, Graduate Center – Social Welfare New York, NY 10016
https://orcid.org/0000-0002-3204-1769

Rosalind Hill-Kane, LMSW
Program Manager, Emergency Services Community Outreach, Maryland Department of Human Services

Andrew Winters, PhD, LISW-S
Assistant Professor, University of Louisville, Kent School of Social Work, Louisville, KY, 40292
https://orcid.org/0000-0002-9244-9803

Cole Hooley, PhD, LCSW
Assistant Professor, Brigham Young University, School of Social Work, Provo, UT 84602
https://orcid.org/0000-0002-5361-5098

Kerry A. Lee, PhD, MSW
Assistant Professor, Bryn Mawr College, Graduate School of Social Work and Social Research, Bryn Mawr, PA 19010
https://orcid.org/0000-0002-4427-3356

Takiya Green, MSW
Community Outreach Social Worker, Maryland Department of Human Services

Geetha Gopalan, PhD, LCSW
Associate Professor, City University of New York, Silberman School of Social Work at Hunter College, New York, NY 10035
https://orcid.org/0000-0002-2600-8030

***Corresponding author:** cpisciotta@gradcenter.cuny.edu

ABSTRACT

From an implementation science lens, sustaining interventions in large, heterogeneous organizations such as child welfare requires attunement to the inner and outer contexts in which the innovative practice is delivered. This case study describes how one child welfare agency sustained implementation of a modified child mental health intervention since Spring 2019 after formal supports were removed and provides a retrospective look at their experiences. Using qualitative data from interviews with a key informant, this case study employed a priori codes from an existing sustainability framework to organize and understand factors of innovation, adopters, leadership and management, inner context and process, outer context, and outcomes. Findings offer insights for child welfare agencies to consider when sustaining an intervention without research supports, including the intervention's alignment with the agency's culture and mission, the agency's ability to adapt and embed the intervention, and child welfare leadership and staff buy-in to the intervention. Implications for policy, practice, and research are discussed.

Keywords: child welfare; child mental health; evidence-based interventions; sustainability

Introduction

Child welfare (CW) agencies face numerous challenges implementing evidence-based interventions (EBIs), such as the complexity and costs;[1,2] thus examining factors that aid in sustainment is important. There have, however, been calls to increase research on the sustainability of new EBIs.[3–5] Sustainability has been described as "one of the most significant translational research problems of our time."[6,7] This case study describes one such effort by a CW agency to sustain an intervention after formal external supports were removed.

Sustainability and sustainment

Sustainability and sustainment are key implementation science constructs. While there is currently no agreed upon conceptual definition for sustainability,[8] Chambers and colleagues[9] point to a difference between the terminology sustainability and sustainment. Sustainability refers to the extent to which an intervention can continue yielding benefits after external supports from a donor agency are removed,[9] while sustainment is the continued use of an intervention.[10] In that sense, sustainment can therefore be viewed as an outcome of sustainability efforts.[11,12] Sustainment is increasingly viewed as a dynamic outcome, wherein adaptations are made over time to meet shifting needs of the organization and recipients.[13] Urquhart and colleagues[14] synthesized the constructs of sustainability and sustainment into three concepts: "(1) continued capacity to deliver the innovation; (2) continued delivery of the innovation; (2a) innovations must continue in the absence of a champion or the person/team who introduced it; (2b) sustainability is only germane to innovations that are still needed; (3) continued benefits for the patient, provider, or health system; (3a) adaptation is critical to ensuring relevancy and fit, and thus delivering benefits; (3b) sustainability is contingent on being able to demonstrate benefits."

Penno and colleagues[15] reviewed sustainability frameworks/models/theories in acute care settings and identified seven broad concepts, with nested factors, influencing sustainability. The first concept is *innovation*, defined as a new process, change, product, practice, or program (sample factors: adaptability of the innovation). The second concept is *adopters*, defined as a stakeholder, staff, user, adopter, actor, or individual using the innovation or EBI, including the presence of champions in the system who advocate for its use (factors: staffing; adopters' individual commitment to and competency to perform the innovation). The third concept is *leadership and management*, which refers to leadership style, approach, behaviors, engagement, support, or feedback (factors: senior leadership actions and involvement; management's approach and engagement). The fourth concept is *inner context*, which refers to the context, practice setting or organization (factors: organizational culture and climate; beliefs/values/ perceptions about and absorptive capacity for the innovation). The fifth concept is *inner process,* which refers to the processes, methods, systems, structures, or strategies used to implement and sustain the innovation (factors: education and training processes; the planning, method, and timing of embedding the innovation). The sixth concept is *outer context*, defined as the conditions, context, systems, or environment external to the inner context (factors: political environment, such as policy/legislation; the financial and non-financial resources for the innovation). The seventh and final concept is *outcomes*, defined as teamwork behaviors, consequences, continuation of benefits, and effects.

Purpose and background of this study

This case study focuses on the sustainability/sustainment of a modified child mental health intervention in one county-administered CW agency in a Mid-Atlantic US state. This agency collaborated with a local University to implement a modified version of evidence-based, manualized, multiple family group intervention designed to reduced youth behavioral difficulties - the modified 4Rs and 2Ss Strengthening Families Program (4Rs and 2Ss).[16,17] The 4Rs and 2Ss was modified to be delivered by CW caseworkers providing case management services to families to prevent child out-of-home placement. A previous publication describes the modification process.[18] Between 2015 and 2017, the intervention was delivered in the CW agency to three cohorts of families, with the University providing critical support – both financial (for transportation, childcare, food) and research (fidelity monitoring and supervision).

After the University ended its involvement and all support was removed, the CW agency continued delivering the intervention in community settings (including virtual). This case study answers the research question: *How did this CW agency sustain the intervention in community settings after University supports were removed?*

Methods

This section is organized into three subsections, which describe the transition period after the University ended its involvement and the agency

prepared to implement the intervention on their own; the sustainment period; and the processes used to gather and analyze data for this case study.

Transition Period

When University support ended in 2017, research staff began working with the agency to ensure they could continue using the modified intervention on their own. This transitional period, which took place in 2018, involved the: (1) recruitment and implementation of a Collaborative Advisory Board (CAB); (2) development and roll out of a Train-the-Trainer (TTT); and (3) development of a training package, which included in-person training resources and online YouTube training modules.

COLLABORATIVE ADVISORY BOARD

To inform and tailor the TTT materials (described later), a CAB was recruited. The CAB was led by the University PI, and included one other University representative, four CW agency representatives, two caregivers, and a community social service provider. Seven meetings were held between February and May 2018. The CAB provided feedback on the content and delivery of each multiple family group session, the intervention manual, and potential solutions to anticipated implementation challenges. The CAB provided input on the recruitment, training, and supervision of facilitators, as well as plans for recruiting and communicating with families. They discussed potential funding sources to support the intervention and the logistics of the group meetings.

Critical decisions were made about how the intervention would be adapted going forward. The CAB renamed the intervention from "a modified 4Rs 2Ss" to *Families Supporting Families* (FSF) because FSF felt less stigmatizing and more reflective of the true collaborative spirit of the model. They decided to move the family meetings outside CW agency offices and into the community to remove the stigma associated with the CW system. The CAB retained the 9-session, closed-group (i.e., all participants begin and end the intervention at the same time) format. The original eligibility criteria, including the family having an open CW case and having a child with a diagnosable disruptive behavior disorder, were also relaxed so that all families could participate. Other ideas discussed during CAB meetings included: parents co-facilitating the groups with CW staff to add to relatability and establishing rapport; having a call-in/live stream option for parents who couldn't attend in person; and offering resources to families (e.g., toys, school supplies, food baskets, gift cards). They also discussed potentially having Spanish-speaking facilitators.

TRAIN-THE-TRAINER

The research team trained the CW Supervisors who were then responsible for training agency caseworkers and others (like caregivers) to deliver the intervention. Supervisors were also trained to perform implementation and sustainability functions, such as adaptation, quality control, troubleshooting, and fidelity maintenance.

The one-day Train-the-Trainer (TTT) curriculum included five main content areas: (1) Becoming an FSF trainer (including trainer roles and responsibilities); (2) Family Engagement, Core Concepts (such as session structure and fidelity), and Adaptations; (3) FSF Trainer Skills (including adult learning principles); (4) Coaching Facilitators (such as the structure of coaching sessions and approaches to addressing issues with facilitators); and (5) Preparing for Facilitator Training (facilitator training agenda, slide presentation). Opportunities for practice and reflection were built into the TTT session. Readiness to become a FSF trainer was measured using the Trainer Skills checklist.

TRAINING PACKET

The research team provided the agency with all the training materials needed to train CW staff to become facilitators, along with a Facilitator Support Guide which gave more in-depth guidance on how to deliver the group sessions. They also left tools to assess the effectiveness of trainers and group facilitators' fidelity to the model. Finally, the research team created YouTube training videos on three topics (an introduction to the intervention; trauma-informed care; and child development) to supplement and prepare caseworkers for the in-person FSF training.

SUSTAINMENT: AGENCY-LED INTERVENTION

As of Fall 2022, the CW agency independently facilitated FSF with a total of seven cohorts: three in person (two at a local library, one in a community center) and, due to the COVID-19 pandemic, four virtual cohorts were facilitated on the Zoom platform. The FSF groups met over the course of nine weeks on Thursdays from 6-8pm, which the CW agency found to be the best time for families due to work, school, and home responsibilities. Parents and children attended the sessions together. Group sessions were jointly facilitated by two CW staff. As of Fall 2022, 41 CW-involved families have participated in the FSF groups.

This Case Study

This case study explores how one CW agency sustained implementation of FSF since Spring 2019 and provides a retrospective look at their

experiences. A descriptive and exploratory case study methodology was chosen because the aim was to answer questions of "how" and "why."[19] Data were collected from a series of two interviews with a critical informant, the Program Manager for the emergency services outreach unit of the CW agency (the second author of this paper; referred to hereafter as the "unit supervisor"), who was directly involved in the implementation of FSF after the University's departure. The Penno et al.[15] work described previously was used as the organizing framework for this study. The authors developed *a priori* codes from the concepts and nested factors to inform the interview guide and subsequent data analysis.

The first interview lasted an hour and was conducted by the first author via Zoom. The questions focused on topic areas including the decision-making process and considerations around continuing FSF; funding and resources; the program setting; staffing; recruitment/eligibility; group logistics; the curriculum; incentives; barriers/challenges; feedback from families, and lessons learned. After completion of the interview, the first author met with the other members of the research team to review the findings and develop additional clarifying questions related to sustainment. A second interview was conducted with the same key informant and included clarifying questions on sustainment and new topic areas such as training, supervision and fidelity, attendance, and plans for upcoming cohorts.

After the second interview, the first author met with the research team again to review the findings. Agreement was reached on the saturation of content related to sustainability/ sustainment of the FSF intervention after University supports were removed. The first author then organized the findings through the Penno and colleagues[15] framework of sustainability concepts and related factors. The first author met with the research team to review the categorization of interview text. All discrepancies were resolved, and findings as presented here were agreed upon by all authors.

Findings

INNOVATION

The first concept is innovation, with adaptation as one core factor. The agency adapted the intervention, as originally designed, in four key innovative ways, all of which were intended to center families' comfort, needs, and priorities and helped contribute to sustainability. This included (1) two planned changes: changes to the location of the groups and removal of eligibility criteria; and (2) two unplanned changes: adaptations for online groups and changes to the curriculum timing.

Changes to the location of the groups. The CW agency decided to move the intervention outside agency walls and into the community. The CW offices are seen by families as "*the big house*" - an intimidating place where staff wear badges, there are security protocols and screening procedures to enter, and where families generally feel uncomfortable. Holding groups in the community was done as a pilot, with the hope of encouraging more families to participate. The CW agency was deliberate in their choice of community locations. The local middle school, where they have an emergency services unit social worker stationed, was excluded as an option because caregivers would still need to present identification and go through security procedures to enter the building. The local library was chosen because of the ease of access, its location near a populated portion of the county, and because an emergency services unit social worker was stationed there. Two cohorts of families completed FSF here. The second location was a local Community Center, also located near a populated portion of the county (but at the other end of the county than the library). One cohort of families completed FSF at this location. The agency planned to facilitate the intervention with a fourth cohort of families at a local church; however, the spread of COVID-19 prohibited this group from taking place there. Instead, the facilitators pivoted to online to deliver the intervention to subsequent cohorts of families. Four cohorts of families received the FSF intervention via the Zoom platform.

Eligibility criteria. When the University was involved in the intervention delivery, CW-involved caregivers said they wished the groups could be open to more families in the community, and both caregivers and CW staff expressed their frustrations with the eligibility criteria. In the original model, one child between the ages of 7 and 11 needed to have a Diagnostic and Statistical Manual of Mental Disorder [5th ed.; DSM-V] diagnosis of a disruptive behavior disorder (i.e., Oppositional Defiant Disorder or Conduct Disorder),[20] and clinicians provided ongoing supervision to the CW staff facilitating the groups. When the CW agency began running the groups independently, they removed the eligibility criteria that were in place when University supports were present. This change aligned with the CW staff's scope of practice since they cannot treat mental health conditions themselves; however, they can provide preventive services to families.

Adaptations for online groups. Adaptations were made when the sessions moved online. Though children were very engaged during in-person sessions, it was harder to engage them online. The unit supervisor added content such as short YouTube videos around session topics (e.g., Family Strengths) to allow children to participate more online rather than just listening to the facilitators talk. Children watched the videos and the facilitators posed questions about the content. The videos were not part of the original FSF manual; however, the facilitators have seen the positive benefits of including them (namely, increased child engagement in sessions) and added the video links to the intervention manual.

Curriculum timing. While CW staff made every effort to cover all of the material for any given session, they would sometimes informally deviate from the manual's topic/activity time specifications (i.e., spend 10 minutes on this activity). They found that families wanted to keep talking about certain topics (such as Respectful Communication) well beyond the allotted time for that material; instead of cutting the families off and moving to another topic, they let the conversation flow. In other cases, families sometimes seemed less engaged in a particular session's material, so the facilitators would not use the full two hours for that session. Finally, at times, there were local or national events that families wanted to talk about that affected them, and the group facilitators would adjust the session to allow for that. This person-centered approach allowed the families to engage with the curriculum in a way that was most meaningful to them.

Adopters

The second concept is adopters. The interrelated primary factors for this concept are staffing and individual commitment to innovation.

Staffing and individual commitment to innovation. The CW agency has a committed and consistent staff available to facilitate the groups, which helped sustain the intervention. Although the agency has about ten CW staff trained to facilitate FSF groups, they consistently use four staff (identified by the unit supervisor as being particularly interested in FSF facilitation) to do so. CW staff who facilitate the groups are unpaid volunteers, but the agency provides them with compensatory time off, allowing them to adjust their work hours to account for the time they spend facilitating. Despite the lack of other tangible benefits, there are other more intrinsic benefits that seem to drive CW staff facilitators to do this work. Some facilitators really enjoy the role, especially when they themselves have faced challenges raising children. Some like it because it is a welcome change of pace from the individual family work that their CW role entails. Some appreciate the additional experiences and skills they gain (e.g., group facilitation skills), which enhances their resume. Notably, caregivers participating in the FSF group sometimes expressed interest in becoming facilitators. The agency already trained one caregiver to become an FSF facilitator and recruited another who will be trained in the future. As with some CW staff, the trained caregiver (who already co-facilitated one group session with a CW facilitator) likes sharing their parenting experiences and offering skills to other parents.

Leadership and Management

The third concept is related to leadership and management. The factor within this concept focuses on the involvement and actions of key leaders within the organization.

Involvement and actions. This CW agency has had two key champions: the emergency services unit's supervisor (the key informant here) and the unit's director. Both established buy-in for FSF early and maintained it throughout, and played a critical role in sustaining the intervention via resources and hands-on management. The unit director identifies possible funding streams to sustain FSF. The unit supervisor handles all the day-to-day activities previously handled by the University's research team, including: conducting Train-the-Trainer sessions; managing logistical aspects of the groups like scheduling; ordering session materials and food/snacks; collecting fidelity data to assess the degree to which facilitators are running the groups as intended; meeting with facilitators post-group to discuss how it went; tracking caregivers' responses to pre- and post-test surveys; and assessing the results to determine if further modifications are needed.

Inner Context

The fourth concept is inner context. A key factor within this concept centers on the agency culture and the beliefs about the innovation.

Agency culture and beliefs about the innovation. The CW agency historically has a very strong preventive mindset. Leadership and staff view preventing families from coming into the CW system as a critical part of their mission and vision. As one practical example, the agency has emergency services unit social workers stationed in the community (e.g., schools, libraries) to help families access critical services like eviction assistance,

furniture, clothes, and utility shut-off help without having to go to the CW agency. The agency similarly views FSF; it is a way to proactively help families address parenting challenges and strengthen the parent-child relationship before ever becoming involved with the CW system. The agency's preventive mindset was a driver in their decision to expand program eligibility to all families, not just already CW-involved families, and to move the intervention to the community. They aim to *prevent* CPS report filings by making sure families have their need for parenting information and skills adequately met.

Although the agency's existing culture played a key role in their interest in continuing FSF, their focus on the needs and wants of families also played an important role. Families who participated in FSF during the University's involvement reported they enjoyed sharing their experiences with other families, and appreciated gaining knowledge and skills in a peer group with trained facilitators. The agency wanted to continue offering FSF because families deemed it valuable. The agency also deemed FSF as valuable because it supported their vision to change the community's perception of the agency (e.g., taking children away vs. supporting families to stay together). FSF is a way to help struggling families and keep them out of the CW system as much as possible. In fact, while CW staff are still mandated reporters, they are clear with families that they can refer them to services instead of making a report in some cases.

Inner Processes

The fifth concept is inner processes. Factors for this concept include education and training, and institutionalizing the innovation within the organization.

Education and training processes. To continue delivering FSF to families, the agency needed to have staff who were competent to deliver it. The University left the CW agency with a FSF Train-the-Trainer model so they could continue to train interested CW staff to serve as group facilitators. The unit supervisor, who conducts the training, has maintained the content and activities (like role-playing, where facilitators-in-training can practice responding to situations that might come up in groups). However, the supervisor has modified the training from one full day to a half-day, both to keep CW staff engaged and to bring the material alive to the participants in a practical way. When the University conducted their one-day training, the training was held in the morning and the "practice" came in the afternoon. The supervisor decided it was more helpful to train the facilitators on a particular component of the material and integrate the practice directly into that training, which reduced the required time for the training in half without sacrificing any content. Of note, the supervisor believes that, while the Train-the-Trainer is good, any gaps that exist are filled in by the staff's existing knowledge and experience as social workers.

Embedding the intervention. The CW agency developed a routine and processes that embed the innovation into their daily practice. Train-the-Trainer sessions are held regularly and conducted one month before the next FSF cohort begins. The agency developed a recruitment process to identify families who would benefit from the group. They created a recruitment flier, outlining the days/times of the next cohort and the topic of each session (e.g., rules and positive reinforcement), and identified recruitment channels (e.g., posting the flier on the agency Facebook page, asking unit social workers stationed in the community to inform families, distributing the fliers internally). The FSF team contacts referred/interested families to provide more information about FSF and has a script for describing what it would involve. The unit supervisor has also developed a schedule for ordering the group session materials (e.g., balls, crayons), as well as the food (i.e., Snack Packs for online, meals for in-person), and transportation. Facilitators connect with families in their homes before each group session to ask about challenges or problems the families are facing, inquire about any recommendations for the FSF group, and to provide families what they need for the next group like Snack Packs or materials.

Outer Context

The sixth concept is outer context. Factors for this concept include assessing the political environment and addressing financial and non-financial resources of the innovation.

Political (e.g., policy, legislation). Although the CW agency historically has a strong preventive focus, the national landscape also shifted toward prevention around the same time the agency began running FSF groups independently. The Families First Prevention Services Act of 2018 (FFPSA),[21] which provided some of the funds this CW agency used to support this innovation, was enacted to focus the current CW system on preventive services to avoid the family trauma that results from foster care placement. The act, which provides for greater access to mental health services and improved parenting skills among other things, aligns well with the goals of FSF, particularly since the FFPA also emphasizes trauma-informed and family-centered

CW services. This synergy provided the agency with concrete resources as well as the political capital and the philosophical support needed to sustain this intervention.

Financial resources of innovation. When the CW agency was partnering with the University, the latter had the funding necessary to support FSF. Feedback from involved agency administrators and staff at that time suggested ongoing funding would be critical for sustainability. The unit director took on the task of searching for available funding to continue running the groups. To date, the funding the agency has received is relatively limited and there are no ongoing commitments for future funding. The agency was able to apply for, and was awarded, two grants (one for $1,000 and one for $800), both from the County. They also have used the FFPSA funds to help in covering some family-specific costs, since FFPSA funds can only be used on families. The expenses associated with administering FSF include food, as well as childcare and transportation (for in-person groups only). Other relevant expenses for both in-person and online groups include session materials, such as double-sided and color printouts of the FSF manual; handouts; flip charts; pencils/markers/crayons; tape; balls; dice and other items used during the groups. The agency also funds incentives, given out at the end of the cohort, and are typically Walmart, Target, or gas gift cards of up to $100 (based on a family's attendance in the group) and extra incentives for families who complete all of the homework and roadwork. To help engage families, the agency also provided families with "goody bags" that reflect caregiver and child interests (e.g., a pan for a caregiver who likes cooking).

Non-financial resources of innovation. Technology was one of the biggest challenges the agency faced when it came to transitioning to an online platform during the pandemic. The state provided the CW agency with netbooks, which they then shared with families to use for the online groups (with families using their own Wi-Fi networks, the public library's network, etc.).

Outcomes

The seventh concept is outcomes. Factors for this concept include assessing the benefits of the innovation, and the overall effects of the intervention.

Benefits of the innovation. Family feedback indicates they enjoy FSF groups and it is helping them, which motivates the agency to continue to offer FSF. They also wish the group lasted longer, with many wanting it to go beyond the 9 weeks. The agency has also received feedback from families about specific topics they would like covered in the group; the facilitators address this by allowing families to bring up topics of interest in group. To date, attendance data has been collected and analyzed for six of the seven cohorts. The overall attendance rate across cohorts was 76% (about 7 out of 9 sessions). The average attendance rate by cohort was: Cohort 1 (n=6 families, attending 85% of the sessions); Cohort 2 (n=7 families, 68%); Cohort 3 (n=6 families; 67%); Cohort 4 (n=7 families; 56%); Cohort 5 (n=5 families; 96%); and Cohort 6 (n=4 families; 100%). Even in the three Cohorts with the lowest attendance rate (Cohorts 2, 3, and 4), in each case, at least three families attended around 80% or more of the sessions (7 or more of the 9 sessions). FSF engagement is best compared to attendance rates for routine outpatient MH services (mean: 3-4 sessions out of 16, or about 58%).[22] From this perspective, these attendance rates exceed what is typically seen in poverty-impacted routine MH services.

Anecdotally, child attendance did seem to decline as the weather improved and children were outdoors more. Attendance data also supports the supervisor's description of participation at the in-person FSF sessions as good, but even better with the Zoom sessions. The virtual sessions (Cohorts 4, 5 and 6) were especially convenient for families because they did not need transportation nor did they have to worry about rushing back and forth from work, home, and/or school and the group. Cohort 4, which had the lowest attendance rate of all cohorts, was held in September 2020 and was the first virtual cohort. The transition to online clearly created some difficulties for the families and facilitators. Although families did receive incentives for participation in the groups (e.g., $100 if they attended 6 or more of the 9 group sessions; a pro-rated amount if they attended fewer sessions), the CW agency did not tell families this in advance because they wanted families to participate because they got something out of the groups. In line with the agency's goal of making the FSF groups meet families' needs, families were allowed to attend a cohort/session more than once, for a booster of sorts. At least five caregivers participated in more than one cohort group. In each case, a year or more had passed between the start of the families' first FSF cohort participation and the start of their next cohort participation.

Effects and future directions. Although the CW agency has been "making it work," there are challenges. They do not have a continuous stream of steady and reliable funding, instead applying for grants as they find them. They also do not currently

have the capacity to serve the many Spanish-speaking families who have expressed interest in FSF due to a lack of Spanish-speaking staff and money to translate the FSF manual.

In terms of future directions, the cohort that started in September 2022, which is the eighth cohort that the CW agency is implementing independently, is using a hybrid model (three in-person sessions at a library, six virtual sessions on Zoom). This innovation of going hybrid makes the intervention both less expensive and more sustainable in the long-run, and still gives families the opportunity to interact in-person, which they report enjoying.

Discussion

From an implementation science lens, sustaining interventions in large, heterogeneous organizations requires attunement to the inner and outer contexts in which the innovative practice is delivered.[10] In an early contribution to the literature on sustainment, Scheirer[23] reviewed 19 empirical studies of health-related programs and found five factors related to sustainment: (1) modifications to the program can be incorporated, (2) champions of the program are needed, (3) program match with the organizational mission is important, (4) clients and staff see continued benefits, and (5) stakeholders provide ongoing support. This case study sought to understand factors that supported the sustainment of the FSF intervention in a CW agency, with findings in alignment with Scheirer's[23] early work. Using qualitative data from interviews with a key informant, this study used *a priori* codes from an existing framework[15] to organize and understand factors of innovation, adopters, leadership and management, inner context and process, outer context, and outcomes.

Agency buy-in

Of paramount importance to the sustainment of FSF were two factors: the CW agency's own beliefs abouts the importance of preventive services and leadership buy-in. Previous research supports these findings. In a qualitative study exploring facilitators and barriers to successful EBI implementation conducted by Beidas and colleagues,[24] participants reported agency buy-in and leadership dedication as primary facilitators to successful implementation. The CW agency views FSF as one more way to support and strengthen families (in addition to their many community-delivered prevention services), and also as a way to positively change the perceived community image of the agency. The fact that families deemed the FSF groups a valuable resource also contributed to its sustainment, as did the fact that the external environment (i.e., the FFPSA) supported the agency's preventive focus.

Support for the intervention across personnel levels also aids in sustainment. Previous research suggests worker buy-in to CW practice change is associated with the connection between the intervention and their sense of purpose in the work,[25] with supervisory support essential to the sustainment of new practices.[26–28] In this agency there was leadership support (a unit director who identified funding streams, a unit supervisor dealing with day-to day implementation, both of whom were champions) and a cadre of workers interested and willing to participate. Aarons and colleagues,[29] in a mixed methods study examining factors contributing to EBI sustainment, found that champions were vital and that strong leadership support was associated with a seventeen times likelihood of sustaining the EBI. Both the unit director and supervisor supported FSF and all that it required, from allowing staff to be trained as facilitators to giving staff facilitators compensatory time for their work.

In a qualitative study conducted by Winters and colleagues[30] exploring the implementation of a universal standardized screening and assessment practice for youth in out-of-home care, CW workers' perceived sense of value in the new practice and support from supervisors and administration were seen as key to successful implementation. In this case study, the CW agency had a committed and consistent staff available to facilitate the groups despite the lack of tangible benefits to do so since the CW facilitators had other motivations (e.g., enjoyment, resume-building skills, personal satisfaction of helping families).

PURPOSEFUL ADAPTATIONS

Purposeful adaptations to interventions can enhance their feasibility and subsequent sustainment.[31,32] Given that previous literature suggests families' prior negative experiences with child welfare[33–35] and feelings of fear, shame, and stigma[36] may deter families from participating in services, the outcomes and attendance data from this case study are remarkable. By comparison, the attendance rates for the modified 4 Rs and 2 Ss Strengthening Families Program were lower than those reported in this study.[18] This may be attributed to a key adaptation the agency made: moving the intervention beyond agency walls into community settings (library, community center, online). Palinkas and colleagues[37] found that providing incentives for participation was an indicator to sustainment of a service. By moving the intervention away from the agency, where staff wear badges and there are security and screening protocols to enter, clients were incentivized to participate. This shift was

intended to both reinforce the perception of FSF as a preventive intervention and to increase families' comfort and willingness to participate. When interventions for in-need families actively help them address stressors, this can free up the personal resources necessary for members to focus on their parenting[38] and facilitate engagement with the intervention content.[39]

Maintaining buy-in and momentum despite inevitable challenges is critical and adjustments to roles, structures, and workflow processes may be necessary to sustain the intervention.[40,41] Bond and colleagues[42] conducted a study to document the long-term sustainability efforts of 49 behavioral health programs implementing an EBI and found a varying degree of adaptation from the original model. Adaptations there were largely driven by changes in state level standards; however, in the current study, adaptations were driven by contextual factors in response to client requests and perceived needs (e.g., changes to timing of manual topics/activities based on families' desires, holding open space for topics families wanted to discuss, removing child eligibility criteria so more families could participate, adding YouTube modules to increase child engagement, allowing families to attend more than one FSF cohort if they needed more support) . The agency also made minor adaptations to the Train-the-Trainer sessions (cutting the delivery time in half without sacrificing content), which are being used to continually train staff to deliver the FSF intervention. Re-imagining the CW staff and family relationship requires a conceptual shift from traditional compliance-based CW practice toward strategies designed to engage families and prioritize sustainable changes within family interactions and systems.[43,44] Studies on sustainment frequently reference fiscal concerns as a barrier to sustainment[24,29,37,42] and the current study was not impervious to those same concerns. Going forward, the agency's decision to make upcoming groups hybrid (some in-person, some virtual) gives weight to both families' desire to meet in person with other families as well as their appetite for the convenience that virtual sessions offer them, while also helping the agency conserve the limited FSF financial resources.

Implications and Limitations

Findings from the current study have implications for policy, practice, and research. The sustainability of the FSF intervention is closely related to the FFPSA, aimed at keeping children safe within their families to prevent trauma resulting from children being placed in out-of-home care. Specifically, while the FFPA acts as a guide for CW systems to aid families whose children are at increased risk for out-of-home placement,[45] the sustainability of the FSF intervention provides a practical guide to other CW agencies struggling to implement this policy in community-based settings. The approaches used by CW staff in this study, which were found to be effective in the sustainability and feasibility of the FSF intervention, can act as a guide as to *how* the main goal of the FFPA can be achieved. Therefore, CW agencies may find it effective in developing specific policies that are in alignment with their state's FFPA plans, if available, to aid in the implementation and achievement of the overall goal of the FFPA.

CW-involved families, who are at risk for out-of-home placements, typically interact with their caseworkers and receive services either within CW agency locations and/or in their homes, with few services offered in community-based settings due to a lack of resources including specialized trained professionals.[46] However, this study shed light on the practical and innovative approaches used by CW staff in providing the FSF intervention to CW-involved families outside of the agency walls and in families' homes to community-based settings. These practices increased the accessibility of the intervention to more CW-involved families while addressing the limited resources often available in community-based settings.[43] Practitioners may find it instructive to utilize the various approaches from this study in the provision of needed EBIs and services to families outside of agency settings to other settings where they feel more comfortable. Additionally, practitioners should consider making modifications that center the needs and desires of the family that can aid in continued engagement with the intervention content.[32,47]

There is a need for more research related to sustainability of new EBIs in general and especially within CW agencies.[6,7,48] Notably, there is a need for us to better understand the relative impact of the various sustainment strategies identified in this study. Increased research regarding the sustainability of EBI's will shed light on how CW agencies are adhering to and managing the FFPA in addition to strategies used to keeping children safe within their family unit, while reducing the trauma associated with placing children in out-of-home care.[49] Research should also be conducted to examine if EBIs, such as FSF, are feasible and sustainable across CW agencies, geographic locations and regions, and sectors (state vs. county CW settings). This is especially important given the varied sociodemographic characteristics of CW-involved families, the socio-political and geographical landscape, in addition to whether states have an approved FFPA plan that delineates

how they plan to keep children safe while providing greater access to mental health services, substance use treatment, and/or improved parenting.

Limitations of this study should be considered when interpreting the findings. Data were collected from one key informant in one CW agency implementing a modified EBI; therefore, it cannot be assumed results are transferable to the larger CW field. Furthermore, other factors at the time such as workload and other internal or external pressures may have influenced responses. This study also underscores the importance of garnering the perspectives of families when adapting interventions in practice settings.

Conclusion

Sustaining an intervention in large, heterogenous organizations once formal supports are removed can be challenging. Findings from this case study offer key insights from the field on how to meet families where they are and deliver a parenting skill-based intervention. Findings also suggest that sustaining an intervention requires alignment between intervention components and the agency mission, and buy-in to the intervention at all staffing levels is key to sustainment.

Disclosure statement: The authors have no conflicts of interest to disclose.

Funding sources: None

References

1. Dopp AR, Hanson RF, Saunders BE, Dismuke CE, Moreland AD. Community-based implementation of trauma-focused interventions for youth: Economic impact of the learning collaborative model. *Psychol Serv*. 2017;14(1):57-65. doi:10.1037/ser0000131
2. Saldana L, Chamberlain P, Bradford WD, Campbell M, Landsverk J. The cost of implementing new strategies (COINS): A method for mapping implementation resources using the stages of implementation completion. *Child Youth Serv Rev*. 2014;39:177-182. doi:10.1016/j.childyouth.2013.10.006
3. Hall A, Shoesmith A, Doherty E, et al. Evaluation of measures of sustainability and sustainability determinants for use in community, public health, and clinical settings: a systematic review. *Implement Sci*. 2022;17(1):1-28. doi:10.1186/s13012-022-01252-1
4. Lengnick-Hall R, Gerke DR, Proctor EK, et al. Six practical recommendations for improved implementation outcomes reporting. *Implement Sci*. 2022;17(1):16. doi:10.1186/s13012-021-01183-3
5. Mundey P, Slemaker A, Dopp AR, Beasley LO, Silovsky JF. Sustaining treatment for youth with problematic sexual behavior: Administrator and stakeholder perspectives following implementation. *J Behav Health Serv Res*. 2021;48(3):410-426. doi:10.1007/s11414-020-09726-0
6. Proctor E, Luke D, Calhoun A, et al. Sustainability of evidence-based healthcare: research agenda, methodological advances, and infrastructure support. *Implement Sci*. 2015;10(1):88. doi:10.1186/s13012-015-0274-5
7. Shelton RC, Cooper BR, Stirman SW. The sustainability of evidence-based interventions and practices in public health and health care. *Annu Rev Public Health*. 2018;39(1):55-76. doi:10.1146/annurev-publhealth-040617-014731
8. Moore JE, Mascarenhas A, Bain J, Straus SE. Developing a comprehensive definition of sustainability. *Implement Sci*. 2017;12(1):110. doi:10.1186/s13012-017-0637-1
9. Rabin BA, Brownson RC. Developing the terminology for dissemination and implementation research. In: Brownson RC, Colditz GA, Proctor EK, eds. *Dissemination and Implementation Research in Health: Translating Science to Practice*. Oxford University Press; 2018:0. doi:10.1093/acprof:oso/9780199751877.003.0002
10. Aarons GA, Hurlburt M, Horwitz SM. Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Adm Policy Ment Health Ment Health Serv Res*. 2011;38(1):4-23. doi:10.1007/s10488-010-0327-7
11. Chambers D. Building a lasting impact: Implementation science and sustainability. Published 2013. Accessed August 30, 2023. https://cancercontrol.cancer.gov/is/training-events/webinars/building-a-lasting-impact-implementation-science-and-sustainability
12. Moullin JC, Sklar M, Ehrhart MG, Green A, Aarons GA. Provider report of sustainment scale (PRESS): Development and validation of a brief measure of inner context sustainment. *Implement Sci*. 2021;16(1):86. doi:10.1186/s13012-021-01152-w

13. Moullin JC, Sklar M, Green A, et al. Advancing the pragmatic measurement of sustainment: a narrative review of measures. *Implement Sci Commun*. 2020;1(1):76. doi:10.1186/s43058-020-00068-8
14. Urquhart R, Kendell C, Cornelissen E, et al. Defining sustainability in practice: views from implementing real-world innovations in health care. *BMC Health Serv Res*. 2020;20(1):87. doi:10.1186/s12913-020-4933-0
15. Nadalin Penno L, Davies B, Graham ID, et al. Identifying relevant concepts and factors for the sustainability of evidence-based practices within acute care contexts: a systematic review and theory analysis of selected sustainability frameworks. *Implement Sci*. 2019;14(1):108. doi:10.1186/s13012-019-0952-9
16. McKay MM, Gopalan G, Franco L, et al. A collaboratively designed child mental health service model: Multiple family groups for urban children with conduct difficulties. *Res Soc Work Pract*. 2011;21(6):664-674. doi:10.1177/1049731511406740
17. Gopalan G, Fuss A, Wisdom JP. Multiple family groups for child behavior difficulties: Retention among child welfare–involved caregivers. *Res Soc Work Pract*. 2015;25(5):564-577. doi:10.1177/1049731514543526
18. Gopalan G, Lee KA, Pisciotta C, Hooley C, Stephens T, Acri M. Implementing a child mental health intervention in child welfare services: Stakeholder perspectives on feasibility. *J Emot Behav Disord*. 2023;31(3):204-218. doi:10.1177/10634266221120532
19. Yin RK. *Case Study Research: Design and Methods*. SAGE; 2009.
20. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. DSM Library. Published 2013. Accessed August 30, 2023. https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596
21. U.S. Department of Health and Human Services. The family first prevention services act. Published 2018. Accessed August 30, 2023. https://www.acf.hhs.gov/cb/policy-guidance/pi-18-07
22. McKay MM, Gonzales J, Quintana E, Kim L, Abdul-Adil J. Multiple family groups: An alternative for reducing disruptive behavioral difficulties of urban children. *Res Soc Work Pract*. 1999;9(5):593-607. doi:10.1177/104973159900900505
23. Scheirer MA. Is sustainability possible? A review and commentary on empirical studies of program sustainability. *Am J Eval*. 2005;26(3):320-347. doi:10.1177/1098214005278752
24. Beidas RS, Stewart RE, Adams DR, et al. A multi-level examination of stakeholder perspectives of implementation of evidence-based practices in a large urban publicly-funded mental health system. *Adm Policy Ment Health Ment Health Serv Res*. 2016;43(6):893-908. doi:10.1007/s10488-015-0705-2
25. Fuller T, Braun M, Chiu Y ling. Increasing worker buy-in for child welfare reform: Examining the influence of individual, organizational, and implementation factors. *Child Youth Serv Rev*. 2018;93:301-306. doi:10.1016/j.childyouth.2018.08.003
26. Beidas R, Kendell P. Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clin Psychol Publ Div Clin Psychol Am Psychol Assoc*. 2010;17(1). doi:10.1111/j.1468-2850.2009.01187.x
27. Jones AS. Effective implementation strategies of differential response in child welfare: A comparative case analysis. *J Public Child Welf*. Published online December 8, 2015. Accessed August 30, 2023. https://www.tandfonline.com/doi/abs/10.1080/15548732.2015.1090365
28. Mildon R, Shlonsky A. Bridge over troubled water: using implementation science to facilitate effective services in child welfare. *Child Abuse Negl*. 2011;35(9):753-756. doi:10.1016/j.chiabu.2011.07.001
29. Aarons GA, Green AE, Trott E, et al. The roles of system and organizational leadership in system-wide evidence-based intervention sustainment: A mixed-method study. *Adm Policy Ment Health Ment Health Serv Res*. 2016;43(6):991-1008. doi:10.1007/s10488-016-0751-4
30. Winters AM, Antle BF, Collins-Camargo C. Implementing trauma-responsive screening and assessment: Lessons learned from a statewide demonstration study in child welfare. *Prof Dev Int J Contin Soc Work Educ*. 2021;24(1).
31. Proctor EK, Landsverk J, Aarons G, Chambers D, Glisson C, Mittman B. Implementation research in mental health services: an emerging science with conceptual, methodological, and training challenges. *Adm Policy Ment Health*. 2009;36(1):24-34. doi:10.1007/s10488-008-0197-4
32. Hooley C, Winters AM, Pisciotta C, Gopalan G. Caregiver-relevant perspectives from a multi-stakeholder collaborative advisory board on adapting a child mental health intervention to be delivered in child-welfare settings. *J Public Child Welf*. 2021;15(3):318-340. doi:10.1080/15548732.2020.1724238

33. Kemp SP, Marcenko MO, Hoagwood K, Vesneski W. Engaging parents in child welfare services: bridging family needs and child welfare mandates. *Child Welfare*. 2009;88(1):101-126.
34. Kerkorian D, McKay M, Bannon WM. Seeking help a second time: parents'/caregivers' characterizations of previous experiences with mental health services for their children and perceptions of barriers to future use. *Am J Orthopsychiatry*. 2006;76(2):161-166. doi:10.1037/0002-9432.76.2.161
35. Anderson CM, Robins CS, Greeno CG, Cahalane H, Copeland VC, Andrews RM. Why lower income mothers do not engage with the formal mental health care system: Perceived barriers to care. *Qual Health Res*. Published online September 1, 2006. doi:10.1177/1049732306289224
36. Scholte EM, Colton M, Casas F, Drakeford M, Roberts S, Williams M. Perceptions of stigma and user involvement in child welfare services. *Br J Soc Work*. 1999;29(3):373-391. doi:10.1093/oxfordjournals.bjsw.a011463
37. Palinkas LA, Chavarin CV, Rafful CM, et al. Sustainability of evidence-based practices for HIV prevention among female sex workers in Mexico. *PLOS ONE*. 2015;10(10):e0141508. doi:10.1371/journal.pone.0141508
38. Ingoldsby EM. Review of interventions to improve family engagement and retention in parent and child mental health programs. *J Child Fam Stud*. 2010;19(5):629-645. doi:10.1007/s10826-009-9350-2
39. Wong JJ, Roubinov DS, Gonzales NA, Dumka LE, Millsap RE. Father enrollment and participation in a parenting intervention: Personal and contextual predictors. *Fam Process*. 2013;52(3):440-454. doi:10.1111/famp.12024
40. Crampton DS, Crea TM, Abramson-Madden A, Usher CL. Challenges of street-level child welfare reform and technology transfer: The case of team decisionmaking. *Fam Soc*. Published online May 3, 2018. Accessed August 30, 2023. https://journals.sagepub.com/doi/10.1606/1044-3894.3823
41. Willging CE, Gunderson L, Green AE, et al. Perspectives from community-based organizational managers on implementing and sustaining evidence-based interventions in child welfare. *Hum Serv Organ Manag Leadersh Gov*. 2018;42(4):359-379. doi:10.1080/23303131.2018.1495673
42. Bond GR, Drake RE, McHugo GJ, Peterson AE, Jones AM, Williams J. Long-term sustainability of evidence-based practices in community mental health agencies. *Adm Policy Ment Health*. 2014;41(2):228-236. doi:10.1007/s10488-012-0461-5
43. Gopalan G, Hooley C, Winters A, Stephens T. Perceptions among child welfare staff when modifying a child mental health intervention to be implemented in child welfare services. *Am J Community Psychol*. 2019;63(3-4):366-377. doi:10.1002/ajcp.12309
44. Stephens T, Gopalan G, Acri MC, Bowman M, McKay MM. Culturally relevant, trauma-informed engagement strategies for child welfare workers: Moving beyond compliance to engagement with families experiencing high levels of exposure to trauma and stress. In: *Trauma Responsive Child Welfare Systems*. Springer International Publishing/Springer Nature; 2018:67-86. doi:10.1007/978-3-319-64602-2_5
45. Children's Defense Fund, American Academy of Pediatrics, Child Focus, et al. Implementing the Family First Prevention Services Act: A technical guide for agencies, policymakers, and other stakeholders. Published online n.d. https://www.childrensdefense.org/wp-content/uploads/2020/07/FFPSA-Guide.pdf
46. World Health Organization, PEPFAR, UNAIDS. *Task Shifting: Rational Redistribution of Tasks among Health Workforce Teams: Global Recommendations and Guidelines*. World Health Organization; 2007. Accessed August 30, 2023. https://apps.who.int/iris/handle/10665/43821
47. Sanders MR, Kirby JN. Consumer engagement and the development, evaluation, and dissemination of evidence-based parenting programs. *Behav Ther*. 2012;43(2):236-250. doi:10.1016/j.beth.2011.01.005
48. Johnson AM, Moore JE, Chambers DA, Rup J, Dinyarian C, Straus SE. How do researchers conceptualize and plan for the sustainability of their NIH R01 implementation projects? *Implement Sci*. 2019;14(1):1-9. doi:10.1186/s13012-019-0895-1
49. Casaneuva C, Ringeisen H, Wilson E, Smith K, Dolan M. NSCAW II baseline report: Child well-Being, final report. Published April 29, 2019. Accessed August 30, 2023. https://www.acf.hhs.gov/opre/report/nscaw-ii-baseline-report-child-well-being-final-report