A Statewide EBP Scale-Up Project:
The Children’s Administration-University of Washington EBP Partnership

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Public systems are using increasingly sophisticated methods to support EBP use in “real world” practice.

- Increasing awareness of role and expectations regarding EBPs
- Growing evidence base for effective interventions and approaches
  - Increasing programmatic options for public systems
  - Reducing the gap between what is known to be effective and problems for which we need effective solutions
- State legislation focused on EBP continue to proliferate
- New federal initiatives
- Establishment of “implementation science” as a field of applied research
Public child welfare systems may be particularly amenable to application of EBP (Chaffin & Friedrich, 2004; Barth, 2008)

• Child welfare systems are accountable for explicit outcomes:
  – Reduced rates of future abuse
  – Placement stability
  – Improved home environments
  – Improved child functioning
Public child welfare systems may be particularly amenable to application of EBP

• Clarity of the child welfare mission and outcomes:
  – Aids design of effectiveness research studies, and thus the identification of new EBPs
  – Facilitates selection of programs likely to achieve these outcomes.
  – Guides the development of federal initiatives to promote relevant EBPs
    • E.g., Initiative to Improve Access to Needs-Driven, Evidence-Based Mental and Behavioral Health Services in Child Welfare grant program (Administration for Children Youth and Families).
  – Facilitates maintenance and use of clearinghouses and inventories (e.g., California Evidence Based Clearinghouse for Child Welfare [www.cebp4cw.org](http://www.cebp4cw.org))
Large-scale programmatic initiatives are often used to purchase defined services found to impact core CW outcomes, e.g.:

- Behavioral health interventions for parents (Anger management, substance abuse, parent training programs, e.g., IY, PCIT)
- MH interventions for children and youth (depression, anxiety, and sequelae of trauma, e.g., TFCBT)
- Programs directed at improved safety and prevention of abuse and neglect (e.g., SafeCare, Homebuilders)
Requests for qualifications and contract language may identify
- Specific research-based interventions to be delivered and/or
- Stipulate that services used must be based on evidence for effectiveness

Centralized procurement and programmatic initiatives are conducive to ensuring presence of implementation supports:
- Use of manuals
- Broad-based training and coaching
- Consistent fidelity monitoring
- Development of other program- or system-wide implementation supports.
Concrete support is needed for EBP implementation in public system EBPs
(Fixsen et al., 2005)

- **Provider selection**
  - Organizational level
  - Individual level
- **Training, consultation, and coaching,**
- **Staff evaluation and fidelity monitoring**
- **Program evaluation**
Washington State Children’s Administration

- Child welfare arm of the Washington Department of Social and Health Services (DSHS)
- CA’s mission is to protect abused and neglected children and provide services that will support families and communities in keeping children safely in their homes whenever possible
- CA has prioritized 7 prevention and intervention evidence- and research-based programs relevant to child welfare outcomes
  - Reduction in child abuse and neglect
  - Reduction in out-of home placement
  - Improvement in child safety
  - Placement stability
  - Safely maintain children in their own homes.
- Children’s Administration contracts with agencies across the State to deliver the services to the children and families it serves.
CA’s Priority EBPs were selected based on their alignment with core outcomes.
Beginning in 2012 the Children’s Administration collaborated with the University of Washington Division of Public Behavioral Health and Justice Policy to:

- Oversee and administer provider trainings on core EBPs
- Conduct fidelity monitoring and quality assurance for providers contracted to provide the selected EBPs
- Conduct outreach and develop implementation support materials as needed to facilitate appropriate referrals and model adherent EBP use

The CA-UW EBP Partnership is guided by a conceptual model based on the conceptual model of implementation research developed by Proctor et al. (2009)

- The model distinguishes but links key implementation processes and outcomes
Implementation Strategies

System Strategies:
- Outreach
- Education
- Legislation
- DSHS-wide EBP policies
- Data analysis

Organizational Strategies:
- Centralized EBP purveyor
- EBP referral guidelines
- Provider tracking database
- Agency readiness assessment
- Data sharing agreements

Group/Team:
- Service broker trainings
- Supervisor training
- Regional leads develop EBP capacity

Individual Strategies:
- Initial EBP trainings
- EBP booster trainings
- Coaching and supervision
- Fidelity monitoring
- Fidelity/certification tracking

Intervention Strategies

Child Welfare EBPs
- Incredible Years
- Parent-Child Interaction Tx
- Functional Family Therapy
- Triple P Positive Parenting Program

Outcomes

System & Organizational Outcomes
- Motivated and educated workforce
- EBP champions
- Clear expectations
- Clear incentives
- Provider readiness
- Adequate supply of EBPs statewide
- Adequate referrals to EBPs
- Data is used to support improvement

Implementation & Service Outcomes
- Fidelity to EBP model
- Acceptability of EBP
- Accessibility
- Equity (of access and quality)
- Efficiency
- Effectiveness
- Cost-effectiveness

Child, Youth & Family Outcomes
- Child Safety
- Safely reduced out of home placements
- Increased Protective Capacity
- Improved Well-Being
- High Satisfaction
- Fewer placement changes
- Improved Functioning
- Reduced Symptoms
Specific strategies and products that extend from the conceptual model

- Establishment of a single EBP “intermediary purveyor organization”
- The “Guidance Tool”
  - Detailed set of EBP referral guidelines for use by CA social workers
- The “Toolkit” – Provider fidelity tracking database
  - Facilitates compliance and provision of technical assistance
- Structured EBP readiness assessment
  - Used by Children’s Administration regional staff persons during contract negotiations
- EBP Staff Selection Guide
  - Includes a Pre-Training Agreement signed by provider agency rep in advance of EBP training
- Outreach and education to supervisors and staff
- Data analysis and use of information to inform programming
  - E.g., differential rates of EBP use across regions
<table>
<thead>
<tr>
<th>PROGRAM CHARACTERISTICS</th>
<th>CLINICAL CONSIDERATIONS*</th>
<th>Capacity to Support a Safety Plan</th>
<th>ADDITIONAL CONSIDERATIONS FOR SERVICE</th>
</tr>
</thead>
</table>
| **Incredible Years (IY)**<br>Birth to 8<br>Group based parent training<br>School and office-based<br>Weekly sessions lasting 10-18 weeks | **Family Needs**<br>• Needs support managing difficult child behaviors.  
• Parents in need of positive, nurturing, non-violent parenting strategies.  
**Family Discipline**<br>• Concerns about parent-child relationships.  
• Caregiver(s) frustrated but uses self-control, discipline may be inconsistent, lacks effective management.  
**Child Functioning**<br>• Child has behavior problems.  
• Child provokes dangerous reactions in caregivers. | LOW | **Decision Points**<br>• Parent good candidate for group training (would like being with other parents; may not need individual coaching)  
• Okay that parent is coached without the child | **Expected Outcomes**<br>• Increase appropriate parenting skills  
• Increase appropriate parental discipline  
• Improve parent-child relationship  
• Decrease in child behavior problems |
| **Parent Child Interaction Therapy (PCIT)**<br>Ages 2 to 8<br>Parent training<br>Office-based and home-based<br>Weekly sessions lasting 12 to 16 weeks | **Family Needs**<br>• Needs support managing difficult child behaviors.  
• Needs one-on-one parenting coaching on a weekly basis.  
• Parents in need of positive, nurturing, non-violent parenting strategies.  
**Family Discipline**<br>• Caregiver(s) frustrated but uses self-control.  
• May have negative feelings toward child.  
• May use violence or threats to control behavior, lacks effective management.  
**Child Functioning**<br>• Child has behavior problems.  
• Child provokes dangerous reactions in caregivers. | LOW | **Office-based**<br>MEDIUM | **Decision Points**<br>• Parent has access to their child to practice skills in between sessions  
• Child can be transported to PCIT sessions (so needs to practice in session with one child) | **Expected Outcomes**<br>• Increase appropriate parenting skills  
• Increase appropriate parental discipline  
• Improve parent-child relationship  
• Decrease in child behavior problems  
• Reduction in occurrence of physical abuse reports |
| **SafeCare**<br>Birth to 5<br>Parent training<br>With a focus on neglect related issues<br>Home-based<br>Weekly sessions lasting 8 to 20 weeks | **Family Needs**<br>• Parents need help creating and maintaining a safe home environment.  
• Needs to learn how to care for the children when sick or injured.  
• Parents in need of basic parenting skills/support.  
**Family Discipline**<br>• Families experiencing neglect related issues such as medical neglect or emotional neglect.  
• Parents learn basic parent-child interaction skills and providing children with rules and consequences.  
**Child Functioning**<br>• Targets typically developing children exhibiting none or mild behavior problems. | MEDIUM | **Decision Points**<br>• Caregiver predominantly needs services to treat neglect  
• Children who were neglected are young (0-5 age range) | **Expected Outcomes**<br>• Increase parents’ understanding and management of child illness and injuries  
• Increase home safety. Improve and enhance parenting skills |
| **Family Functional Therapy (FFT)**<br>Ages 10 to 18<br>Youth and family therapy<br>Typically home-based<br>Weekly sessions lasting 15 to 20 weeks | **Family Needs**<br>• Needs support managing difficult pre and teenage behaviors.  
• Some monitoring and safety concerns.  
**Family Discipline**<br>• Caregiver(s) not effectively monitoring pre/teenage youth.  
• Moderate to high family conflict, youth is displaying some high risk behaviors.  
**Child Functioning**<br>• Adolescent has behavior problems.  
• Self-destructive behavior  
• Provokes dangerous reactions in caregiver | MEDIUM | **Decision Points**<br>• An adult caregiver is able to consistently participate with the youth  
• Other family members are not involved (when another adult(s) involvement is needed to solve problem)  
• Helpful for high conflict situations | **Expected Outcomes**<br>• Increase in youth disruptive behaviors  
• Increase parenting skills and appropriate discipline  
• Increase in youth academic and social competence  
• Increase supportive family communication  
• Reduce youth substance use  
• Increase placement stability |
| **Homebuilders**<br>Birth to 17<br>Family intensive home-based intervention<br>Therapists are on call 24/7<br>Services range between 30 to 45 days | **Family Needs**<br>• Needs intense support managing child behavior (40-50 hours a week) in the home environment. Family conflict, maintain child placement and/or serious safety concerns.  
**Family Discipline**<br>• Caregiver(s) need immediate, intense support with not using physical discipline, maintaining child in home and meeting youth’s basic physical and emotional needs.  
**Child Functioning**<br>• Child behavior problems.  
• Lack of behavioral control  
• Provokes dangerous reactions in caregiver | HIGH | **Decision Points**<br>• Child must be placed with the referred caregiver  
• Intense support for a short period of time is needed (vs. longer term, less intense support)  
• Connection of families to community resources  
• Reduction in lengthy out of home placement  
• Reduction in new referrals | **Expected Outcomes**<br>• Parents’ ability to safely care for this child is increased  
• Child can remain safely in the parent’s care  
• High cost to community/resources  
• Reduction in child behavior problems |
| **Positive Parenting Program (Triple P)**<br>Standard: Ages 2 to 12<br>Parent training<br>Homes, community, or office based<br>Weekly sessions lasting 1 to 15 weeks | **Family Needs**<br>• Needs individualized support managing typical developmental transitions and/or dealing with significant behavioral challenges.  
• May need improvements in the parent-child relationship.  
**Family Discipline**<br>• Caregiver(s) frustrated, may occasionally lose self-control, discipline may be inconsistent and lacks effective management.  
• May use violence or threats to control behavior.  
**Child Functioning**<br>• Range from typical developmental challenges to behavioral problems  
• Provokes dangerous reactions in caregivers. | LOW | **Office-based**<br>MEDIUM | **Decision Points**<br>• Caregiver would benefit from a more individualized parenting plan  
• Triple P can be provided without the child present  
• Allows for less intensive option (i.e., fewer than 10 weeks) for caregivers with less intense need | **Expected Outcomes**<br>• Increase appropriate parenting skills  
• Increase appropriate parental discipline and behavior management  
• Improve parent-child relationship  
• Decrease in child behavior problems |
### Incredible Years

**Age of Child**
- Birth and 8 months for baby group
- 9 months and 2 years for BASIC toddler group
- 2 and 8 years for the preschool BASIC group

**Reasons to Refer**
- **Family Needs**
  - Parents in need of positive, nurturing, non-violent parenting strategies.
  - Needs support managing difficult child behaviors.
- **Family Discipline**
- **Child Functioning**

**Venue of Care**
- Office-based

**Frequency & Duration of Care**
- Weekly sessions lasting 10-18 weeks

**Expected Outcomes**
- Increase appropriate parenting skills
- Increase appropriate parental discipline
- Improve parent-child relationship
- Decrease in child behavior problems

**General Capacity to Support a Safety Plan**
- LOW: No contact with family in the home. No after-hours support for the family

**Referral Form & Provider**
- Provider information: R1 | R2 | R3
- Referral form

**More Tools**
- Decision Points
  - Parent good candidate for group training (would like being with other parents; may not need individual coaching). Okay that parent is coached without the child.
- Parent Handout
- Referral Form
- Developer website

- Restrictions
- Videos of service
- Program supports

- Service Element
- 17 Safety Threats
- Features of service

**SafeCare®**

**Age of Child**
- Birth to 5

**Reasons to Refer**
- **Family Needs**
- **Family Discipline**
- **Child Functioning**

**Venue of Care**
- Home-based

**Frequency & Duration of Care**
- Weekly sessions lasting 18 to 20 weeks

**Expected Outcomes**
- Increase parents’ understanding and management of child illness and injuries.
- Increase home safety.
- Improve and enhance safe parenting skills.

**General Capacity to Support a Safety Plan**
- Medium: Provided in the home, provider reviews safety plan each week, no after-hours support for the family

**Referral Form & Provider**
- Provider information: R1 | R2 | R3
- Referral form

**More Tools**
- Decision Points
- Parent Handout
- Referral Form
- Developer website

- Restrictions
- Videos of service
- Program supports

- Service Element
- 17 Safety Threats
- Features of service

**Parent Child Interaction Therapy (PCIT)**

**Age of Child**
- Ages 2 to 7

**Reasons to Refer**
- **Family Needs**
- **Family Discipline**

**Venue of Care**
- Office-based and home-based

**Frequency & Duration of Care**
- Weekly sessions lasting 12 to 16 weeks

**Expected Outcomes**
- Increase appropriate parenting skills
- Increase appropriate parental discipline

**General Capacity to Support a Safety Plan**
- Low: Office-based
- Medium Low: Home-based, no after-hours support for the family
CA-UW EBP Cross Program Fidelity Reporting
Incredible Years, SafeCare, PCIT, Triple P

Monthly Fidelity Check

Cases
- Carrying sufficient cases to be assessed

Compliance
- Provider is compliant with the specified consultation and training requirements

Competence
- Adherence to the essential protocol elements
- Demonstrates adequate skills in delivering the model
- Uses an adequate amount of the intervention

Technical Assistance Support

Insufficient Fidelity

Consultant uses TA support specified for the area that needs improvement. Provider has up to three months to demonstrate necessary improvement.

Status of Informal Plan
- In Process
- Resolved
- Moved to Formal

Formal Improvement

Notice of formal improvement plan given to Children’s Administration. Provider is given an additional three months to demonstrate improvement.

Status of Formal Plan:
- In Process
- Resolved
- Contract terminated (per CA internal review process)
Child Welfare Evidence-Based Practice Toolkit

The Evidence-Based Practice toolkit is a centralized resource for marketing the EBP expertise of providers and managing fidelity information for programs. The toolkit is a joint effort of the University of Washington Division of Public Behavioral Health and Justice Policy’s Evidence-Based Practice Institute and Children’s Administration of the Department of Social and Human Services.

The toolkit serves a dual purpose. Providers receive recognition for EBP expertise on a publicly available website that can assist in marketing efforts to increase referrals. In addition, trainer/consultants for the EBPs listed below will use the toolkit to enter and retrieve fidelity information that will be used to develop quality assurance reports for Children’s Administration. Efforts are also underway to assess providers’ interest in accessing the toolkit as a repository for screening and progress information on individual clients to track client progress over time.

To be eligible for an account on the toolkit, providers must be working for an agency contracted through Children’s Administration to provide one or more of the following evidence-based practices to child welfare children and families:

- SafeCare, a weekly home based training program for parents of children birth to five;
- Incredible Years (IY), a weekly group-based parent-training program for children birth to 8;
- Parent-Child Interaction Therapy (PCIT), a weekly parent-training program for children 2-7 that can be delivered in an office or home setting; and
- Positive Parenting Program (Triple P), a weekly parent-training program for children 2-12 that can be delivered in the home, community, or office setting.

Who has access to the database?

The public will be able to access a list of providers who meet fidelity criteria for one of the above programs. This list is termed the “roster.” The public will not be able to see any specific fidelity or compliance information associated with the provider. The roster includes the provider’s name and contact information along with the EBPs he/she provides.

EBP service providers will be able to login, update their profiles on the roster, and obtain information about EBPs (e.g., updates on fidelity requirements).

Washington State EBP trainers and consultants will access the toolkit to enter training and fidelity monitoring information. The database will allow for direct entry of fidelity information obtained through video or audio reviews, consultations, and coaching.
## Toolkit For Evidence-Based Mental Health Providers in Washington State

### Add Status Report

**Provider:**

**EBP Status:** Accredited Triple P Provider

**Activity Month:**

Enter the month of activity that this report pertains to.

### I) Cases

**Does the provider have sufficient cases to make an assessment about fidelity?**

- Yes
- No

### II) Compliance

**Attendance Calendar**

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**Did the provider comply with the specified consultation requirements (in phone or in person)?**

- Yes
- No

**Did the provider comply with specified supervision requirements (e.g. peer, group, or individual)?**

- Yes
- No

### III) Competence

**Since the last review:**

**To your knowledge, does the provider adhere to the essential protocol elements as outlined by the model?**

- Yes
- No

**To your knowledge, does the provider demonstrate adequate skills in delivering the model?**

- Yes
- No

**To your knowledge, did the provider use an adequate amount of the intervention for the time being rated?**

- Yes
- No
# Toolkit for Evidence-Based Mental Health Providers in Washington State

Treatments that are proven to work

## Reports » CA Fidelity

### CA Fidelity

**Filter:**  
- **Agency:** Triple P  
- **Date:** Mar 2013  

<table>
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<tr>
<th>PROVIDER</th>
<th>AGENCY</th>
<th>CONSULTANT</th>
<th>OVERALL FIDELITY ASSESSMENT</th>
<th>CASES</th>
<th>COMPLIANCE</th>
<th>COMPETENCE</th>
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<th>NOTES</th>
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<td>Brigid Collins</td>
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<td>Meets Fidelity</td>
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Readiness Assessment
Section 1: Background information and General EBP Readiness

Script: First, I am going to ask you a few questions that will help us understand your agency and what kind of support or help your agency might need to.

1. How did your agency become interested in providing EBPs?

2. Which EBP or EBPs are you interested in providing? (e.g., SafeCare, PEERS, etc.)

3. I'm interested to learn about the EBPs your agency currently provides.
   a. How many staff and on what EBPs?
      - EBP 1: _______N Staff: _______N
      - EBP 2: _______N Staff: _______N
      - EBP 3: _______N Staff: _______N
      - EBP 4: _______N Staff: _______N
   i. If you have or do now provide EBPs service, what are the challenges for ensuring compliance with fidelity monitoring and historic fidelity status of your staff?

4. What is the background of the staff who would implement new EBPs?
   a. What is their experience with specific interventions, evidence-based programs?

Section 2: Adequacy of preparation and readiness to implement the EBP

Script: Thank you for providing that information about your organization. Now I would like to ask you a few questions about your plans for implementing your chosen EBP(s).

9. Can your agency manage the requirements of an intensive training plan? For example, can it release clinicians for an initial training of up to 40 hours, give them time and backfill for ongoing training, consultation, and supervision, and so forth?

10. EBPs often require the time of a support staff for implementation (e.g., food ordering, materials set up, telephone engagement with parents, and setting up video or audio recording of sessions). Can you tell me about your agency’s capacity to help with these kinds of logistical details of EBP program delivery?

11. EBPs often require having sessions regularly audio or video recorded and reviewed by experts in [the selected EBP]. How do you think the clinicians in your agency would respond to this requirement?

12. Please describe how your agency has presented its plan for implementing [the selected EBP] to staff that may be expected to implement it.
   (If prompts are needed): Have you informed them of the idea and described the expectations of clinicians? Have you solicited and addressed any concerns?
This section of the questionnaire is to be completed by the interviewer administering the assessment immediately following the interview. Please circle the most appropriate score, based on the answers provided by the respondent to the open-ended interview questions.

### Section 1: Background Information and General EBP Readiness

<table>
<thead>
<tr>
<th>EBP Readiness Items</th>
<th>Rating scale</th>
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<tbody>
<tr>
<td>1. The agency currently implements behavioral health EBP</td>
<td>0 = no EBPs&lt;br&gt;1 = one EBP / several staff&lt;br&gt;2 = 2 or more EBPs / many staff</td>
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<td>2. The experience of staff and supervisors is adequate to implementing child specific EBP</td>
<td>0 = Not at all&lt;br&gt;1 = Somewhat&lt;br&gt;2 = Definitely</td>
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<td>3. The agency has staff (coaches, supervisors) who are certified to aid in the implementation of EBP</td>
<td>0 = none&lt;br&gt;1 = one&lt;br&gt;2 = 2 or more staff are certified to supervise/coach</td>
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<td>4. The agency’s clinicians like using EBPs (because of their structure, because they have been found to work, etc.)</td>
<td>0 = none/few clinicians or no/little support&lt;br&gt;1 = half of clinicians or some support&lt;br&gt;2 = most or all clinicians; clear/universal support</td>
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<td>5. The agency’s clinicians consider research evidence for effectiveness more important than clinical experience and judgment</td>
<td>0 = most or all clinicians prefer clinical judgment&lt;br&gt;1 = around half of clinicians prefer clinical judgment, the other half research evidence&lt;br&gt;2 = most or all clinicians base decisions on research evidence</td>
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<td>6. The agency’s leadership explicitly and repeatedly expresses support for and promotes use of EBP</td>
<td>0 = no specific examples&lt;br&gt;1 = 1-2 examples of how leadership supports and promotes&lt;br&gt;2 = 3 or more examples of leadership support</td>
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<td>7. Clinicians in the agency routinely use standardized assessment (SA) procedures (e.g., to screen for trauma, identify targeted clinical conditions, and/or measure client progress)</td>
<td>0 = Few clinicians or infrequent use of SA procedures&lt;br&gt;1 = About half of clinicians or some use of SA&lt;br&gt;2 = Most or all clinicians; very consistent use of SA</td>
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<tr>
<td>8. The agency consistently collects evaluation data (e.g., on client outcomes and perceptions) and uses it to improve its programming</td>
<td>0 = Few or no examples of evaluation&lt;br&gt;1 = Agency conducts some evaluation but few examples of how it is integrated for CQI&lt;br&gt;2 = Agency consistently collects and uses data</td>
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Staff Selection Tool
Evidence-based practices (EBPs) are manualized interventions that have been proven by research to work. Children’s Administration is currently seeking to increase utilization of EBPs that facilitate short-term outcomes such as improving parenting skills and reducing safety factors, and long-term outcomes such as permanency and prevention of abuse and neglect.

If your agency is contracted to implement an EBP selected by Children’s Administration—such as SafeCare, Incredible Years, PCIT, Triple-P, FFT, or Homebuilders—you will periodically have the opportunity to choose staff to attend trainings on these programs.

**Careful selection of staff is critically important to the success of EBPs, and to the optimal utilization of resources in EBPs. Practitioners who are chosen must have appropriate background and education. Equally important, their values, attitudes, and preferences of staff must be consisent with the EBP.** Finally, they must be committed to applying their new skills in practice.

For these reasons, C.A. expects participating providers to (1) attend to the 10 points listed below in selecting staff who will be trained, and (2) sign a pre-training agreement that attests to completing this staff selection process.

As you select staff who will be trained on EBPs, consider the following questions: **Ideally, you consider a practitioner for EBP training, the answer to all of these questions will be “Yes.” If not, you may wish to consider whether or not he is an appropriate candidate.**

1. Have you interacted with your staff person about this upcoming EBP training opportunity, and confirmed their interest and enthusiasm?
2. Have you confirmed that your staff person will be able to deliver the EBP to welfare families for at least one year post training? The C.A. views these trainings as investments in the children/Welfare workforce that will help in meeting the needs of children and families it serves.
3. Does your staff person have the required educational background for this EBP? Most CA contracts require trainees to have at least a bachelor’s degree. For Incredible Years, PCIT, SafeCare, Triple P, and Homebuilders, it is also recommended that trainees have some background and/or understanding of child development and experience working with families.
4. Does your staff person like to take on new challenges or enjoy learning about new ways of working with children and families? To learn a new EBP, the practitioner must have the opportunity to learn and practice a new approach. EBPs require extensive training, coaching, and monitoring and will work better for practitioners who are motivated and self-directed.

5. **Does your staff person enjoy learning intervention strategies in a variety of ways?** All EBPs consist of both didactic and practice activities. It will be important for your staff to be comfortable with role playing during training and conducting role playing with parents and their children to teach them new skills.

6. **Is your staff person open to following a manual?** All evidence-based programs and manuals that practitioners must follow in order to ensure that are being provided with an effective version of the program. Staff must feel comfortable with using a manual as they learn and practice using the EBP.

7. **Will your staff person agree to video-taping or audio recording their sessions?** Many EBPs require this for certification in the intervention and to monitor practice.

8. **Does your staff person possess good engagement and clinical skills?** Each EBP teaches and rehearse certain skills during training, but it is important for your staff to possess basic counseling skills such as active listening, use of standardized assessment, and developing treatment plans. Because EBPs are based on these skills, an inexperienced staff person may not be the best candidate for EBP training.

9. **Does your staff person seek out supervision and input on their performance?** EBPs emphasize coaching and feedback, often based on observation of practice. An ideal trainee seeks self supervision and input on their performance, rather than avoid it.

10. **Is your staff person strengths-based?** All EBPs ask the practitioner to identify and use family strengths to overcome issues and problems affecting their ability to safely parent.

---

**PRE-TRAINING AGREEMENT**

I attest that the staff person(s) selected for the upcoming training have been screened based on the 10 criteria listed above. I am aware that only staff members who are listed on the attached roster can attend the training. If there are any changes to the list of training participants, I will notify and receive approval from the CA Program Manager prior to the training.

<table>
<thead>
<tr>
<th>Printed Name of Agency Supervisor</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Printed Name of CA Regional Lead</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

*Note: Please retain a copy of this form for your own records. In addition, please forward a completed and signed copy of this agreement as well as a roster with the names and emails of the staff member(s) who have been selected to attend the EBP training to:*
Using Data to Stay on Track

System and project (e.g., providers trained, referral and utilization)

Implementation and Service (e.g., equity of access, fidelity by region, organization, provider, EBP)

Outcomes (child and family outcomes, system outcomes)
EBP Trainings FY 2012-2013

Other EBP Training Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th># of Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>SafeCare Coach Training</td>
<td>1</td>
</tr>
<tr>
<td>SafeCare Curriculum Update</td>
<td>2</td>
</tr>
</tbody>
</table>
Total # Providers Trained by EBP

<table>
<thead>
<tr>
<th>Program</th>
<th>FY 2012</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent-Child Interaction Therapy</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Project SafeCare</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Positive Parenting Program</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>Incredible Years</td>
<td>0</td>
<td>58</td>
</tr>
</tbody>
</table>

SOURCE: CA-UW EBP Partnership
Provider Satisfaction with EBP Trainings

<table>
<thead>
<tr>
<th>Program</th>
<th>Satisfaction with Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incredible Years Infant Program (N = 44)</td>
<td>100%</td>
</tr>
<tr>
<td>Incredible Years Home Coach Training for Preschool BASIC &amp; Toddler Programs (N = 11)</td>
<td>97%</td>
</tr>
<tr>
<td>SafeCare (N = 30)</td>
<td>95%</td>
</tr>
</tbody>
</table>

Source: CA-UW EBP Partnership
## Providers Meeting Fidelity

**Graphic Description:**
- **Bar chart** showing meeting fidelity for Incredible Years, SafeCare, PCIT, and Triple P.
- **Colors:**
  - **Blue** indicates January.
  - **Red** indicates February.
  - **Green** indicates March.

<table>
<thead>
<tr>
<th></th>
<th>PCIT</th>
<th>IY</th>
<th>SafeCare</th>
<th>Triple P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Active</strong></td>
<td>37</td>
<td>44</td>
<td>32</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Meeting Fidelity</strong></td>
<td>17</td>
<td>36</td>
<td>15</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>January</strong></td>
<td>37</td>
<td>44</td>
<td>32</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Meeting Fidelity</strong></td>
<td>17</td>
<td>36</td>
<td>15</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>February</strong></td>
<td>34</td>
<td>65</td>
<td>47</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Meeting Fidelity</strong></td>
<td>13</td>
<td>39</td>
<td>21</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>March</strong></td>
<td>39</td>
<td>68</td>
<td>52</td>
<td>29</td>
</tr>
<tr>
<td><strong>Meeting Fidelity</strong></td>
<td>14</td>
<td>34</td>
<td>24</td>
<td>17</td>
</tr>
</tbody>
</table>

**Source:** CA-UW EBP Partnership
Rate of EBP Utilization by N of Children Served
DSHS Regions 2009-2012

* Rates are calculated by dividing the number of children for whom reimbursement was sought for IY, SafeCare, PCIT, and Homebuilders, by the number children with accepted CPS referrals within each region for 2011. **2012 rates do not represent all billings from May-June.**
Lessons Learned

• Central entity for coordinating training and monitoring creates opportunity for efficiencies
• Partnership model provides rich environment for reviewing data, brainstorming ideas, and developing tangible implementation supports
• Jointly developed products and resources have been well-received by child welfare leadership and staff
Lessons Learned

• Maintaining a true spirit of partnership can be challenging
  – Esp. given contractual relationship between CA and UW
• Tension can arise over delineation of roles, e.g.:
  – UW outreach role
  – Who will manage / analyze relevant data
• Different expectations of pace of change
• System is complex and doesn’t transform overnight
  – EBP awareness and referral is a perpetual challenge
  – EBP services are only a small part of the enterprise of a child welfare system
Continuing our emphasis on increasing appropriate referral and utilization of EBPs.

Use data more consistently to inform our efforts and evaluate our collective success.

Take on new EBP expansion opportunities as a partnership.

- e.g., development of appropriate and targeted, short-term, evidence-based models for CA’s approach to implementing Family Assessment and Response (FAR)
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