








Implementing a healthy lifestyle program in residential out-of-home care: What matters, what works and what translates?

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Abstract

The Healthy Eating, Active Living Matters (HEALing Matters) program is being scaled up across residential out-of-home care (OOHC) in Victoria, Australia and is providing young people with the knowledge, skills and resources to promote better health through healthy eating and activity. HEALing Matters was piloted as the HEAL program, a dual-intervention program that aimed to provide young people living in residential care with education and opportunities to improve their eating and physical activity habits, while simultaneously building the capacity of their carers to promote, encourage and role model healthy lifestyle behaviours. Qualitative findings indicated that HEAL resulted in increased participation in community sport, increased availability of sports equipment, healthy meal preparation and healthy food availability and improvements in perceived young person self-esteem and independent living skills. Findings also revealed some limitations of the program. Following the pilot, a participatory methodological approach was used to better understand how to align the HEAL program with individual and community needs. This approach engaged diverse stakeholders to better understand the barriers and enablers, address limitations, identify key intervention points and build trust and a shared vision to co-design the HEALing Matters program. HEALing Matters is now delivered within a framework that is informed by attachment, trauma and resilience theories. This paper outlines the HEALing Matters journey from what matters, to what works, to what translates in relation to a healthy eating and active living intervention in OOHC.

KEYWORDS

healthy lifestyle, implementation, out-of-home care, scale-up

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In Australia, out-of-home care (OOHC) refers to court-ordered temporary, medium or long-term living arrangements for children and young people (herein referred to as young people) who are unable to live with their families (Commission for Children and Young People [CCYP], 2019). This includes kinship, foster and residential care and lead tenant arrangements. Recent national statistics indicate that, 7% of young people living in OOHC reside in residential care settings, where paid staff provide care in a residential building (Australian Institute of Health and Welfare [AIHW], 2021). It is well established that in comparison to their peers, young people in OOHC experience higher rates of poor physical and mental health, including developmental delays and disabilities (Cox et al., 2016; Hatzikiriakidis et al., 2021; Monson et al., 2020; Norrish et al., 2019; Smales, Savaglio, Morris, et al., 2020). As a result of the trauma they have experienced, they are also at increased risk of substance abuse, and other ongoing health concerns, resulting from inadequate or inconsistent access to preventative healthcare, including increased risk of chronic disease, such as obesity (Smales, Savaglio, Morris, et al., 2020; Smales, Savaglio, Webster, et al., 2020; Smales et al., 2021). Historically, significant disadvantage across a range of other domains has also been documented among young people in OOHC, including placement instability (Bollinger et al., 2017), poorer access to education and academic underachievement (Forsman & Vinnerljung, 2012; Trout et al., 2008), underemployment and reliance on social welfare payments (Dixon, 2007; Mendes, 2009) and an increased risk of involvement with the criminal justice system (McFarlane, 2017; Mendes et al., 2014). Furthermore, young people experience an increased risk of housing instability and homelessness upon the conclusion of their placement and their transition into independent living (CCYP, 2020; Martin et al., 2021; Muir et al., 2019).

The Healthy Eating, Active Living Matters (HEALing Matters) program is being scaled up across OOHC in Victoria, Australia, as an intervention to provide young people with the knowledge, skills and resources to promote better health through healthy eating and physical activity. The journey to this point of scale up has been a long one. The aim of this paper is to outline this journey from what matters, to what works, to what translates in relation to a healthy eating and active living intervention in OOHC. The findings of our formative research and randomised trial, the co-designed¹ adaptations of our existing intervention based on the limitations of, and lessons learned from the trial, and the widespread implementation of HEALing Matters, using the National Implementation Research Network's (NIRN) Active Implementation Formula as an organising framework, are presented and discussed below.

1 | WHAT MATTERS AND WHAT WORKS FOR HEALTHY LIFESTYLE INTERVENTION

In 2011, we reported that only six peer-reviewed studies had been published on overweight/obesity in young people in OOHC, revealing that (1) internationally, the rates of overweight/obesity increased

What is known about this topic?

- Young people in out-of-home care (OOHC) experience higher rates of poor physical and mental health, because of the trauma they have experienced, compared with their same aged peers not living in care.
- There is a need for health improvement programs and/or interventions in residential OOHC.

What this paper adds?

- Population and contextual factors impact the feasibility and acceptability of conducting efficacy trials in this setting.
- It is feasible to train, resource and support the OOHC sector to positively influence a young person's eating and/or physical activity habits.
- Participatory approaches in combination with implementation frameworks can identify the factors likely to influence the adoption, implementation and sustainment of interventions in residential OOHC.

significantly while young people in care and (2) there was a paucity of interventions focused on addressing overweight/obesity in these young people (Skouteris et al., 2011). This review paper initiated our formative research. We then published the first Australian study to (1) report rates of overweight/obesity among young people living in residential OOHC and (2) use objective measures of young people's height and weight (Cox et al., 2014). Almost two thirds of the young people (62.8%) were classified as being overweight/obese ($n = 78$; age range 12–17 years; 22.3% of the total number of young people in residential care at the time; Cox et al., 2014). We also showed that residential carers' knowledge of healthy lifestyles was poor and compounded by a lack of support, training and resources, specific to fostering a healthy lifestyle for young people (Cox et al., 2015). Finally, we found young people living in OOHC have high rates of disordered eating (Cox et al., 2016; Cox, Emond, et al., 2017; Norrish et al., 2019; Savaglio et al., 2019).

Collectively, our formative research led to the development and randomised trial evaluation of the 'HEAL program' (Australian Research Council Linkage (LP120100605)). HEAL was a dual-intervention program that aimed to provide young people living in residential care with education and opportunities to improve their eating and physical activity habits, while simultaneously building the capacity of their carers to promote, encourage and role model healthy lifestyle behaviours (see Cox, Skouteris, et al., 2017; Cox et al., 2018 for further description of the HEAL program). HEAL was delivered by trained coordinators and was evaluated using a randomised trial in 48 residential OOHC homes (25 allocated randomly to the intervention and 23 to the control) across three community service organisations in Victoria (Cox, Skouteris, et al., 2017). Qualitative findings indicated that HEAL resulted in (1) increased

participation in community sports groups and healthy meal preparation; (2) increased availability of sports equipment; (3) conscious effort by staff to provide healthy snacks/meals and (4) improvements in carers' perceived self-esteem and independent living skills of young people (Cox et al., 2018). Interviews with key stakeholders (including residential carers and HEAL coordinators) also revealed limitations of HEAL, including the following: (1) lack of a trauma informed philosophy to guide carers' understanding of the lifestyle behaviours of young people and how they can be improved; (2) lack of cultural connectedness to Indigenous young people in OOH, which was identified as a significant gap given that there is currently an over-representation of Aboriginal and Torres Strait Islander young people in the Australian OOH system (Aboriginal and Torres Strait Islander young people are eight times more likely to receive child protection services compared with non-Indigenous young people and have an elevated risk of experiencing poor outcomes upon leaving care; AIHW, 2021; CCYP, 2020; Hunter et al., 2020) and (3) a sole focus on individual behaviour change, and ignoring the presence of organisational practices and/or policies.

2 | WHAT TRANSLATES—IMPLEMENTING HEALING MATTERS INTO PRACTICE

Following the randomised trial, a workshop (led by a systems science expert from City University, NY) was held with 20 key stakeholders. This group was convened to identify the resources, system and community infrastructure and strategies needed to activate and support positive behaviour change and effectively implement 'HEAL' interventions in residential OOH in Victoria. Three key intervention points were identified: (1) increased buy-in (at organisational level); (2) improved credentialing/qualification (direct-care staff) and (3) broader system reform, including adaptation of existing policies and development of new policy directions. This method of incorporating knowledge from diverse stakeholders generated a health promotion agenda focused on potential system and sector improvements, as well as modifiable lifestyle attitudes and behaviours (at the service provision and individual (young person and carer) levels).

Following this workshop, we adopted a participatory methodological approach to engage key stakeholders once again (including those who provide beneficiary input, such as residential carers and young people with lived experience) to better understand how to align the HEAL program with individual and community needs. This included the first named author spending 1 year working in residential OOH. Two young people with lived experience of OOH were also employed to work in our team as research assistants, one of whom is currently undertaking a PhD. Peer research, a participatory approach to research where members of the target population embed themselves as researchers, offers an opportunity for researchers to apply their shared experiences and better understand the issues faced by their community (Dixon et al., 2019). Specific roles included the following: contributing to and reviewing data collection methodology and co-hosting/facilitating youth participation

workshops to inform program content. We also worked closely with local Victorian Aboriginal organisations via workshops and invitations to review and provide feedback on the training content. This approach allowed us to address the identified limitations of the randomised trial, better understand the barriers, enablers and needs of the target population (i.e. residential OOH) and co-design the HEAL program (now HEALING Matters). This co-design process allowed us to build trust and promote a sense of shared vision in young people, their carers and community service organisation providers for system change and co-ownership of HEALING Matters.

Through this co-design process, we also addressed the limitations of the HEAL pilot and built upon the findings of our initial exploratory research, including the lessons learned from our evaluation of the HEAL program (Cox, Emond, et al., 2017; Cox, Skouteris, et al., 2017; Cox et al., 2016, 2018; Green et al., 2021; Norrish et al., 2019). The HEALING Matters intervention is now delivered within a framework that is informed by attachment, trauma and resilience theories. Importantly, HEALING Matters has moved beyond a solely behavioural approach to healthy eating and active living to one that recognises that food and physical activity are a powerful way of demonstrating trust, care, predictability, flexibility and attuned parenting. Hence, training, resourcing and supporting the sector to positively influence a young person's eating and/or physical activity habits provides an opportunity to improve carers' skills: to respond appropriately, and therapeutically, to young people's pain-based behaviour; and prepare young people for a healthy future by using food and activity to normalise their experiences, promote socially acceptable behaviours, and instil a sense of belonging, value, trust, safety, security and predictability.

As can be seen from the information provided above, the scale up of HEALING Matters has not followed the typical trajectory of moving from a successful efficacy trial to an effectiveness trial, and then to dissemination research and scale-up (Glasgow et al., 2003). The highly transient nature of this population (both young people and carers in OOH), coupled with young people's vulnerability, impacted recruitment, participation and retention of our randomised trial and only trends towards positive shifts in lifestyle health behaviour change were found (Cox, Skouteris, et al., 2017). Other researchers in this field have also questioned the feasibility and acceptability of conducting efficacy trials in OOH (Dixon et al., 2014; Mezey et al., 2015). In contrast, our extensive qualitative research with key stakeholders showed they all agreed there was a need for a HEAL program in residential OOH. Our qualitative research also informed necessary revisions to the intervention, demonstrated feasibility for scale-up across OOH, and revealed the factors likely to influence the adoption, implementation, and sustainment of the intervention in the next phase of research—state-wide implementation (Cox et al., 2018).

The widespread implementation and scale-up of HEALING Matters was informed by the NIRN's Active Implementation Formula (Metz et al., 2017). This formula stipulates that to achieve socially significant impact, an intervention needs to be (1) evidence-based; (2) match the needs, values and goals of participating organisations; (3)

implemented in a considered and adaptive manner and (4) supported by hospitable environments that use data to ensure continuous quality improvement (CQI; Metz et al., 2017). We have used this formula as an organising framework to guide our HEALing Matters implementation across residential OOHC, mapped to the following stages of implementation: Exploration, Installation, Initial Implementation and Full Implementation (Bertram et al., 2015). Below we outline each of these stages and provide the findings of research conducted to evaluate them.

3 | EXPLORATION STAGE

The overall goal of the exploration stage is to determine how well a program or intervention aligns with the organisation, community and system needs and whether implementation is feasible (Bertram et al., 2015; Metz & Bartley, 2012). For HEALing Matters, the exploration phase focused on the 'effective practices' component of the NIRN formula and involved assessing the needs of the community, determining appropriateness (e.g. acceptability, perceived fit and compatibility of HEALing Matters for implementation in residential OOHC) and evaluating the feasibility of implementing HEALing Matters at scale.

3.1 | Data indicating need

Both qualitative data (collected via post-training semi-structured interviews, $n = 27$ residential carers from six Community Service Organisations) and quantitative data (collected via online surveys embedded within the training platform, $n = 613$ residential carers from 12 Community Service Organisations) explored how well HEALing Matters meets the needs of our target population (see Supporting Information for a full description of the study methodology). At baseline, less than a quarter (23.0%) of survey respondents reported that their organisation offered training to improve carers' health literacy, and only half of respondents (49.9%) felt they could easily access information to support young people to lead a healthy lifestyle. These findings were reinforced during post-training interviews with staff, with participants highlighting that prior to implementation of HEALing Matters, there was a lack of adequate training to build the capacity of staff to encourage healthy lifestyle behaviours among the young people in their care. There was a general sense that this was 'assumed' knowledge:

I think with a lot of these things [encouraging healthy lifestyle behaviours] it's assumed that we know how to do them. Like how to cook nutritious meals. But I don't know if all staff have that education or that lived experience. [Interview, Staff 6]

Prior to beginning HEALing Matters, residential carers were asked to indicate their level of agreement with the statement '*There is a strong*

need for HEALing Matters' (using a 7-point Likert scale (1 = strongly disagree, 7 = strongly agree)). The baseline survey completed by 613 residential carers indicated that most respondents (62.6%) either strongly agreed or agreed that there is a strong need for HEALing Matters. We also assessed whether carers' perceptions regarding the need for HEALing Matters changed from baseline to post-training completion. Using data from 421 residential OOHC staff who completed both surveys, a Wilcoxon signed-rank test revealed a non-significant difference in the level of agreement with the statement '*There is a strong need for HEALing Matters'*'; $Z = 1.713$, $p = 0.09$. This indicates that for carers who agreed there was a great need for HEALing Matters prior to commencement of their training, this perception was maintained upon completion.

3.2 | Data indicating appropriateness

Proctor et al. (2011) define appropriateness as 'the perceived fit, relevance or compatibility of the innovation or evidence-based practice for a given practice setting, provider or consumer; and/or perceived fit of the innovation to address a particular issue or problem' (p. 69). Feedback regarding the appropriateness of HEALing Matters for residential OOHC was again collected via quantitative surveys and post-training interviews with staff. During the post-training survey, participants were given the opportunity to provide feedback regarding the quality of the training program via free-text responses. A total of 363 participants provided feedback, and their responses were analysed using inductive content analysis and an iterative process of open and axial coding (Elo & Kyngäs, 2008). Feedback from participants who completed the HEALing Matters training frequently described the training as '*educational and informative*', '*relevant to their role as a residential carer*', '*helpful*', '*useful*', '*valuable*' and '*worthwhile*'. This is reflected in the following comments:

The HEALing Matters training program acknowledges and supports every individual within the residential program, i.e., young people, residential carers, supervisors, management. It teaches us how to manage ourselves and each other through the process of building self-esteem, confidence, good health practices, positive growth, security and endurance. It heals whatever matters in our personal and work life. [Survey, Staff 93]

It [HEALing Matters] is probably one of the more relevant trainings that I've done because you can see the link through everything we do. It's not, we're doing this training and it's just going to help us in this one area—it goes across everything we do. [Interview, Staff 10]

The top four reported reasons residential carers found the training beneficial were as follows: (1) it enhanced their practice, work

performance and/or skillset; (2) reinforced prior learning and built upon other completed training; (3) provided opportunities for self-reflection and (4) improved their own self-care practices. Participants were further asked to comment on their perceptions regarding how well HEALing Matters 'fit' within existing work processes. Most participants ($n = 325$, 70.2%) strongly agreed or agreed that delivering HEALing Matters is part of their role as a residential carer. The top three reasons carers reported HEALing Matters is a good fit included the following: (1) it complements existing household practices and expectations regarding 'good' practice; (2) the principles of HEALing Matters are relevant to the care giving role and work setting and (3) HEALing Matters addresses current gaps in knowledge. Some examples of comments included the following:

But as far as the program goes, I think it's a fantastic initiative. I know that every module has so many resources and all sorts of things that are really fabulous in the residential care environment. And I think that they are relevant and fit in to that environment really well. [Interview, Staff 16]

I liked how it was health focused because almost no other training goes through that, and I was able to learn things I didn't already know. [Interview, Staff 3]

HEALing Matters fits well into the frame of our existing work processes and practices, and our role within residential care. [Survey, Staff 173]

The large majority of staff who participated in post-training interviews ($n = 27$) also specifically indicated that HEALing Matters is compatible with their own personal values and existing programs within their organisation:

I think nutrition is really important and it kind of goes hand in hand with the total wellbeing of our young people. So, yes, I think it does align well with what we try to do with the kids anyway. [Interview, Staff 11]

3.3 | Data indicating feasibility

Proctor et al. (2011) define feasibility as 'the extent to which a new treatment, or an innovation, can be successfully used or carried out within a given agency or setting' (p. 69). For each of the six core training modules (see Supporting Information for module descriptions), we assessed potential implementation behaviour determinants using survey items informed by the Determinants of Implementation Behaviour Questionnaire (DIBQ; Huijg et al., 2014)—these determinants provide insight into carers expectations regarding the implementation of HEALing Matters in practice. Specifically, we assessed frequency of 'strongly agree' and 'agree' responses for each core module, across the following items: knowledge, skills, confidence,

attitude (i.e. carer perception that HEALing Matters is worthwhile), intention and motivation (to put module information into practice). For all domains, except confidence, more than 75% of residential carers strongly agreed or agreed with each item. This suggests that carers felt they had the knowledge and skills to implement HEALing Matters and that doing so is worthwhile. Carer's confidence in implementing the program—where a young person(s) was not motivated—was less certain. Further qualitative exploration revealed that for a small number of staff, they found it difficult to engage the young people in adopting either healthy eating practices or increased participation in physical activity. This was noted as a potential barrier to implementation and highlighted the importance of developing additional strategies/tools to boost carer confidence/self-efficacy to use HEALing Matters in practice with young people who are disengaged. Finally, regarding carers' motivation and intentions, overall, the results imply carers had good intentions to implement HEALing Matters in practice, and they were optimistic about having a positive influence on young people's healthy lifestyle behaviours. In post-training interviews, the results of which are forthcoming, residential carers talked optimistically about using the training in practice and provided examples of 'healthy' changes they have implemented within their residential homes.

Overall, analyses indicate that HEALing Matters is a valuable program, which is viewed as a worthwhile adjunct to the residential OOH program. Key stakeholders reported a good fit between the program and community needs, and staff reported that participation in HEALing Matters led to positive behaviour change and 'healthier' habits. This highlights the appropriateness and feasibility for staff to be trained, resourced and supported to positively influence a young person's eating and/or physical activity habits.

4 | INSTALLATION STAGE

It is widely recognised that effective implementation requires robust infrastructure supports (including practice, organisational and system supports) and capacity-building strategies (Metz et al., 2017; Meyers et al., 2012). To this end, the installation stage is concerned with examining the structural supports that are necessary to embed an innovative intervention within the context of interest (Bertram et al., 2015). This stage focused on understanding the 'effective implementation' component of the NIRN formula and included (1) an assessment of the necessary organisational and system supports for implementation success and (2) developing staff competency—in the case of HEALing Matters this refers to the competency of residential workers and carers. The discussion in this section will focus on our chosen implementation drivers—defined as the 'core components or building blocks of the infrastructure needed to support practice, organisational and systems change' (p. 49, Metz et al., 2017). Implementation of HEALing Matters relied on a multi-pronged approach made up of the following elements: (1) competency drivers—mechanisms used to develop, improve and sustain residential carers ability to implement HEALing Matters and positively influence

young people's health and well-being; (2) organisation drivers—organisational supports that ensure staff are effectively supported to implement HEALing Matters and (3) leadership drivers—which includes responsive strategies to address identified barriers (discussed in the third stage of implementation; Metz et al., 2017).

4.1 | Competency drivers

Agencies across Victoria have prioritised opportunities to upskill staff and complete the HEALing Matters training. In the case of HEALing Matters, competency drivers focused on training the existing residential care workforce to promote staff competency and confidence to implement HEALing Matters in practice. Specific competency drivers used at this stage included (1) professional development training for residential OOH staff and (2) implementation resources (e.g. video and printable healthy recipes, team talk kits (reflective practice questions used to facilitate individual reflection or group discussion in team meetings), access to professional support)—both were provided through an online platform (see: <https://healing-matters.org>). Eighty-five percent of Community Service Organisations in Victoria agreed to implement HEALing Matters in Victoria, with 50% considered 'highly engaged'. In this installation phase, over 1300 residential carers registered to complete the training and 501 staff completed the HEALing Matters training.² Data were collected to assess gains in knowledge and skills based on completion of the six core HEALing Matters training modules and to determine both the ongoing training needs and interests of carers.

4.2 | Gains in skills and knowledge

Many factors can potentially influence the effective transfer of knowledge into routine practice, including an individual's skills, attitudes and how HEALing Matters fits within their professional role and identity (Huijg et al., 2014). Subsequently, to better understand residential carers' implementation behaviours, directly after completion of the six core training modules, we assessed carers' knowledge, skills and role clarity using the DIBQ (Huijg et al., 2014). A total of 463 staff completed the post-training survey, including the DIBQ, and encouragingly most participants strongly agreed or agreed that that they had the knowledge and skills to deliver HEALing Matters, and reported that the program is compatible with their role as a residential carer (Table 1).

Online surveys completed by residential carers (pre- and post-training) were also used to measure change relating to increased competencies and knowledge attainment ($n = 421$), and a series of Wilcoxon-signed rank tests were conducted to evaluate the significance of the difference between assessment time-points. See Table 2 below for a summary of outcomes measured. Overall, the results suggest carers had good intentions to implement HEALing Matters in practice, and they were optimistic about having a positive influence on young people's healthy lifestyle behaviours.

TABLE 1 Participant agreement with DIBQ items ($n = 463$)

Determinant of implementation	Proportion of participants who agreed: n (%) ^a
I know how to deliver HEALing Matters	319 (68.9)
I have been effectively trained to deliver HEALing Matters	294 (63.5)
Objectives of HEALing Matters and my role within them are clearly defined	322 (69.5)
I have the skills to deliver HEALing Matters	324 (70.0)
Delivering HEALing Matters is part of my role as a residential carer	325 (70.2)

Abbreviations: DIBQ, Determinants of Implementation Behaviour Questionnaire; HEALing Matters, Healthy Eating, Active Living Matters (HEALing Matters).

^aFigures reported in this table are reflective of the proportion of participants who responded with 'Agree' or 'Strongly Agree' with each of the statements presented.

4.3 | Ongoing training needs and interests of carers

Over the course of implementation, key stakeholders (e.g. residential carers, therapeutic practitioners, case managers, etc.) fed back additional content areas they would benefit from additional information, strategies and resources to promote optimal health and well-being among the young people in their care. Based on this feedback, eight new modules were developed and incorporated into the HEALing Matters Training package: (1) Understanding Eating Behaviours; (2) Sexual Health and Respectful Relationships; (3) Oral Health; (4) Physical Activity and Disability; (5) Healthy Eating and Disability; (6) Gender and Sexuality Diversity; (7) Living Smoke Free and (8) Mental Health. In response to the coronavirus (COVID-19) pandemic, an information hub providing carers with the latest evidence-based information on the pandemic, and how they can continue to support the health and well-being of the young people in their care was also developed by the HEALing Matters team. As a 'one-stop shop' for carers, its value is clear:

Yes, that would definitely be more proactive for us on the floor to just have the one space [for health and wellbeing information]. Because at the moment [prior to HEALing Matters], we very much have to go to multiple different places. We don't have that opportunity to go to the one place and get everything that we need. [Interview, Staff 10]

4.4 | Organisation drivers

Organisation drivers are those factors that create a hospitable environment for implementation; that is, the organisational supports

TABLE 2 Participant competencies and knowledge attainment

	Outcome	Evidence
General health promotion	Increased understanding of health promotion necessary to improve the health and well-being of young people	Statistically significant increase in agreement with the following survey item: I have a high standard of knowledge to contribute to the continuous improvement of the health and well-being of young people in out-of-home care; $Z = 4.648$, $p < 0.001$
Nutrition	Increased understanding of what constitutes a healthy diet	Statistically significant increase across the following variables: My understanding of the Australian Dietary Guidelines to my role as a residential worker or carer is of a high standard; $Z = 7.942$, $p < 0.001$ I consistently apply the Australian Dietary Guidelines to my role as a residential worker or carer; $Z = 7.969$, $p < 0.001$
	Increased confidence in providing/suggesting healthier food options to young people	73% of participants strongly agree or agree that they felt confident to use the health information provided in the training, even when there is little time
	Increased motivation to provide/suggest healthier food options to young people	78% of participants strongly agree or agree that they felt motivated to put the information provided in the training into practice
	Increased intention to prioritise healthy food options in the home	81% of participants strongly agree or agree that they will definitely attempt to use the health information provided in the training for and with the young people they care for in the near future
Physical activity	Increased in understanding of the importance of regular activity	Statistically significant increase across the following variables: My understanding of the Australian Physical Activity and Sedentary Behaviour Guidelines to my role as a residential worker or carer is of a high standard; $Z = 9.513$, $p < 0.001$ I consistently apply the Australian Physical Activity and Sedentary Behaviour Guidelines to my role as a residential worker or carer; $Z = 9.417$, $p < 0.001$
	Increased confidence in encouraging young people to participate in community sport and recreation activities	69% of participants strongly agree or agree that they felt confident they could encourage the young people to engage in physical activity ^a
	Increased motivation to provide/suggest opportunities to increase physical activity	80% of participants strongly agree or agree that they felt motivated to put the information provided in the training into practice 82% of participants strongly agree or agree that they felt motivated to encourage young people to engage in physical activity
	Increased intention to prioritise and support young people to prioritise physical activity in their daily routine	80% of participants strongly agree or agree that encouraging young people to engage in physical activity is a priority 84% of participants strongly agree or agree that they will definitely encourage the young people to engage in physical activity in the near future
Trauma-informed care	Increased standard of knowledge to work from a trauma informed philosophy	Statistically significant increase in their standard of knowledge; $Z = 3.488$, $p < 0.001$

^aData were collected during the Coronavirus (COVID-19) pandemic, it is likely that physical activity participation was impacted at the time of data collection, due to Victoria being in an extensive lockdown in which all sports/physical activity/recreation centres were closed. Despite these restrictions, homes did report maintaining active living at home.

and systems in place that ensure that residential care workers who are implementing HEALing Matters are effectively supported, and that data is collected and used to inform CQI (Metz et al., 2017).

At this stage of implementation, the organisation drivers focused on facilitative administration and included the following: (1) a HEALing Matters contact person assigned from each area of the

participating organisation; (2) an agreement of the necessary steps to establish the local capacity to implement the HEALing Matters training within each participating residential home and (3) clarification of the level of support required for the successful implementation of HEALing Matters training (e.g. who managed implementation at the local level, did the organisation allocate additional paid time for staff to complete the training or were staff required to complete the training within their current workload). Systems intervention, (e.g. collaborative partnerships, policy, advocacy and funding) was also used during the installation phase of implementation. This included brokerage funding, which was provided to residential homes to incentivise training completion. Specifically, HEALing Matters booster grants were offered to support residential care staff implementing HEALing Matters in practice to make changes to the home environment that encourage young people to eat healthy and be active. Grants could also be used to support young people to meet their individual health and well-being goals. Upon completion of the six core training modules, grant payments of \$250 per residential worker or carer (up to a maximum of \$1000 per residential home) were provided to participating community service organisations. This funding was used to purchase physical activity equipment (e.g. basketball ring, boxing equipment, bikes, etc.), fitness trackers, exercise machines (e.g. treadmill, exercise bike, rowing machine), gardening equipment/supplies (to plant a vegetable garden) and cooking utensils/kitchenware. As a direct result of this funding, we saw increased availability of equipment to promote physical activity in the home. Through data collected from surveys and semi-structured interviews, staff reported an increase in the availability of physical activity equipment (e.g. gym and sporting equipment, trampolines and bicycles) on conclusion of the training program, alongside an increase in frequency of use from pre- to post-training completion. Funding was also used to purchase kitchenware and cooking utensils. This encouraged increased participation in meal preparation, which carers acknowledged as an important step to developing young people's skills for independent living. Feedback from residential carers about the HEALing Matters booster grants included the following:

We got funding for the boxing bag and things like that. We used some funding to get some new pots and pans as well. The funding actually helped a lot because we were able to get things that we needed. [Interview, Staff 4]

We are slowly getting equipment to make a gym in the garage, which is just going to be so good. Kids are really interested in doing that, like boxing and getting a bike. And we've recently got bikes for the house so that we can do activities with the kids, because often they'll be like, 'We want to go for bike rides', and we're like, 'We would but we don't have the equipment'. [Interview, Staff 5]

Other systems intervention included in this phase of implementation included, regular meetings with our funding body regarding systems collaboration activities and expert advice and support offered to community service organisations during implementation.

4.5 | Opportunities to strengthen implementation of HEALing Matters in practice

During the installation phase, feedback was sought from staff and other key stakeholders via interviews ($n = 27$) and workshops to determine the barriers to and opportunities for implementation improvement. Overall, participation in the HEALing Matters training was highly valued. When prompted to discuss what worked well in implementation, carers identified several contextual factors that positively influenced the implementation of HEALing Matters. This included the following: (1) strong engagement by leadership; (2) keeping HEALing Matters on the radar (i.e. including HEALing Matters as a standing agenda item to discuss during their team meetings (staff) and/or house meetings (staff and young people)); (3) engaging a HEALing Matters 'champion' within the home and (4) adequate resourcing—the booster grants facilitated implementation of HEALing Matters in practice because the funding allowed carers to purchase necessary items to engage young people in healthy lifestyle behaviours. Key barriers faced when implementing HEALing Matters, were also identified by residential carers. Although it was a minority, several participants provided feedback on the degree of support provided by the broader organisation, beyond their immediate residential home environment. Specific reference was made to a poor introduction to the program (i.e. they had limited or no awareness of the HEALing Matters training prior to beginning implementation), and HEALing Matters was not considered a priority (due to competing staff pressures associated with client complexity and staff shortages). For some participating agencies, training uptake was significantly impacted by the Coronavirus (COVID-19) pandemic. Staff provided examples of further support that they would like to see from their organisation regarding implementation of HEALing Matters. Examples included (1) dedicated time outside of their current role to complete the training; (2) dedicated time for group discussion/reflective practice sessions—relative to the training content; (3) increased accountability for training completion; (4) whole-team approach (i.e. expectation that staff at all levels of the organisation who work directly with young people in residential care would complete the training); (5) integration of HEALing Matters into broader organisation policies and (6) development of a face-to-face package to supplement the online training.

This feedback has helped identify key outcomes and actionable findings for the next phase of implementation. An actionable finding is 'one that provides information about changes that can be made to a program to improve its effectiveness or to program implementation to improve its uptake into practice' (p. 7, Keith et al., 2017).

5 | INITIAL IMPLEMENTATION STAGE

During the initial implementation stage, embedding the intervention of interest works towards altering the 'status quo' and attention is directed towards examining and addressing the challenges that are encountered to ensure that the intervention can succeed (Bertram et al., 2015). However, each stage of implementation does not occur in isolation—one stage does not need to end before the next can begin. Often activities overlap, with activities occurring or re-occurring in one stage as the next begins (Metz & Bartley, 2012). This is true of HEALing Matters, whereby staff competency was built through training, while simultaneously implementing the initiative in practice. This has allowed us to build readiness while simultaneously collecting evidence regarding the key implementation drivers for the long-term sustainability of HEALing Matters. The implementation of HEALing Matters is currently (at the time of publishing) in the initial implementation stage. During this stage, we will focus on the final component of the NIRN formula, 'enabling context'. The key activities of this stage will be to continue using data to assess the ongoing implementation, identify solutions and address any barriers to promote continuous improvement. To do this, our plan is to focus on the following implementation drivers and actions—see Table 3 (Bertram et al., 2015; Metz et al., 2017).

The initial implementation stage will transition to the next phase when a clear understanding of the capacity for, and scope of, implementation at the organisation and local level is established.

6 | FULL IMPLEMENTATION

Full implementation occurs when an intervention is embedded at all levels of an organisation and becomes integrated into routine practice and organisation and system settings (Bertram et al., 2015). In this phase, residential care staff should be routinely applying learnings from HEALing Matters and the program should be integrated into 'business as usual'. Key outcomes we would expect at this stage include the following: (1) trained residential care staff actively work towards (a) changes in the physical environment of participating residential homes relative to healthy food options and opportunities to engage in physical activity; (b) enhanced understanding and application of health literacy information by residential care staff and (c) changes in residential care staff's knowledge and practices relevant to providing care that promotes young people's health and well-being; (2) HEALing Matters training is incorporated into the recruitment or induction for all new residential workers/carers and (3) improved health outcomes for youth living in residential care in Victoria.

7 | LIMITATIONS

Although the findings from our evaluation have provided insight into the implementation of HEALing Matters in residential OOH

in Victoria, and its acceptability among stakeholders, some limitations must be acknowledged. First, although more than 1300 staff are currently registered to complete the training program, only one third have completed all six core modules and participated in the online evaluation, with a subsample of carers participating in a semi-structured interview. As such, it is possible that the generalisability of findings regarding the perceived need for HEALing Matters, its acceptability and feasibility of implementation, may be impacted by non-response bias (i.e. the perspectives of staff with low acceptability may have been missed in the current evaluation). It is important to note that the HEALing Matters evaluation is ongoing, and it is expected that training and survey completion rates will increase as program implementation continues. Regardless, the preliminary findings are encouraging. Another limitation of the current evaluation is the reliance on the experiences of staff who have directly participated in the training program. While the views of staff are essential in exploring the program implementation, the views of young people (who are also beneficiaries of participation) may provide additional insight into the determinants of implementation and the outcomes they have experienced. Although ethical approval to include young people in data collection was obtained by the administering university, this evaluation was conducted during the Coronavirus (COVID-19) pandemic and shifting priorities within organisations across the OOH sector meant that non-essential tasks, including organisational approval to conduct external research that directly involved the recruitment of young people, were delayed. It is recommended that future research should aim to engage young people to ascertain their views and experiences, if logistically feasible.

8 | CONCLUSION

Overall, the data indicates that HEALing Matters is a necessary program, and there is a good fit between the program and the community needs. HEALing Matters aligned well with staff's personal values, especially around the importance of connecting with young people and engaging them in healthy lifestyle behaviours. Importantly, staff recognised how supporting the well-being of young people in care was compatible with the broader vision/goals of their organisation, as well as their individual roles as a residential carer. Feedback from residential carers who have completed the HEALing Matters training, indicates that HEALing Matters has provided them with the knowledge and skills to introduce general health, nutrition and physical activity information into routine care. Since implementation commenced in Victorian residential care homes, our forthcoming results have indicated an environmental shift towards healthier practices, healthier meals, more activity and a general sense of healthy living, for carers and young people living in care, including the encouragement and development of independent living skills among young people (e.g. cooking, budgeting etc.). HEALing Matters has also given carers the opportunity to navigate and understand the relationship between trauma and attachment, and a young person's past food

TABLE 3 Summary of implementation drivers and actions to facilitate ongoing implementation

Implementation drivers	Actions to facilitate implementation
1. Staff selection	Work with organisations to incorporate HEALing Matters philosophies into staff position descriptions and integrate HEALing Matters competencies into hiring protocols (e.g. job interview questions) and ongoing appraisals (e.g. KPIs, supervision and performance appraisals)
2. Training	Continue to build organisation capacity and capability through ongoing training. This will include working strategically with online Human Resource systems to embed the training into routine induction and ongoing professional development for all staff and create mechanisms for effective follow-up action at the area level if levels of staff participation are low Enhance post-training supports by developing a HEALing Matters 'top-up' module, that is, a refresher module that carers would be required to complete every 6–12 months to ensure carers are consistently updating their knowledge in reference to HEALing Matters
3. Coaching	Further develop the 'champions' model (i.e. allocation of a champion in each residential home to lead discussions about HEALing Matters, checking in with staff and driving practice changes) to include ongoing coaching and supervision for team development and improvement
4. Decision-support data system	To provide a hospitable environment for HEALing Matters, community service organisations must establish systems that support data-driven decision-making relative to the implementation of the HEALing Matters program (e.g. collecting and reviewing fidelity and outcome data for continuous improvement). Data collection should focus on how new learnings, skills and interventions are being used in practice and the extent to which they are improving outcomes for young people
5. Facilitative administration	Establish local implementation teams to oversee organisation-wide implementation and sustainability. The key functions of these teams will be to ensure the outlined implementation supports are in place, and focus on continuous improvement of HEALing Matters (e.g. providing the necessary leadership to overcome barriers and create solutions so that program outcomes are achieved and sustained) We will also strengthen implementation by adjusting and/or developing organisational policies and procedures to support HEALing Matters in practice—this may include things like reviewing compliance and quality audits to determine if there is scope to include questions relating to nutrition (food quality), physical activity and the provision of material goods to promote health within the home
6. Systems intervention	Develop Health Promotion Guidelines for the out-of-home care sector to supplement/support existing guidance, such as the Victorian Program Requirements for Residential Care, the Victorian Handbook for Foster Carers and the Victorian Manual for Kinship Carers. Specific health promotion guidance will improve the consistency of care provision, the cohesiveness across the care system, and provide clearer objectives for carers

behaviours and experiences. This, in turn, has enabled carers to better support the well-being of young people, reshape these behaviours into positive, healing experiences and better prepare young people for their transition out of the care system into independent living—this is especially important given the ongoing disadvantage that this cohort often experiences.

Since the beginning of implementation, we have collected ongoing feedback from stakeholders (e.g. young people with lived experience, residential carers, supervisors/team leaders, therapeutic practitioners, residential care coordinators, community service organisation CEOs, departmental staff) to support learning, adaptation and CQI. This has provided actionable information that organisations implementing HEALing Matters can use to improve the success of the program in real time. To deliver our HEALing Matters vision, we are focused on the following four objectives to drive planning and decision-making in the next phase of implementation:

1. Continue to build organisation capacity and capability through ongoing training.

2. Support residential provider agencies to make changes to their policies and practices, which prioritise healthy eating and active living in the home.
3. Robust evaluation with timely and effective communication of outcomes to the sector and individual agencies.
4. Support widespread adoption, adherence and program sustainability.

Finally, it is important that the next phase of research further develops our understanding of the mechanisms and/or theoretical drivers that lead to successful implementation and practice change and the intervention factors that most influenced it.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

AUTHOR CONTRIBUTIONS

Study design and conception: R.G, H.S. Data collection: R.G., R.T., L.B. Data analysis: K.H., R.T., A.C.-P. Writing: R.G. Reviewing and revising drafts: All authors.

ETHICS STATEMENT

This research was approved by the Monash University Human Research Ethics Committee (MUHREC; Project ID: 12116).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are not shared due to privacy or ethical restrictions.

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ENDNOTES

¹ Our co-design process involved consumer and community involvement, including consultations with residential OOH staff and young people with a lived experience.

² Participation and training uptake was impacted in 2020 and 2021 by the Coronavirus (COVID-19) pandemic. Staff completions reflect the number of staff who have completed the six core modules. Although comparatively, the number of completions is low, at the time of publication there were 1,032 users completing the training.

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SUPPORTING INFORMATION

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