When Implementation Can’t Wait: Focusing on the Impact of Context

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Initial Outer Context Considerations

- Economic, political and social contexts influenced planning and implementation at the beginning and throughout the project.
  - Braam Settlement
  - “Implementation fatigue” at the system level
    - WISE; other initiatives happening at the same time
  - Leadership changes
  - Just coming out of the recession
  - ACF focus on trauma screening and psychotropic medications
  - Anticipated movement to one managed care organization for children/youth in foster care
Initial Inner Context Considerations

• “...structural, political, and cultural contexts through which the implementation process will proceed” – Damschroder et al., 2009
  – Structural characteristics:
    • Children's’ Administration is a large, statewide agency divided into regional areas
    • Children's Administration serves 8,000 - 10,000 children in out of home placement in any given year.
    • Childhood Health and Education Tracking (CHET) screeners routinely evaluate children’s behavioral, physical, and educational health at entry into care (for those staying in care longer than 30 days)
  – Networks and communication:
    • Survey results during planning year revealed mixed relationships with mental health service providers at the local level
  – Culture:
    • Busy work lives for employees; child mental health and other crises destabilize work flow; dedication to improving the lives of children in care
Results from Year 1 Survey of Mental Health Providers

Of the following sources of information, which do you receive or use regularly to get information about State Dependent children and youth for your case assessment and planning?

- Consultation w/ caregiver
- Other assessments
- Consultation w/ caseworker
- CA sponsored case meetings
- Consultation w/ bio parents
- ISSP
- Consultation w/ BRS staff
- CASA reports
- CHET screening

- Regularly receive
- Do not regularly receive
Creating Connections Project Plan:
Trauma symptoms identification

• **Population of focus:**
  – Children and youth placed in foster care (expected for >30 days)

• **Trauma screen:**
  – Screen for Child Anxiety Related Emotional Disorders (SCARED):
    brief anxiety subscale (5 items) and trauma subscale (4 items)

• **Schedule:**
  – Within first 30 days of care, and every 6 months

• **Training:**
  – Trauma screening tool
    • Training occurred during a 2-day training conference
    • Statewide technical assistance plus ongoing consultation
  – Linking children/youth with appropriate services
    • Training for new and existing social workers on how to use screening results for case planning
Creating Connections Strategies

Case Planning
Create a common language between child welfare, mental health, and families to enhance engagement in effective services.

Referral for Mental Health Treatment
Increase social worker confidence in identifying mental health behavior problems for child welfare involved children, youth and parents.

Screening
Embed tools that screen for trauma into existing screening processes.

Progress Monitoring
Screen children and youth for mental health and trauma needs at regular intervals after entering out-of-home care and track their progress.

Service Array Reconfiguration
Increase use of data to support system level planning that aligns EBP capacity building with the mental health needs of children and youth in care.

Training

New Trauma Tool in CHET

Ongoing Mental Health Screening

Gap Analysis
Implementing the SCARED Trauma Tool

**CHET: Child Health and Education Tracking**

- 30 Days
  - ASQ-SE, PSC-17, **SCARED**, GAIN-SS, among others
    - (In person)

**OMH Screening: Ongoing Mental Health Screening**

- 6 months
  - ASQ-SE, PSC-17, **SCARED**, GAIN-SS (Telephonic)
    - [pilot testing 3 trauma-symptom questions]

**OMH Screening**

- 12 months
  - Re-screening, same tools as 6-month screen
Methods to track progress and impact

• Self-report surveys
  – Y1, Y3, and Y5 from CA caseworkers and MH providers
  – Y2 and Y4 surveys at CHET conferences

• Administrative data analysis
  – Received data on over 10,000 children/youth entering out-of-home care from 2010-2015
  – Examined demographics, experiences, and outcomes
Results from Year 1/3/5 Surveys with Child Welfare Personnel

Social worker satisfaction with mental health services, communication with therapists, and screening

- Communication regarding referral
- Mental health system meets child needs
- Information regarding assessments of functioning
- Information received regarding treatment
- Information regarding child progress
- Comfort describing treatment options to caregivers
- Comfort discussing treatment options with MHP
Pathway of Youth Aged 3-17 Entering Foster Care in Washington State between July 2010 and July 2014

PRELIMINARY DATA – Prior to the Introduction of the Trauma Screening Tool

Note: Study population is all children aged 3-17.5 entering out of home care for 30 days or more between July 2010 and July 2014. “Screened above criteria” indicates that the youth scored above established clinically significant criteria at least on mental health measure by at least one reporter (e.g. self-report, parent, teacher), indicating further assessment may be warranted. Mental health service receipt includes at least one mental health service on at least one occasion during the time period (e.g. assessment, outpatient therapy, hospitalization).
Complexities of implementation

- Choosing a screening tool that is feasible, acceptable, and effective
- Staff required to implement new screening tool
- Adapting database structure to accommodate screening measure
  - We crashed the database...
  - Influenced later database development
- Embedding training within Alliance for Child Welfare Excellence (WA state’s child welfare academy) training
  - Limited project control, enhanced sustainability
- Informing and sustaining management understanding and support
- Development of Ongoing Mental Health Screening program
- Budget modifications to accommodate emerging and evolving strategies
SCARED Completion Rates & Impact

CHET Screens July 2014 - July 2015:

1252 children and youth aged 7+ received the SCARED at intake to care (81% of the eligible population)

- 662 (53%) children and youth screened above cutoff on the SCARED
- 587 (47%) children and youth screened below cutoff on the SCARED

- 97 (15%) children screened above cutoff on *only* the SCARED
- 565 (85%) children screened above cutoff on the SCARED and another measure

Therefore, the addition of the SCARED resulted in an additional 97 out of 1,252, or 8% of youth screened, being identified as possibly having a MH need.
CHET positive screening rates before and after SCARED implementation

Sample: All children/youth receiving a CHET screening between July 2010 and July 2015
Impact of embedding the trauma tool on the screening workforce (inner context)

• Screeners provided information on:
  
  – Feasibility (time to administer)
  
  – Knowledge of screening tools
  
  – Perceptions of skills to deliver the tools
  
  – Satisfaction with the tools
Screener time needed to complete the SCARED decreased over time

How much extra time (in minutes) did the Trauma Tool require during the CHET process for...

**Adult report only**
(66% of screens)

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<th>Discussing</th>
<th>Data Entry</th>
<th>Report Writing</th>
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<td>8</td>
<td>6</td>
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<td>2016</td>
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**Total:**
2014: 31.5 min
2016: 30 min

**Adult + Child report**
(34% of screens)

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<td>20</td>
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**Total:**
2014: 65.5 min
2016: 58 min
Screener knowledge, skills and comfort of SCARED increased over time

- PSC-17 knowledge and skills
- Trauma tool knowledge and skills
- Improved ability to identify trauma
- Confidence in using trauma tool
Inner Context– Service Workforce
A tale of two trainings

• **Using Screening Results to Inform Case Planning**
  – Over 1000 child welfare social workers have been trained on topics such as interpreting and using CHET results, trauma and mental health treatments
    • Required 4 hour Regional Core Training (RCT) for all newly hired social workers
    • Optional 6 hour In-service Training (IST) for any currently employed social workers
  – High satisfaction with trainings
  – Strong knowledge gain, especially with regard to how to use the trauma screening in case planning

• **Understanding the Child Welfare System and Integrating Unique Needs of Foster Care within Evidence-Based Practice Protocols**
  – Over 150 mental health providers have participated in the training
  – Includes training by parent allies and alumna of care on ‘culture of foster care’ and how to include biological families in treatment
  – High satisfaction with trainings
  – High knowledge gain
Child Welfare Training Results: Strong knowledge gain on key items

Before and after training, how knowledgeable are you in the following areas?

For the 4-hour training:
- Referring to EBPs/other services
- Use and interpret new trauma screening tool (SCARED)
- Overall knowledge
- Ask the right questions of mental health providers

For the 6-hour training:
- Referring to EBPs/other services
- Use and interpret new trauma screening tool (SCARED)
- Overall knowledge
- Ask the right questions of mental health providers

N = 710

N = 161
Mental Health Professional Training Results: Strong self-reported knowledge gain

How much knowledge did you gain in the following areas?

- Youth perspectives on "culture of foster care"
- Timeline of dependency court
- Prevalence of MH concerns for children/youth in care
- Specific factors unique to working with youth/families in foster care
- Prevalence of child welfare involvement
- Strategies for involving caregivers in treatment
- Cross-system collaboration between child welfare and mental health
- Pathways and responses to CW referrals
- Mission of CW
- Special concerns around psychotropic meds for foster youth

N = 147
Percentage of children receiving MH services (split by age group): Too soon to see a difference?

Sample: All children/youth receiving a CHET screening between July 2010 and July 2015
Data smoothed using a 3-month moving average to reduce random variation
*Workforce turnover estimated at 18%, compounded annually
At each screening time point, the percentage of children/youth who have clinically significant scores ranged from 44 to 66%.

**CHET screen** 3239 screened* → 2144 (66%) clinically significant

**6-month OMH** 1427 screened* → 628 (44%) clinically significant

**12-month OMH** 126 screened* → 85 (67%) remained clinically significant

(Only includes those who were clinically significant at 6-month screen)

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*For whom we have data in this cohort. See Appendix 1 for more details on the sample and overall screening numbers. Note: CHET start date began January 2014; 6-month screening began July, 2014; 12-month screening began December, 2015.*
Of those children/youth who had non-clinically significant scores on the CHET, 33% who screened clinically significant on the 6-month OMH screen received MH services after screening.

- CHET POSITIVE: 65%; n = 923
  - OMH POSITIVE: 52%; n = 480
    - Continued problems: 36%
    - Initiated services after OMH: 19%
    - Stopped services: 23%
    - Gap in services: 2%
  - OMH NEGATIVE: 48%; n = 443
    - Deteriorated: 28%
    - Improved: 15%
    - Changed/resilience: 37%

- CHET NEGATIVE: 35%; n = 504
  - OMH POSITIVE: 30%; n = 149
    - Improved: 34%
    - Continued resilience: 56%
  - OMH NEGATIVE: 70%; n = 355
    - Continued services: 1%
    - Initiated after OMH: 11%
    - Stopped services: 21%
    - Gap in services: 21%

Note: Service receipt was calculated as a yes/no in three, four-month windows: 0-3, 4-7, and 8-11 months after entry into care.
Children who initiated services in either the 4-7 or 8-11 window are in the “initiated after OMH” category.
Children who stopped services in either the 4-7 or 8-11 window are classified as “stopped services.”
Children who received services in the 0-3 and 8-11 windows, but not the 4-7 month window, are classified as “gap in services.”
Conclusion

• Context matters
• Complex initiatives across systems make it difficult to document impact
  – Context precluded experimental design
• Modest changes observed at 6 month screening
• Population level changes take additional time given inner context challenges
• Building relationships across systems enhances all efforts and encourages sustainability
• System needs to remain flexible and responsive, while keeping overall goals in mind
Translation to policy and practice

• Deeply rooted systems provide pros and cons to implementation:
  – Pre-existing structures provide major support for quick roll-out and adoption of new practices, if the practices fit
  – However, when practices do not fit, pre-existing structures can be barriers to implementation
  – Our recommendation: adapt the practice to fit deeply rooted systems rather than vice-versa

• Implementation practices with long logic chains and a single mechanism of change (e.g. screening and training will lead to increased identification, which will lead to increased referrals, which will lead to increased services, which will lead to improved functioning) more easily suffer from any single weak link; make implementation approaches multi-pronged and more proximal to outcomes whenever possible.
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