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Increasing worker buy-in for child welfare reform: Examining the influence of individual, organizational, and implementation factors

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A B S T R A C T

In an effort to improve outcomes for children and families, child welfare systems across the U.S. have placed an increased emphasis on implementing evidence-supported interventions (ESIs). Evaluations of these programs often reveal, however, that implementation of child welfare reforms are incomplete and front-line workers sometimes use their discretion to selectively implement certain practice changes while failing to implement others. Implementation frameworks and guidebooks have been developed to facilitate the translation of ESIs into effective practice with clients; these guides often suggest that a critical first step in the implementation process is to gain buy-in from stakeholders within the agency and surrounding community. Few studies, however, have examined the influences on worker buy-in for child welfare reform efforts. The current study uses data collected during the statewide implementation of a child welfare reform to examine the individual, organizational, and implementation factors that predict worker buy-in for the reform. Using the results of a worker survey ($N = 558$), stepwise regression found a positive association between a participant's sense of purpose in their work and buy-in for the new initiative. In addition, receiving coaching on specific practices associated with the new initiative was related to higher levels of buy-in. The paper concludes by discussing limitations of the study and the implications of the findings for child welfare implementation efforts.

1. Introduction

In an effort to improve outcomes for children and families, child welfare systems across the U.S. have placed an increased emphasis on implementing evidence-supported interventions (ESIs). Process evaluations often reveal, however, that implementing ESIs in real-world practice settings is complex and fraught with challenges. Frequently, programs that demonstrate effectiveness in controlled clinical settings fail to produce expected results when implemented in human service agencies in which there is less control over practitioner behavior (James Bell Associates, 2013). This may be especially true of implementation efforts within child welfare agencies, which are negatively affected by highly bureaucratic organizational structures; inflexible laws, mandates, and policies; inadequate infrastructure to support implementation efforts; and a high degree of worker turnover (Aarons & Palinkas, 2007; Akin, Brook, Byers, & Lloyd, 2016; Hansen, Self-Brown, Rostad, & Jackson, 2016).

The challenges associated with effective implementation has led to the development of a field of research known as implementation science that examines the factors that facilitate the translation of evidence-supported practice into effective real-world practice with clients, and several conceptual frameworks have been developed that describe the broad categories of factors that are thought to influence the implementation process (Aarons, Hurlburt, & Horwitz, 2011; Barbee, Christensen, Antle, Wandersman, & Cahn, 2011; Damschroder et al., 2009; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Glisson & Schoenwald, 2005). A recent review of these various frameworks (Akin et al., 2014) identified six broad categories that were common across most implementation frameworks: 1) process factors such as staff selection, training, coaching, and fidelity assessment; 2) provider factors including their worker skills, stress, knowledge, and attitudes toward the intervention; 3) characteristics of the intervention including its complexity, adaptability, and cost; 4) client factors including their presenting problems and perceptions of the intervention; 5) organizational factors such as the culture, climate, and leadership; and 6) structural factors that occur at the system level and include workforce issues and interagency collaboration.

Several recent qualitative studies have examined the factors that facilitated or impeded the implementation of evidence-based programs in child welfare and related human service fields. These studies found that practitioner attitudes or buy-in toward the newly-implemented intervention were a critical factor in whether or not the implementation effort was successful (Gray, Joy, Plath, & Webb, 2012; Mendenhall, Iachini, & Anderson-Butcher, 2013; Shapiro, Prinz, & Sanders, 2012; Williams et al., 2015). In one study, lack of buy-in among frontline staff was related to insufficient knowledge and training, as well as staff burnout that was a result of constantly changing initiatives and improvement efforts (Mendenhall et al., 2013). A process evaluation of the

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implementation of Differential Response (DR) in Illinois revealed that a sizeable number of child protection workers had negative attitudes toward the new program and therefore tried to impede its implementation by manipulating the eligibility criteria for family inclusion in the intervention (Fuller, Kearney, & Lyons, 2012). Implementation evaluations in other states also highlight the importance of staff buy-in in achieving program fidelity; staff were much more likely to perform the new practice requirements if they believed that they were important and worthwhile (Pacific Research & Evaluation, 2016; Winokur et al., 2012). However, despite its conceptual and practical importance in the implementation of evidence-based practices in child welfare and related fields, little is known about the factors that are related to worker buy-in for reform efforts. The current study therefore aims to address this knowledge gap by examining several individual, organizational, and implementation factors and their relationship to worker buy-in for a child welfare practice reform using quantitative data from a statewide staff survey.

1.1. Worker buy-in and street-level bureaucracy

Many conceptual frameworks of organizational change emphasize the central importance of worker attitudes or buy-in for the new innovation or intervention. In his diffusion of innovation theory, Rogers (1995) describes the decision to adopt an innovation as a "process through which an individual or other decision-making unit passes from first knowledge of an innovation, to a decision to adopt or reject, to implementation of the new idea, and to confirmation of this decision" (p. 21). A framework developed by Frambach and Schillewart (2002) proposes that the decision to adopt an innovation occurs at two levels: a decision that is first made by the organization, followed by a decision made by the individuals within the organization. According to this theory, the innovation process can only be considered a success when it is accepted and integrated into the organization *and* the adopters demonstrate commitment to continuing to utilize it over a period of time.

The theory further specifies the factors that may impact an individual's adoption of an innovation (Frambach & Schillewart, 2002). Direct influences on individual acceptance and use of an innovation include the individual's cognitive beliefs and attitudes toward the innovation (i.e., buy-in), acceptance and use of the innovations by the individual's social network (colleagues and supervisors), and "personal innovativeness," which describes the individual's tendency to accept new innovations and is similar to the construct of receptiveness to change. Organizational factors, such as training, technical support, and incentives, are thought to influence innovation use primarily through their effect on attitudes or buy-in toward the innovation.

The importance of individual worker buy-in for a new innovation or policy is also highlighted in Lipsky's (1980) seminal study of "street level bureaucracy." According to Lipsky, public service workers, which include front-line child welfare workers, interact directly with the public and have the power to exercise a degree of discretion over the services, benefits, and sanctions received by service recipients. These street-level bureaucrats therefore function, in effect, as policy decision makers in the day-to-day implementation of public policy and programs. In other words, "social policies enacted reflect the actions (and strategic non-actions) of implementing agents that are likely to produce (or fail to produce) behavioral and other outcomes consistent with the objectives of policymaking" (Meyers, Glaser, & MacDonald, 1998, p. 2). Using this theory as a lens, researchers examined the implementation of welfare policy reform in California by observing the face-to-face transactions between welfare workers and their clients to determine if the goals of the policy were implemented as intended. Their results revealed that interactions in which the policies were enacted as intended were exceedingly rare. Instead, most workers continued to rely on a pattern of behavioral transactions that reflected the previous welfare policy (Meyers et al., 1998) and therefore the policy reform was not enacted on the street level.

1.2. Influences on worker buy-in for reform

Few studies have examined the factors that influence worker buy-in for reform, despite its hypothesized importance in achieving organizational change. One line of early research examined the factors that predicted mental health service provider attitudes toward evidence-based interventions in general by using the Evidence-Based Practice Attitudes Scale (EBPAS; Aarons, 2004;Aarons et al., 2012; Aarons & Sawitzky, 2006). The results of these studies found that African American clinicians and clinicians with more years of experience reported more negative attitudes toward evidence-based practices after controlling for other characteristics (Aarons et al., 2012; Aarons & Sawitzky, 2006) and that organizational culture influenced worker attitudes toward the use of evidence-based practices. The first study found that clinicians working in organizations with more constructive cultures, defined as those characterized by norms of achievement, motivation, individualism, humanism, and supportiveness, were more open to adopting evidence-based practices (Aarons & Sawitzky, 2006). A second study (Aarons et al., 2012) found that clinicians who work in proficient cultures have more positive attitudes toward the use of evidence-based practices; proficient cultures have expectations that the clinicians will place the well-being of clients first, be competent, and have up-to-date knowledge.

Two additional studies examined the role of individual and organizational characteristics on child welfare workers' attitudes toward specific practice reforms. The first study examined the impact of organizational climate (conflict and stress, hours outside of work, role clarity, and workload) on attitudes toward a practice reform effort called Individual Courses of Action (ICAs), which emphasized the use of a family strengths approach, family engagement in case planning, use of informal supports, and family team meetings (Gushwa, 2009). The results of the analyses found that, among the organizational climate constructs examined, workload was most consistently and significantly associated with attitudes toward practice reform. Another study examined factors related to child welfare worker buy-in for a new statewide practice model (McCrae, Scannapieco, Leake, Potter, & Menefee, 2014) and found that higher levels of buy-in were reported among male workers, staff with 16 or more years of tenure, staff working in small agencies, and supervisors and senior management staff. Unfortunately, the study did not include multivariate analyses of the factors to predict worker buy-in. In addition, although they are believed to be an important factor in the implementation process, none of the past research has examined the role of training, coaching, and supervision on worker buy-in toward specific evidence-supported interventions.

2. Methods

2.1. Study context

The current study uses data collected during the implementation of Differential Response (DR) in one state. DR implementation in this state began in 2014 using a staged roll-out that utilized the implementation driver framework developed by the National Implementation Research Network (NIRN; Fixsen et al., 2005). Child welfare staff in counties that implemented DR received comprehensive training and coaching on the core elements of the DR practice model, including modules on screening and track assignment, CPS assessments (including initial contacts with families and family interviewing techniques), family engagement and trauma-informed practice, collaboration and shared decision-making, and strengths and needs assessments. Additional trainings about DR were provided to child welfare staff and community partners throughout the state that described the vision and goals of the reform as well as the similarities and differences between the two CPS response tracks. As part of the implementation evaluation, a staff survey was administered to all child welfare staff in the state that included measures of training and coaching receipt and effectiveness, supervisor