ORIGINAL ARTICLE

Partnering for Success: Factors Impacting Implementation of a Cross-Systems Collaborative model Between Behavioral Health and Child Welfare

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Abstract

Cross-system implementation efforts can support needed mental health (MH) service utilization among children involved in the child welfare (CW) system. The Partnering for Success (PfS) initiative is one such effort that promotes greater collaboration between the CW and MH providers by building capacity within and across each system. Frontline CW providers learn to accurately identify child MH treatment targets, link families to locally-provided evidence-based treatments (EBTs), and monitor treatment progress. Concurrently, local MH providers are trained along with CW workers to utilize Cognitive Behavioral Therapy plus Trauma-Focused CBT (CBT +), a common elements training and consultation approach focusing on typical MH issues for CW-involved children: Anxiety, Depression, Behavioral Problems, and Traumatic Stress. Finally, agency leadership receive support around promoting implementation and sustainment. This paper examines factors identified by participating CW and MH staff which impacted PfS implementation. Twenty-nine frontline, supervisory, and executive CW and MH providers were interviewed via audio-recorded web-based calls in six focus groups and 10 individual interviews. Factors facilitating implementation success included training/consultation, support from supervisors and agency leadership, improved referral processes, high quality relationships and communication between CW and MH frontline staff, PfS tools and resources, opportunities to use PfS, as well as buy-in from providers and families. Implementation barriers included poor communication between CW and MH providers, conflicts over role expectations, workload and turnover challenges, lack of buy-in, as well as provider (e.g., not aligned with CBT +) and client characteristics (e.g., frequent crises).

Keywords Partnering for success · Child welfare · Mental health · Implementation · Partnership · Evidence-based treatment

Literature Review

Many children involved in child welfare (CW) services struggle with behavioral and/or emotional challenges, yet are often not connected with necessary mental health (MH) services (Bronsard et al., 2016; Burns et al., 2004; Casanueva et al., 2011; He et al., 2015; Pullmann et al., 2018).

This section reviews causal factors situated within and across the CW and MH service systems, benefits of existing cross-system implementation efforts, and an overview of the Partnering for Success (PfS) initiative (Barth et al., 2019) which was developed to increase the combined ability of CW and MH systems to recognize, evaluate, and effectively serve the MH needs of CW-involved youth. This exploratory, qualitative study examines factors which impacted PfS implementation from the perspectives of participating CW and MH providers in order to improve upon PfS implementation and inform similar efforts.

System-Level Barriers

The separate, siloed nature of the CW and MH services in the United States results in vertically-organized child serving systems that operate with separate policies, procedures, and priorities despite frequently sharing clients (Kerns et al.,

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2014; Lyons, 2004). CW and MH providers often have difficulty navigating the other system, with substantial confusion around confidentiality policies that constrain effective communication between providers on shared clients. As a result, both MH treatment utilization and CW permanency planning can be negatively impacted (Kerns et al., 2014).

Limited knowledge and skills to accurately identify MH issues and make appropriately targeted MH referrals (Barth et al., 2008; Kerns et al., 2014; Stiffman et al., 2001) further result in uneven and vague treatment recommendations from CW workers (Burns et al., 2004; Dorsey et al., 2012; National Child Traumatic Stress Network, 2008). CW workers (aka "gateway providers," or brokers; Stiffman et al., 2004) are among the first professionals who can identify child MH needs, with subsequent responsibility for ensuring linkage to treatment. To be effective MH service brokers, CW providers require specific knowledge and skills related to accurately identifying child MH difficulties, locating relevant and accessible evidence-based treatments (EBTs), assessing the appropriateness of MH treatment, monitoring treatment progress, and facilitating families' engagement in child MH services (Dorsey et al., 2012).

Additionally, the average community-based MH provider has not received training in EBTs, despite the proliferation of effective, research-generated interventions to address children's MH difficulties (Bruns & Hoagwood, 2008; Chaudoir et al., 2013). Instead, MH providers require knowledge and skills for effectively treating the most common MH challenges among CW-involved youth: behavior problems, traumatic stress, depression, and anxiety (Dorsey et al., 2016). That said, however, existing EBTs generally focus on singular MH challenges, rather than being able to address the diversity and comorbid nature of clinical difficulties impacting CW-involved youth (Chorpita et al., 2011).

Finally, agency leaders are not typically trained to support workplace change initiatives critical for integrating EBTs into routine practice (Aarons et al., 2015; Berliner et al., 2013). Agency leaders are best prepared when they understand the prevalence and impact of child maltreatment, trauma, and MH difficulties; identify central EBT components; and address common barriers to successful EBT adoption and sustainment within and across publicly funded service systems (e.g., high workload, role confusion, vague referral documentation, limitations on information sharing, frequent turnover, limited resources; Aarons et al., 2011; Akin et al., 2017; Berliner et al., 2013; Garland et al., 2013; Hwang et al., 2016; Kerns et al., 2014; Mor Barak et al., 2001; Palinkas et al., 2017; Woltmann et al., 2008).

Benefits of Cross-System Implementation Efforts

Existing research documents how greater coordination between CW and MH systems can enhance assessment, service utilization and treatment outcomes (Bai et al., 2009; Chuang & Wells, 2010; Glisson & Hemmelgarn, 1998; Hurlburt et al., 2004; Rivard et al., 1999). To date, a number of initiatives involving cross-system implementation efforts to address the MH needs of children involved in CW services have emerged in the United States. Collectively, these efforts have increased receipt of needed MH services (Glisson, 1994; Glisson & Hemmelgarn, 1998; Hanson et al., 2018, 2019), improved CW-relevant outcomes (e.g., less restrictive placement, improved placement stability, enhanced child safety and well-being, increased reunification rates; Akin et al., 2017; Chinitz et al., 2017; Glisson, 1994; Glisson & Hemmelgarn, 1998), reduced child MH symptoms (e.g., improved prosocial behavior, reduced hyperactivity, inattention, post-traumatic, internalizing, and externalizing symptoms; Bartlett et al., 2016; Sullivan et al., 2019), and improved caregiver outcomes (e.g., trauma knowledge, parenting self-efficacy and practices; Chinitz et al., 2017; Sullivan et al., 2019).

Many cross-system efforts identified in our review received federal funding specifically designed to enhance linkage and utilization of trauma-related treatments among children served by public CW systems (Akin et al., 2017; Bartlett et al., 2016; Chinitz et al., 2017; Collins-Camargo et al., 2019; Fraser et al., 2014; Hanson et al., 2018, 2019; Lang et al., 2017; Sullivan et al., 2019; Verbist et al., 2020; Winters et al., 2020). Some models utilized autonomous specialized teams across service systems to elicit referrals, link to treatment, and monitor progress (Bunger et al., 2019; Chinitz et al., 2017; Glisson, 1994; Glisson & Hemmelgarn, 1998), while others involved all available CW and MH providers across specific jurisdictions for training and implementation efforts (Akin et al., 2017; Bartlett et all., 2016; Collins-Camargo et al., 2019; Fraser et al., 2014; Hanson et al., 2018; Hanson et al., 2019; Lang et al., 2017; Sullivan et al., 2019; Verbist et al., 2020; Winters et al., 2020). However, to our knowledge, no U.S.-based CW and MH cross-system implementation effort utilized EBTs to address multiple MH difficulties common in CW populations (i.e., behavior problems, trauma, depression, and anxiety).

Partnering for Success (PfS)

The Partnering for Success (PfS) initiative was developed as a cross-system (CW and MH) implementation effort, coordinated by the National Center for Evidence-Based Practice in Child Welfare (NCEBPCW; http://www.ncebpcw.org/) at the University of Maryland School of Social Work, and funded by the Administration of Children and Families Children's Bureau (Grant number 90CT7001). PfS was designed to address federal objectives around increasing local jurisdiction (e.g., city, county, or state) capacity to implement and sustain EBTs for CW-involved

youth, establish efficient assessment strategies to identify MH needs, facilitate timely and relevant linkages to services, and monitor MH treatment over time (Barth et al., 2019). Building on an existing intervention utilizing CW workers as brokers for MH services (Project Focus; Dorsey et al., 2012), NCEPBCW staff trained CW providers to identify child MH needs using a standardized screening measure (i.e., Pediatric Symptom Checklist [PSC-17]; Murphy et al., 2016), determine local EBT availability, engage families in identification of treatment needs and referral, initiate treatment referrals, and track MH treatment progress. The PfS model further integrated a core set of partnership practices for CW workers focused on engaging with families, assessing child MH needs, matching MH needs to appropriate community-based treatment, and tracking MH treatment progress in collaboration with MH providers. Concurrently, MH providers were trained in Cognitive Behavioral Therapy plus Trauma-Focused CBT (CBT+), a pragmatic approach for efficiently training MH providers in four EBTs that target the most common MH difficulties among CW-involved youth (e.g., behavioral difficulties, depression, anxiety, trauma; Dorsey et al., 2016). Finally, CW and MH agency leadership participated in a series of workshops addressing EBT installation, continuous quality improvement, sustainability, and scale-up in order to support the creation and maintenance of intentional service linkages between CW and MH providers on shared cases.

The comprehensive Implementation Drivers framework from the National Implementation Research Network (NIRN; Fixsen et al., 2005; Metz & Bartley, 2012) guided additional implementation activities for PfS. Competency drivers (staff selection, training, coaching performance enhancement) refer to strategies to enhance practitioner and supervisory capacity to implement an EBT. Organizational drivers (decision-support data systems, facilitated administration, systems interventions) focus on ensuring a receptive context for EBT implementation through building supports within organizations and across systems. Finally, leadership drivers (technical, adaptive) encourage the use of diverse strategies addressing a variety of challenges present throughout organizations. As a result, multiple operational procedures and tools were integrated across both CW and MH systems to promote implementation success. PfS providers established clear protocols to maintain regular communication about shared clients' treatment progress. Joint training allowed CW and MH staff to develop shared knowledge on facilitating referrals and treatment monitoring. Web-based fidelity, treatment- and symptom-monitoring systems (i.e., EBP Toolkit; www.ebptoolkit.com), consultation with NCEBPCW staff, regularly scheduled cross-system implementation team meetings, as well as post-training transfer of learning

activities and consultation, were further integrated to support competence and adherence with the PfS model (Barth et al., 2019).

Study Purpose

The current study seeks to understand providers' perspectives on factors that facilitated or impeded PfS implementation. Prior research documents the general feasibility of the model, significant knowledge gain among CW and MH practitioners, and symptom improvement among children and youth served across four PfS implementation sites (Barth et al., 2019). Given the documented challenges frequently plaguing implementation efforts within and across publicly funded services, CW and MH providers across varying roles (i.e., front-line, supervisory, administrative) may have important insights not readily captured by quantitative performance indicators. The current study's findings can inform future PfS and similar efforts, as well as build upon existing cross-system implementation research.

Methods

Study Overview

This qualitative, exploratory study focused on PfS implementation in a single county-administered jurisdiction. The study was initiated in response to the county leaders' desire to understand provider perception of PfS, integration of skills and processes into overall practice, and sustainment. In order to pragmatically develop knowledge relevant to stakeholders and inform future PfS model improvements (Patton, 2014), research staff applied a grounded theory approach to explore context-based and process-oriented descriptions of phenomenon, inductively derived from CW and MH staff perceptions. (Lawrence & Tar, 2013). Such an approach aligned with the interpretivist nature of this research (Pham, 2018), allowing researchers to elicit rich descriptions of participants' perceptions regarding potential mechanisms that supported or hindered implementation success. All study procedures were approved by an urban health sciences campus Institutional Review Board.

Procedures

From March 2017 to September 2017, all PfS participating staff in a single county-administered jurisdiction were recruited for the current study, including one public CW authority, and three non-profit community-based MH agencies. This suburban county (population > 600,000) is situation within a major metropolitan area, with a poverty rate of 8.9% (compared to U.S. overall 10.5% in 2019; U.S.

Census Bureau, 2020). Potential participants were drawn from the first three cohorts (2014–2017) of PfS implementation. This site was chosen as it possessed the longest PfS implementation track record, thus facilitating insight into PfS implementation and sustainment over time.

To ensure representation from multiple perspectives, purposive sampling strategies focused on recruiting staff from both CW and MH service systems, and across different professional roles (e.g., frontline worker, supervisor, agency administrator). A recruitment email crafted by NCEBPCW staff was forward to CW and MH staff by their respective agency administrators. Interested staff subsequently contacted the first author (GG) via email to set up interviews. In total, 131 CW and 114 MH staff were contacted to participate in virtual, web-based conference calls lasting 60–90 min. Twenty-nine PfS participants (15 CW and 14 MH; 12% response rate) volunteered to be interviewed (see Table 1 for participant demographic information). All interviews were conducted by the first author (GG), who served as Principal Investigator for this study. GG has had prior clinical and research experience in both CW and MH service systems, and was involved in PfS development and evaluation. This background allowed for greater sensitivity with participants' experience and competence in using probes to elicit more information.

Participants were offered the choice of engaging in either a focus group or individual interviews, although no participant indicated a particular preference. All attempts were made to ensure focus group participants were homogenous in terms of service system and role. However, research staff later discovered that in two focus groups with frontline providers, at least one superordinate participant (e.g., supervisor/agency administrator) was also present. Scheduling primarily determined if participants took part in individual interviews or focus groups: if at least two participants were available at the same time slot, a group interview was scheduled. Otherwise individual interviews took place. All interviews were conducted virtually, including six focus groups and 10 individual interviews using a semi-structured standardized interview guide (See Supplemental files).

Interview guide questions aligned with stakeholder-relevant areas of interest: provider perception of PfS, integration of PfS skills and processes into overall practice, and PfS sustainment. Although the NIRN Implementation Drivers framework guided development of PfS, it was not explicitly used to develop interview questions as the intent of the current study was to apply a more inductive, grounded theory approach to eliciting participants' perceptions. The interview guide was structured with a broad opening questioning, followed by probes to gain greater clarity about efforts to engage families, consultation, partnership, agency support, fidelity, changes to practice, and recommendation for sustainability. Interview questions were tailored for each participants' system involvement (CW or MH) and role (e.g., front-line worker, supervisor, administrator).

For this study, we focused on participants' responses to questions regarding their experiences with PfS implementation (e.g., "What facilitated/hindered the process of partnering?," "How did your agency support using PfS,"?", "What has helped with integrating PfS in your overall practice? What has gotten in the way?"). All participants received a $50 gift card as an incentive for their participation in this research. Interviews were audio-recorded, transcribed verbatim, de-identified, and verified to ensure accuracy and quality.

Analysis

Preliminary qualitative data analyses focused on obtaining an initial overview of main themes across all interviews using a descriptive analytic framework and template method (Crabtree & Miller, 1999). Preliminary categories (i.e., Benefits of PfS, Challenges of PfS, What helped PfS implementation, What hurt PfS implementation, and Recommendations) were placed on an excel spreadsheet to

Table 1 Participant demographic information by service system

		Child Welfare N=15 (n, %)	Mental Health N=14 (n, %)	Total N=29 (n, %)
Race/Ethnicity	White or Caucasian	11 (73%)	8 (57%)	20 (69%)
	Black or African American	3 (20%)	3 (21%)	6 (21%)
	Mixed	0 (0%)	1 (7%)	1 (3%)
Highest level of education	MSW	14 (93%)	7 (50%)	21 (72%)
	MA/MS	0 (0%)	6 (43%)	6 (21%)
Current position	Frontline Staff	9 (60%)	9 (64%)	18 (62%)
	Supervisor	5 (33%)	4 (29%)	9 (31%)
	Administrator	1 (7%)	1 (7%)	2 (7%)

% may not add up to 100 due to missing data

organize interview summaries. This process elicited an initial set of a priori themes reflecting planned aspects of the PfS model (e.g., training, consultation, supervision, fidelity, tools).

The second, more rigorous phase of analysis integrated strategies from Consensual Qualitative Research methods (CQR; Hill et al., 1997). CQR draws heavily from grounded theory strategies by developing a conceptual network of related constructs about phenomena and iteratively coding data using constant comparative analysis (i.e., exploring similarities and differences across data; Hill et al., 1997). However, CQR differs from traditional grounded theory strategies by using a team of researchers to arrive at consensus judgments, with special attention to power dynamics within research teams, rather than typical grounded theory strategies where work may be coded separately and then compared for reliability amongst coders. We felt this approach would be appropriate in order to mitigate against biases of any single researcher, as well as ensure maximum reliability of all data and among coders where discrepancies are resolved via consensus before application of final codes. Moreover, we applied the CQR strategy of carefully defining our sample of interest first and collecting data using the same protocol to ensure consistency in responses across all participants, rather than a more typical grounded theory strategy of alternating between data gathering and data analysis (Hill et al., 1997). Our strategies diverged from traditional CQR methods by focusing on the domain of "Implementation Determinants" and constructing its core ideas for the current study, rather analyzing across all domains and cases (Hill et al., 1997).

Specifically, a primary analysis team (n = 3; GG, MJH, JL) read through five randomly selected transcripts to further develop the codebook, using open coding (i.e., distinguishing emerging and a priori themes by specific attributes), axial coding (i.e., connecting themes to their subcomponents, and to other themes), as well as constant comparative analysis (i.e., exploring similarities and differences across data). MJH participated in PfS implementation team meetings and provided technical assistance as a member of NCEPCW staff. JL was a recent Masters-level Social Work graduate with clinical experience in MH settings. Each team member independently coded transcripts utilizing Dedoose qualitative software (Dedoose, 2018). Coding differences between team members were subsequently identified, discussed, and resolved via consensus. The remaining 11 transcripts were independently coded by two analysis team members (MJH, JL) who ensured reliability by comparing independently coded excerpts and resolving discrepancies via discussion. Any remaining discrepancies were discussed with the first author until consensus among all analysis team members could be reached. An independent auditor was consulted periodically to resolve any remaining discrepancies.

Having all data reviewed by each coder and final coding assigned after reaching consensus ensured, essentially, 100% inter-rater reliability.

Excerpts coded with the domain "Implementation Determinants" were extracted for further identification of core ideas (e.g., "Training/Consultation"; See Supplemental Files). Core ideas were grouped under larger thematic categories (e.g., PfS Partnership Features) to structure our findings. We further identified areas where findings reflected the NIRN Implementation Drivers in order to confirm theoretical processes, as well as identify any emerging constructs useful for implementation theory development.

Strategies of Rigor

The research team employed a number of strategies to promote rigor during data collection and analysis (Cohen et al., 2018; Hill et al., 1997). Such strategies included an audit trail of notes during and after interviews, as well as documentation during analysis (i.e., memos) and following research meetings. The primary analysis team consulted periodically with an independent auditor during analysis to resolve any remaining discrepancies and guide procedures. Peer debriefing between research staff during analysis allowed findings to be shared and mitigated against potential biases. Given the power differential between the first author and other members of the primary research team, a continual process focused on reflexivity ensured that potential biases were acknowledged and that all voices felt heard. Findings following the first and second phase of analyses were disseminated and discussed with the PfS implementation team (including co-author MJ, as well as participating CW and MH administrators and supervisors) as a form of member checking. The first author (GG) presented a written summary of findings at an implementation team meeting, and requested feedback. Implementation team members confirmed that study findings were representative of CW and MH staff experiences. Finally, we utilized the Standards for Reporting Qualitative Research guidelines to ensure transparency in reporting research methods (O'Brien et al., 2014; See Supplemental files for checklist).

Findings

Participants identified multiple factors that impacted implementation of PfS. Major thematic core idea categories included (1) PfS Partnership features (2) Organizational resources and capacities, as well as (3) Provider and client characteristics.

PfS Partnership Features

The following section examines those aspects of the original PfS design that were intended to promote overall implementation success. Core ideas include training & consultation, supervision, tools & resources, referrals, executive leadership, shared language, communication, relationships, and roles.

Training and Consultation

Participants mainly commented on their perceptions of the in-person, MH and CW joint learning tracks with CW and MH frontline providers and their supervisors. Training, initially implemented over 3 days, was reduced to 2 days following participant feedback. Content focused on assessment, inter-disciplinary partnership, and CBT + specific skills. Following training, participants received ongoing telephone consultation (CW providers for 3–4 months, MH providers for 6 months) from NCEBPCW staff to reinforce direct application of training concepts into practice. Participants reported that the training and consultation facilitated implementation by setting expectations for collaboration, highlighting the importance of open communication, as well as increasing CW and MH providers' clinical skills. According to this CW caseworker:

> "But I will say that the information that I gained at the training has definitely just expanded my toolbox, per se. And so I often go through the participant guide and utilize some of what's in there, or just review some of the things with even [children on my caseload] that I'm working with..."

However, some MH providers commented that the PfS training did not provide sufficient practice when it came to specific aspects of CBT +, such as the developing of a trauma narrative with clients to modify cognitive distortions (Dorsey et al., 2016). One MH clinician asserted:

> "I will also say the challenging part, when it came to just the trauma narrative, I think during the three day training... They didn't really prepare you too much to know how to use the things that were going on. So when it got to the part of the trauma narrative, we were just like, okay, so how do we actually start this? How do we engage the client? What is that step by step process look like? And that part was the hardest."

In this case, participants would have preferred greater experiential preparation with the series of activities composing the trauma narrative process.

Participants further acknowledged that training opportunities were too infrequent to keep up with ongoing turnover within their agencies. Challenges emerged when only segments of agency staff received PfS training. As indicated by a CW administrator:

> "when we kicked off three years ago, we just did a smattering of anybody interested in working with us on this and we got a few therapists from this organization, a few from that organization. And it wasn't strong enough to really institute the practice change across the referral base for who [we] were making referrals to … I think when we targeted the particular agencies where they really made the commitment to infuse their agency-wide practice with CBT+ and then we became more reliably able to make referrals and get referrals in and to have that whole team supported by their supervisor in the model, it became easier to make referrals and to really maintain those partnerships."

According to this participant, the commitment to train all MH clinicians in an agency in CBT + ensured that every child who was referred received appropriate treatment.

Supervision

NCEBPCW staff intentionally trained supervisors alongside front-line staff, so that supervisors could effectively monitor frontline worker fidelity to the model, as well as build worker buy-in. As exemplified with this CW supervisor:

> "Every supervision, unless there's a total emergency, we're talking about this model at some point. 'Have you done your PSC-17s?' 'What did that look like?' 'How is the engagement with the therapist?' 'How can we improve that?' 'Or how's the kid responding to this?' 'Are you seeing differences right now?' Once again, trying to get them to buy in on this model and so talking about it."

As a result, frontline staff recognized how their supervisors supported overall PfS implementation. This CW caseworker reported:

> "They [Supervisors] are, on a regular basis, reiterating, make sure you do the PSC-17, and um we're-, you know they [NCEBPCW staff] want us to talk about some [of] it in supervision with our supervisors. You know, uh, they want it to be something that we're regularly doing… But they do, you know, remind us. And encourage us to make sure we do the referrals and that we are checking in with the therapist and talk about it in supervision. So that we can address any issues or concerns or bumps along the way."

However, the utility of supervision to support PfS implementation was limited by training saturation. When supervisors were not trained, they were unable to support frontline worker activities. Additionally, one MH supervisor reported challenges when workers were not all trained within an agency:

> "Well, it's a little trickier now. Because some people have been trained in it, and some haven't. You know, for the … other people, they don't know what I'm talking about. So, I have to do it with just the people that know how to do it. But we just use different terminology now. We talk about targets and we talk about assessment. … We talk about [CBT] triangles."

As a result, supervisors had to tailor their approach with front-line staff depending on exposure to PfS training, limiting their ability to support more widespread PfS implementation.

Tools

Practical tools and resources, such as standardized screening and assessment measures (e.g., PSC-17), asynchronous online orientation to PfS and Trauma-Focused CBT (https://tfcbt2.musc.edu/), as well as the web-based EBP toolkit, were disseminated in order to develop and sustain internal capacity, effectively implement CBT +, and leverage outcome and fidelity data to foster iterative improvements to practice (Barth et al., 2019). According to one MH clinician:

> "The program is very easy to use and the toolkit is very easy to use. ... I'm actually on the website now... All the handouts. That is very helpful in my opinion. That I can kind of show what this is about and show what we're doing as opposed to just talking about it."

CW providers also valued using the PSC-17 assessment tool with their clients as a means to justify MH treatment referrals and pinpoint specific treatment needs. One CW administrator commented on perceived practice changes:

> "It's how we use the PSC-17 assessment tool to really target those symptom areas. And I think previously workers would use their clinical judgment to assess that a child was struggling with emotional or behavioral issues. And would vaguely refer them to therapy to address their emotional issues or their acting out, without being clear about specifically what the target area was. Or what those symptoms meant. "

Other CW staff also acknowledged the "habit of making referrals to therapy just for therapy's sake" being replaced through the use of the PSC-17 assessment tool.

Referrals

PfS encouraged the creation of intentional service linkages between CW and MH providers on shared cases, which involved CW staff utilizing the PSC-17 to identify specific child MH needs, including assessment information when referring to PfS-trained MH partners, and partnering with MH clinics prioritizing PfS referrals. PfS participants perceived that the referral process was often accelerated, where youth were ultimately assigned to a MH provider and received an intake appointment much faster than prior to PfS. When asked what really helped in partnering with MH providers, this CW supervisor indicated that the fast turnaround could be seen with those clinics who committed to prioritizing PfS referrals:

> "Having that commitment to, I don't want to say putting our referrals first, but at least us not having to wait for months on end to get a provider. That time has been reduced."

Conversely, delays in the referral process hindered implementation. As indicated by this CW caseworker:

> "And a problem I was running into when I discovered this was that some of the providers, their psych appointments are so far out that we couldn't have the youth discharge for their current provider prematurely because then they'd be out of medication."

Implementation challenges also occurred when MH providers reported only a limited number of appropriate referrals from CW partners, as well as for youth who could no longer be served by the MH agency. According to this MH Supervisor:

> "We didn't get a ton of Partnering for Success specific referrals from DSS….So twelve from about November to April. … And so I think of those referrals in particular, maybe half of them stayed enrolled in the program and half needed discharge because of non-compliance or they moved to a different placement and wasn't in the area anymore. Or they went inpatient, whatever it was."

As a result, PfS implementation challenges emerged along multiple points of the referral process.

Executive Leadership Activities

Intervention by senior executives, who also participated within the cross-system implementation teams, was seen as critical to supporting PfS implementation success. For example, according to this CW supervisor:

"Well, I'll tell you our administrator is fabulous. And she's actually done what I think has been very helpful. She's attended some of the consultation calls. And she's on board with this. And she sends us reminders sometimes like, hey, these are the new cases that haven't had PSC-17. What's going on there? Even if there's no referral. Having that support is a necessity and she's on it."

Participants' valued senior leadership for their responsiveness and accessibility, as well as "real-time" efforts to resolve challenges between CW and MH partners, and promote PfS fidelity.

Shared Language

A "shared language" arose through joint CW and MH provider training, involving strategies for screening, assessment, family engagement, CBT + delivery, treatment monitoring, customized referral and communication protocols, as well as collaborative planning and service delivery expectations (Barth et al., 2019). Participants reported that the shared language supported PfS integration into daily practice, solidified partnerships between CW and MH providers, and made interactions more efficient. This MH clinician reported:

"So that's where that language, understanding each other's language comes in, because in those calls [between CW and MH providers], they won't be as long if you don't have to give a lot of explanation. So just give bullet points."

Shared language also facilitated discussion with clients about MH issues. CW providers reported being able to reinforce CBT + treatment strategies with youth, as well as promote greater engagement and understanding with families. One CW supervisor shared:

"So one specific example, feedback from one of the workers that I had the opportunity to talk with about using the PSC-17 is that it really gave her and the client the understanding of what these behaviors meant. And it really validated the caregiver's experience in dealing with their child. So to be a child that's acting out and be able to attribute that to internalizing behaviors as opposed to just being lazy. That they've [been] suffering from depression was really validating for the family. So it gave, not only the worker, but the consumer of the mental health services the language to go in and talk in an informed way about what they were seeing and how they were experiencing that."

Communication

The PfS model promoted specific guidelines for CW and MH partners around maintaining regular communication over time. As a result, many participants reported greater perceived responsiveness and receptivity ("we all want to be on the same page") among PfS trained partners, even when situations called for "hard conversations" to ensure appropriate MH treatment for shared clients. According this CW Caseworker:

"And then I called the therapist and said, if you are not addressing this trauma, I don't know whether this is going to be the best for him at this point in time. And she said, well you know, I've been building rapport. And he's just now starting to talk to me. And part of me was kind of concerned. Just because I was thinking, okay, so he is building a rapport with her, and I don't want to disrupt that. But I guess I had to weigh it with the potential for future growth for him.… And so I talked to the therapist and said, look, I think that all things considered, while I appreciate the rapport that you've been building with him, and I don't want to discount that, I do think that he needs this other type of treatment. And she wasn't happy about it. It was a hard conversation to have. But she ultimately acquiesced and I referred then this client for this other therapist …and it seems to be going well so far."

High quality communication between CW and MH providers ensured that information about shared cases could be relayed easily, facilitating collaborative problem-solving ("We give each other advice" [CW Caseworker]) for specific case challenges. Communication quality could be enhanced by establishing mutual expectations for communication content and frequency between providers at the outset. This CW Supervisor stated:

"… when the therapist is calling and saying, I've received this referral, I'm gonna call the foster parent and set up an initial intake. And when the social worker is able to have the conversation, you know, wonderful, what track are we looking at? I just want to let you know that I'm gonna be checking in periodically about treatment goals and progress and homework so that I can partner with you to address the needs that we've identified. Then it kind of lessens the feeling on the therapist's part about feeling checked up on or questioning what they're doing."

CW supervisors also encouraged their frontline providers to use communication with MH partners as opportunities to become more clinically attuned to their shared cases.

"And so when they have conversations with therapists or anyone involved with the kid, that they really think about things on a clinical level, so that those conversations don't have to be, well this is you know, me versus you. This is, alright, we're just having a clinical conversation about what's, you know, how do we help this kid or this family?"

That said, CW providers reported that it was sometimes difficult to get information about their client from the MH partner. According to one CW supervisor:

"One of my unit people had a therapist that just refused to provide any information about the kid. And it was in this model and was very difficult to communicate with. And didn't want to say, really what she was working [on], didn't want to say how the kid was doing. And we ended up having to switch, but you know, that protectiveness, I get it. But when we're trying to work on a partnership and understanding that it's about the kid and so that we can also be part of that, sometimes it's still a process."

Scheduling difficulties, turnover, as well as individual provider characteristics, often resulted in challenges with maintaining communication. In response, a tailored protocol was developed in collaboration with the PfS implementation team where providers utilized email and documentation to support communication and accountability, as well as contacting supervisors when partners remained unresponsive. As indicated by one MH supervisor:

"…the clinician would be calling to report something… and couldn't get ahold of the DSS worker and ended up having to call the supervisor. Which is something we talked about in [the PfS implementation team] meeting, that DSS made the suggestion that … if you call the worker twice and you can't get ahold of them, then call the supervisor. So that, I passed along to my staff and that actually seemed to be helpful because I guess the staff felt like they had some kind of recourse if they couldn't get hold of anybody."

As a result, the protocol empowered providers when encountering communication disruptions.

Relationships

PfS encouraged collaboration between CW and MH workers through the in-person cross-training and networking opportunities. Participants valued being able to understand the others' perspectives, which subsequently facilitated communication, referrals, treatment monitoring, and problem-solving. For example, according to this CW worker:

"I really enjoyed spending time with the therapists at the variety of agencies at the training… I loved being able to sit with them and hear about, okay, I know that this girl from this agency really enjoys working with these two …Or this girl, man, she has a lot of experience and she's been doing this for years with teenage girls. And man, she just really has passion about that. Or she's done all these trainings. She knows something really interesting and so having opportunities for us to just in general, have mental health training and awareness…I'm learning something about some sort of mental health issue and getting to know some of these therapists. And you know, for me, that's super helpful.

At times, however, PfS efforts were unsuccessful in producing a shared understanding of the partnership. Some CW workers reported having to educate PfS-trained MH providers on partnership activities, as reported by this CW Supervisor:

"And from a worker level, that's the feedback that I've gotten, that they spend a whole lot of time educating and not a whole lot of time receiving kind of good quality information that they can use. Whether it be for court or for whatever treatment planning needs to happen. They feel like right now it's a one sided relationship when obviously it doesn't have to be that way… And again, not across the board. Just in certain case examples."

While CW staff reported that MH partners were "more open to having that [treatment monitoring] conversation," they also recognized the potential for conflict. As a result, some CW staff adjusted their approach. According to this CW Supervisor:

"…especially for you know, a fairly new therapist in the field, it can definitely feel like the worker's being judged. You know, if DSS is calling and asking well, what's the progress and why isn't this being done or this and that?... so you know, trying to kind of, again, kind of take it from their point of view, it can definitely feel like that.... So we have to be sensitive to that, I think. And to have those conversations in a way that's positive."

Providers recognized the importance of being empathetic to each other's perspectives as relationships developed and evolved.

Roles

New roles emerged for CW and MH providers as part of the PfS initiative: CW staff now focused on identifying targeted

MH needs based on standardized assessments, as well as actively monitoring MH treatment quality. MH providers delivered CBT + and coordinated with CW providers on shared clients. According to participants, PfS implementation success often hinged on all parties understanding what was expected of them through the structure and process of partnership. While lack of clarity on each partner's role hindered implementation, this CW worker indicated what was helpful about role clarity:

> "The structure and the process, we're all pretty much following the same thing we know what's to be expected for the most part. And I guess that provides a little, some understanding and fluidity to the process since we're all aware of how it should work, I would say."

Participants also valued understanding partners' roles within their own agencies and through the CW court process. For example, this CW worker reported:

> "But actually getting to know these people, getting a face to the name, and explaining a little bit about foster care or about what does it mean that a child is under an order of protective supervision…And that was such an added benefit for me, personally."

As exemplified in the above quote, the importance of understanding partners' respective roles extended beyond PfS structure and processes.

However, some MH providers had negative reactions to these new roles, particularly when treatment monitoring by CW staff was perceived as a violation of existing boundaries. According to this MH clinician:

> "So even though increased contact is wonderful, that's great, but like, there are clear, defined roles for DSS and for therapists. And so I think it's important that everybody kind of stick to their role. … That you can't get too comfortable and start kind of telling a therapist what to say in front of a judge. I mean, that's not good."

Organizational Resources and Capacities

The following section examines additional factors identified by participants related to the resources and capacities within their organizations that impacted PfS implementation. Core ideas included available treatment modalities, opportunities to use PfS, turnover, and workload.

Available Treatment Modalities

The setting within which CBT + treatment could be provided impacted overall PfS implementation. Specifically,

the ability for MH therapists to provide in-home and off-site services often helped CW staff ensure that referrals were tailored to clients, as well as providing MH therapists greater flexibility to meet fidelity on the exposure components of CBT + treatment for anxiety and trauma. According to this MH supervisor:

> "…one of my supervisees, who had a client, whose target was anxiety, um, and she had been in … a bad car accident and was now afraid of cars and afraid to ride in a car. …The supervisee was able to take her through the relaxation calming, coping skills, and was, I think the thing that stands out the most was the exposure piece because she was able, because we do offsite therapy for the most part, she was able to do a lot of that in vivo exposure with her surrounding vehicles and just being near a vehicle at first and then getting into a vehicle and then riding in a vehicle."

However, the CBT + model emphasized caregiver involvement to support treatment progress. MH providers operating within the schools reported frequent challenges when attempting to engage caregivers. This MH clinician reported:

> "…I'm seeing their child at school, like things are going well, so parents are just assuming that all is well, there's nothing much that they need to do in order to also contribute to making improvements with the kid at home."

The physical context and location of MH treatment impacted the extent to which MH providers, for some treatment targets, could provide CBT + with fidelity, as well as the ability to engage caregivers in the CBT + treatment process.

Opportunities to use PfS

Implementation and sustainment benefitted when participants consistently used PfS processes and language, allowing new activities and strategies to become integrated into standard practice over time. As one CW supervisor reported:

> "Well, they [CW frontline staff] weren't happy about it. But I think you know, change is difficult in any aspect of life. And so then, to give them an additional piece of something put on to them, piece of work.... But as they've been doing it more and it becomes more habit, like I'm hearing them now starting to say, oh, I haven't done the PSC-17 yet. It's becoming more of a natural thing.... So I'm seeing, like I said, the upswing

of you know, us kind of pushing it initially and then becoming more natural at doing it."

Conversely, the inability to apply PfS processes and language consistently hindered integration. According to this CW supervisor:

"Yeah, you know, me having been through it [PfS Training] three times, I'm feeling like this time, things are finally starting to click for me, personally… I'm actually able to really pull from my brain, this intervention and that intervention and this homework and really talk with my staff about that. But it's taken a couple of years to really absorb that. Because that's not regular part of practice of this partnering."

As seen in this exemplar, those supervisors who felt they had not been able to use PfS daily reported difficulties absorbing and utilizing the information.

Turnover

Although a number of providers were initially trained, turnover, particularly in MH agencies, resulted in shortages of trained providers, as well as subsequent treatment referral lags and disruptions. As reported by this CW Supervisor:

"And I would say more so therapists and you know, our partners than DSS workers. Our staff tend to stay for some period of time. But therapists seem to, that turnover seems to be pretty high. And that's really difficult for kids, when they're right in the midst of something and, oops, got a new therapist or we gotta build rapport again. We gotta get to know 'em again. And we gotta learn to trust 'em again."

In addition to requiring more frequent training for newly hired employees, turnover also led to confusion about to whom to send client information during the referral process. This CW caseworker explained:

"And then, some places, when I sent the referral, I mean, there were times where like, it took me two or three days just to figure out who the right person was, because I didn't have updated forms about who the referral person was gonna be."

As reported in these exemplars, the capacity (or lack thereof) of MH agencies to retain their clinicians impacted the ability for referred youth to receive timely and consistent treatment.

Workload

The perceived burden of PfS activities added onto existing workloads created additional implementation barriers. CW workers reported that "crises" among families often hindered their ability to implement the PfS model with fidelity. As a result, workers reported falling behind on entering their notes, or skipping procedures, particularly when the extra work seemed duplicative. This CW worker indicated:

"Like, to me, it's completely crazy that someone would ask me to then make another log of all of my communication with a therapist. In addition to all of the work that I already do. And the fact that I have to document those in [state CW administrative data information system] so personally, I didn't do it, I didn't fill out the log. … Just like, little things like that, the actual kind of going through the Partnering for Success training part of it was for me, just a huge burden."

For MH providers, partnership building activities with CW workers as well as documentation in the EBP toolkit could be neglected as clinicians would not be paid for those services. According to one MH Supervisor:

"… at least in our agency, we're fee for service, so anytime that we're asking our clinicians to take out of their day to do things like this is unpaid time. And for them, money."

In this exemplar, the added challenge of their reimbursement structure often forced MH clinicians to choose which activities to complete, such that billable procedures (e.g., individual therapy) would be prioritized over non-billable ones (e.g., documentation).

Individual Participant and Client Level Features

Specific provider-level features that influence PfS implementation in this section focus on provider and caregiver buy-in and personal characteristics.

Buy-in

In this study, buy-in was manifested when workers would report being "excited" about the PfS model, or expressed belief in its efficacy and benefits to practice. Ultimately, providers who were both comfortable and willing to initiate the changes required by PfS were more likely to achieve successful implementation. As this CW Supervisor indicated:

"Like, if you believe in it, you're gonna use it. …So it's easier for me, because I believe in it, and I talk about it, and I kind of try to reinforce it. Like anything in life, if you… believe in it, you can push it, yeah."

Moreover, lack of buy-in hindered MH providers' motivation to use CBT+ with PfS clients. One MH supervisor commented:

"So there are clinicians who come into the training identifying themselves as CBT clinicians. …And so they're much more likely to use it consistently than somebody who comes in saying, you know, well I don't really like CBT or I don't believe CBT should be used in every case. You know, when you have a psychoanalytic clinician going to a CBT+ training, it's like, 'well, what am I even doing here?'"

Provider buy-in built over time and with PfS' increasing penetration within the organization. Initially, this meant "working through some of our own discomforts," with supervisors actively ensuring frontline provider were "sticking to the model". Over time, however, providers became "more natural at doing [PfS model activities]". According to this MH Supervisor:

"So I think it just really is a cultural, the more people you have who understand the program, who speak the language, who have had success, who are using it, the more likely somebody who doesn't want to use it, will use it."

For MH providers, caregiver buy-in also facilitated CBT + treatment adherence. According the MH clinician quote below:

"…I did have... a trauma case. So the grandmother, she was involved and when I would do exposure, I did psychoeducation about my exposure techniques with grandma and asked her if she could do things with my client when I'm not there. … And grandma would do the exposure and she would come report back….when I prepared for the trauma narrative sharing, she was very supportive and did not have an extreme reaction to it."

When MH providers were unable to engage caregivers in CBT + treatment, implementation ultimately suffered, especially in cases focused on child behavioral difficulties. For these cases, CBT + utilized behavioral parent management training strategies, which require caregiver commitment to changing parenting behavior. In this example, one MH supervisor described the challenges posed by limited caregiver buy-in:

"With the behavioral cases, you know, the clinician has to try very hard to engage the parent to make sure that the parent has buy-in for the program. And one of the most interesting complaints among clinicians has been that they'll sit with the parent in the session and either the parent is not engaged in the session, they're on their phone and they're not paying attention and they're doing a hundred other things at the time. Or if they are engaged in the session that they seem to be

understanding everything that the clinician is saying, but then there's no follow through … then the case just feels sort of hopeless in a way."

As demonstrated by these exemplars, buy-in from both provider and caregivers can be critical to PfS implementation success.

Personal Characteristics

According to a number of MH providers, caregiver personal characteristics (e.g., lack of follow through, high stress, MH issues and crises) frequently impeded the ability to progress through CBT + treatment. According to this MH clinician:

"We have parents who do lack patience and they get easily frustrated that they don't want to practice these techniques and do the positive one on one time, do the positive praise. Like, my one parent he said, 'oh my dad never gave me praise, so that's why it's hard for me to give praise.' And was like, 'my kid doesn't really do much good, so it's hard for me to give praise, because I didn't get that.'"

Provider characteristics also impacted PfS implementation. As reported by a CW supervisor, younger and less experienced caseworkers were often highly motivated to participate, in comparison to older caseworkers:

"Baby social workers [laughs] and so they're still you know, for lack of a better way of saying it, trying to save the world. And this is just a new resource for them. And it's very exciting. Like, they make me excited about it. And I'm an older social worker. So it's actually helped me to re-engage, … you tend to like go through the daily process of putting out fires and forgetting sometimes what it's about …so they're just newer and fresher.…"

As seen by these exemplars, variability in overall PfS implementation success often depended on stakeholders' (provider, caregiver) personal characteristics.

Discussion

This qualitative, exploratory study identified factors impacting the implementation of the Partnering for Success (PfS) initiative, a cross-system implementation effort designed to ensure children and youth involved in child welfare (CW) services received effective mental health (MH) treatment. Specifically, this study focused on the perspectives of CW and MH staff who participated in the PfS initiative within one jurisdiction over three consecutive

cohorts. Identified implementation determinants included planned components of the PfS initiative itself (i.e., training & consultation, supervision, tools, referrals, executive leadership activities, shared language, communication, relationships, and roles), organizational resources and capacity (i.e., available treatment modalities, opportunities to use PfS, turnover, and workload issues), as well as client and provider individual factors (i.e., buy-in, personal characteristics). Overall, a greater breadth of themes and core ideas were elicited from focus groups compared to individual interviews, although the interviewer (GG) did not note any substantial differences in interview quality. Discussion of this study's findings are organized by main thematic categories below, comparing findings to other cross-system efforts and noting when findings align with NIRN's implementation drivers.

PfS Partnership Features

Other cross-system implementation efforts have documented the benefits of training to increase providers' skills and knowledge (Chinitz et al., 2017; Hanson et al., 2018), the important of sufficient training saturation within an agency to promote provider buy-in and maximum EBT access (Bartlett et al., 2016; Hanson et al., 2019), and the need to tailor training iteratively to be responsive to provider needs (Akin et al., 2017). Similar to prior research (Bunger et al., 2019), participants in the current study emphasized the importance of supervision as a critical factor to promote frontline provider buy-in and fidelity to various aspects of the PfS model. PfS training, consultation, supervision activities reflect the key functions of NIRN's *Training* (e.g., increasing knowledge and skills) and *Coaching* (e.g., building on training to promote skills mastery) competency drivers (NIRN, n.d.). Our findings further emphasized the need for additional technical training around initiative-specific skills (e.g., trauma narrative).

A number of cross-system implementation efforts have also integrated technological and clinical tools to justify MH treatment referrals as well as promote cross-system implementation success (Akin et al., 2017, 2019; Collins-Camargo et al., 2019; Lang et al., 2017). The EBP toolkit, used by MH providers in the current study, provided an additional benefit of enhancing client and caregiver buy-in through the ability to visualize symptom progress over time, thereby promoting continued treatment adherence. Such findings also reflect the progress monitoring function of NIRN's *Decision Support Data Systems* driver (NIRN, n.d.).

Our findings emphasized the benefit of high-quality referrals between CW and MH providers, responsive leadership to resolve challenges in "real time", a shared language to make communications more efficient and build buy-in, active strategies to promote communication effectiveness,

role clarity, and effective working relationships ideally facilitated by face-to-face contact between CW and MH partners. These findings resonate with those of other cross-system implementation efforts (Akin et al., 2017, 2019; Bartlett et al., 2016; Fraser et al., 2014; Glisson & Hemmelgarn, 1998; Hanson et al., 2018, 2019; Verbist et al., 2020). Moreover, findings reflect key functions of NIRN's *Systems Intervention* (e.g., creating structures and procedures to facilitate partnership between systems) and *Leadership* (using technical and adaptive strategies to resolve problems) drivers (NIRN, n.d.).

Communication challenges between CW and MH systems impeding information sharing have also been documented in prior cross-system implementation efforts. Specifically, long-standing legal barriers were reported when navigating HIPAA (Health Insurance Portability and Accountability Act [HIPAA], United States, 2004) regulations and exchanging information across CW and MH service systems in efforts to implement trauma-informed practices (Akin et al., 2017; Hanson et al., 2019). Similarly, CW participants in the current study perceived reticence from MH providers to relay information on shared clients, which could have been due to concerns about violating HIPAA regulations.

Organizational Resources and Capacities

In line with prior cross-system implementation efforts, the current study demonstrated implementation challenges due to high workloads and turnover (Akin et al., 2017; Bartlett et al., 2016; Fraser et al., 2014; Glisson & Hemmelgarn, 1998; Lang et al., 2017). In particular, our study findings documented difficulties faced by MH providers when conducting cross-system implementation activities while also adhering to MH billing structures that only incentivized direct client contact. As seen in our study, MH providers were often faced with difficult choices about conducting PfS model activities that they could not bill for. This issue has also been reported in other cross-system efforts (Fraser et al., 2014). While frontline provider turnover emerged as an implementation barrier in our study, the data did not speak to turnover being an issue among administrators and other leaders, although this has been known to also hinder similar cross-system implementation efforts (e.g., Akin et al., 2017). The current study highlighted the importance of opportunities to use newly trained skills on the job to support implementation and sustainment. Such findings echo recommendations from transfer of training research, where post-training opportunities to utilize skills on the job are critical to successfully sustaining behavioral changes (Blume et al., 2019). Findings from this study also emphasized the importance of flexible

treatment modalities to support implementation success. MH providers who were able to provide treatment outside of the clinic were more able to implement the exposure-related treatment elements of CBT + . At the same time, school-based services struggled with parent engagement, which ultimately hindered implementation of treatment components requiring parental involvement. Other studies have also documented similar challenges with caregiver engagement in school-based MH services (e.g., Woodward et al., 2020), as parents do not have to be present for their child's treatment and may have conflictual relationships with school personnel. Addressing these organizational resources and capacities limitations would fall within the purview of NIRN's *Facilitative Administration* driver, which focuses on identifying and addressing barriers related to internal processes (NIRN, n.d.)

Individual Participant and Client Level Features

The influence of provider buy-in and client characteristics on implementation success has been noted within other cross-system implementation efforts (Akin et al., 2017, 2019; Chinitz et al., 2017; Hanson et al., 2018, 2019; Lang et al., 2017). PfS implementation benefitted when front-line providers believed in the model and were committed to its use, while lack of buy-in impeded implementation efforts. The current study highlighted the impact of providers' level of experience on implementation success, where motivation was greater with newer, less experienced providers who may have greater energy, less burnout, and limited pre-existing knowledge. Additionally, not all providers considered themselves theoretically aligned with CBT + practices, thus further hindering uptake and implementation success. Client crises and caregiver MH issues, common among families involved in CW services (Kemp et al., 2009), often impeded CBT + treatment adherence due to missed appointments, and in some cases, treatment dropout. The current study also highlighted the importance for client/caregiver buy-in, particularly for those treatment strategies, like behavioral parent training, that require significant parental involvement and behavior change. Treatment engagement difficulties with behavioral parent training are common for among families experiencing high levels of psychosocial stressors (Chacko et al., 2016), and suggest that additional caregiver supports may be needed. While identifying provider characteristics that can impact implementation is accounted for in NIRN's *Selection* driver (NIRN, n.d.), client characteristics are critical implementation determinants in other frameworks which focus on treatment adherence, such as the Practical Robust Implementation and Sustainability Model (PRISM; Feldstein & Glasgow, 2008). It may be worth considering ways to integrate the NIRN Implementation Drivers framework with other implementation models which explicitly address the role of client characteristics.

Implications for Practice

Given that individual provider characteristics (e.g., experience level, alignment with CBT practices) influenced implementation, findings suggest that a greater focus on the *Selection* driver may be warranted. Specifically, practice recommendations include targeting implementation activities with new (and relatively inexperienced) CW and MH staff to maximize implementation success. Conversely, experienced workers or those not already aligned with CBT + principles may require additional motivational enhancements to support implementation. Additional micro-level practice recommendations focus on alleviating treatment adherence challenges by providing additional supports (e.g., parent peer support partners; Wisdom et al., 2014) to caregivers when substantial parental involvement is required. Chronic issues of high worker turnover within agencies may require frequent and recurrent training opportunities built into implementation and sustainment planning in order to mitigate against the loss of trained workers. PfS implementation improvement efforts may also include partnering with MH providers with existing capacity for in-home services (particularly for clients requiring exposure strategies) and ensure sufficient practice opportunities to master complex CBT + components (e.g., trauma narrative). Finally, general micro-level practice recommendations include prioritizing CW and MH staff relationship development and role clarity, ideally through targeted face-to-face networking events.

At the mezzo practice level (i.e., focusing on client groups and practices between systems), specialty task groups within implementation teams may promote the ability for agencies to address some of the more challenging implementation issues (e.g., turnover leading to lack of CBT + trained MH providers). Findings from this study also suggest the need for further *Systems Intervention* activities centered on facilitating information exchange between MH and CW partners. Potential solutions include developing integrated data infrastructure across CW and MH systems, which have been successfully utilized in other cross-system implementation efforts (e.g., Collins-Camargo et al., 2019). Other technology-driven solutions, such as electronic "backpacks" (Daigneau, 2014), or digital repositories of health and MH records for CW-involved youth, may provide access to important information that could follow children to minimize MH treatment disruption incurred by placement instability.

Implications for Policy

Macro-level implications may entail the development of cross-system policies to ensure that CW and MH frontline practitioners are able to exchange relevant information about shared clients without fear of violating confidentiality. This may involve delineating circumstances when withholding information on shared clients may be appropriate, as well as reconciling existing HIPAA regulations (United States, 2004) with CW information requirements. Existing reimbursement structures for MH providers will also require modification to allow remuneration for cross-system collaboration activities (e.g., partnership calls, training, consultation calls). Given the level of investment, infrastructure, and intensive implementation activities needed for cross-system implementation, effective financing will also be key. Replicating PfS in other jurisdictions may benefit from federal waivers, which relax requirements that entire programs be tested in rigorous clinical trials and, instead, allow reimbursement for specific service activities and components that have been shown to be effective.

Findings from the current study may also have implications for the Family First Prevention Services Act of 2018 (H.R. 5456 (Family First)), which was designed to prevent foster care and congregate care placement. As many state plans include building comprehensive service arrays that span across MH and CW service systems, the core CW partnership practices developed in PfS (engage families, assess MH need, match to appropriate MH treatment, and track MH treatment progress) can support any EBT implementation within prevention programs, where CW workers often liaise with community-based providers to link families to services.

Implications for Research

Future research should focus on common issues that hinder implementation success in publicly funded human service settings (Aarons et al., 2011): high turnover and workload. While some evidence suggests that training in an EBT can reduce turnover (Aarons et al., 2009), it would be worth examining if similar findings result with CBT + and the overall PfS model. Exploration is also needed into strategies that increase workload efficiencies, reduce documentation burden, and align new initiatives with current workflows specific to CW and MH service contexts. Promising strategies include technology-based decision support tools that minimize paperwork burden in other cross-system efforts (e.g., Akin et al., 2019).

Limitations

Findings from this study are limited to a single jurisdiction, as well as those CW and MH staff volunteering to participate. It is possible that staff from different jurisdictions, as well as those we were unable to recruit, may have had different experiences than our current participants. Recall bias or memory loss may also have emerged through participants' retrospective accounts of PfS implementation. Findings reflect CW and MH staff perceptions elicited through inductive analyses, which may be subject to researcher bias and interpretation. This study is further limited to staff perceptions only, while views from caregivers and youth served through the PfS initiative would provide a more thorough understanding of factors impacting its implementation. Finally, a well-powered, methodologically rigorous quantitative study would be necessary.

to confirm causality among the factors identified in this study.

Conclusions

The Partnering for Success (PfS) capacity building initiative aimed to increase collaboration between CW and MH providers, improve access to evidence-based MH treatments, and improve MH outcomes for children and youth involved in the CW system. PfS reflects the values and hopes of long-standing system of care initiatives. However, with an evidence-informed treatment model as the core intervention, PfS holds unique promise in providing MH benefits for children and their families compared with prior efforts at systems' collaboration (e.g., Glisson & Hemmelgarn, 1998). Findings from the present study may be used to further improve upon PfS implementation and spawn future innovations in the ongoing challenge to improve CW and MH collaboration for society's most vulnerable children.

necessarily represent the official views of the Children's Bureau of the US Department of Health and Human Services.

Declarations

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent Informed Consent was obtained from all individual participants included in the study.

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