Successful adoption and implementation of a comprehensive casework practice model in a public child welfare agency: Application of the Getting to Outcomes (GTO) model

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ABSTRACT

In recent years, several states have been developing or adopting casework practice models in an effort to shape the thinking and behavior of front line child welfare workers with a commitment to improving the safety, permanency and well-being outcomes of vulnerable children in their care (Antle, Christensen, Barbee & Martin, 2008; Christensen, Todahl & Barrett, 1999; Courtney, 2009; Folaron, 2009). This article presents one framework for approaching the organizational changes that need to be made in order to support a practice model. The Getting to Outcomes" Framework (Wandersman, 2009) is a useful approach for ensuring that all areas to support practice change are addressed.

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1. Introduction

In recent years, several states have been developing or adopting casework practice models in an effort to shape the thinking and behavior of front line child welfare workers with a commitment to improving the safety, permanency and well-being outcomes of vulnerable children in their care (Antle, Christensen, Barbee & Martin, 2008; Christensen, Todahl, & Barrett, 1999; Courtney, 2009; Folaron, 2009). This trend is noteworthy in several respects, 1) that so few states up to this point use a coherent casework practice model, and 2) that there has been so little research done in child welfare on any large-scale, comprehensive casework practice models (Antle, Barbee, Sullivan, & Christensen, 2008; Antle Barbee, & van Zyl, 2008; Antle, Christensen, Barbee, et al., 2008; Antle, Barbee, & Van Zyl, 2009 — Solution Based Casework, Folaron, 2009 — Indiana's Practice Model). A handful of empirical studies touch on specific areas of child welfare practice (e.g., Budd, 2005 — mental health assessments of parents in the child welfare system; Chaffin & Friedrich, 2004 — child abuse and neglect treatments; Gleeson & Philbin, 1996 — model for working with kinship care providers; Liese, Anderson & Evans, 2003 — an emergency shelter model; McMillen, 1997 — a practice model for reducing stress and enhancing coping in families in the child welfare system, Sholnsky & Wagner, 2005 — contextual and risk assessment model, Sprinson & Berrick, 2010 — work with foster children in residential care).

Child welfare advocates and leaders seeking an evidence-based practice model will find that there is little written for a child welfare setting about how a state might go about making the critical decision of choosing a comprehensive casework practice model with the potential for significantly impacting child and family outcomes (The Child Welfare Policy and Practice Group, 2010; National Child Welfare Resource Center for Organizational Improvement, 2008). One useful resource is the California Evidence Based Clearinghouse for Child Welfare (http://www.cebc4cw.org/) which rates individual practices for level of evidence as well as level of applicability to child welfare. Furthermore, there are relatively few empirical articles on implementation practice specific to child welfare, with the exception of a recent special issue of the journal *Protecting Children* on innovations in child welfare (Cahn, 2010). A framework drawn on research on implementation in other fields of practice has been developed by the National Implementation Research Network (NIRN) (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005) and is in use by a variety of training and technical assistance programs sponsored by the federal Children's Bureau. The NIRN model has yet to be tested empirically in child welfare.

2. What constitutes a public child welfare casework practice model?

Before describing how a state or jurisdiction adopts and implements a casework practice model for child welfare case management,

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it is useful to define what constitutes a casework practice model. Wandersman (2009) says that any effective model, program or intervention must have four keys to success: 1) a theoretical base including a theory of change (Anderson, 2005), 2) a fully articulated set of actions and skills that can be observed for presence and strength, 3) system supports, and 4) evaluation results including data benchmarks to monitor the efficacy of the model (Wandersman et al., 2005). Thus, we define a child welfare casework practice model: *A practice model for casework management in child welfare should be theoretically and values based, as well as capable of being fully integrated into and supported by a child welfare system. The model should clearly articulate and operationalize specific casework skills and practices that child welfare workers must perform through all stages and aspects of child welfare casework in order to optimize the safety, permanency and well-being of children who enter, move through and exit the child welfare system.*

The first component, theoretical foundation, delineates how to think about or conceptualize the practice with the population of focus. The theoretical foundation can respond to four areas: 1) the conceptualization of the problem (e.g., child maltreatment is embedded in the stage of a family's life development), 2) the change theory that informs how that problem can be remediated (e.g., self efficacy theory), 3) the theory that guides the critical contribution and influence of the relationship alliance or partnership (e.g., solution focused theory), and 4) the core practice values that underlie the approach to clients and the problem (e.g. family centered or strengths based).

The second component of a child welfare casework practice model for case management should flow logically out of the theoretical foundation. A casework practice model should specify the practice skills that are to be carried out and measured for fidelity and implementation adherence. These include: 1) core practice skills that guide practice across the life of a case (e.g., engagement, assessment, planning, and decision making) so that even when there is no direction about a specific type of encounter, the theory and meta-skills together can guide practice, 2) clearly specified and distinct practice skills for each stage of a child welfare case including intake, investigation, in-home services, placement into and monitoring of progress in out of home care (reunification, foster care recruitment and certification, adoption) and 3) specific skills for dealing with distinct family issues as child sexual abuse, neglect, or domestic violence involvement. The NIRN model mentions core components, but is not as specific as it needs to be useful to the formation of a practice model.

The third component involves the ability to create a system infrastructure that supports and reinforces the theoretical orientation and practice skills that are a part of the practice model. This would include systemic issues such as policy, training, documentation requirements and forms, a SACWIS system (IT), supervision and worker performance evaluations that align with the casework practice model, as well as quality assurance (QA) and continuous quality improvement (CQI) processes that align with and evaluate adherence to the casework practice model. The importance of systems alignment and a list of drivers of systems change has been supported by research in other fields of practice, collected in the NIRN model (Fixsen et al., 2005) and by research on implementation in child welfare (Cahn, 2010).

And finally, the fourth component involves development of data points to monitor fidelity to the model and, once fidelity is achieved, to evaluate the impact on outcomes, in this case for children and families in the child welfare system. Benchmarks important in child welfare would include the federal Child and Family Services Review outcomes of safety, permanency and well-being as well as other intervening or process measures that may be relevant (e.g. employee retention, engagement of community partners, and so on). Again, this aspect of our definition of a child welfare casework model resonates with the NIRN model's emphasis on data supports (Fixsen et al., 2005).

This article focuses on how to bring about the kind of system infrastructure changes and supports to ensure success of the casework practice model. For selecting the case management model in the field of child welfare, it is also important to consider any available research on the model itself, or on components of the model. A casework practice model should be evidence based or evidence informed, but is broader than a typical evidence-based practice (EBP) or evidence-informed practice (EIP) for treatment intervention. A casework practice model and EBP for treatment intervention have in common a theoretical foundation, operationalization of skills to intervene and a basis in research findings, clinical wisdom and client preference. Usually an EBP involves a more narrow set of steps and skills that make up the intervention that addresses a specific problem such as depression (e.g. Beck & Alford, 2009), whereas a casework practice model is a much broader case management approach to working with all types of problems, using a variety of EBP interventions, with a variety of families that enter a particular system.

The wide-ranging scope of a casework practice model has implications for implementation that differ from the implementation of one evidence-based practice. For example, because a casework practice model encompasses a wide range of agency practices and procedures, the core components and implementation drivers (Fixsen et al., 2005) are more extensive than those for an evidence-based practice. In addition, it is even more imperative for a casework practice model for case management in a large bureaucracy to have extensive administrative supports, although for an agency to adopt and execute a casework intervention model (EBP) with fidelity there still needs to be administrative support and training of clinicians and supervisors, and quality assurance inspections. It is easier to conduct a clinical trial on the efficacy of an EBP than of a casework practice model because an EBP is more narrowly focused and the outcome measured is usually uni-dimensional. A casework practice model for case management can incorporate an EBP into its conceptualization and skill sets involved in implementation (e.g. cognitive–behavior therapy or motivational interviewing).

Based on the above definition of a child welfare casework practice model, we have only been able to identify two full casework practice models used in public child welfare settings. The first is the model developed by several authors of this article: Solution Based Casework (SBC). SBC has a growing evidence base (Antle, Barbee, Sullivan, et al., 2008; Antle Barbee, & van Zyl, 2008; Antle, Christensen, Barbee, et al., 2008; Antle et al., 2009; Antle, Barbee, Christensen, & Sullivan, 2010; Antle, Christensen, van Zyl, & Barbee, in press; Courtney, 2009; Martin, Barbee, Antle, Sar, & Hanna, 2002; van Zyl, Antle, & Barbee, 2010). Several of the authors have been involved in fully implementing this model in Kentucky and are involved in implementation in Washington State, as well as parts of Florida (circuits 3 and 8) and to some degree in Tennessee.

The second model that fits the above definition was originally developed by the Child Welfare Policy and Practice Group in Alabama which many call "Family Centered Practice". This has been fully adopted in Utah and Indiana (Folaron, 2009) and to some degree in many other states with positive outcomes for clients. For example, in Indiana several of the child welfare outcomes were reached after the adoption of a new practice model (Folaron, 2009). The Family Centered Practice Model does not explicitly point to a theory of problem conceptualization or change (although implicitly relies on attachment theory), but does include values, addresses all aspects of casework, emphasizes the importance of system support, and has some evidence to support its success (Folaron, 2009).

Other popular approaches that are sometimes adopted by states (e.g., Systems of Care Approach, Differential Response, ACTION for Child Protection's risk and safety assessment model) leave out one or more key components necessary to fit our definition of a practice model. Some consist primarily of a set of principles that are not fully operationalized with practices. While the core values may be in place,

the conceptualization of problems, change theory, specific operationalization of all practices and emphasis on organizational support for the model are missing. Other partial practice models only focus on one stage of a case such as intake or one component of the work such as safety and risk assessment rather than on all stages and aspects of casework in public child welfare practice.

The problem with approaches that specify only core values is that workers are not provided with specific concrete direction as to what to do when assessing, case planning and conducting ongoing work with families. Specific practices such as diligent recruitment, family group decision making, and multi-systemic therapy, while empirically supported, are specific to only one stage of practice or one client family challenge. These specialized techniques and EBPs are important in child welfare practice and can form components of a comprehensive casework practice model, but in and of themselves, they are not truly casework practice according to our definition.

The danger in labeling a specialized technique a casework practice model is that when workers become frustrated that the "model" does not explicitly direct all aspects of practice and when administrators encounter resistance when trying to apply the principles of one component of practice to other areas of practice, they may call into question their original choice of a "practice model." Our concern is that failures in states to produce desired outcomes will decide that the practice model *concept* does not work and will abandon the use of any practice model; that is why any state that adopts a practice model should ensure that the chosen model incorporates all four keys to success noted earlier (Wandersman, 2009). Properly adopting a comprehensive casework practice model, with a solid theoretical foundation, clear components of practice across the child welfare continuum, systems supports, and drivers for implementation, and data/evaluation can improve practice and outcomes and can be the way out of problematic issues in child welfare systems (e.g. Antle et al., in press). This article outlines steps needed to adopt such a comprehensive casework practice model and embed it in the organizational structures of a child welfare agency. These steps may be applicable to states and jurisdictions that are adopting new techniques, interventions, EBPs or some combination of new practices in child welfare as well.

3. Introducing change in multi-level systems: a review of the literature

The introduction of a practice model into a child welfare system is a massive undertaking that involves an entire set of multi-level changes in order to accommodate, assimilate and integrate the new model into the system. In order for the change to be successful and sustained past the current administration of the public child welfare agency, motivation needs to be high and a number of adjustments need to occur at the larger system level, the organizational level, the team level and the individual level.

A review of important research on organizational change can help gain perspective. Lewin (1951) was an original organization development researcher who provided conceptual and empirical support for the notion that organizational change happens in three stages: 1. *unfreezing*, this entails the process when key internal stakeholders gain motivation and make the decision to change, 2. *transitioning*, the stage in which the actual changes are made, 3. *re-freezing*, where lasting change is consolidated and maintained through a dynamic process of the organization attempting to seek equilibrium. Lewin's model is the foundation of most organizational change theories (Weick & Quinn, 1999).

Recent scholars have built on Lewin's original work by delineating both the pre-conditions for change, the steps in the change process that lead to success (Kotter, 1996; Schein, 2001; Kelman, 2005; Rogers, 1995) and the mechanisms that enhance the stability of change (Senge, 1994, Sente, Scharmer, Jaworski, & Flowers, 2005) Pre-conditions for change that have been identified in corporate and human services sectors include: vision (Covey, 1989), leadership (e.g., Bass, 1990; Collins, 2004; Kotter,

1996; Quinn, 1988), and having an open organizational culture conducive to change (Schein, 2001; Schein, 2004; Lehman, Greener, & Simpson, 2002). Additional considerations related to the process of implementation include: whether or not employees are included in the process (Cooperrider, 1996), whether the duration of the change is adequate to the task, and the time between formal reviews of milestones (Kotter, 1996). Still others point to the importance of strong backing from the most influential executives and stakeholders such as legislators, media, and funders (Altshuler & Behn, 1997), as well as family, community, and youth stakeholders (Comer & Vassar, 2008) and support from line employees who are being influenced by the change (Kelman, 2005; Rogers, 1995), and the amount of work the change initiative requires beyond the regular workload of those employees (Sirkin, Keenan, & Jackson, 2005).

The theoretical model called Stages of Change (Prochaska & DiClemente, 1983) has been studied extensively in the therapeutic literature and generalized to the level of change in larger systems. This model's construct of "readiness to change", has been shown to be applicable to organizational readiness to change (Horwath, 2001; Lehman et al., 2002).

An important body of knowledge from which child welfare advocates have drawn is research on diffusion of innovations across a wide range of settings collected and developed into theory by Everett Rogers (1995). Rogers' research isolated findings regarding key roles in adoption, and important engagement and communications strategies that work. His work to distinguish the specific role of, and engagement strategies for, change agents, early, middle, and late adopters, and resistors is often quoted in later literature. Much of the reviewed work has focused on organizational change, but utilizes a systems perspective amenable to applications to larger public system integration efforts (Corbett & Noyes 2008) and larger system changes (Kelman, 2005). Over the past 60 years governmental agencies have been evolving to a point of increasing reliance on a blend of public and private partnerships in delivering services. Therefore, an emphasis on communication, cooperation, and collaboration across organizations has emerged (Goldsmith & Eggers, 2004) that is applicable to the child welfare system.

4. Getting to Outcomes (GTO) Framework

A framework members of this team have begun to use in working with public child welfare systems wishing to adopt Solution Based Casework, is the "Getting to Outcomes" (GTO®) Framework (Wandersman, Imm, Chinman, & Kaftarian, 2000; Chinman, Imm, & Wandersman, 2004; Chinman et al., 2008; Wandersman, 2009). This framework, embedded in empowerment evaluation theory (Fetterman & Wandersman, 2005) and using a social cognitive theory of behavioral change (Ajzen & Fishbein, 1977; Bandura, 2004) has the advantage of being a results-based accountability approach to change that has been used in smaller organizations to aid them in reaching desired outcomes for clients in such areas as preventing alcohol and substance abuse among teens as well as developing assets for youth (Fisher, Imm, Chinman, & Wandersman, 2007) and teen pregnancy prevention (Lesesne et al., 2008). Using a longitudinal, quasi-experimental design, Chinman et al. (2008) examined the impact of using GTO on improvements in individual capacity to implement substance abuse interventions with fidelity and on overall program performance in programs that did and did not utilize a GTO approach. They found the programs utilizing a GTO approach performed significantly better at both the individual and program levels than those that did not utilize the GTO approach (Fig. 1).

The framework uses a 10 step accountability approach that we have applied to the challenges a child welfare system faces when adopting a practice model into their system.

The GTO model synthesizes the findings of years of organizational development and organizational change work (e.g., Argyris & Schön 1978; Argyris and Schoen, 1996; Lewin, 1951; Pettigrew, Woodman, & Cameron, 2001; Senge et al., 2005), helps to create learning organizations (Preskill & Torres, 1999), and adds to the growing
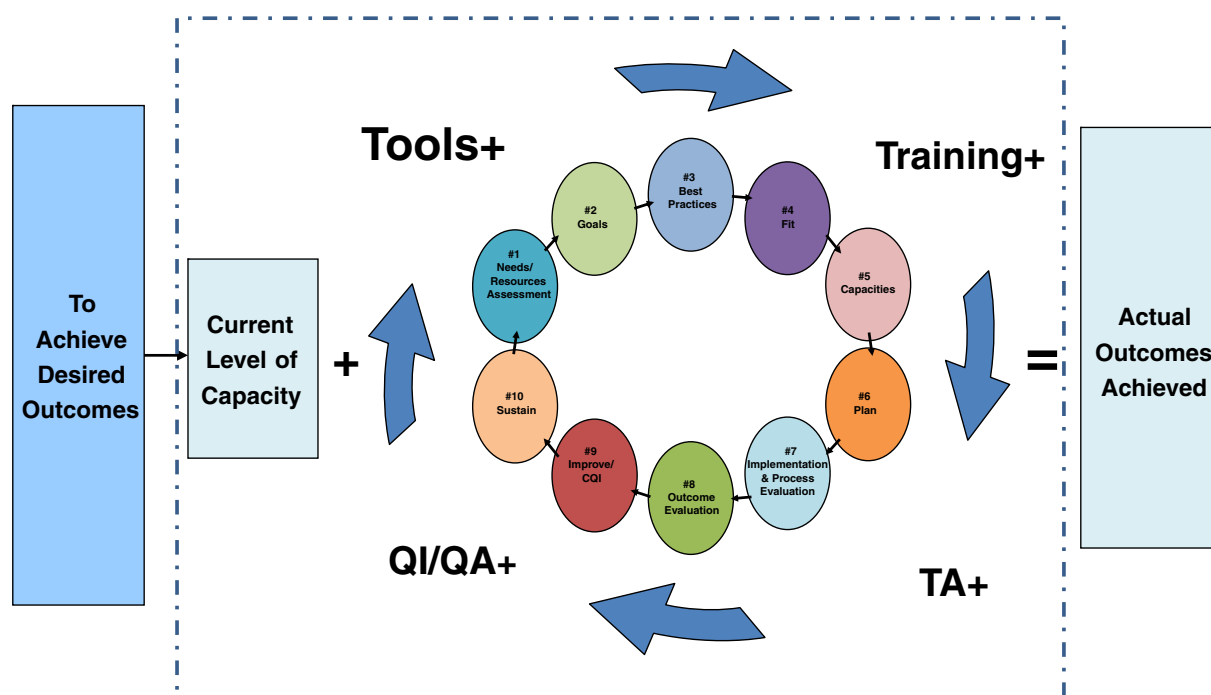
Fig. 1. GTO Support System Model.

literature on implementation science in human services (e.g., Aarons, 2006; Fixsen et al., 2005; Smale, 1998).

The 10 steps in the GTO model are easy to grasp, and useful when working with organizations in the field. They include

1) *Identifying* needs and resources,
2) *Setting goals* to meet the identified needs,
3) Determining what science-based, *evidence-based (EBP) or evidence-informed practices* or casework practice models exist to meet the needs,
4) Assessing actions that need to be taken to ensure that the EBP *fits* the organizational or community context,
5) Assessing what organizational *capacities* are needed to implement the practice or program,
6) Creating and implementing a *plan* to develop organizational capacities in the current organizational and environmental context,
7) Conducting a *process evaluation* to determine if the program is being implemented with fidelity,
8) Conducting an *outcome evaluation* to determine if the program is working and producing the desired outcomes,
9) Determining, through a *continuous quality improvement (CQI) process,* how the program can be improved and
10) Taking steps to ensure *sustainability* of the program.

The remainder of the article will show how the University of Louisville (U of L) authors have begun to use the GTO model when working with states who desire to adopt and sustain a casework practice model, in this case the Solution Based Casework model (Christensen et al., 1999), though it would apply to other practice models as well.

5. Forming the implementation team

An implementation team must be formed to learn and implement the GTO model. Key stakeholders in the organization and in the surrounding community can form an implementation team to oversee a strategic planning process for implementing the casework practice model including the necessary systems supports such as agency policy and procedures, technology, training, quality assurance, continuous quality improvement, supervision, and communication.

Stakeholders should include state policy and program leaders, agency staff, and community stakeholders. State policy and program leaders would include heads of the Health and Human Services committees in the state house and senate, and current appointed head(s) of the child welfare agency. Agency staff would include middle managers who are likely to remain with the agency after the leader (who is usually politically appointed) departs: head of programming in child welfare services, leaders of unions, internal agency evaluators/researchers, any external research partners, usually from a university in the state, head of the policy division of the agency, head of the technology division or the person who manages the state SACWIS system, head of training both in the agency and in the partnering universities, head of quality assurance or the CQI process, representatives from regional or county offices at the managerial, and front line supervisory levels, as well as front line workers and any staff responsible for internal and external communications. Community partners would include key community partners from the courts, private child care agencies (such as those providing residential care to foster children), mental health, substance abuse, juvenile justice, developmental disabilities services, the domestic violence coalition, the pre-school, elementary, middle and high school systems that serve children across the state or jurisdiction, culture leaders such as church pastors or tribal leaders, and former families and youth from all cultural groups who have been the recipients of child welfare services to add the important client perspective. The stakeholder strategic planning group will oversee the utilization of the "Getting to Outcomes (GTO)" Process.

This list of stakeholders is extensive, and such a large number may create challenges, but these stakeholders will have a significant effect on the success of implementation and their early buy-in to the process will be critical when the hurdles to change need to be overcome. Each one has expertise on a particular aspect of the implementation process. For example, in the U of L team's experience of working with states wanting to implement a casework practice model, a large

stakeholder group has been invaluable in identifying obstacles, building a consensus for change, and in communicating the grand scope of implementing a new practice model.

But the size of the large group also has the potential to make operation steps awkward and inefficient. An early task for this group can be to approve the formation of a smaller executive committee to carry out the strategic plan of the larger group, reconvening the larger group periodically to report change and gain input. This smaller "executive committee" should consist of those in the system who can make change happen and have the resources to follow up the many small details that emerge in such a large undertaking. They should consider themselves accountable to the larger group and report regularly.

6. Utilizing the GTO model

6.1. Step 1: assessing needs and resources

The first step in the GTO process involves naming the needs of the organization and community that have led to the desire for change. The question that is asked at this stage is "*What are the underlying needs and conditions that must be addressed by the casework practice model?*" This is a process of defining and framing the issue, problem or condition. Usually, public child welfare agencies are faced with failures in outcomes of safety, permanency and well-being among children who come into contact with the child welfare agency. These failures can be highlighted in a Child and Family Services Review (CFSR), a lawsuit (which could lead to a consent decree), a Council on Accreditation (COA) process or a highly-publicized crisis in the agency (e.g., a child fatality, unethical behavior by state workers, exposed abuse of foster children). It is usually at this point that the agency is motivated to find a better way of practicing with families to address deficits in performance or outcomes. Child welfare, like all bureau-cracies, is designed for stability and consistency and does not change easily. External crises provide enough energy to, in Lewin's terms (1951), 'unfreeze' the agency's stable state. In addition to the hard data produced for CFSR, COA and lawsuits, the stakeholder commit-tees may want to review client satisfaction results (or assess clients for the first time), or survey or conduct focus groups with staff and community partners to determine why the state is failing to reach desired outcomes. All of these types of data can pinpoint the areas that need to be addressed in a new casework practice model or intervention protocol.

6.2. Step 2: setting goals

The next step in the stakeholder process begins after the needs are identified and motivation for change is reinforced. The stakeholder committees can ask "*What are the goals and objectives that, if realized, will address the needs and change the underlying conditions?*" This, of course, is the process of identifying goals and objectives for meeting the identified need and can quickly lead to the search for information prescribed in the third GTO step. Many states include these goals in their Program Improvement Plan (PIP) or bi-annual Child and Family Service Review (CFSR) or IV-B Plan. Consent decrees often outline goals that must be achieved. The practice can be identified by the stakeholder committee that is in charge of practice reform (see Step #6 on planning as well).

The goals and objectives collected at this stage often correspond closely to the philosophical attitudes about casework that some states have used in place of a more comprehensive casework practice model. For instance, one need that will typically emerge in child welfare agencies undergoing a crisis for change is that there are too many children in out of home care and those children are staying in out of home care too long. This can be identified with particular attention to children of color being disproportionally represented in care and

staying longer than other children (Johnson, Antle, & Barbee, 2009; Rivaux et al., 2008).

When reaching Step #2 (goal setting), a state might set a goal of working more collaboratively with their families and community partners in the hope of changing a control-based relationship (e.g., "*You need to comply with court orders*") to one in which the family and the caseworker develop a collaborative relationship and are able to build a consensus on how to proceed (e.g., "*To provide family centered casework services*" or "*To provide strength-based services*").

In some states, a list of these values has emerged as a "practice model." To realize real change, research on implementation (Fixsen et al., 2005) notes the need for specification of concrete practices. Staff members need to know what to do, and community stakeholders need to know how it is different from current practice.

Solution focused casework practice emerged from a clear identi-fication of goals but implementation required that stakeholders move through steps 3,4, and 5 before selection of a practice model. The next three steps, steps 3, 4 and 5 while seeming to be linear, are actually conducted somewhat concurrently. In step 3 the stakeholder committees examine possible candidate programs or strategies and steps 4 and 5 help the committees narrow down to a chosen program or strategy by helping assess the candidates.

6.3. Step 3: finding best practices

Here the implementation team will ask "*Which science-based, evidence-based or evidence-informed casework practice models or best-practice programs can be used to reach our goals?*" To choose which casework practice model is best for the state and the workforce that the state can afford, a review of the literature may yield casework practice models that have evidence of positive impact for client families. Ideally in this step, multiple models would be available to be studied and a model could be chosen to address the identified needs and goals for improvement. Consultants, national technical assistance providers from federal, private, or philanthropic initiatives, and university partners may provide assistance in the identification of a practice model or a specific practice for a specific issue.

One of the challenges stakeholders may have is that their perspective on what is possible in child welfare may be limited by their experience in child welfare. From the U of L team's experiences in helping large child welfare systems evaluate casework practice models and the evidence that supports them, we offer some criteria for assessing models based on the most common needs and goals that we have seen assessed in steps 1 and 2 in these jurisdictions (Table 1).

6.4. Step 4: assessing fit of selected model to agency context

Once a "candidate" casework practice model is under consideration, the implementation team can move to the question of fit. Because there are very few casework management models to choose from, and fewer still that have had the opportunity to be studied on a large scale, this step can be facilitated by a short training experience with members of the implementation team by someone skilled in the model.

Leadership support is one of the first aspects of fit. In order to adopt a casework practice model, agency leadership must make a clear commitment to the model and express that commitment both inside the organization and outside with external community partners (e.g., Martin et al., 2002). This expressed commitment is facilitated by firsthand experience with understanding the model from the beginning.

With Solution Based Casework, this has been a critical step for leadership to hear an overview of the model, ask questions and discuss answers together. Even though the same information could be obtained by everyone on the team reading the same material (in this case the Solution Based Casework text by Christensen et al., 1999), the high level training process has provided the implementation team

Table 1
Criteria for assessing practice models.

Example of possible goals	Criteria
To be more collaborative with families, more family centered.	• Does the model provide a way to define the problem in a way that creates a low threshold for family concurrence? • Does the model address how to be family centered in all phases of casework (investigation, case planning, casework management)? • Does the model address the need to alter forms and tools to be more family-friendly? • Does the model address specific interviewing skills that would facilitate family consensus and collaboration? • Does the model promote collecting data on strengths/accomplishments as well as deficits/failures?
To be more structured in investigating risk so that case planning is able to stay focused on risk identified	• Does the model promote a family assessment versus just an incident investigation? • Does the model provide a conceptual map for the assessment that assists workers in consistently identifying objectives that must be addressed in case planning? • Does the model address specific interviewing skills that would facilitate a strength-based family assessment?
To be more organized in case planning so that outcomes for safety, well-being and prevention are clearly described, and casework stays focused and timely.	• Does the model facilitate "family-owned" case plans? • Does the model have a case planning structure that highlights risk reduction objectives at both the *family* and *individual* level? • Does the model focus the worker on measuring objectives while retaining flexibility about what specific tasks will best accomplish those objectives? • Does the model set expectations for how progress on the case plan objectives will be measured and in what time period?
To better measure whether or not progress is being made on objectives tied to risk reduction.	• Does the model shift away from measuring services to measuring skill acquisition in identified areas of risk? • Does the model conceptualize needed skills in ways that are easily recognized by the service provider network (e.g. cognitive–behavioral)? • Does the model address how service providers will assist in the documentation and celebration of skill acquisition?
To strengthen the use of family treatment teams to improve collaboration with families, providers, and child protection caseworkers.	• Does the model incorporate and integrate family inclusion models of decision making (e.g. family team conferences, or family group decision making)? • Does the model address intra-system integration in areas of case transfer or shared responsibility (e.g. intake to ongoing, ongoing to provider, in-home to foster care)?

with a glimpse of how certain segments of the system might react to the model and its implications, hear answers to potentially challenging questions, and understand important implementation challenges as well as test its core strength of support.

In addition, the question the implementation team must ask at this stage is "*What actions need to be taken so that the selected program, practice, or set of interventions fits our child welfare agency?*" At this point, the organization has to assess adoption (fit) issues and possible adaptations of parts of the model that are not core components (Fixsen et al., 2005). For example, the team may find a name that brands the model for that state or jurisdiction, while still acknowledging the original source, (e.g., SBC was called Family Solutions for a while in Kentucky) or changing aspects of the existing model to accommodate cultural groups which are particular to the state. For example Solution Based Casework was developed in Kentucky, a state without any recognized tribes. When Washington state adopted the SBC practice model, tribal input was included in the process of implementation. The implementation team and tribal representatives found the values and core principles of the SBC practice model compatible with tribal values, so this was not a difficult adaptation.

A significant challenge of this step is the stakeholder's progressive realization that in order to change practice in the field, so many aspects of the system's infrastructure must change to facilitate the new practice. Many of these systems cannot be changed before those who would change the systems fully understand the new practice and its implications. In every state, there has been a naturally occurring tension between the need for infrastructure change (information systems, policy, supervision, and quality assurance), and the desire to train the personnel who provide the direct practice. Training typically occurs first because 1) often the degree of system change is at first underestimated, 2) training is easier to accomplish quickly and improves worker acceptance of infrastructure change, and 3) infrastructure change is

more challenging due to costs, past financial investment in old systems, and past administrative investment.

When training occurs first, those initially trained may not feel free to practice differently in the "old practice" environment. For instance, their supervisor may not seem supportive of the new practice direction (or may even be directly opposed to it), or existing policy seems incompatible, or the information system asks for different information (or in a different format conceptually) than the investigator or ongoing worker is being trained to collect in the new model. Many of the structural changes take time and resources that may not have been anticipated at the onset, creating further tension in implementation. A significant risk for the implementation at this stage is that if structural changes needed for model fit are not given high enough priority, the training investment may be lost due to the workers' sense that the new casework practice is not really supported by "central office."

Large system employees are typically wary of the "latest thing out of central office" and hesitate to stretch their own practice skills if they think "this will never last anyway". While any change process will have a certain number of people voicing these type of concerns, thoughtful identification of issues of fit will help focus change efforts and help keep the balance tilting in favor of change. Communication about the long-term implementation plan (assuming there is a long-term plan) can help offer perspective. The U of L team has observed in implementation projects in Washington State and areas in Florida that the concern for whether this new approach will last can be a positive sign of new practice acceptance, i.e., the impatience is expressed because staff like the change and don't want to get their hopes up. Therefore, clear and repeated communication about the ongoing steps in infrastructure change that are planned in the future can offer needed reassurance to "early accepters" that the risk involved in embracing the new practice is worth the risk of being disappointed with lack of follow through and organizational support.

6.5. Step 5: assessing organizational capacities

The next related step is to explore the organizational capacities needed to support implementation of the model. This includes assessing the organizational capacity for change in two major areas: the human capacity (identifying potential champions for the change, as well as clinical skills of staff, as well as where resistance may lie) and the organizational capacity (facilitators of change, and barriers to change), referred to by other models (Fixsen et al., 2005) as 'infrastructure' changes.

The change will be launched successfully and sustained with identification of agency champions and change agents (Rogers, 1995; Smale, 1998). An example of identifying, engaging and supporting early adopters comes from federal government reform. When Kelman (2005) sought a massive overhaul of the Federal Procurement Office during Clinton's administration, he used these features. He focused on the pre-existing constituency for change. He activated the discontented, those that did not like the present practices. He helped those change agents set in motion a process where the vanguard moved forward even in opposition to the status quo types of people that are embedded in every bureaucracy. He found that when the top administrators signaled that the new practice was valued, it allowed the change vanguard to help move the change process along. Twenty percent of his staff members were in the change vanguard at the beginning, another 25% were early recruits and 17% were fence sitters. The rest were skeptics, but even half of them adopted the new practices by the end of the rollout. There is a delicate balance between acknowledging reluctance to implement a new model, exploring the reasons behind the reluctance, making reasonable attempts to address concerns and slowing down so much that the change process becomes stymied or fails.

The members of the change vanguard who champion the change can engage those who are open (early recruits) and those who wait a while to see how the change effort proceeds (fence sitters) through persuasion, social influence and support. These engagement strategies (developing the human 'capacity') are consistent with those found in Rogers' work on the stages of diffusion of innovation, where change agents engage early adopters, who engage middle adopters and eventually bring late adopters along, neutralizing the resistors (Rogers, 1995). Kelman (2005) found that through conscious engagement strategies the change perpetuated itself.

In the experience of the U of L team, good news of early successes spread and mere exposure to the change got people used to it and less resistant. This was the early engagement stage "working for that critical mass" of early adopters. Thus, change efforts need to be prolonged for the positive change to emerge and for people to get used to it. This is similar to Lewin's (1951) model that argues that promoters of change need to be utilized to overcome resisters to change and to the Kotter (1996) model that argues that leaders must find the people who are champions for change in order for the change process to move forward and that change must be sustained long enough for positive results to emerge. Gerald Smale (1998) noted the value of both champions and minders (people who protect the change behind closed doors) in child welfare.

The experience in Washington State is consistent with this approach, where the implementation team identified "early adopters", or champions, and recruited them for special notice and additional training. These staff became site-based consultants, a cadre of additional local and respected colleagues who could serve as ready consultants available in every district office. An additional strategy in that implementation effort has been a proactive effort of targeting and capturing the occurrence of successful new behavior (model adoption) and creating an audience to hear about that change. The sharing of "good news" about success with the new casework practice model is an important activity during this stage and was put to optimum use in Washington. Using all available forums to highlight the efforts of early adopters helped create a climate of expected change.

Similar to Kelman's program, the early adopters did not create a sense of urgency or try to pressure the reluctant. They focused their engagement on those open to the program. As Rogers predicts (1995) most resistors eventually joined the change effort, others left the agency through early retirement, while still others simply quit. This experience has shown that too much attention or concern about those reluctant to adopt change gives them more influence and takes time away from building that critical mass of change-oriented employees necessary to tip the balance decisively toward successful implementation.

The assessment of human resource capacity should include an assessment of the clinical skills of workers and their ability to implement the casework model as designed. Some providers have the characteristics of self efficacy, openness to change, and readiness to implement a practice model and some do not, thus an assessment of readiness/openness to EBP (Aarons, 2004) and a readiness to learn (Coetsee, 1998; Van Zyl and van Zyl, 2000) should be conducted as a part of the early organizational culture and climate check. Some casework practice models may require more clinical skills in the workforce than do others. Models that are broad and which require a great deal of worker discretion in using tools in the model are more appropriate for child welfare systems that hire MSWs for front line and supervisory positions. At a very minimum, all workers using clinical models should have a BSW degree with special training in child welfare to engage these types of practice models (Barbee, Antle, Sullivan, Huebner, & Fox, 2009; Barbee, Sullivan, Antle, Hall, & Fox, 2009, Fox, Barbee, & Miller, 2003; Fox, Burnham, Barbee, & Yankeelov, 2000). States that hire persons with a BA degree, without requiring social work training, need casework practice models that are more explicit.

Organizational capacity must be assessed for the ability to support the casework model. It is in this phase that the stakeholder team may need to work on ways to help the agency 1) enhance agency and system leadership, particularly help leaders create a vision and support for the change effort, 2) assess and help to change the organizational culture so that it is a learning environment that is open to and ready for change, 3) engage, train, and retain a more qualified and motivated workforce using participatory approaches such as appreciative inquiry (Cooperrider, 1996) and empowerment evaluation (Fetterman & Wandersman, 2005) to achieve the support needed for transformational change, 4) build cross-functional and cross-organizational teams to achieve change in policy, practice, process, and personnel, 5) identify the resources and other infrastructure to bring about the change on top of day to day duties, and 6) communicate results of quality improvement and change efforts to continue the momentum of these efforts.

Organizational culture is an important aid or barrier to implementation. Before taking on a big change in the casework practice model, an assessment of organizational climate and culture as well as implementation climate should take place to determine if the organization is ready for change and can support change (e.g., Glisson & Hemmelgarn, 1998). For example a learning organization prides itself on continual improvement, using data to make changes along the way, openness to information, feedback, concerns, problems, and both process and outcome evaluation results (Senge et al., 2005). If any consultants and/or leaders in the organization discourage questions, concerns, or feedback, then the implementation and outcomes will not be successful.

Another part of assessing capacity is to find the organizational resources that will be needed to implement the plan. It is here that the child welfare organization will need to study how to adapt systemically to the needs of the new practice model by making progress on the time-consuming infrastructure changes. Some of the issues that typically emerge are the a) financial and personnel resources to support the new practice, b) rewriting of policy, c) criteria revisions for quality assurance and CQI procedures, and d) model-specific training for administrators, managers, and front line supervisors.

Large-scale training of new and veteran workers will need to be conducted (if it has not already begun by this point) and the pace of that training will have to be continuously monitored in light of the stress and motivation of the workforce. Pilot training data will need to be quickly analyzed so that CQI adjustments in the content and delivery of the training are made in a timely way before a rushed introduction of the casework practice model to the larger system.

One of the most difficult systemic issues in our experience is assuring the SACWIS (information) system and other technical devices used to support practice are in conceptual consistency with the new practice model. A typical challenge is that the programmers and those in charge of changing the information system are intent on solving data problems, not practice problems. For instance, they are more likely to want to know how many abuse and neglect cases show change, versus whether a given case is conceptualized in a way that will facilitate change and its measurement. However, the way these systems are organized greatly influence worker field behavior, i.e., workers order and structure of assessment interviewing (and therefore case conceptualization) will tend to quickly adapt to the order and structure of what the assessment screens. Therefore assessment of the SACWIS system should note whether forms for case assessment, safety and permanency planning, and aftercare plans must be redesigned to reflect and reinforce the conceptual map basic to the new practice model. If this aspect is not given high priority, the new information system will tend to prevent practice change rather than facilitate it.

The assessment of the basic infrastructure can include other partners so that they not only know about the change, but are engaged in designing how the changes will improve casework across all systems. Partners that must be contacted at this stage are hopefully part of the implementation team; if not, sound planning about how to best approach them must be completed. In particular, the court system will be one of the most eager supporters of progress changes in casework practice and should be engaged early on. In some jurisdictions (Washington State's implementation of SBC), early engagement of courts and agency councils in a joint effort to bring court orders into conceptual consistency with the practice model greatly facilitated worker acceptance, since it removed the restraint of concern over court acceptance of the new case plan formats.

6.6. Step 6: implementation planning steps

The assessments will lead the implementation team to the development and implementation of two specific and long range plans: 1) a plan to train and maintain staff competency in the new practice model, and 2) a plan for infrastructure change to support the new practice model. Typically, jurisdictions quickly recognize the need for the first (training staff). However, it is equally important (and more difficult) to develop and implement a plan for the related agency infrastructure changes necessary to support the practice model (e.g. changes in policy, information systems, quality assurance, and staff evaluation). Each of these two plan areas has significant depth to consider. Therefore, although many of these issues have been mentioned in prior sections, they are discussed in more detail below to insure that stakeholder groups target these specific issues within their plans.

6.6.1. A plan for training the practice model across the system

A clear and multi-stage plan for training of the model is needed at multiple layers of the organization. Seven stages have been identified by the U of L team. First, leadership in central office, and in each area, region or county needs to be trained in the principles of the model, the theories underlying the model, the basics of the model, and the research which supports the use of the model. This training should not be the "executive summary" version. While this might be appropriate in the early adoption decision time frame, once a model is selected, top administrators must be conversant in the details of the model to weigh the important decisions that will have to be made during implementation. If research exists on a casework practice model (currently this is the exception), clarification should be made that explains whether it is an evidence-based practice or an evidence-informed practice, and review the outcomes of those studies. The implementation leaders need to be able to know which aspects of the model are essential and which can be tailored to a particular area or county, and how the model affects outcomes of safety, permanency, and well-being (see Antle et al., in press for an example).

The second stage of training is the development of a comprehensive transfer of training program. The NIRN research summary by Fixsen et al. (2005) notes that training alone is less effective than training supported with transfer of learning supports such as in-house coaches and mentors. A training of trainers (TOT) and/or a training of key experts who will provide mentoring on the use of the model, reinforce key concepts in the model and trouble-shoot where questions and concerns are raised must be conducted to insure that internal expertise is developed (Fixsen et al., 2005). Thoughtful consideration of the selection of this group can have a significant impact on their acceptance by front line workers. Rogers (1995) notes that the majority of potential adopters are most-persuaded by credible peers, not by trainers or change agents from outside the system. U of L has found that asking field supervisors to put forward workers who are seen as leaders by their peers and who are known to be client-centered works well.

There should be several leads in the state, preferably in the training branch and among partnering universities who become as familiar with the practice model as any consultant(s) that may be involved. If consultants are the experts in the practice model, then they must spend a great deal of their time equipping these lead trainers, field liaisons, mentors, and lead workers who can, in turn, train and support supervisors, veteran workers and new workers. This TOT and coaching of key personnel both ensures enough people to execute all the training statewide and that the practice model is now owned by persons inside the agency, not just the change agent or consultant. This large pool of trainers and mentors will allow for the selection of a sub-group of practice model coaches to emerge. The development and mentoring of highly skilled practice coaches, to help troubleshoot practice issues that arise as the new model is being enacted, is a critical component for long-term project success. These internal practice coaches will need several years of access to the practice model consultant so that their skill level can reach the expert level. This allows the jurisdiction to become self-reliant and the practice sustainable.

At this second stage, training materials matter. As part of the early training phase, development of an FAQ (Frequently Asked Questions) about the model and how to specifically implement it should be posted on a website for anyone to access as they are learning and practicing the new skills. After this point, training needs to be rolled out beginning with pilot counties (some rural and some urban) to work out any kinks in localizing the model and training of the model. Rigorous evaluation must accompany this rollout period to inform the system of how the process is going and to begin to track outcomes. The evaluation results need to be immediately fed back to the system so that improvements in training, coaching, and implementation can occur, and so that practical barriers in the infrastructure can be identified and addressed.

Third, a pilot group of front line supervisors needs to be trained in the model and have a good working knowledge of the model, how it relates to policy and procedures, the computer program, and the CQI and data monitoring processes. Supervisors need to be trained at a deep level so that they eventually will be able to coach and mentor their workers in use of the model and provide appropriate casework supervision. The supervisors in the pilot counties should be trained first, then after enough time has passed to evaluate the model and the training of the model, the rest of the supervisors can be trained.

Training of supervisors should shift quickly from the large classroom to individual coaching sessions and case consultations.

The U of L consulting team found that even when supervisors understand the model, they often have difficulty with translating the model into their mentoring and supervisory role. Follow up coaching can provide team case consultations, under the direction of the supervisor and facilitated by a practice coach. This type of consultation coaching allows supervisors to help their workers on case specific issues in a safe learning environment and to learn their coaching role. This is often a time-consuming part of the implementation, but without this direct attention and demonstration, team culture can be highly resistant to change (Antle et al., 2009; Antle et al., 2010; Antle, Barbee, Sullivan & Christensen, 2008; Antle, Christensen, Barbee, et al., 2008; Barbee et al., in press).

Fourth, veteran workers in the pilot counties need to be trained in the model. All worker training must include training reinforcement in the field with supervisors and other key leaders (field liaisons, mentors, and team leaders) who can coach workers in the fine details of conducting the practices. If a practice model that requires clinical skills is adopted by a state without clinicians in front line positions, then additional clinical skills training is necessary for supervisors and front line workers in order for the practice model to be executed with fidelity. Clinical specialists need to be thoroughly familiar with the model so that they can conduct case consultation when difficult cases arise.

Fifth, all other supervisors and workers not in the original pilot should be trained and both the training and the practice evaluated. This training rollout is the most time-consuming part of the process and thus having a large contingent of competent trainers to participate greatly helps this phase. Consideration must be given to quickly revamping the new employee core training so that the new model is integrated into the classroom curriculum and on the job training modules as new workers enter the field. In the experience of the consulting team, this can be one of the more challenging system level changes, due to the investment that the training program and program level stakeholders have in the existing training. Allowing existing coursework to remain unchanged can be a workable solution in the short term, and allows the project to keep moving until there is more system buy-in. At that point, stakeholders will be able to support the revision of the training program, letting go of parts that are not as important in the new model.

Sixth, as mentioned above, all of the training conducted at each level of the organization needs to be evaluated to assess reaction to the material, perceived usefulness of the model to practice with clients, learning the knowledge and skills necessary to execute the model in the field, transferring the knowledge and skills to the workplace and seeing the impact of their careful execution of the model on families and children (Antle, Barbee, & van Zyl, 2008). In the consulting team's experience, it has been the evaluation of training that often helps the state evaluate the casework practice model itself (Antle et al., 2009; Antle, Barbee, Sullivan & Christensen, 2008; Antle, Barbee, Christensen & Sullivan, 2010; Barbee, Antle et al., 2009; Barbee, Sullivan, et al., 2009; Antle, Christensen, Barbee, et al., 2008; Sullivan et al., 2009; Yankeelov et al., 2000; Yankeelov et al., 2009).

Finally, training or presentations for community partners are important, because the external context must be aligned with the new practice model (Cahn, 2010). These partners may include judges, attorneys, guardians ad litem (GALs), CASA workers, family preservation workers (e.g., visiting nurses, in-home service providers), private child care facility administrators, supervisors and workers (residential care facilities that house foster children), foster and adoptive parents, kinship providers, mental health providers, substance abuse treatment providers, domestic violence shelter providers, teachers and counselors in the school systems as well as community culture leaders, families and youth. While these trainings may be short and more structured (like a meeting), the diligence in developing and pursuing a comprehensive orientation training program for community partners helps in coordinating treatment plans, and helps with consistent targeting of outcomes. Keeping everyone on the same page can be done through inviting partners to planning meetings, leadership trainings, or supervisory trainings.

6.6.2. A plan for changes in infrastructure

Financial and personnel resources need to be in place, increased or rearranged to re-write policy, change the computer system, change the CQI/QA tool, increase CQI case reviews, increase and modify the curriculum and delivery mode of training, provide materials for learning, coaching and mentoring, keep work loads manageable, conduct evaluation and educate other organizational partners. Particular attention should be given to insuring that those who volunteer or are assigned these tasks are considered highly knowledgeable about the new casework practice model. Where someone highly knowledgeable in the high tech system area but without practice knowledge is chosen, some jurisdictions have invested in expensive adaptations that are later realized to be seriously flawed in their ability to promote and support the practice model. The old adage that a little bit of knowledge is a dangerous thing is applicable during early implementation efforts; sometimes systems experts who lack practice expertise don't know what they don't know. Nowhere is this more important than in changes in the information system and forms area. Implementation teams would be wise to form a small team to head up this task consisting of the practice model consultant, a top program designer, a few high ranking administrators who are freed up to focus on the project and who have direct access to the top administrator. Once this group makes significant progress on capturing the practice model in its worker interface, feedback can be sought from the larger implementation team.

Alignment of the policies and procedures with the new practice model is essential. Policies and procedures need to change as the new model is adopted so that there is no confusion in the field about how to conduct the practice. Supervisors rely on policy and standards of practice (SOPs) to direct practice. If a problem of a legal nature arises, it is the SOPs that the court system looks to in determining if the supervisor monitored the casework correctly and the worker followed the policy and executed the practice correctly. Because policy often takes considerable time to re-write and complete its review process, policy memos from the chief executive office are important bridge tools to use as identified issues in the field emerge.

Computer and paper systems that support practice need to change to accommodate the new practice model. New forms, assessment tools, case planning tools (e.g. prevention plans, safety plans, in-home treatment plans, out of home care plans, and aftercare plans), case monitoring or progress tracking tools, and closure tools need to be modified or added and old tools need to be deleted so that the new ways of practice are not competing with the old ways. It has been our experience that forms play an underestimated role in shaping worker behavior in the field. Workers tend to gravitate their sequencing of questions based upon the order of the form they are filling out, or will have to fill out once back in the office. It is better to change the form to be conceptually consistent with the practice model than to expect to train the worker to resist the structuring pull of the old form.

Every jurisdiction or organizational system should want to insure a consistently high quality of service delivery. As such, the CQI/QA system needs to align the case review tool, not only with the CFSR tool, but also with the new casework practice model components. The new practice model components should be incorporated into the case review tool. This is essential for measurement of: a) the fidelity of daily practice to the model, b) the impact of adherence to the model on outcomes of safety, permanency, and well-being, c) the levels of adherence to the model statewide and by area, county, team, and individual which will, in turn, aid in determining training and supervision needs, and d) the impact of the model on outcomes. In order to have enough data to track adherence and outcomes, some

states may need to conduct CQI case reviews more frequently in order to have enough data to make judgments about how the process is going. An inexpensive way to do this is to involve front line supervisors and specialists as well as quality assurance personnel in a randomized case review process.

A final but critical infrastructure issue that must be considered is worker caseload size and overall workload. A study of caseload including creation of a complex formula to assess caseload (for example taking into consideration the number of front line workers that are on leave or out for disciplinary measures) and workload sizes (for example assessing the number of out of home care cases workers are carrying as well as number of additional tasks a worker is executing above those in their caseload) may need to be enacted in order to assure that each worker meets the standards that produce the best outcomes in their state or the CWLA standards for caseload size (Child Welfare League of America, 2008).

If the caseload or workload is too large, no amount of training or reinforcement of a good practice model will make up for the inability of staff to devote the time needed to execute the particulars of the model in daily practice. Fidelity and outcomes will suffer. It is at this point that a casework practice model can succeed or fail. If a state finds that caseload size and overall workload is too large, the leadership can a) go to the legislature for funding and permission to hire more staff to cover the workload b) re-organize staffing to ensure that there are adequate numbers of staff to meet the demands in different offices across the state, c) re-align existing staff duties to ensure front line coverage of cases, and/or d) use a triage method for managing cases at the supervisory level to ensure that each worker has a mix of easier and more difficult cases on their load to enhance the ability to practice effectively.

The next four steps in the GTO process for incorporation of a new casework practice model focus on evaluation, quality improvement, and sustainability processes. These processes will help monitor the implementation process and effectiveness over time.

6.7. Step 7: process evaluation

Stakeholder team members need to ensure that a process evaluation takes place. While the practice model is being piloted and rolled out across the state, there needs to be a process evaluation to answer questions such as, "*Is the practice model being implemented as it was intended? Is the practice model being implemented with fidelity? Who adheres to the practice model and who does not adhere? Do those who adhere differ in any significant way from those that do not adhere? How do they differ? Is the difference based on something inherent in the worker such as intelligence, motivation, personality or general skills (e.g., interpersonal skills)? Is the difference based on something about the situation such as supervisor support, caseload size, team support, or lack of resources in the agency or community?*" The answers to these questions may send the team back to Step 5 which works on organizational capacity issues including workforce recruitment, hiring, training, promotion and supervision (Wheatley & Frieze, 2006).

This is also the time to ensure that the QA and/or CQI process includes measures of fidelity to or adherence to the practice model in its case review measurement tool. In Kentucky, the original measurement tool used in the evaluation of the impact of adherence to SBC in worker cases on outcomes used by external researchers from 2000 to 2004 and the subsequent CQI case review tool used by all workers, supervisors, clinicians and central office personnel from 2004 to 2008 included thirty three items that specifically measured aspects of Solution Based Casework (out of 178 in the CQI tool). These tools helped in the assessment of fidelity to the model across the state, as well as in comparing cases with high versus low adherence to the model on outcomes of safety, permanency and well-being (Antle et al., in press).

6.8. Step 8: outcome evaluation

In addition to the process evaluation, the casework practice model execution needs to be studied not only to understand how it is rolled out, but whether or not it is effective in creating positive change for families and children. The agency must invest in an outcome evaluation to confirm the expectation of improved positive outcomes when the practice model is adhered to in each case with high levels of fidelity (e.g., setting a cut off of 70% adherence on the fidelity measure). The research in Kentucky found in numerous studies that high adherence to SBC led to superior casework and outcomes for children (Antle, Barbee, Sullivan, et al., 2008; Antle Barbee, & van Zyl, 2008; Antle, Christensen, Barbee, et al., 2008). The most recent study found that those cases with high fidelity to the model (N = 1260) met all of the CFSR outcomes. If all of these cases were to be pulled for a CFSR review, then Kentucky would pass in every category of safety, permanency and well-being (Antle et al., in press).

The outcome evaluation can answer "*How well is the practice model working? What is the impact of the practice model on worker retention, child safety, permanency and well-being, family preservation and self sufficiency? Should an experimental or quasi-experimental design be used?*" This last question involves difficult implementation issues, but could influence the way the results are measured and whether or not effectiveness is tested. It is easier to use a quasi-experimental design, but assigning teams or counties to various conditions at the beginning of the rollout of a casework practice model is a more rigorous test of the effectiveness of the model. Whatever design the implementation team decides to undertake, the results need to add to the growing research literature in ways that enable other states, territories, tribes and counties to benefit.

6.9. Step 9: continuous quality improvement

Process and outcome evaluation, along with the CQI process of case reviews, can help the agency engage in continuous improvement of the model (e.g., Deming, 1986). Stakeholders should be asking at this step, "*How can the practice model be improved? How can the implementation of and adherence to the practice model be improved?*" The results of the CQI can be used to answer these questions if the results are fed back to all stakeholders. In Kentucky, county-level and regional focus groups are conducted with front line workers, supervisors, clinical specialists and managers to generate hypotheses for what led to various results in CQI case reviews. The ideas generated have helped make the CQI process useful to practitioners and improve practice. Sometimes additional data can be collected at this point to pinpoint specific problems. Building in these steps into the CQI process, above and beyond simply rating cases in a CQI case review process, can lead to solutions that ultimately improve practice as well as outcomes for families and children.

6.10. Step 10: sustaining the practice

Finally, the stakeholder committees must plan for sustainability, particularly in light of the fact that child welfare agency leaders turn over on average every two years. *If the practice model and its execution are successful, how will the initiative, and use of the practice model be sustained?* In steps 7–10, the agency must develop and administer measurable indicators of immediate, short-term, and long-term outcomes so that when the next administration comes on board, the data will be available to demonstrate effectiveness. Also, by including state senators and house representatives, program leaders, policy, training, university, and community leaders as well as families who have benefitted from the practice model on the stakeholder committees, institutional memory will be retained from one administration to another.

These long-term participants in the practice model change process can help new leaders in several ways. The long-term stakeholders can help new leaders understand the importance of the practice model for effective service delivery and for reaching mandated outcomes at the federal and state levels. These stakeholders can also show new leaders that this is not just one leader's vision, but the work of a system of administrators and providers who are invested in ensuring that the needs of families and children are met. The testimony of agency partners and clients can be as powerful in sustaining a practice model as any data that are collected or outcomes that are reached.

7. Implications for other states

The hope is that state and county child welfare agency administrators, Children's Bureau Federal Program Officers, directors, and consultants for the many child welfare National Resource Centers and Implementation Centers will benefit from the experience with the ten-step GTO model to aid in planning, implementation and evaluation of a sustainable comprehensive casework practice model as a part of their child welfare agency reform efforts. This should improve outcomes for the families and children nationally.

The GTO model as described in this paper can be implemented in counties, states, territories and tribes at any stage of ongoing reform efforts. It can be used to evaluate an ongoing effort to improve sustainability. For those jurisdictions that are contemplating a major change process, particularly in the area of developing or adopting a new practice model, the GTO model can be a useful guide through the process.

Acknowledgment

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