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Evaluating the Implementation of Bounce Back: Clinicians' Perspectives on a School-Based Trauma Intervention

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ABSTRACT

Bounce Back is a school-based program developed to reduce the negative psychological impact of trauma for elementary school children, and research has shown its effectiveness. Recently, Bounce Back was piloted in a large urban school district using a community partnership model. Clinicians can provide important insights into challenges and promoting factors that are essential for the successful implementation and future scale-up of the program. Two focus groups were conducted with 10 Bounce Back providers serving diverse elementary students in the school district. In addition, quantitative measures of fidelity, satisfaction, school organizational structure, and treatment outcomes were examined. Focus groups were audio-recorded, transcribed, and coded by trained research assistants and themes were identified using ecological models of implementation. Clinicians reported high satisfaction with the program. Several challenges were universal across schools, including limited resources, time intensity of the program, and lack of trauma awareness among members of the school community. Schools with stronger implementation were identified and differentiating factors were examined. Overall, highly supportive school climates and administrations were associated with stronger implementation. However, the effects of less supportive climate and leadership could be mitigated with support from community partnerships and clinician flexibility and creativity. Results from this study underscore the importance of multiple levels of support for providers of Bounce Back.

Introduction

The high prevalence of childhood trauma has been widely documented (Finkelhor, Turner, Shattuck, & Hamby, 2015). Exposure to trauma in childhood has been associated with long-term negative psychological outcomes, including increased risk of depression, anxiety, and disruptive behavior disorders (Copeland, Keeler, Angold, & Costello, 2007). Many communities most affected by trauma have increased barriers to accessing mental health treatment, such as transportation, health insurance, and stigma (Davis, Ressler, Schwartz, Stephens, & Bradley, 2009). To address these barriers to treatment, evidence-based treatments (EBTs) have been developed for delivery within schools, and research has supported the benefits of mental health services in schools (Kataoka, Stein, Nadeem, & Wong, 2007). School-based interventions increase access to mental health

care for children who may not otherwise receive it (Jaycox et al., 2010), particularly for children in historically underserved communities (Lyon, Ludwig, Stoep, Gudmundsen, & McCauley, 2013). In fact, most youth receive mental health services at school (Farmer, Burns, Phillips, Angold, & Costello, 2003). Despite the benefits of implementing EBTs in schools, schools are not designed as mental health care facilities, and challenges in implementation can arise (Crisp, Gudmundsen, & Shirk, 2006). Therefore, examining the successes and challenges of implementation is critical to successfully integrate EBTs into school settings.

One school-based intervention is Bounce Back, which was created to decrease the psychological sequelae of trauma exposure in diverse groups of elementary school children (Langley, Gonzalez, Sugar, Solis, & Jaycox, 2015). Bounce Back was developed in partnership with school stakeholders (e.g., educators, school-based clinicians, parents)

as a developmentally modified version of the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program appropriate for elementary-age children (Langley, Santiago, Rodríguez, & Zelaya, 2013). Although Bounce Back integrates some features of trauma-focused cognitive behavioral therapy (TF-CBT; Cohen & Mannarino, 2008), it differs in that it was developed specifically for school-based delivery and is delivered in a group format (see Langley et al., 2013). Recently, Bounce Back demonstrated effectiveness in reducing posttraumatic stress symptoms in two randomized control trials (Langley et al., 2015; Santiago et al., 2018). Although research supports Bounce Back as effective in real-world settings (Langley et al., 2015; Santiago et al., 2018), further analysis of the factors that promote and impede the implementation of Bounce Back in school settings is needed.

Bounce Back was designed in collaboration with school stakeholders; however, many interventions designed with support from universities and other research institutions fail to match the community need following initial implementation (Atkins, Rusch, Mehta, & Lakind, 2016). Therefore, it is important to examine factors that may promote or impede effective implementation. Implementation science uses an ecological framework to examine how to effectively integrate EBTs into the receiving context while maintaining fidelity to the intervention (Atkins et al., 2016). When working within schools, it is particularly important to view this process within a social-ecological framework given that contextual factors (e.g., school policies, school climate, clinician attitudes) may impact how EBTs are implemented and disseminated (Domitrovich et al., 2008).

Several implementation models have adopted this ecological model to guide the dissemination of prevention and intervention programs (e.g., Damschroder et al., 2009). In a model designed specifically for the unique challenges of a school setting, Domitrovich et al. (2008) examined how macro (e.g., district policies, community context), school (e.g., school culture, administrative leadership), and individual (e.g., professional characteristics, attitudes) contexts can directly or indirectly impact implementation. According to the model, on a macro level, governmental and district

policies and community capacity can impact whether implementation is successful and sustainable over time (Domitrovich et al., 2008). For example, community–university partnerships can allow for more targeted implementation support and evaluation of outcomes (Domitrovich et al., 2008). On a school level, availability of resources, administrative support, and school and classroom characteristics are several implementation factors to consider. For instance, school administration supportive of EBTs will likely lead to smoother implementation of the school-based program (Domitrovich et al., 2008). Finally, individual-level factors, such as professional experience or training and receptiveness to the intervention (Domitrovich et al., 2008), are important to consider because clinicians have an instrumental role in implementing the program. For example, a high level of professional burnout and competing demands among school clinicians may lead to challenges in implementation (Domitrovich et al., 2008).

Examining the interactions between these multi-level factors can provide a comprehensive understanding of how to implement and sustain interventions in schools. In another implementation model, Exploration, Preparation, Implementation, and Sustainment (EPIS; Aarons, Hurlburt, and Horwitz (2011) incorporated both the ecological systems model of Domitrovich et al. (2008) and the multiple stages of implementation (exploration, adoption/preparation, active implementation, and sustainment) for intervention work. Aarons and colleagues posited that “outer-level” and “inner-level” factors intersect with each stage of implementation to promote or inhibit this process. Outer-level factors include policy, funding, and community–academic partnerships, whereas inner levels include organizational climate, leadership, and ideological fit of the intervention with the receiving context (Aarons et al., 2011). The EPIS model provides important guidance for examining the active implementation phase of Bounce Back within a general ecological context, whereas the Domitrovich et al. model provides a school-specific framework from which to view the successes and challenges of implementation. As schools and school districts adopt Bounce Back, clinician’s perspectives on the multisystemic factors that

promote or impede the implementation phase are important for informing future scale-up.

Mixed methods provide the opportunity to gain rich understanding of the challenges and promoting factors involved in the implementation of an EBT within a community setting (Palinkas, 2014). Acquiring on-the-ground qualitative and quantitative feedback may inform the quality of intervention through corrective and preventive measures taken to improve the EBT implementation over time (Bishop & Dougherty, 2005). A combination of quantitative and qualitative research methods is especially useful when studying EBT implementation within large-scale systems (such as school districts), in which stakeholder relationships span levels vertically (e.g., school to district leaders) and horizontally (e.g., between schools; Palinkas et al., 2015). In particular, qualitative methods assist in understanding the reasons for success and failure of EBT implementation and identifying strategies for facilitating implementation (Palinkas et al., 2015). Although quantitative data have already been used to reveal the effectiveness and feasibility of Bounce Back (Langley et al., 2015; Santiago et al., 2018), additional qualitative research is needed to further understand implementation outcomes. Clinicians who implement Bounce Back can provide important insights regarding the supports and resources that are essential for future implementation.

Current study

The current study was designed to evaluate the implementation of Bounce Back in partnership with community mental health agencies across a large midwestern city. Thus, Bounce Back was in the active implementation phase during this study, with the aim of future scale-up. To examine the factors that promoted effective implementation, the current study used both the EPIS framework, with a focus on the implementation phase, and the Domitrovich et al. (2008) model, which organizes ecological factors into levels of context specifically for schools.

A deductive approach (e.g., based on structure of predetermined themes) was used to design the focus group questions, using the EPIS (Aarons et al. 2011) and Domitrovich et al. (2008) models to guide the focus group script (Bradley, Curry, &

Devers, 2007). Moreover, questions were added that may have been relevant to providers within the school system, including questions targeted toward district-specific components and requirements (e.g., If your school has a Behavioral Health Team, how did it support you in identifying students for Bounce Back?). Two focus groups were conducted with Bounce Back providers serving diverse elementary students in a large urban school district. Quantitative outcome and fidelity data were abstracted from district data collected as part of standard district policies for new interventions. Universal challenges and strengths of implementation across schools were examined. In addition, the current study sought to identify key differences between schools that implemented Bounce Back with greater or lesser success. This study aimed to identify key contextual supports that improve the implementation of Bounce Back in diverse school districts.

Method

Participants

Eight urban schools were identified and trained in Bounce Back, and seven of the trained schools implemented groups. District partners assisted in identifying the eight schools in which to pilot Bounce Back. Consideration of both need (e.g., high levels of trauma exposure) and feasibility (e.g., availability of school-based clinician and/or community agency partner, clinician experience) were considered. Providers from the eight schools who were trained in Bounce Back, regardless of whether they implemented, were invited to participate in a focus group assessing their positive and negative experiences in implementing as well as recommendations for improving future implementation and dissemination. Ten Bounce Back providers representing seven schools participated in the focus groups. Clinicians were divided into two groups in order for providers to speak freely about the nature of partnerships between school and agency providers. Of the 16 providers contacted, seven (of 10) school-based providers participated in the first focus group and three (of six) community partners participated in the second focus group.

The majority of participants identified as female (70% female). Ages of participants ranged from 25 to 60 ($M = 38.50$, $SD = 10.96$). Three participants had master's in social work degrees (MSW), and two were doctoral-level psychologists (Ph.D. and Psy.D.) Forty percent of participants identified as Black or African American, and 60% identified as White. No clinicians identified as Latino or Hispanic. Years working as a school-based clinician ranged from 1 to 16 ($M = 7.75$, $SD = 5.70$), and years working in the school at which Bounce Back was implemented ranged from 1 to 8 ($M = 2.70$, $SD = 2.52$).

Implementing schools all had greater than 80% of their student body classified as low income per the state Board of Education. All the schools served either primarily African American/Black students or had a diverse racial/ethnic student makeup including Hispanic/Latino, Asian, and Caucasian students, as well as students that identified as "other ethnic group." Schools A, D, and G predominantly served a diverse racial/ethnic student body, and Schools B, C, E, F served majority (> 80%) African American/Black students. More specific demographics per school were not included to maintain confidentiality of implementation schools.

Procedure

Bounce back

Bounce Back consists of 10 weekly group sessions, three individual sessions (parents are invited to the third session for sharing of trauma narrative), and up to three parent psychoeducation sessions with a school-based mental health professional. As part of Bounce Back training, clinicians are encouraged to be flexible and creative with parent sessions, for example, combining sessions for a longer meeting and/or delivering parent sessions to parents in a group format. The program also includes parents in children's telling of the trauma narrative, a developmentally appropriate format created for TF-CBT (Silverman et al., 2008). Bounce Back was piloted using a community partnership model; efforts were made to partner school-based providers with providers from community mental health agencies to implement Bounce Back during the school year. However, some schools had two school-

based providers partner for implementation. Training was conducted by clinicians from a university-based research hospital who were completing the official Bounce Back "train-the-trainer" process and were supervised and observed by the Bounce Back developer (Audra Langley, Ph.D.) to ensure that they met all requirements. Training was 1½ days, and clinicians were excused from their buildings to attend. The trainers provided technical assistance to implementers via one workshop session (to which all trained schools were invited), performed monthly site visits throughout implementation, and collected information on intervention fidelity to provide targeted feedback to implementers. Referral, screening, and group formation were consistent with district policies, which primarily relies on teacher referrals, though parents and other building staff may also refer students for services. School-based clinicians screened referred students and obtained parent consent for treatment for eligible students.

Qualitative data collection

Focus groups were conducted by a university that was unaffiliated with the training hospital group and the implementing school district. Two 90-minute focus groups were conducted—one with school-based implementers and another with providers from community agencies who partnered to provide Bounce Back in schools. Each participant provided verbal consent and received a \$50 merchandise gift card and breakfast for participating in the focus group. This study was conducted in compliance with the university Institutional Review Board and school district's review board. The groups were held in a private room at a location outside of the implementing schools. A deductive approach was employed to create the focus group script (Bradley et al., 2007) by using the conceptual frameworks from EPIS (Aarons et al., 2011) and Domitrovich et al. (2008) to develop the focus group questions. The focus group questions were structured around each context as outlined in the Domitrovich et al. model (e.g., individual, school level) integrated with the implementation factors found in the EPIS active implementation stage of the model (e.g., readiness for change, structure/resources). Example questions included "How did the Bounce Back program

work in the context of your school?” (Adaptability; Aarons et al., 2011) and “Are there other staff at your school who spend time also helping with Bounce Back groups?” (Organizational Structure/Resources; Aarons et al., 2011; Domitrovich, 2008). A semistructured protocol ensured that all concepts in the Domitrovich et al. and active implementation stage of the EPIS model were discussed but allowed for flexibility to encourage discussion of other topics. Groups were facilitated by researchers without professional relationships to the participants. Facilitators encouraged individual opinions (e.g., “What do other people think?”). The full focus group script is available upon request.

Quantitative data

Quantitative data were accessed in three ways: (a) Fidelity and outcome data were collected as part of standard school district procedures for tracking new interventions and were accessed to provide complementary information to the qualitative data (Palinkas et al., 2011); (b) prior to focus groups, participants completed questionnaires assessing demographics, experience with EBTs, and satisfaction with Bounce Back; and (c) data were examined from publicly accessible school district databases to examine key areas of school organizational culture.

Implementation strength

Implementation strength was determined based on (a) fidelity to treatment protocol, (b) student comprehension of content as rated by the facilitators of the group, (c) clinician satisfaction, and (d) qualitative accounts of delivery of core components. These areas (fidelity, delivery of core components, and satisfaction) have been identified as frequently assessed dimensions of implementation integrity (Domitrovich & Greenberg, 2000). Each area was examined from both quantitative (fidelity, satisfaction) and qualitative (clinician report of student understanding of core components, delivery of core components) data. These areas were discussed by the research group and then discussed with the supportive implementation team. Then, through consensus, schools were ranked from less effective to strong.

Measures

Clinician demographics

Clinicians reported on their degree, gender, age, ethnicity, and clinical experience with EBTs. Demographic questions included how many years working as a social worker or psychologist and years working as a school-based provider.

Satisfaction

Clinicians were asked to rate their satisfaction with the Bounce Back program by responding to 28 questions. Using a 5-point scale from 0 (*not at all*) to 4 (*a whole lot*), clinicians rated how much they liked the program overall, how difficult it was to implement, need for the program, and satisfaction with the training. Further, clinicians rated how helpful each group session was for their students and how difficult each group, individual, and parent session was to implement.

School climate

Publicly available data collected as part of the 5 Essentials Survey from the state Board of Education were examined on key measures of school organizational culture (University of Chicago, 2015). Examined data included results from surveys completed by teachers, parents, and students on areas such as Effective Leadership (e.g., teacher–principal trust, program coherence, principal leadership), Supportive Environment (e.g. safety, student–teacher trust, peer support for academic work), and Family Involvement (e.g., outreach to parents, teacher–parent trust).

Fidelity

Clinicians reported on their fidelity following each session. They rated the degree to which they covered each element of the session on a 4-point scale from 0 (*not at all*) to 3 (*thoroughly covered*). Clinicians also used this 4-point scale to report on their ability to manage the group, severity of behavioral challenges, level of participation and motivation, and overall comprehension for each session. Records were kept on attendance for each child, whether sessions were retaught, and whether adaptations were made for each session.

Child outcomes

Trauma symptoms were assessed using the Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001). This questionnaire includes 17 items that assess for *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994) posttraumatic stress disorder symptom frequency, daily functioning, and functional impairment. The CPSS was administered verbally by clinicians to children before the intervention and has been used to evaluate CBITS (e.g., Jaycox et al., 2010). The clinical cutoff score for this measure is 14. Teachers also reported on children's functioning in school using the Strengths and Difficulties Questionnaire (SDQ Teacher Report; Goodman, 1997), a 25-item measure. This measure includes five subscales: Conduct Problems, Hyperactivity/Inattention Problems, Emotional Symptoms, Peer Problems, and Prosocial Behavior. A total difficulties score was calculated for each child by summing the first four subscales.

Data analysis

Focus groups were audio-recorded and transcribed by trained research assistants. The transcripts were imported into ATLAS, a qualitative software program designed to facilitate thematic coding. Using an integrated framework, both deductive and inductive approaches were used to develop a coding matrix (Bradley et al., 2007). More specifically, Domitrovich et al.'s (2008) ecological model of implementation and the EPIS (Aarons et al., 2011) active implementation phase were used to create a predetermined set of codes (deductive approach). After a careful review of transcripts by trained research assistants, additional codes were generated based on the participants' responses (inductive approach), and these data were used to fine-tune the existing coding structure. Categories of codes included ideological fit, adaptability, demographics, resources, supervision/training, and systems interventions. These categories were applied across contexts per implementation models: intervention, clinician, school, and community. Simple codes were defined within this coding matrix. For example, an aspect of ideological fit could be examined across levels with a simple code such as "attitudes towards trauma" coded

separately under community, school, and clinician-level systems. Bounce Back (i.e., intervention characteristics) specific level codes were also examined. After an initial coding period, codes were clarified and revised as necessary. Transcripts from each focus group were then double coded by trained graduate students. Coded transcripts were reviewed by the research team to resolve any coding discrepancies and to identify broad themes. Ninety estimated total hours were spent coding manuscripts and developing consensus. Following consensus building, codes under each level that were the most frequently discussed and/or reflected differing experiences across schools were identified. The themes presented next were discussed in depth, and significant agreement and consistency was noted, suggesting saturation was achieved. Examples of theory-driven codes are included in the appendix.

Results

An overview of implementation schools can be found in Table 1. Of the initial eight schools, 72 students were referred to Bounce Back and 43 were screened. Seven schools with 35 students total started groups, and 24 students completed the program (69%). Attrition was due to behavioral difficulties (54.50%) and transfers (36.33%). Of the implementing sites, Schools A and E emerged as the strongest implementation sites. Schools B, F, and G emerged as having the least effective implementation, with the lowest fidelity (no parent sessions completed, not completing the full program, or not implementing at all). Schools C and D emerged as the middle ground between these groups, with strengths and weaknesses in implementation quality.

Total change scores in posttraumatic stress symptoms on the CPSS reflected the implementation strengths of each school: Schools A and E had the largest reductions in pre- to postintervention CPSS scores. However, the highest reduction in SDQ scores were seen in School C (moderate) and School D (moderate). Of note, some factors from the school climate data mapped onto implementation strength: Strong implementation schools had the highest rated supportive environments; however, there was a more nuanced picture with other school-level ratings.

Table 1. Overview of implementation sites.

	School A	School B	School C	School D	School E	School F	School G
Effective Leadership	Strong	Neutral	Weak	Neutral	Neutral	Strong	Neutral
Supportive Environment	Strong	Weak	Weak	Weak	Very Strong	Weak	Neutral
Family Involvement	Strong	Neutral	Neutral	Neutral	Neutral	Weak	Strong
Implemented on Time?	Yes	Yes	Yes	Yes	Yes	No	No
Parent Participation?	Yes	Yes	Yes	Yes	Yes	No	N/A
<i>M</i> Element Fidelity	2.71	2.66	2.27	2.96	2.76	2.07	N/A
<i>M</i> Comprehension of Materials	2.70	2.40	2.22	2.36	3.00	2.50	N/A
<i>M</i> Pre-CPSS	31.75	MI	20.25	22.71	27.17	MI	N/A
<i>M</i> Pre-SDQ	21.33	MI	21	20.85	18.83	MI	N/A
<i>M</i> CPSS Change	18.75	MI	14.75	11.86	17.67	MI	N/A
<i>M</i> SDQ Change	9.25	MI	14.5	11.71	4.75	MI	N/A
Implementation Strength	Strong	Less effective	Moderate	Moderate	Strong	Less effective	Less effective

Note. School climate ratings ranged from very weak to very strong. N/A = data that was not applicable to the school; CPSS = Child PTSD Symptom Scale; MI = missing data; SDQ = Strengths and Difficulties Questionnaire.

A school with a strong rating on 5 Essentials Family Involvement and neutral ratings on Supportive Environment and Effective Leadership was not able to start the groups. Furthermore, a school with strong leadership but weak environment and family support had less effective implementation. Overall, several themes emerged that were common across implementing schools, whereas other themes varied across schools. These themes are described next in terms of how they mapped onto the Domitrovich et al. (2008) implementation framework. Table 2 summarizes themes that differed across implementation sites.

Intervention level

Satisfaction with Bounce Back

Clinician satisfaction with Bounce Back content and applicability of the program was a common theme across school- and community-based providers. A clinician at a moderately strong implementation site stated, “I think everybody should be trained in the materials. ... I can see myself doing these individual sessions with different kids. I might do three sessions working on these things, like the courage thoughts. ... It was really awesome.” Some school-based clinicians stated that they had initial reservations about the trauma narrative but that they were pleased with this component in the end. Clinicians highlighted components such as the uplifting name of the program, the use of the feelings thermometer, helpful thoughts, courage cards, CBT triangle, and progressive muscle relaxation as effective tools for their students. They noted that these tools were easily understood, and engaged parents were eager to learn these strategies:

[The parents] would ask us “At home this is happening, do you have any suggestions for me?” and they loved all of the handouts we gave them; they totally understood the feelings thermometer and would ask for copies of that. ... They just liked all of the kind of resources we gave them, I think because it was easy to understand and easy to apply at home.

A clinician at a strong implementation site stated,

I started [working] with TF-CBT ... so because of that background ... it was just a very easy program for me to learn, but this is still different from what I’ve seen before. The way they have implemented it with the visuals and with the books, I think there are just so many extra factors here that are very beneficial with this program.

Despite initial reservations for including the trauma narrative component of the program, clinicians found this tool especially effective:

One of our students enjoyed, well they all did, but one really enjoyed the trauma narrative piece, and so whenever he has a problem now, he writes stories. [For example,] there was a miscommunication between him and his teacher, and I saw him in the hallway and we sat down and wrote a quick little story together, and he showed it to her. They were able to work out the situation and resolve it, which I thought was so great. He’s been using those and been able to resolve conflict that way. ... He would just start writing and creating his own stories.

Clinicians’ main challenges with the content of Bounce Back were with explaining the fear hierarchy (I Can Do It Ladder) to students. Clinicians also underscored the importance of continued support for the program for scale-up; a clinician at a less effective implementation site stated,

Table 2. Example quotations across schools at different levels of implementation.

	Community Level		School Level		Clinical Level
Strong Sites	Community partnership	Administration support	Clinician-teacher relationship	Clinician flexibility and creativity	Clinician flexibility and creativity
Example Quotations	Felt supported and cooperated well. Integral part of implementation. "I couldn't have done it without just a partner in general whether its community or school."	One felt supported and the other felt completely unsupported. "They actually came to training with me" "zero support"	Strong relationships with teachers. "we would send emails to the teachers so there was good collaboration"	High flexibility and creativity in engaging with parents and teachers. I called parents during evening time to talk to them. ... The amount of phone calls or the amount of time I spent on the phone trying to call the parent at three different phone numbers."	
Moderate Sites	Was a helpful component	One felt supported and the other felt the administration was unresponsive.	Moderate support from teachers from one school and no support from another.	Moderate flexibility engaging with teachers.	
Example Quotations	"just being confident in her skill set too, knowing that she was going to do her part and that it wouldn't be an issue."	"I don't think [the administration] considers [our relationship with the students] at all"	"I hounded teachers during prep time ... then we sent out more emails blasts the counselor. Hounded, and we only got four referrals."	"I said they have free food give away, the food pantry on the third Thursday of the month, that's where you hit them up."	
Less Effective Sites	Disconnect between partner and the community. Lack of feelings of support.	Felt completely unsupported by the administration.	Poor relationship; lack of support.	Moderate flexibility with engaging with parents to little flexibility.	
Example Quotations	"[the parents] were like 'what is this?' and 'who is this extra person?' ... it was a challenge."	"my coordinator didn't even know when I asked them about it they was like well wait a minute. 'What do you have to participate in?'"	"We are not babysitting service, but that's what they wanted."	"I keep the one binder in my car so whenever I go to school I have it, and the other binder I keep in the office and I literally during my individual sessions will take pages."	

I think it's a really good program. I think it has the potential to flourish in [the school system]. It's just the way that it's going to be rolled out. I think that there has to be consideration for the people that are doing it.

Time intensity of Bounce Back

Clinicians across schools discussed how implementing groups, specifically the Bounce Back program, was time intensive. One clinician stated,

We had a hard time fitting everything into one hour, and I feel like the approximate weekly time which includes consents, writing to the parents, answering questions, talking to teachers, is two to two and a half hours a week. That's the minimum time that is needed for people to implement in schools. It's one hour for the session, at least one hour for prep, making copies, getting color copies, it all takes time.

Another clinician described how Bounce Back requires more time because of the emotional processing that is involved in trauma-focused groups: "It would have been nice to do forty-five minute [individual] sessions to give my kids that time to be like 'You know this is not rushed take your time, think things through and express yourself like how you want,'" Clinicians described having schedules that did not permit more flexibility with the amount of time Bounce Back requires. Many stated that they believed that Bounce Back was more time intensive than other group interventions. One clinician summarized the need for more time allocated to Bounce Back implementation: "Give us time to do this stuff, and we'll do it so well."

Parent participation

The most discussed component of Bounce Back was the parent sessions. Clinicians discussed the challenges of getting parents to come to sessions. A clinician at moderate implementation school underscored the challenges of engaging parents in high-need communities: "I think in a perfect world, if the parents show up it would be amazing, but it's not something, unfortunately, that is reality in some of our areas." A clinician at a less effective implementation site stated, "I've done CBITS and Anger Coping and Think First [other group-based interventions with less emphasis on parent engagement] and for me the parent component was hard. I could

barely get the parents in." Despite the challenges associated with contacting parents, the clinicians who could get some level of parent involvement observed greater improvement among the students. A clinician from a strong implementation site stated, "It was really cool to get to meet with some of the parents multiple times and have them involved in it ... but, [it was] far more time consuming." A clinician from a strong school also observed this:

I almost feel like by having the parent component, I feel our implementation was more effective because, to be able to see the parents in the sessions say, "Oh I can use this in this situation" or ask us about some difficulties at home and how they can use the different strategies in different situations, was something really effective.

A community provider from a moderate implementation school also articulated this point: "We had about fifty percent engagement from parents, and the ones that did come. ... I definitely feel like we have a different type of connection just with them being part of the group."

Although parent participation emerged as a challenge across schools, there were variations in how successful schools were in engaging parents. Schools A, B, C, D, and E reported some parent participation, whereas School F did not conduct any parent sessions. One clinician at this site stated,

I didn't get parents and I really wish that I had that opportunity so I would be curious for ways to engage parents in tough neighborhoods because that was such a big piece, and I hate that we missed that because I feel like my kids could have probably ... responded different; they did well but I wonder what they would have done if they knew "Oh you know my mom cares just as much or my dad cares just as much that I'm in this."

School clinicians who could engage parents described problem solving and creativity in getting parents in (see Flexibility and Problem Solving section).

Clinician level

Flexibility and problem solving

Clinicians varied in the amount of problem solving and flexibility in which they engaged. Clinicians from Schools A (strong), C (moderate), and E (strong) demonstrated the highest levels of

flexibility, engaging in multiple problem-solving strategies despite challenges. For example, although clinicians from School E were not able to get parents in for sessions, they problem-solved with consultants and adapted the trauma narrative component by working with a student's teacher to share a trauma narrative with the teacher. Overall, clinicians' creativity and flexibility was mostly related to parent engagement. A clinician from School A described her flexibility with contacting parents:

I called parents during evening time to talk to them. [For] one specific student where the parents still didn't come in [regularly], the amount of phone calls and the amount of time I spent on the phone trying to call the parent at three different phone numbers, the checking [the student contact data system] ... you ended up talking to them late in the evening.

Clinicians at School C stated, "[To] get some of our parents to show up for some of our evaluations, there is a food pantry on the third Thursday of the month, so you know that's where you hit them up." The School B (less effective) clinician also displayed flexibility, keeping a copy of her Bounce Back manual in the back of her car to be able to move between schools quickly; however, this flexibility was somewhat less than that described at A, C, and E. Schools D (less effective) and F (less effective) displayed the lowest levels of flexibility.

School level

Trauma awareness

Lack of awareness regarding trauma in schools was a consistent theme across schools. School-based providers at Schools C (moderate), D (moderate), E (strong), F (less effective), and a community provider at School G (less effective) described staff who were unaware of the level of trauma and psychosocial sequelae associated with it in their schools. One clinician from School C stated,

For the adults who are interacting with these children just being more aware of how trauma affects a child, academically, socially, emotionally, behaviorally, because that's one of the main challenges that I've come across is the people who are interacting with the children and not all of them ... have

enough understanding of that and so their behavior is often misinterpreted.

A clinician from School A stated,

At our school the teachers know that a lot of kids are exposed to trauma, but I don't think they really understand because maybe they haven't been exposed to trauma themselves or they haven't heard some of these kids' stories to really feel anything or understand the severity of some of it.

Community-based providers from School E (strong) and School C (moderate) stated that *some* staff at schools were excited to understand more about how trauma impacts youth. A clinician from School E stated,

I think that staff that are open to [trauma sensitivity] are the ones who don't necessarily need it because they already know it, and then some staff, when we offer trainings, the staff that really do need it aren't the ones who are most willing to show up ... but a lot of it is one-on-one too, you know we're in the middle of the hallway, and I see a teacher and she's telling me her concerns, and a lot of teachers are very willing to get any skills or interventions that they can.

Limited resources

Limited resources were a challenge across schools. In schools with limited resources, seemingly simple tasks such as making copies of worksheets were difficult. One clinician at a strong implementation site stated,

That's the frustrating thing, when something that should take you five minutes takes you an hour because you have to run to different copiers and you get there there's no paper, so you run back and get paper and then you come back and someone else is using it and have a hundred copies. ... Making copies can be an hour-long process.

A clinician at a less effective implementation site lacked even basic resources:

The building I'm in, none of the printers work, none of the copiers work, no paper, and when I found color paper and it was working, I made copies, but one week we couldn't send the parent letter home because nothing was working.

In these high-need schools, finding a space to conduct groups was difficult. Many schools faced the challenge of allocating a room with enough

privacy to conduct groups, and some clinicians reported wanting one consistent classroom for children to feel comfortable in for group. Several school-based clinicians noted how important it was to have materials provided for Bounce Back and stated that they were concerned that future scale-up would not include the materials necessary for the intervention:

I think my experience at [this school district] over the many years has been that when a program is a pilot, they give you all these wonderful resources to implement. They give you the lovely gift bags, and the wonderful treasure chest, but the fact of the matter is, especially in the current climate, that if it's implemented in over six hundred schools next year, they're not going to give us all six hundred little treasure chests. ... When you implement it city wide, the resources all of a sudden go away.

Beyond this concern, clinicians noted how helpful the quality of the materials provided were to students receiving the treatment and making the intervention engaging for young children.

Relationships with teachers and other staff

Schools differed regarding the strength of the relationships between clinicians and teachers, both before and after the intervention. Although some clinicians used their existing caseloads to screen for Bounce Back, many relied on teacher referrals. Schools differed regarding the strength of the relationships between clinicians and teachers, both before and after the intervention. A moderate implementation school (School C) relied on teacher referrals for their group and had a difficult time receiving referrals: “We targeted grades three and four, and sent out email blasts, I hounded teachers during prep time, then we sent out more emails blasts from the counselor. Hounded, and we only got four referrals.” A clinician at a less effective implementation site (School B) also noted frustration with teachers’ referrals for his Bounce Back group: “Some of the teachers want us to just take the problematic kids out for an hour. We are not babysitting service, but that’s what they wanted.” On the other hand, some school-based clinicians observed that they developed stronger relationships with teachers due to Bounce Back and noticed improvements in children’s behavior

because of these new connections. A clinician at a strong implementation site (School E) noted,

I think it worked really well. We would send emails to the teachers so there was good collaboration at that point and even just leaving to go and get SDQs and things like that helps build more relationship with staff. Staff are very helpful in helping us reach parents; I think it helped to collaborate a little more because I feel like when I’m in the schools I go kid after kid after kid, and I try my best to reach out to all of the teachers, but this gave me more of an opportunity to have a closer relationship with some of the staff.

She also stated, “The teacher sold the group, she got everyone interested. ... It was so fantastic, and she had parents’ numbers that staff didn’t have, so that was very helpful.”

Administration support and consultation

There was variability in the amount of perceived support from administrators across schools. Some clinicians felt supported by administrators at their schools. Clinicians at Schools C (moderate), D (moderate), and E (strong) perceived that their administrators supported their implementation efforts. A clinician at School D stated,

I built a good relationship with the principal, and when I knew I was going to do [Bounce Back], I went into her office and I just said I need second, third, and fourth grade teachers. She sent an email out saying ‘can you come in thirty minutes before work before school starts?’, so I did a little presentation with all the teachers. ... That’s how we got our referrals.

One clinician from School C (moderate) noted that her supervisor came to Bounce Back meetings with her. School-based clinicians at Schools A (strong), B (less effective), and F (less effective) felt that there was very little support from their administrators during implementation. In response to the question of support from their school, a school-based provider from School A stated, “I felt like I got zero support ... zilch.” A provider from School F responded “none.” School F’s school-based provider stated that her supervisor was unaware that she had been implementing Bounce Back: “My coordinator didn’t even know when I asked them about it, they [were] like, ‘Well, wait a minute. What do you have to participate in?’”

Community level

Community partnership

The relationship between school providers and partners varied across schools. Of the seven schools that participated in the focus groups, five of the schools were partnered with coleaders from community agencies. The other two school providers, School A (strong) and School D (moderate), were partnered with another provider at their school. School-based providers from Schools C (moderate) and E (strong) described the community partnership component as being essential for implementation given time constraints and competing demands on school-based providers. A provider from School C stated,

[My community partner] was awesome ... because of the prep time we just said, 'Divide it up into parts, you do evens, I do odds, and you know I'll glance over your part, if you need SOS I'll jump in and help,' but without that formulation it would have taken so much longer to read through all the stuff and make sure I knew every single session so that really helped, and just being confident in her skill set too, knowing that she was going to do her part and that it wouldn't be an issue.

Other schools had difficulty collaborating with community providers. At a less effective implementation site, the community provider was new to the school and parents were skeptical of her: "[The parents] were like 'What is this?' and 'Who is this extra person?' It was a challenge." The community provider at another less effective implementation site (at which the intervention was never started) stated that the partnership between him and his school-based partner was very challenging. The focus groups revealed that the partnership component played a large role in the overall effectiveness of Bounce Back implementation. However, whether the partner was school based or agency based did not appear to play a role in the effectiveness of the implementation.

Discussion

Bounce Back was developed in community partnership with school stakeholders to extend school-based cognitive behavioral group therapy for trauma to elementary-school-age children. Recent replication trials have found Bounce Back to be

effective in two low-income and high-need communities (Langley et al., 2015; Santiago et al., 2018). In this study, Bounce Back was piloted in a large urban school district using a model that attempted to pair community providers with school-based providers where possible. Within this pilot implementation, clinician focus groups were used to understand the challenges and strengths of Bounce Back implementation across schools. Barriers and facilitators of implementation are discussed next and organized by themes across the intervention, clinician, school, and community levels.

Intervention level

Overall, implementing clinicians were highly satisfied with the program. They remarked on the quality of the materials and the age-appropriateness of the activities. Clinicians discussed the effectiveness of several Bounce Back strategies, including progressive muscle relaxation, courage cards, and the trauma narrative. Bounce Back's parent sessions proved challenging for all the providers. However, all but one of the schools that implemented achieved at least partial parent engagement. Clinicians who engaged with parents stated that they believed that this was one of the most important components of the program. Clinician's noted initial reservations about the trauma narrative; however, clinicians from both groups stated that this was an effective component of the intervention. Other challenges associated with implementation were the overall time commitment involved in implementation, as clinicians stated that the program required significantly more time and energy as other manualized group CBT interventions utilized in the district. Despite these challenges, clinicians described Bounce Back as effective and stated that they would like to continue the program after the initial pilot program with supports (i.e., resources and scheduling accommodations).

Clinician level

Clinician flexibility and problem solving had an impact on how schools implemented Bounce Back. Domitrovich et al.'s (2008) model emphasizes the importance of professional and psychological characteristics of the school-based provider. All

schools had considerable challenges with limited resources and parent participation. However, clinicians who engaged in problem solving for obtaining referrals, encouraging parent participation, and adapting the intervention for their students' needs (e.g., facilitating the trauma narrative with the teacher instead of the parent) had the best implementation. All clinicians exhibited some level of flexibility; however, those who did not consistently use creative strategies to engage parents or problem solve had more difficulty overcoming barriers to implementation. Hence, along with school-level factors, clinician-level factors are important in determining the quality of implementation. This type of creative problem solving and flexibility can be supported by allowing time for peer consultation and collaboration among implementers where creative strategies can be shared (e.g., professional learning communities, online forums).

School level

Clinicians across all levels of implementation quality also identified several other barriers to implementing Bounce Back: competing demands, time constraints, and limited resources. Clinicians often have many other responsibilities, including managing individual caseloads, special education planning, and administrative tasks, which can impact their ability to learn and implement an EBT (Crisp et al., 2006). Moreover, clinicians discussed how the sensitive nature of the traumas addressed in Bounce Back often required more time and preparation than other interventions. Furthermore, limited resources, including access to a copier, group materials, and space to conduct groups, were identified as challenges. Consistent with the implementation literature, limited funding allocated to mental health care hinders schools from implementing or sustaining interventions over time (Pinkelman, McIntosh, Rasplica, Berg, & Strickland-Cohen, 2015).

Across the different levels of implementation strength, clinicians reported a strong need for trauma education in the community. Given the high rates of trauma among children, schools serve as a critical support system and ideal context for intervention (Bell, Limberg, & Robinson, 2013).

Clinicians echoed the need for both schools and communities to adopt a trauma-sensitive lens. Indeed, research has identified lack of trauma sensitivity as a critical obstacle to addressing trauma in the school system (Tishelman, Haney, O'Brien, & Blaustein, 2010). Often, symptoms of trauma exposure may be difficult to assess and confounded with attentional or behavioral issues (Tishelman et al., 2010). Moreover, in underserved communities, trauma may be viewed as a common occurrence and therefore normalized within these communities. This is consistent with research linking chronic trauma exposure to community violence with desensitization and normalization among urban youth (Ng-Mak, Salzinger, Feldman, & Stueve, 2004). Hence, schools that do not operate with a trauma-sensitive lens may not readily identify children exposed to trauma, which can deter the implementation of EBTs for trauma or place the burden of educating school staff about trauma on implementers.

Among moderate and strong implementers, relationships with teachers and staff helped in identifying referrals and strengthened relationships between providers and teachers. Teacher "buy-in" has been associated with successful implementation and sustainability in schoolwide intervention programs in other research (Pinkelman et al., 2015). When teachers or staff see the need for these programs and generalize the treatment's core components to their classrooms, they may be more likely to support EBTs. Similarly, administration support and consultation is a strong factor in successful implementation (Pinkelman et al., 2015). Past studies have found that administrators who oversee the implementation, are present for training and consultation, and believe in the need for such an intervention have an instrumental role in promoting implementation (Forman, Olin, Hoagwood, Crowe, & Saka, 2009). The current study was consistent with these findings, as schools with moderate and strong implementation reported the most administration support. In contrast, schools with administrators who offered limited support or had limited knowledge about Bounce Back seemed to struggle more. Less effective administrative support can lower morale and exacerbate the competing demands faced by many clinicians (Domitrovich et al., 2008). However, strong implementation at

School A was noted even in the context of lower levels of administrative support. Strong teacher–clinician partnership, cofacilitator collaboration, and high levels of flexibility appeared to compensate for this challenge.

Community level

A unique component of this implementation of Bounce Back was the partnership between school providers and community agency clinicians. School-based clinicians that collaborated with their community partners were able to lessen the burden of the time intensity of the program and prepare in advance for Bounce Back. In accordance with the literature, having strong school–community partnerships may expand the quality of services for children in these contexts (Valli, Stefanski, & Jacobson, 2014). Regarding the less effective implementation sites, those who did not have a good working relationship with their community/school-based partner had difficulty sustaining or starting Bounce Back. Therefore, given the complex nature of treating trauma under the constraints of time and resources, having a coleader from the community may be instrumental in implementing an EBT. For example, successful partnerships may have benefitted from community partners' availability to screen students, prepare materials for group, communicate with parents and process sessions with coleaders afterward. This combined with the knowledge that school-based clinicians had regarding participating families and existing relationships with the school community allowed for effective division of labor. However, trainers should attend to the relationship between the school and community-based clinicians, clarify the roles for each of the clinicians, and provide time for collaboration to ensure this collaboration facilitates implementation and does not become a challenge.

Implications

There are several implications of the present study. First, results supported Domitrovich et al.'s (2008) model of multiple levels of systems affecting implementation success: Individual factors, school factors, and community factors all impacted Bounce Back

implementation. These findings underscore the importance of supporting school-based providers at multiple levels. This study found that administrative support was a key element in effective implementation. School-based EBTs should be implemented with school administration preferences in mind, and school administrations should be encouraged to actively engage with intervention providers. Teacher awareness and support, another important factor in implementation success, should also be cultivated. Trauma interventions like Bounce Back may benefit from being implemented in “trauma-sensitive schools,” schools that are trained in understanding the effects of trauma and use this knowledge to put in place schoolwide supports (Cole, Eisner, Gregory, & Ristuccia, 2013). Schools that have already made efforts to become trauma sensitive will likely have higher levels of trauma awareness and teacher buy-in for a trauma-focused intervention—two factors that were identified as important for referral and implementation in this study. Further trauma-sensitive schools (e.g., NCTSN, 2017) typically incorporate classroom skill building, view behavior through a trauma lens, and work to resist retraumatization through a trauma aware and responsive classroom and building. These more universal approaches would complement and likely augment the more intensive intervention occurring in Bounce Back. Still, many schools that serve students in need of Bounce Back may not have yet taken on formal efforts to become trauma sensitive. Although this should not prohibit schools from implementing Bounce Back, it may mean that clinicians will need to provide education about trauma to school staff and be supported in such efforts. Some recommendations for how to provide this type of psychoeducation to school staff are included in training and supported implementation of Bounce Back but could be augmented in schools that have not had previous exposure to this information.

Providers succeeded when they had a high level of flexibility; however, given the competing demands and limited time and resources that school-based clinicians often confront, policies that promote clinician flexibility and reduce clinician burnout should be examined as promoters of trauma-focused EBTs. Finally, this study found a more nuanced picture of the qualities that lead to strong implementation than has been presented in past research. For one, publicly

available data on school environment, leadership, and family involvement did not explain all differences in implementation strength. Schools with the most supportive environments did have the strongest implementation; however, some schools with weak environments implemented with moderate success. Data revealed that, although administration support is ideal, implementers could compensate for one weakness with another strength. For example, one school that perceived low administrative support had a strong relationships with their community partners and teachers, which led to an overall strong implementation. This finding is in contrast with past research showing the central importance of organizational climate for successful implementation of EBTs (Williams, Ehrhart, Aarons, Marcus, & Beidas, 2018). In the present study, lower organizational support was overcome by higher support from community partners and teachers in the school. Weaker overall school environments may be buffered from poor implementation outcomes when provided with additional resources, including partnering with community agencies. Future research should examine the relative importance of these factors in determining EBT implementation and sustainability.

Limitations and future directions

Limitations of this study include the small sample size and missing data. Clinicians at schools varied in reporting consistency of child outcome data, and therefore several schools were missing treatment outcome data. Given the real-life setting, fidelity was self-reported and no observational fidelity ratings were obtained. Finally, although the focus group format promoted creative discussion, some participants may have had ideas that differed from the group that they did not state because of implicit pressure to conform to group opinions.

Clinicians discussed several recommendations for scale-up, such as incorporating online support for clinicians (i.e., accessing materials online, engaging with parents online). Clinicians also discussed wanting support in processing the emotional impact of delivering a trauma intervention and discussing creative strategies with other providers. In addition, future research should examine trauma-sensitive schools and whether overall

trauma knowledge of the school improves the implementation of Bounce Back. Finally, research should continue to focus on the unique perspectives of providers when implementing EBTs.

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Appendix. Example items from codebook

	Bounce Back	Individual Characteristics (Clinician)	School Characteristics (Teachers/Administrators)	Community Level (Macro)
Ideological Fit	<ul style="list-style-type: none"> • Applicability 	<ul style="list-style-type: none"> • Perceived social emotional concerns • Attitudes toward groups (EBT) • Attitudes toward trauma 	<ul style="list-style-type: none"> • Perceived social -Emotional concerns • Attitudes toward groups (EBT) • Attitudes toward trauma 	<ul style="list-style-type: none"> • Need • Parent participation • Attitudes toward trauma
Adaptability	<ul style="list-style-type: none"> • How flexibly the materials could be applied 	<ul style="list-style-type: none"> • Flexibility/problem solving 		
Demographics		<ul style="list-style-type: none"> • Years in school • Years in EBT Diverse identity (e.g., gender, race) 	Cultural match with providers	
Resources	<ul style="list-style-type: none"> • Materials • Online support 	<ul style="list-style-type: none"> • Competing demands • Time constraints 	<ul style="list-style-type: none"> • Space availability • Paper and printing • School as a community resource 	
Supervision/ Training	<ul style="list-style-type: none"> • Training • Consultation/Coaching 	<ul style="list-style-type: none"> • Collaboration with peers 	<ul style="list-style-type: none"> • Supervision quality • Multiple supervisors 	<ul style="list-style-type: none"> • Consultation • Evaluation
Core Elements	<ul style="list-style-type: none"> • Quality of content • Generalizability of content • Delivery 			
Systems Interventions	<ul style="list-style-type: none"> • Referral/group formation 		<ul style="list-style-type: none"> • Teachers' relationships with students • Teachers' relationships with parents 	<ul style="list-style-type: none"> • Community partnership • Tier 2 requirements

Note. EBT = evidence based treatment.