HHS Public Access

Author manuscript

Am J Community Psychol. Author manuscript; available in PMC 2020 June 01.

Published in final edited form as:

Am J Community Psychol. 2019 June ; 63(3-4): 366–377. doi:10.1002/ajcp.12309.

Perceptions among child welfare staff when modifying a child mental health intervention to be implemented in child welfare services

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Abstract

In order to increase access to child mental health evidence-based interventions (EBIs) for vulnerable and hard-to-engage families involved in the child welfare (CW) system, innovative approaches coupled with input from service providers are needed. One potential solution involves utilizing task-shifting strategies and implementation science theoretical frameworks to implement such EBIs in CW settings. This study examined perceptions among CW staff who were members of a collaborative advisory board involved in the implementation of the 4Rs and 2Ss Strengthening Families Program (4R2S) in CW placement prevention settings, utilizing task-shifting strategies and the Practical, Robust, Implementation, and Sustainability Model. Advisory board members reported difficulties engaging families, heavy workloads, and conflicting implementation initiatives. While 4R2S was perceived as generally aligned with their organization's mission, modifications to the intervention and to agency procedures were recommended to promote implementation success. Suggested modifications to the existing 4R2S training and supervision are discussed. Findings underscore the importance of understanding the experiences of CW service providers, which can inform future efforts to implement child mental health EBIs in CW services.

Keywords

Child Welfare; Child Mental Health; 4R2S; Multiple Family Groups; Task-shifting; PRISM; Implementation

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Compliance with Ethical Standards: The authors of this manuscript have complied with APA ethical principles in their treatment of individuals participating in the research, program, or policy described in the manuscript. The research has been approved by University of Maryland, Baltimore Human Research Protections Office.

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

Background

Despite high rates of behavioral difficulties (e.g., oppositional, aggressive, disruptive behavior; Hinshaw & Lee, 2002) among children involved in child welfare (CW) services, service utilization, particularly among those youth who remain at home with their families, remains poor (ACF, 2005; Burns et al., 2004). Limited availability of qualified providers (Asen, 2002) is a frequent barrier. Given that child behavioral difficulties are significant risk factors for future maltreatment (Barth, 2009), innovative ways to increase access to and utilization of effective evidence-based interventions (EBIs) for such families are needed.

Emerging service delivery innovations to increase access and utilization in areas with limited professional workforce capacity often involve the use of lay, indigenous, or community health workers to provide effective health and behavioral health services (Barnett, Gonzalez, Miranda, Chavira, & Lau, 2018; Bhutta, Lassi, Pariyo, & Huicho, 2010; Patel, Chowdhary, Rahman, & Verdeli, 2011). Services are provided by individuals who are typically members of the communities they serve or already employed in existing low-resource settings, yet lack formal specialized health or behavioral health training. In the United States and the developing world, services provided by this workforce have resulted in significant improvements in health and behavioral health outcomes (Barnett et al., 2018; Bhutta et al., 2010).

Such outcomes have been primarily achieved through the process of task-shifting, which provides practical and cost-efficient strategies for facilitating EBI implementation where there are shortages of trained specialized professionals (WHO, 2008). Successful task-shifting models in behavioral health service delivery emphasize: (1) modifying the EBI for non-specialized/indigenous providers, (2) training those providers, and (3) establishing regular supervision and monitoring of non-specialized providers by behavioral health clinicians (e.g., Patel et al., 2011; Verdeli et al., 2003). To date, task-shifting efforts have successfully reduced behavioral health symptoms in children and adults (Barnett et al., 2017; Patel et al., 2011). In the case of families involved with CW services, behavioral health service access and utilization could be improved by relocating effective treatments to community-based organizations (CBOs) already providing services to reduce maltreatment risk. This would involve task-shifting child behavioral health EBIs to be delivered by existing CBO providers, namely CW caseworkers, who typically lack advanced specialized behavioral health training (Aarons, Fettes, Sommerfeld, & Palinkas, 2012).

Although a number of evidenced-based interventions exist to reduce child behavioral difficulties, which hold promise in reducing maltreatment risk (e.g., Chaffin et al., 2004), few such EBIs have been successfully implemented in CW contexts (Aarons, Fettes, et al., 2009). The extant literature on EBI implementation efforts in CW contexts has documented the system-wide implementation of casework, clinical supervision, and family-centered practice models (Barbee et al., 2011; Collins-Camargo & Millar, 2012; Kaye, Depanfilis, Bright, & Fisher, 2012; Michaelopoulos, Ahn, Shaw, & O'Connor, 2012) as well as more constrained implementation of treatment models addressing family and youth socio-emotional difficulties (Akin et al., 2014; Akin et al., 2015; Akin et al., 2016; Kaye et al. 2012; Maher et al., 2009). These efforts have reported a number of significant barriers to

implementation in CW contexts. Workers tend to have large caseloads, multiple responsibilities, and few available avenues for sharing knowledge (Aarons et al., 2011; Collins-Camargo & Millar, 2012; Michaelopoulos et al., 2012). Limited funds in CW services frequently hinder efforts to provide additional training, supervision, and other supports required by the given EBI (Michalopoulos et al., 2012). Finally, EBIs developed initially for use in behavioral health settings may require modifications based on staff roles/responsibilities, consumer characteristics, regulatory and fiscal requirements, and organizational readiness of the new setting (McKleroy et al., 2006).

That said, a growing body of literature indicates that successful behavioral health EBI implementation can be facilitated through the use of ongoing consultation with EBI experts following initial training (Beidas, Edmunds, Marcus, & Kendall, 2012), which aligns with the task-shifting stage of supervision and monitoring of non-specialist providers by behavioral health clinicians. Consultation gives providers opportunities to clarify questions, learn and practice new concepts, consult on specific cases, and problem-solve around implementation barriers. Consultation has been shown to promote provider behavior change and adherence to EBI fidelity (Beidas et al., 2012), and is viewed by CW staff as an important means to support EBI implementation (Akin et al., 2016).

Consequently, the perspectives of CW staff when planning to implement EBIs in CW services are particularly important. As street-level bureaucrats (Lipsky, 1980), CW staff frequently exercise immense discretion over how policies are enacted into practice. When work conditions hinder the ability to conform to best practice ideals, front-line workers play a critical role in the extent to which new evidence-based practices are ultimately delivered as intended (Smith & Donovan, 2003). As such, implementation success relies on the ability and willingness of front-line providers to change their practices (Aarons & Palinkas, 2007; Feldstein & Glasgow, 2008). Furthermore, such changes require support from multiple levels within the organization, including supervisors and agency administrators responsible for allocating appropriate resources, ensuring reasonable workloads, promoting safe “trial and learn” climates, and promoting effective communication throughout the organization (Akin et al., 2014).

Current study

The current paper focuses on the first phase of a larger study, which examined the feasibility and acceptability of implementing a child behavioral health EBI in the CW context utilizing task-shifting strategies. Specifically, the first phase solicited feedback from key stakeholders (CW staff, parents) about how an EBI created for behavioral health settings would need to be modified in order for it to be successfully implemented in the CW context. Thus, the current paper focuses on the task-shifting strategy of EBI modification as a first step in a larger implementation process – setting the foundation for task-shifting strategies involving training and supervision to be conducted in the subsequent pilot-testing phase of the study. To our knowledge, this study is the first attempt to utilize task-shifting to bridge child behavioral health and child welfare services in the United States.

We also utilized the Practical, Robust, Implementation, and Sustainability Model (PRISM; Feldstein & Glasgow, 2008) to further guide modification efforts. PRISM is an

implementation determinants framework (Nilsen, 2015) that articulates key domains to support the successful uptake of new practices (Feldstein & Glasgow, 2008). PRISM suggests that four key domains influence adoption: intervention perspectives, recipient characteristics, implementation and sustainability infrastructure, and external environment. Intervention perspectives include the views and attitudes taken towards the intervention across all ecological levels of the organization (e.g. leaders, managers, staff, etc.) and consumers. Similarly, recipient characteristics include both the characteristics of the members within the organization and consumers. Finally, organizations and consumers are influenced by and influence the implementation and sustainability infrastructure, as well as demands from the external environment (e.g., courts, regional CW authorities). PRISM fits the aims of the current study given its emphases on how members of an organization perceive a particular intervention to be implemented and how existing organizational characteristics could impact implementation. To our knowledge, this is the first study to document the use of PRISM to guide implementation efforts in CW services.

The specific evidence-based intervention (EBI) we utilized was the *4Rs and 2Ss for Strengthening Families* Program (4R2S; see Chacko et al., 2015 and Gopalan et al., 2015 for more complete descriptions of the 4R2S program), a multiple-family, group-based behavioral training program held for parents over the course of 16 weekly sessions. 4R2S emphasizes four family-level processes for treating child behavior difficulties (rules, responsibilities, relationships, and respectful communication), and two factors impacting behavioral health service engagement and outcomes (stress and social support; Kazdin, 1995; Kazdin & Whitley, 2003; Wahler & Dumas, 1989). Core intervention components prioritize family engagement in child behavioral health treatment, as well as behavioral parent training and family therapy strategies that address empirically-supported family-level influences on disruptive behavior disorders (Chorpita & Daleiden, 2009; Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008).

To our knowledge, few if any studies have documented the perspectives of CW staff prior to the implementation of an EBI. Understanding providers' perspectives of the implementation context can facilitate proactive planning around barriers, and can help identify those factors which could be leveraged to facilitate implementation success. The current paper focuses exclusively on how *CW staff* perceive the 4R2S modifications required to ensure caseworkers' successful implementation of this EBI in placement prevention services. The depth of information may be particularly useful for administrators when considering implementing EBIs into their programs. A separate, planned paper will provide a complementary focus on *parent perspectives* of these modification efforts. Consequently, the current paper addresses the following objectives:

(1) Identify CW staff perspectives of the potential facilitators and barriers to implementing the 4R2S in CW placement prevention services, based on their existing characteristics and their understanding of the 4R2S intervention.

(2) Based on CW staff perspectives, identify potential 4R2S modifications or strategies to overcome implementation barriers.

Method

Research Design

The current study reports findings from the first phase of a two-phase study. In this first phase, Collaborative Advisory Board (CAB) members were recruited in order to (1) inform how to modify the 4R2S curriculum for caseworkers to deliver, (2) recommend agency-level changes to facilitate successful implementation, (3) inform the development of a training and supervision protocol for caseworkers, and (4) provide feedback on research materials (e.g. recruitment materials, consent documents, surveys, focus group questions, etc.). Information from this first phase informed the second phase involving pilot testing the modified 4R2S in CW services for feasibility and acceptability. As we were most interested in understanding CAB member perspectives and recommendations based on conversations, interactions, and products within the CAB process itself, a qualitative methodology utilizing ethnographic observation (Emerson, Fretz, & Shaw, 2011) and document analysis (Bowen, 2009) was chosen to address research questions from this first phase of the larger study.

Participants

The research team formed a CAB in the Summer of 2014, comprised of casework staff (n=2), supervisory staff (n=2), an administrator (n=1) from a CW CBO (referred to as “CW CAB members”; n = 5) and parent advocates (n=3) The parent advocates, in addition to being affiliated with a parent advocacy CBO, also had personal experiences of child-welfare involvement. As such, they were able to speak about their perspectives as former clients as well (Please note that for the purposes of this manuscript, parent advocates perceptions were not included and will be presented in a subsequent planned paper). Additional CAB members included four research staff with expertise in the 4R2S intervention, for a total of n=12 CAB members. Three of the research staff are co-authors on this paper (GG, CH, TS), and have multiple years of experiences working with CW services. CW CAB members were female, with ages ranging from 25–65 years old. CW CAB members reported having at least 5 years’ experience in the CW field, with 40% (n = 2) reporting more than 10 years. They identified as 20% White/Caucasian (n=1), 40% Black/African American (n=2), and 40% Latina/Hispanic (n = 2). All CW CAB members held bachelor’s degrees, and 40% (n = 2) held advanced graduate degrees.

Procedure

The study utilized different processes for ensuring rigor. Specifically, the use of prolonged engagement – with seven meetings spanning the course of six months – allowed participants to build the trust deemed essential for the production of “rich and thick data” (Morse, 2015, pg. 21). CAB sessions took place on Saturday mornings for 4 hours at a time at a university-based research and policy center in New York City. Research staff planned meetings, prepared session materials and feedback worksheets, facilitated discussions, simulated portions of the intervention, and made modifications to the intervention based on CAB discussions. CW CAB members received round-trip subway vouchers, breakfast/lunch, onsite childcare, and a $20 gift card for their participation at each meeting. CAB sessions were guided by the task-shifting framework and the PRISM domains of interest (organizational and consumer recipient perspectives of the intervention; organizational and

consumer recipient characteristics; and external environmental factors), and were focused on: orientation and cohesion building; 4R2S modification; training and supervision; and implementation considerations. Between meetings, CAB members completed feedback worksheets concerning the most recent session (sample question: *Did the activities seem relevant and useful to families?*). These worksheets captured CW staff feedback and their recommended adaptations to 4R2S, informed by relevant PRISM domains (e.g., organizational perspectives of the intervention). Subsequent CAB meetings solicited feedback about the development of training and supervision protocols, as well as implementation considerations (sample question: *Are there any issues or concerns with the intervention that would put the organization at legal or regulatory risk?*). The researchers used key questions recommended by Feldstein & Glasgow (2008) within each PRISM domain. In the final meeting, CAB members provided feedback on research materials to be used during the second pilot-test phase (e.g., consent documents, recruitment materials, surveys, interview/focus group questions).

Measures

Non-participating note-takers (n=3), who were neither members of the standing research team nor co-authors for the current paper, observed all CAB meetings and captured data through field notes. Note-takers were first-year graduate students who received six hours of training on ethnographic observational methods and field note writing (Emerson et al., 2011; Wolfinger, 2002) prior to starting on the study. Note-takers were instructed to document feedback, information, and suggestions, as well as the processes, dynamics, and interactions among all CAB members including the participating research staff during meetings. In addition, note-takers completed structured observation guides that organized data under pre-specified headings based on PRISM domains and elements (Dewalt & Dewalt, 2002; Emerson et al., 2001). Following each CAB meeting, note-takers submitted their raw written notes and observation guides in digital word processing files to research staff. These documents were reviewed by research staff who attended the CAB sessions. The note-takers met with a member of the research team after each of their first two meetings to process their experiences, in an attempt to increase note-taker reflexivity as well as reduce the potential for bias in the note-taking process. All field notes, observation guides, session feedback, pictures of notes taken on newsprint, and relevant email communication between research staff, Institutional Review Boards, and the local CW authorities became the data sources for the current paper's analysis. In total n=106 documents/artifacts were analyzed.

Analysis

Rigor was infused throughout the analytic process starting with the use of both a directive method and grounded theory strategies to analyze the data (Barbour, 2001; Hsieh & Shannon, 2005; Onwuegbuzie, Dickinson; Leech, & Zoran, 2009). *A priori* codes based on the aforementioned PRISM domains guided the initial reading of the data, while coders remained alert to the emergence of additional content that was subsequently coded. Both sets of codes were combined to produce the initial codebook.

The volume of data necessitated using data management tools to both organize and assist in analysis. First, Microsoft Excel was used for the iterative, check-coding process (Miles &

Huberman, 1994). Two research staff coded small sections of the data, allowing them to track their percentage of inter-rater agreement over time, and engaged in discussions with the first author (GG) to resolve discrepancies and refine the codebook as needed. The check-coding process ended once coders reached 90% inter-rater reliability. While adhering to standards of rigor in qualitative analysis, the process also fostered a deep understanding of the data through discussion of discrepancies (Barbour, 2001). All data sources and the codebook were then uploaded to Dedoose Version 7.0.23 for coding.

Documents were distributed equally between two coders to be coded independently. Then, 20% (n=21) of the documents were randomly selected for dual-coding, resulting in a final inter-rater reliability score of 89.66%. Analysis then proceeded to axial coding, with consolidation of codes into broader units of meaning according to similarities, and elimination of redundancies across data sources (Strauss & Corbin, 1990).

Results

Analysis of the coded documents focused on eight themes organized into three main categories: Existing characteristics of the child welfare (CW) agency and context; CW CAB members perspectives of the intervention; and suggested modifications. Due to the mixed nature of the data sources used, quotations here indicate participants' words verbatim as well as note-takers' summarized perspectives. At times, note-takers were able to record the emotional valence of participant responses, which might otherwise be lost if using participants' verbatim quotations alone. The multiple sources of data used in this study constitute one of its primary strengths, as the viewpoints of various stakeholders and observers were leveraged to modify the 4R2S intervention.

Existing characteristics of the child welfare agency context

This category included family engagement and workload concerns particular to the CW agencies and contexts adopting evidence-based interventions (EBIs).

Family engagement.—CW CAB members expressed a strong desire and motivation to help families, while acknowledging that a variety of factors can interfere with the execution of such support. One note-taker captured this sentiment from a CW CAB member, documenting her, ."... passion to improve quality of life for clients, and that although she cannot help everyone, if she can help one family she feels successful." While CW CAB members indicated that caseworkers were interested in gaining more clinical skills to support their work with families, they acknowledged that certain CW staff characteristics would influence a family's willingness and ability to engage in services. In particular, caseworkers' ability to navigate their dual role of helper and mandated reporter can alter how they are perceived by parents and can limit how much parents feel they can share without incurring repercussions. According to one CW CAB member, "the mandated reporter element is tough, and facilitators just have to be upfront about it."

CAB discussions also focused on the need for caseworkers to be conscious of parents' prior negative experiences with service providers and how these experiences may impact parents' willingness to engage. Underscoring the pervasiveness of this problem, note-takers observed

a caseworker and a parent advocate articulating almost in unison that, “you are lucky if you get someone who is nice to you.” Another note-taker summarized a CW CAB member’s concern “that new caseworkers are often judgmental and hold a lot of stereotypes [about families].” CW CAB members also expressed concerns that newer, younger caseworkers had limited credibility with parents as many caseworkers have never parented themselves.

Workload realities and concerns.—CW CAB members uniformly expressed that large workloads, demanding paperwork expectations, and the emotionally draining nature of the work all combined to take a toll among CW staff. One caseworker noted, “caseworkers cannot take vacation without having to double up on their home visits.” CW CAB members described expectations that they achieve dramatic changes within families over short periods of time. As a result of this high-stakes expectation with a quick turnaround, caseworkers described frustration when clients failed to show progress. One caseworker highlighted the inherent struggle in their work with families experiencing multiple stressors, saying, “we can give so many opportunity[ies] and chances but clients often do not meet expectations.” Burnout and high turnover rates were cited as consequences of work pressures. However, nested within their frustration was an element of realism tinged with hope. As one supervisor stated, “We don’t fix everything, but we are helping.”

CW CAB Members’ perspectives of the 4R2S

This category reflected CW CAB members’ perspectives on the 4R2S components, and their perspectives on the 4R2S in the context of other EBIs.

CW CAB Members’ Perspectives on the 4S2S Components. *Areas of alignment and misalignment.—*CW CAB members identified several areas where the 4R2S intervention aligned with their agencies’ mission statements, existing strength-based practice values, and the day-to-day execution of their duties. For instance, as noted by one note-taker, several CW CAB members appeared “Receptive to and enthusiastic about the [4R2S] curriculum and the broader values that underlie it.” CW CAB members were generally “On board with the strengths-based, client-centered approach exemplified with this intervention.” Among the most valued aspects of 4R2S were its recognition of positive behavior in children, teaching empathy and respectful communication, and valuing parent choice rather than forcing families to participate as part of their CW service mandate. CW CAB members also liked the manualized, step-by-step approach to the 4R2S curriculum.

With regard to individual sessions and activities, CW CAB members provided a mixture of positive and negative feedback. For example, one caseworker stated that she had “observed [that] some of the intervention could be done in the home and could be tailored for home visits. In fact, I have already begun using some techniques from the [4R2S] intervention in my home visits, and one client in particular is loving it.” The groupwork modality was perceived to be an efficient way to complete casework contact requirements. At the same time, CW CAB members provided critical feedback on certain activities. For example, one note-taker recognized that “one administrator stated she did not like the toolbox images, and other board members appeared to agree with her opinion. Not everyone relates to the images of tools.” Other CW CAB members emphasized the need for more experiential activities so

that families could practice some of the concepts in real-time. Finally, CW CAB members were overwhelmingly opposed to the length of the 4R2S, with administrators and supervisors indicating that "16 weeks is too long, and the intervention should be truncated to 8 sessions over the course of 2 months."

Can the 4R2S respond to cultural factors and families' stresses?—CW CAB members were also attuned to the life demands placed on families and resulting concerns that may arise. For example, CW CAB members questioned whether families would be able to follow through with the entire intervention. They also wanted to ensure that clients had choices regarding how their treatment could be enhanced. Other concerns focused on whether families would buy in to all 4R2S concepts. For example, CW CAB members suggested that culturally-defined values around parenting may affect how or whether parents accept the 4R2S concept of children providing input on family decision-making. CW CAB members also indicated that it is often difficult to get families to identify their strengths. Many questioned how the 4R2S would address the high levels of domestic violence they observed among their cases. As a result, at least one CW CAB member was skeptical that the 4R2S would help her clients.

Implementing 4R2S alongside other EBIs.—Although CW CAB members had positive opinions about 4R2S, they had strong reservations regarding the feasibility of executing the program. One CW CAB member stated "it would not be possible to implement [the 4R2S] intervention alongside pre-existing...interventions used by [my] agency." CW CAB members indicated that specific funding priorities, which were tied to the existing EBI, posed a barrier. Current funding streams financially supported existing staff, yet no such funds were available to implement the 4R2S. As one administrator expressed, implementing 4R2S in tandem with an existing EBI, "might be possible if the agency gets a grant" to hire additional staff in order to meet both existing work expectations and the anticipated work associated with the 4R2S.

Not enough time.—CW CAB members felt that their current caseload expectations would not permit enough space/time to engage families using the 4R2S. The pervasiveness of this sentiment among CW CAB members was reflected by one of the note-takers: "Caseworkers raised the point that some clients might be more appropriate [for 4R2S], or might prefer [4R2S] to [current EBI], and some caseworkers might feel more effective in a group setting and might also prefer [4R2S] to [other EBI]. Caseworkers and Supervisors seemed to agree that there is not time or room in a given workday to implement [4R2S] on top of [EBI], and that doing so would only be feasible if there were some sort of exchange."

Potentially conflicting priorities.—There was a general sense in the group that it would be difficult to complete existing tasks on top of the 4R2S requirements. For example, the existing EBI required safety/risk assessments, and many CW CAB members questioned how that would fit with the 4R2S, which did not require such assessments. Other concerns involved managing logistics around determining eligibility, making referrals, and delivering both services. One CW CAB member reported, "regardless of the support provided by the research team, there will still be paperwork and notes requirements for the agency." CW

CAB members felt overwhelmed and overworked after just learning how to implement the existing EBI. As one CW CAB member summarized, “the major concern was feasibility due to workload and a lack of direct staff support.”

Suggested modifications

This category captures suggestions for modifications to the 4R2S curriculum, caseworker workload, and 4R2S training and supervision (See Table 1).

Modifications to 4R2S curriculum.—In response to CW CAB members’ concerns about the intervention length, research staff entered discussions with the 4R2S developer and proposed reductions to nine core sessions covering introductions, all 4Rs and 2Ss core constructs, and termination. Four sessions were included to be used as needed. The researchers also proposed modifications addressing CAB critiques of curriculum activities and modalities (e.g., adding word choices, changing imagery). As documented by one note-taker, “Group members, including caseworkers and parent advocates, appeared to show support for a supplementary home visit guide to accompany the intervention, as home visits would cut down on time spent in the agency office.” As a result, each session included instructions for conducting home visit sessions, if needed. Given concerns CW CAB members raised about parents rejecting 4R2S concepts that may conflict with culturally-defined parenting values, each session was amended to include “Old School meets New School” vignettes. These vignettes described parents’ values regarding how they were raised, as well as how they were open to newer, more helpful parenting strategies. Given concerns raised regarding family engagement, CW CAB members suggested being transparent with parents about caseworkers’ mandated reporting role, as well as the limitations of 4R2S to address co-occurring family issues (e.g., domestic violence).

Caseworker Workload.—The current study provided financial incentives for CW staff during the second phase pilot testing, which were strongly endorsed by CW CAB members as a way to encourage participation by caseworkers. Given CW CAB members’ concerns about potentially increased workloads, they felt that getting buy-in from caseworkers would be critical. A note-taker summarized caseworker and supervisor ideas on how best to market the intervention: “Market [4R2S] to caseworkers as an opportunity to enhance clinical skills, and sdecrease family crises. Also, frame [the] intervention as coming with built-in support, emphasize that the intervention will help workers to build additional clinical skills.”

To address administrative demands for productivity as well as the value caseworkers placed on quality practice with families, supervisors suggested reducing caseloads for caseworkers delivering the 4R2S. This suggestion mitigated caseworkers’ concerns that adopting 4R2S would potentially involve sacrificing time they needed to devote to their existing case families. A note-taker summarized: “Caseworkers anticipate that staff will buy into the [4R2S] intervention because group work requires less individualized effort/home visits. Lowering [the] number of required home visits by having two [4R2S] sessions per month lessens [the] burden on agency staff to complete home visits.”

CW CAB members also believed a progress note template may help to ensure that documentation standards and timelines are met. One caseworker asserted: “Frontline staff

can feel overwhelmed by paperwork. To minimize that burden, notes should be short, to the point, and concise." Suggestions included briefly summarizing topics covered per family as well as content of group discussion.

4R2S Training and Supervision.—CW CAB members expressed a desire for training in the 4R2S intervention, group work skills, and ongoing support post-training. They preferred training delivered by "someone well versed" in the intervention, as well as ongoing guidance through outside consultation by "someone who created the program/is very familiar with the program." As reported by a CW CAB member, "[it] is important for support beyond that of a direct agency supervisor. This outside supervision needs to be constant." One note-taker documented suggestions for external 4R2S supervision to support implementation and promote model fidelity: "Caseworkers suggested that a tool [could] be created [and] incorporated into supervision to guide discussion surrounding the intervention. Such a tool would uphold fidelity to the intervention and would give both practitioners and supervisors a sense of how the intervention is going. Additionally, there would be a relief of caseworkers to complete extensive paperwork before supervision because the tool could provide a list of things to focus on during supervision."

As the CAB meetings progressed, further clarification regarding the scope of external supervision was elucidated. A note-taker summarized CW CAB members' suggestions that "the role of the [external supervisor] will be in relation to [4R2S] only and thus, there need to be clear rules as to what's appropriate with [4R2S] calls and what's for regular [internal CW] supervision." Concerns also arose about what to do if crises emerged during group work, which led to productive discussions on crisis management. A note-taker summarized a CW CAB member's suggestion that, "[The 4R2S Supervisor] should be alerted to signs of potential crisis, and advise caseworkers when immediate referrals to formal [behavioral] health intervention are required."

CW CAB members also recommended training caseworkers on child development and parent behavioral health issues in addition to 4R2S-specific content. A caseworker expressed that, "training on development was needed, with specific focus on 7 to 11-year-olds in terms of where they're at cognitively, what behaviors to expect, and what the impact of trauma might be." Another CW CAB member also suggested that "it might be worthwhile to train caseworkers to be able to speak with parents about what to expect as [the] child gets older as well." This was perceived as helpful because these families may have older children at home, and having that developmental knowledge could help parents adapt and apply 4R2S principles as children age. Caseworkers felt they would need training on managing parental behavioral health issues.

Additional recommended training topics included engagement with parents, cultural sensitivity, and trauma-informed care. CAB discussions frequently focused on parenting practices, expectations, and norms connected to culture. Furthermore, the potential impact of families' prior traumatic experiences on their perceptions of 4R2S was acknowledged, and guidance was requested on addressing such issues. For new caseworkers, who may arrive with pre-established negative biases towards parents, CW CAB members recommended "caseworkers should be trained in communication with their clients." More specifically, this

training would instruct workers to "..talk with people, not at them" and to acknowledge that "respectful communication at all levels is important. It's important parents have a voice and are heard when expressing concerns." This training would also equip workers with skills to communicate "in a style and language families could comprehend," and would be based on the assumption that "clients are experts on their own children." In order to ensure the parent perspective was conveyed to caseworkers, one suggestion included having caseworkers trained by both a 4R2S expert as well as a parent consumer of CW and child behavioral health services.

Discussion

The current study explored CW CAB members' perceptions of the 4R2S intervention in CW placement services, particularly when tasked with identifying barriers and potential modifications to support implementation of the intervention in their specific agency settings. This study adds to the literature on task-shifting, by demonstrating how a preliminary focus on EBI modification guided by PRISM domains identified specific needs for subsequent task-shifting strategies of training and supervision. Planned future papers will focus on the feasibility and acceptability of the modified 4R2S eventually implemented in a different CW organization and jurisdiction.

Consistent with findings from the Akin et al. (2016) study, our results indicate that CW staff view ongoing consultation (or supervision) following initial EBI training as critical to implementation success. Their preferred implementation strategy – a combination of expert training, ongoing consultation, and technical assistance – aligns with other recommended techniques such as the external facilitation implementation strategy (Kirchner et al., 2014). Ideally, this strategy engages both an external expert to provide training and consultation, and an internal facilitator who supports various implementation activities bolstering provider buy-in (Kirchner et al., 2014).

High workload and limited pre-existing knowledge emerged as perceived implementation barriers, corresponding with the existing literature on prior CW implementation efforts (e.g., Aarons et al., 2011; Akin et al., 2016; Collins-Camargo et al., 2012; Michaelopolous et al., 2012). Also consistent with prior literature, CW CAB members generally experienced the introduction of new practices as complicating existing workflows and increasing their workload (Akin et al., 2016).

The tendency for newer workers to be harsh in their assessments of parents, when compared to more seasoned workers was also consistent with prior research. This highlighted prevailing CW practice views of parents as the source of problems, with limited importance placed on motivating parents towards change (Lalayants, 2013; Smith, 2008). Despite the desire to help families become more stable, CW CAB members remarked that many new caseworkers have never parented children themselves, and, are often not equipped with the skills needed to engage families struggling with intergenerational trauma, poverty, and marginalization. Moreover, CW staff themselves frequently faced external pressures prioritizing parent compliance (e.g., court mandates) and, as noted in the results, "quick turnaround expectations" which may not be realistic for parents struggling with multiple

psychosocial stressors (Stephens et al., 2018). That said, caseworkers' desire to enhance their clinical skills, as revealed in this study, speak to a potential leverage point with which to gain caseworker buy-in. This mirrors findings from prior CW implementation demonstrating the value CW staff place on increasing and strengthening their clinical skills (Akin et al., 2016; Collins-Camargo et al., 2012).

Practice recommendations.

Practice recommendations identify the importance of staff selection as well as training and preparation. Caseworker biases can limit their ability to effectively engage CW-involved families, which can subsequently increase caseworker stress and lower self-efficacy, eventually contributing to higher turnover rates (Chen & Scannapieco, 2010). Consequently, practice recommendations include careful staff selection for EBI facilitation, paying attention to those characteristics that are supportive of implementation efforts (Akin et al., 2016). Once selected, supports for staff may include the introduction of self-reflection exercises uncovering biases and negative stereotypes as well as providing more education on child development and parent behavioral health issues. Such additional training would be salient not only to child behavioral health EBIs, but also inform existing CW practice with families. These supports can assist novice caseworkers in obtaining skills typically garnered through graduate level education and/or the wisdom of practice experience (Barth, Lloyd, Christ, Chapman & Dickinson, 2008).

Specifically, education on trauma-informed practice approaches (Freeman, 2001; Harris & Fallot, 2001) may sensitize CW staff to the pervasiveness and impact of intergenerational trauma among CW-involved families. Training in collaborative, non-confrontational practice strategies (e.g., Motivational Interviewing; Miller & Rollnick, 2002) can provide skills which promote respectful communication keenly desired by CW-involved families (Kemp et al., 2009). Such a re-imagination of the CW staff-parent relationship requires a paradigm shift from traditional compliance-based CW practice towards strategies designed to engage families and prioritize sustainable changes within family interactions and systems (Stephens et al., 2018).

Transparency with parents regarding caseworkers' mandated reporting status was strongly recommended within the modified 4R2S curriculum. Mandated reporting remains a substantial engagement barrier for any provider working with CW-involved families. Other CW implementation efforts have struggled with the innate tension between engaging families with high needs and mandated reporting requirements (Akin et al., 2016; Michaelopolous et al., 2012). Specifically, parents are fearful that any disclosure to CW staff may result in the removal of their child or extend foster care stays (Gopalan, Fuss, & Wisdom, 2015). Innovative practice solutions to counteract this fear have included the use of parent *advocates* (e.g., parents with prior CW experience; Lalayants, 2013) as adjunctive supports for parents within CW services. Parent advocates are viewed by many parents as allies and less threatening than caseworkers. Their presence within CW response teams offers parents an additional resource in times of hardship or crisis.

Caseworkers, who operate at the interface of a complex and highly tiered system, have limited organizational power, as they are subject to external demands for documentation on

their interactions with parents, service plans, and other materials relevant for court proceedings. Factors related to workflow and workload have an association between the workers experience of their job and later decisions to stay or leave (Benton, 2016). Consequently, attention to promoting workflow efficiency in CW practice and using existing data structures could reduce the workflow/workload strain, and potentially, turnover. Tools like supervision checklists, manuals, and documentation templates with drop-down menus (where appropriate) could reduce the amount of time spent doing paperwork or other EBI-related tasks which could also minimize workflow interruptions. Given the salience of workload burden and limited resources, our study aligns with recommendations from other CW implementation efforts (e.g., Akin et al., 2016) to ensure that managers and administrators think carefully about ensuring there is adequate allocation of work time and availability of supports.

Policy recommendations.

This paper's findings also offer policy-level implications about funding EBIs in CW services. CW CAB members noted that their funding was tied specifically to the provision of a particular EBI. Even though they viewed the 4R2S as being a good fit for some of their clients, they would not be able to offer it to families without ongoing funding once the study was completed. The impact of funding sources tied to specific EBI implementation projects has been experienced by others (Akin et al., 2016). Fixed funding arrangements may not allow agencies the agility to provide the best fitting services for clients. The evidence-based practice approach has been described as "the integration of best research evidence with clinical expertise and patient values" (Institute of Medicine [IOM], 2001, p. 147). However, being locked into a particular practice due to funding restrictions may hamper providers' ability to select a practice that best aligns with the research evidence, their expertise, and clients' values. Consequently, greater flexibility in funding requirements for CW agencies that allow for the provision of multiple EBI options, particularly when addressing different needs among CW-involved families is needed.

Recommendations for future research.

Recommendations for future research involve expanding the exploration of CW staff perspectives across multiple agencies, jurisdictions, and with a variety of EBIs in order to identify core similarities, as well as variations in perspectives which are affected by change in context and/or EBI. Although beyond the scope of the current paper, it will also be important to explore if these perspectives change when implementation utilizes these recommended modifications. For this study, we were unable to complete the second phase (feasibility pilot testing) with the CBO involved in the CAB due to regulatory barriers. However, future research that can juxtapose CW staff perceptions before and after implementation can inform which, how, and why perceptions may change. This can provide useful information to agency administrators for new strategies to support EBI implementation.

Limitations.

As with any study, there are limitations to these findings. First, this study was based on a handful of representatives from one CW CBO, and as such, their perspectives may not be

readily generalized to all CBOs or all CW jurisdictions. While the CW CAB members could have sought feedback from other staff members between CAB sessions to inform their recommendations, they were not explicitly told to do so. As such, we assumed that CW CAB members were speaking from their personal experiences and observations rather than conveying the views of their co-workers. However, findings from this study do provide useful perspectives that cut across multiple levels within the organization (administrators, supervisors, caseworkers). Given the low morale evidenced by CW CAB members as well as their prior experiences with EBI implementation, findings also provide insight into the current landscape of CW systems which are inundated with multiple mandates to implement EBIs. An additional limitation involves the CAB context itself. Because caseworkers were also present with their supervisors and administrator, it is possible that feedback may have been censored for fear of potential reprisals. That said, the sheer number of concerns raised by CW CAB members about implementing the 4R2S and complaints about agency workload seem to have mitigated that possibility. Instead, CAB discussions focused on marketing the 4R2S to caseworkers and getting their buy-in indicate their relative power as front-line providers and “street-level bureaucrats” (Lipksy, 1980), within the larger context of organizational and external factors (e.g., policies) which influence implementation in CW settings (Aarons et al., 2011).

Despite these limitations, this study took an important step in addressing a problem central to CW practice with families: the delivery of high-quality and evidence-informed interventions to those with limited access to resources. The suggestions for modifications as well as the identified training needs elucidate what task-shifting looks like in the CW context within the United States. Synthesizing the perspectives of staff involved at various organizational levels gathered here cannot be overstated. CW CAB members in this study were frank in identifying where 4R2S aligned with existing strengths-based practices, as well as the funding and workload concerns that needed to be addressed in order for the EBI to be successful implemented and sustained. Heeding provider feedback in future implementation efforts may help ensure that effective practices are available and utilized by families in need.

Acknowledgements:

The authors gratefully acknowledge support from Taiwanna Lucienne and Kerry-Ann Lee

Funding: This study was funded by the National Institute of Mental Health (NIMH; R21MH102544). Additional funding for CH was provided by NIMH 5T32MH019960-24. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute of Mental Health or the National Institutes of Health.

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Table 1.

CAB members' suggested modifications for the intervention, agency delivery structure, training procedures, and ongoing supervision protocols.

Modification targets	Recommendations
4R2S curriculum	Reduce intervention length from 16 sessions to 8 core sessions + 1 termination session Replace metaphors, images, and vocabulary in the modules to be more salient to target population Adapt module content so that it could be delivered in the home with a single family as well as in the agency with multiple families Create additional vignettes which describe parents' values regarding how they were raised, as well as how they are open to other helpful parenting strategies Ensure that facilitators are transparent with group members about mandated reporting requirements and limitations of the intervention in addressing co-occurring problems
Agency	Market the intervention to caseworkers as an opportunity to enhance clinical skills, and decrease family crisis Reduce caseload size of the workers Create documentations templates (e.g. progress notes, etc.) for the workers and supervisors
Training	In addition to the intervention training, develop trainings on child development and trauma informed practices Additional skill development targets should include: parent engagement, cultural sensitivity, empathy, reducing negative biases, and respectful communication Training should be provided with by an intervention expert and a parent advocate (co-facilitators)
Supervision	Include an external consultant to support intervention efforts and help monitor intervention fidelity Develop a fidelity tool to guide supervision