



Washington State's adoption of a child welfare practice model: An illustration of the Getting To Outcomes implementation framework



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ABSTRACT

Despite a great need for evidence-informed practices in child welfare, very few child welfare systems have implemented evidence-based case management models state-wide. While the literature on implementation from the perspective of model developers and researchers is steadily increasing, there has been little attention to the process of implementation originating from the reverse direction, by community organizations themselves, or with regard to going-to-scale implementation in child welfare. The Getting to Outcomes (GTO) model, which was originally created to help organizations choose and implement prevention programs, is a promising guide for child welfare systems seeking to initiate system-wide implementation of evidence-based practices. The GTO framework provides a step-by-step guide for surveying a system, building motivation, training, and evaluation. This article will illustrate the state-wide implementation of Solution-Based Casework (SBC), an evidence-based model of case management, by Washington State's Children's Administration, following the GTO framework. Despite some barriers and obstacles, the GTO model proved to be feasible and to aid in the implementation of SBC. Implications for the GTO model as a framework for empowering community organizations to choose and implement relevant evidence-based practices will be discussed.

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1. Introduction

In recent years, many state child welfare agencies have come to realize that they do not have a coherent casework management practice model. Although evidence-based practices are beginning to be implemented in child welfare agencies across the country (e.g., Aarons & Palinkas, 2007; Johnson-Motoyama, Book, Yan, & McDonald, 2013; Michalopoulos, Ahn, Shaw, & O'Connor, 2012), there have been few attempts by entire states to adopt practice models that guide their case management practice from intake to case closure. Regardless of the challenges, many states are contemplating the implementation of a practice model to provide a common framework through which child welfare workers across agencies can improve outcomes for children and families.

The decision for a child welfare system to adopt a practice model can stem from a variety of factors. Often a significant factor is the aspiration to reform the current system to better meet specific outcomes and federal guidelines, such as those set forth by the Adoption and Safe Families Act of 1997 (ASFA; P.L. 105–89) and the related Child and Family Service Reviews. States are under both political and financial pressure to conform to these federal standards and perform well on the

reviews or they will face significant penalties. A comprehensive practice model serves as one possible solution to many of the challenges posed by these federal trends. In addition, some states, such as Utah and Alabama (CWPPG, 2008), have pursued practice models in response to class action lawsuits or other legal mandates that require they undergo significant systemic reform. Other states, such as Kentucky, Washington, and Florida, have adopted an evidence-supported practice model voluntarily in efforts to improve outcomes and meet specific needs of the child welfare populations they serve (Antle, Christensen, van Zyl, & Barbee, 2012).

Despite these various motivations for practice model implementation, there is limited empirical evidence regarding the science of implementing a child welfare practice model, especially when the desire for such implementation originates from the community agencies/organizations that will be carrying out the practice. One exception is a recent article that sets forth the Getting to Outcomes (GTO) model as a blueprint for states or private agencies to follow when implementing a child welfare practice model (Barbee, Christensen, Antle, Wandersman, & Cahn, 2011). GTO is a viable model to help organizations work from within the setting to overcome the comfort of inertia, transition to the change process, and solidify gains made. In the tradition of other work seeking to illustrate the process of implementation of evidence-based practices in the mental health and health fields (e.g., Bindler et al., 2012; Gotham et al., 2008), this paper will describe the use of the GTO framework in implementing an evidence-based case management model, Solution-Based Casework (SBC), state-wide in Washington

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State. Such an illustration may prove useful to other states and jurisdictions seeking to implement child welfare best practices or practice models across agencies.

1.1. What elements make up a child welfare practice model?

Before describing Washington State's implementation process, it is important to define the concept of a practice model. In 2010, the Positioning Public Child Welfare Guidance initiative (PPCWG, 2010) suggested that a practice model sets the standards of practice for how workers use evidence-informed strategies to meet the unique needs of children and families. Similarly, the National Child Welfare Resource Center for Organizational Improvement and National Resource Center for Permanency and Family Connections (2008) defines a practice model as a conceptual map and organizational ideology of how agency workers, families, and community resources come together to plan for the safety, permanence, and well-being of maltreated children. Barbee et al. (2011), in their article on using the GTO model as a guide for implementation, define a child welfare practice model as: "A practice model for casework management in child welfare should be theoretical 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." (p. 623).

Based on this view of a practice model, the leaders in Washington concluded that the research and literature pointed to only two fully functional casework practice models existing in public child welfare agencies that operationalize behaviors and tasks across levels of the system. The first model was developed in Alabama and is referred to as "Family-Centered Practice" (Folaron, 2009). This model has also been adopted and implemented in Utah and Indiana. The second model, Solution based Casework (SBC), was developed in Kentucky in the mid-1990s (Christensen, Todahl, & Barrett, 1999). Solution Based Casework is a casework management practice model that has a promising evidence base with published studies covering relevance, training transfer, and outcome effectiveness (Antle, Barbee, Christensen, & Martin, 2008; Antle et al., 2012; Antle, Sullivan, Barbee, & Christensen, 2010; Martin, Barbee, Antle, Sar, & Hanna, 2002; van Zyl, Antle, & Barbee, 2010). Since 2005, other jurisdictions have begun the implementation process of SBC in their systems (Washington State, Florida (Circuits 3 & 8), New Hampshire, and New York City). SBC is a family centered practice model of child welfare assessment, case planning, and ongoing casework. The model utilizes Family Life Cycle Theory (Carter & McGoldrick, 1988) to target specific everyday events in the life of a family that have caused the family difficulty. It also combines the problem focused relapse prevention from cognitive-behavioral therapy approaches that evolved from work with addiction, violence, and helplessness (Beck, 1995; Marlatt & Gordon, 1985; Pithers, 1990), with solution-focused models that evolved from family systems casework and family therapy (Berg, 1994; deShazer, 1988). By integrating these theoretical approaches, partnerships between family, caseworker, and service providers can be developed that account for basic needs, and restore the family's pride in their own competence.

Based on its strong evidence base and comprehensive nature, leaders in the Washington State child welfare system chose SBC as the practice model they would implement state-wide. The process Washington State's Children Administration followed in selecting SBC as the practice model will be discussed in more detail below.

1.2. Frameworks for implementation

Multiple conceptual frameworks for understanding and guiding the process of successful going-to-scale implementation from the viewpoint

of model developers and implementation researchers have been put forth recently, including the Consolidated Framework for Implementation Research (CFIR; Damschroder & Hagedorn, 2011) and the Core Implementation Components/Driver theory (CIC; Fixsen, Blase, Naoom, & Wallace, 2009). Overall, these models assert that a number of factors impact the effectiveness of implementation including intervention characteristics, outer setting/external systems, inner setting (facilitative administration), individuals/staff involved, the implementation process (pre-service and in-service training, on-going coaching and consultation, staff performance assessment), and decision support data systems. Conversely, from the standpoint of agencies and systems, the GTO is a general framework for promoting accountability for the implementation of any innovative practice, and can be used by a variety of intended consumers across different target populations and targeted outcomes (Wandersman, Chien, & Katz, 2012; Wandersman, Imm, Chinman, & Kaftarian, 2000). While it attends to many of the factors included in the models developed for external researchers, the GTO provides in-structive, step-by-step guidance for organizations seeking to adopt best practices in their own systems. Importantly, this broader application also differentiates the GTO framework from other frameworks designed to link sites to specific programs focused on preventing child psychological or behavioral difficulties or where the focus is explicitly on improving inter-agency or community-university collaboration, such as Communities that Care, Evidence2Success, PROSPER and Common Language (Axford & Morpeth, 2012; Feinberg, Jones, Greenberg, & Osgood, 2009; Ripper & Ortiz, 2012; Spoth & Greenberg, 2011). The foundation of GTO is the operationalization of empowerment evaluation theory, which seeks to empower organizations to fully participate in the evaluation process to lead to outcomes that are the most helpful and meaningful to them (Chinman et al., 2009). GTO brings together several theoretical concepts of evaluation and accountability such as traditional program evaluation, Results-Based Accountability, and Continuous Quality Improvement. The goal of GTO is to provide an arena in which program implementers work together with evaluators and provide them with the information necessary to engage in accountability activities associated with quality outcomes.

The GTO framework uses a ten step accountability approach. The ten steps include:

1. Identifying needs and resources.
2. Setting goals and objectives to meet the needs.
3. Selecting the evidenced-based, evidence-informed practice model to address the needs.
4. Assessing actions to ensure that the selected program fits the organization.
5. Assessing what organizational capacities are needed to implement the program.
6. Creating and implementing a plan.
7. Conducting an evaluation process to assess the quality of implementation.
8. Conducting an outcome evaluation to measure how well the program worked.
9. Determining how a continuous quality improvement process can improve the practice.
10. Taking steps to ensure sustainability of the program.

It is important to point out that the GTO framework is not necessarily linear. Agencies and organizations may have the need to move ahead to specific steps or revisit previous steps during implementation. Some situations may require a different order of these steps to address agency protocol. For example, some jurisdictions may not have the time to conduct a thorough needs assessment, their planning may be more of an adjustment process, triggered not internally but as a response to legislative intervention of a new program or expectation. In such cases, the organization may have had the first few steps of the process decided for them, which is not ideal but not unmanageable if they can re-group within the structure of a thoughtful implementation protocol. In addition, it is

important to link each step of the process to ensure successful implementation and measurable outcomes. The underlying needs outlined in Step 1 must be clearly connected to the statement of goals and desired outcomes identified in Step 2. These goals and outcomes then set the stage for selecting a practice model in Step 3 and developing strategies in Step 6 for a successful implementation plan. These same goals and outcomes from Step 2 also impact the elements that will be used in Step 8 regarding quality assurance.

GTO promotes cultural competence at each step of implementation and evaluation. Organizations must incorporate their client populations' cultural characteristics, norms, values, and experiences when implementing any program or practice model. The remainder of this article will describe the process by which Washington State's Children Administration implemented Solution Based Casework as their practice model using the GTO framework. The steps outlined in the GTO framework and the extent to which Washington State's Children Administration exemplified these steps are described below (also see a summary of the steps and the corresponding actions taken by Washington State in Table 1).

2. Implementation of SBC: Utilizing the GTO Framework Lens

2.1. Identifying needs and resources

The first step in the GTO process is the identification of the agency's needs. The question asked at this initial step is "What are the underlying needs and resources that must be addressed?" This question helps to define the problem area and outline the desired reasons for change (Barbee et al., 2011; Wandersman et al., 2000, 2012). In most public child welfare agencies, the desired need for practice change is influenced by several factors. The most common are reactions to crises, legislative mandates, lawsuits, Child and Family Service Review (CFSR) results, leadership initiatives, or highly publicized incidents such as a child death (Barbee et al., 2011). Agencies can answer this first question by compiling data and information from the CFSR, client and worker surveys, communications with stakeholders and community partners, and results from lawsuits.

In 2006, through the direction of the Assistant Secretary, Washington State's Children Administration (CA) was tasked with partnering with service providers in the exploration of using more evidenced-based interventions. As a result of conversations among the CA's leadership, a review of data from past surveys, the CFSR results, and the BRAAM vs. State of Washington 2004 settlement agreement to improve the treatment of children in state custody, this task expanded to investigate evidenced-based practices the CA could adopt to improve outcomes. A Practice Model Workgroup, composed of 14 members, was formed to begin identifying the areas needed for improvement using this information. The workgroup brought together experts from within the CA, universities and national resources centers, as well as held focus groups in every region of the state to determine what issues staff thought it would be important to tackle to improve outcomes for children. The workgroup invited internal consultants to participate in sub-group breakouts (e.g. staff in the resource department to discuss placement resource).

It was determined that the CA was in need of a consistent framework of casework practice, a research-based risk assessment, and legislation to expand the definition of "relative" in regards to child placement. These needs were supported by CA leadership and exemplified the motivation for the desire to change.

2.2. Setting goals and objectives

Once Washington's need for improved outcomes was clearly identified and defined, the focus shifted to the second step in the GTO system, the process of specifying goals and objectives. Following the steps of the GTO model (Barbee et al., 2011; Wandersman et al., 2000, 2012), committees designed to bring practice change were asked, "What are the goals and objectives that will address the identified needs and change the underlying conditions?" This question helped the organization to clearly state what they hoped to accomplish, what population the change would benefit, and why the desired change was critical. Clear goals and measurable outcomes can assist agencies in the selection of the most appropriate best practices and later determine the progress towards those goals.

Table 1

Steps taken by Washington State in the implementation of Solution-Based Casework corresponding to the getting to outcomes framework.

| GTO step | Washington State's CA actions |
|---|---|
| 1. Identifying needs and resources | <ul style="list-style-type: none"> • Consulted with experts from the CA, universities, and national resource centers • Held focus groups in every region of the state • Recorded needs |
| 2. Setting goals and objectives | <ul style="list-style-type: none"> • Formed a Practice Model Workgroup • Practice Model Workgroup developed 3goals designed to achieve 4 outcomes |
| 3. Finding best practices | <ul style="list-style-type: none"> • Practice Model Workgroup developed criteria for selecting best practice approaches • Practice Model Workgroup in small teams searched nationwide for practice models |
| 4. Assessing fit of selected practice model to agency context | <ul style="list-style-type: none"> • Practice Model Workgroup invited SBC model developer to present to internal and external stakeholders • Stakeholders discussed the fit of SBC to the professional values of stakeholders and cultural values of the families served • Practice Model Workgroup was transformed into a Practice Model Implementation Team |
| 5. Assessing organizational capacities | <ul style="list-style-type: none"> • Implementation Team reviewed literature and successful models for training child welfare workers • Implementation Team brought in external partners to provide additional guidance regarding implementation • Implementation Team decided on a model for training staff that included initial training and coaching in the field • Implementation Team recommended to CA leadership form a specialized practice model team to provide training and coaching to SBC staff |
| 6. Implementation Planning Steps | <ul style="list-style-type: none"> • Implementation Team secured matching funds from the state CA and a private foundation to hire SBC trainers and coaches • Implementation Team and CA Leadership decided on areas that would be the main focus of training for SBC trainers and coaches • Implementation Team developed a Practice Model Implementation Project Charter, which described the framework for implementation of SBC in Washington State including (1) readiness assessment activities, (2) communication activities (3) training activities and (4) a review of the implementation |
| 7. Process Evaluation/8. Outcome Evaluation | <ul style="list-style-type: none"> • The CA requested that an outside organization, Partners for our Children (POC) conduct ongoing implementation and outcome evaluation • POC conducted implementation/process evaluation during the pilot and supervisor trainings • POC conducted outcome evaluation at baseline |
| 9. Continuous quality improvement | <ul style="list-style-type: none"> • The Practice Model Implementation Team met monthly to review data |
| 10. Sustaining the practice | <ul style="list-style-type: none"> • The CA made changes to the infrastructure to support sustainability of SBC including news policies and procedures related to information systems, coaching, assessment and case planning tools, case review system, new caseworker training, inclusion of practice model strategies the statewide Program Improvement Plan, and formal quality assurance system |

It was also during these early steps that the CA expanded the Practice Model Workgroup and formed an implementation team that expanded the roles and responsibilities originally assigned to the Practice Model Workgroup. Leadership realized the breadth of the stated goals and outcomes and chose to create a high level Implementation Team with representatives from every major function in the CA that would need to be engaged if the goals were to be reached. This greatly expanded the roles and responsibilities that had previously been carried out by the Practice Model Group, although the total number ($n \approx 20$) was still a manageable size. This team of high level leadership established four objectives: 1) A uniform skill set for CA social workers that would support the agency's mission; 2) Increased family engagement throughout the assessment, case planning, and service delivery process; 3) Defined role of supervisor as teacher, mentor, and coach (clinical supervision); and 4) Family-Centered Practice integrated throughout the day-to-day operations of CA. With clearly defined goals and desired outcomes, this workgroup began the search for a practice model that met these criteria.

2.3. Finding best practices

In this step of the GTO process, the question asked is, "What science-based or evidenced-based practice model or best practice programs can be adopted to reach our goals?" In order to implement the most effective practice model, it is important for an organization to explore which models exist and are currently being utilized in similar organizations. The GTO model emphasizes that clinical directors and practitioners use prevention programs that have proven to be effective through data collection and research (Wandersman et al., 2000, 2012). This is also the approach that should be used for child welfare agencies wishing to adopt a practice model (Barbee et al., 2011). Administrators and other leaders must decide by reviewing literature of other casework models and best practices as to which of those are a good fit for their population. This step also reassures funders (i.e. state legislature, private agencies) that the model selected is based on the latest science and research and is most likely to achieve stated goals and outcomes for families and children served.

The Washington State Practice Model Workgroup, in 2006, began this step by assigning small teams to conduct a nationwide search for models of practice and best practice approaches enacted in other state and private child welfare agencies. The workgroup came to a consensus that, at a minimum, the following criteria possessed by a practice model would move them closer to improving outcomes for children and families: (a) A clinical framework for child welfare practice that is based on a theoretical foundation where safety of children is the top priority, (b) A framework that emphasizes engagement with families by working to improve the lives of children through and within their birth and extended families, and, whenever possible prioritizes partnership with mothers, fathers and extended family members to ensure children's safety, well-being and stability in their families of origin, (c) Assessments and services are provided with respect to the families' cultural, ethnic and religious heritages, and a cultural competent approach that will assist to reduce disproportionality in the delivery of services and in differential outcomes for children, (d) A family-centered approach that treats birth and extended families, foster parents and community members with respect and works to include them in collaborative planning for children, (e) An emphasis on clinical supervision, and (f) The possibility of application of the model in all levels of the organization.

The Practice Model Workgroup encountered an initial barrier in that there was limited information regarding any state using a coherent model of practice that addressed all criteria set forth by the committee. There were many states that had moved to family-centered practice and fit a majority of the criteria listed above. However, none of these best practice approaches included a theoretical underpinning. In addition, members of the workgroup saw a frequent theme from many agencies that consisted of listing principles and values of family-centered practice,

but with minimal follow through on how these principles would be operationalized.

After numerous literature reviews and communications with other state agencies, and attending conferences, two workgroup members presented information they had collected while attending a teleconference through the Child Welfare League of America on Solution Based Casework (SBC; Christensen et al., 1999). Upon further investigation, the Practice Model Workgroup explored the level of empirical study that had helped refine the model, as well as the evidence base for its theoretical components (Antle, Barbee, Christensen, & Martin, 2008; Antle, Christensen, Barbee, & Martin, 2008; Antle, Barbee, Christensen, & Sullivan, 2009; Antle et al., 2010). The outcome of this assessment helped answer the question of goodness of fit reflected in the next implementation stage.

2.4. Assessing fit of selected practice model to agency context

Following the GTO framework, the question asked in the 4th stage is, "What actions need to be taken so that the selected best practice or model fits the agency context?" In this step the agency must ensure that the selected model will enhance other program initiatives and not detract from the overall mission. Also, the extent to which the selected model is compatible with the cultural needs of the served population and agency is examined. Lastly, defining "fit" refers to the organizations readiness and leadership's commitment to implementing such a change (Barbee et al., 2011; Wandersman et al., 2000).

For Washington State, the Practice Model Workgroup invited the model developer to present to leadership and members of the workgroup. Internal and external stakeholders were able to hear an overview of SBC, ask questions, and discuss answers with their peers. It was through this overview and other early conversations that CA identified challenges to implementation, areas within the agency that needed further support and education, and a clear sense of leadership support and commitment. It was clear to all that SBC was in concert with the intrinsic values and needs of staff and external partners, however leadership had to examine whether SBC was a cultural fit to those served, as Washington State is rich with Indian heritage and has 46 federally recognized tribes. The input of tribal representatives was thus sought out early and they were involved in the decision-making. DSHS provided tribes with numerous documents, communications, and resources related to SBC. Presentations were also made to those tribes that have tribal courts. In general, tribal representatives indicated that SBC was consistent with their cultural values. For example, one tribal representative said, "SBC helps in defining issues of abuse and neglect in communal/family terms and not the signaling of one individual." Another representative said, "Staying curious about developmental stages and tasks reinforce a cultural respect for how Indian families and their Tribe take care of their children." Of note, during the initial training and rollout of SBC statewide from 2008 to 2010, all tribes were informed and invited to the trainings. As a result of these efforts, four Indian tribes requested and received intensive, 4-day SBC training for all their child welfare staff.

Subsequent to the initial assessment activities, leadership and other stakeholders agreed to adopt Solution Based Casework as the Practice Model for Washington State CA. Soon after this decision, the Practice Model Workgroup was dissolved and a 12-member Practice Model Implementation Team (PMIT) was designated as the key leadership vehicle to carry out the task of successful implementation.

2.5. Assessing organizational capacities

This step in the GTO process helps to ensure that the agency has the capacity and capability to implement a model of practice (Barbee et al., 2011; Wandersman et al., 2000, 2012). An agency must evaluate the resources the agency already possesses for successful implementation and what is needed to implement in regards to staff, leaders, technical

assistance, and funding. Assessing organizational capacity includes: 1) ability and resources in training the workforce; 2) a vision and support for large change; 3) evaluation of the organization's readiness to make change; 4) systemic infrastructure (i.e. policies, forms, information system) and the ability to make changes to be compatible with practice model concepts; 5) ensuring a quality assurance system that will sustain change; and 6) funding resources.

The PMIT explored several options for training staff. In the past, Washington's CA, as well as many other nationwide child welfare agencies, would tackle staff training in one of two ways. One would be to utilize current trainers that were a part of a new worker training academy or pre-service training. The other option would be to hold a train-the-trainers session that would include a mix of staff from varying disciplines and roles within the agency. The PMIT reviewed literature and successful models for training child welfare workers in other practice approaches. This team also brought in external partners to be a part of the Implementation Team to give them a fresh look and a better understanding of implementation science. These external partners included project manager representatives from Boeing and a local consulting firm. Both these members stressed the idea that successful implementation and transfer of learning does not occur in the classroom alone. Through consultation with the project managers it was decided that training staff would include a coaching element that would extend into individual units and field work. A novel concept for the CA came out of this, in that CA would be instrumental from moving from a "train and hope" organization, or one in which workers received a one-time training without additional efforts to reinforce information learned, to a "comprehensive learning organization".

At this point in the process, the PMIT developed a recommendation for leadership to form a specialized practice model team that would provide the training and coaching of SBC to all staff statewide. This recommendation meant that new positions would need to be created or pulled from other areas, which also meant that the state legislature would be involved to determine funding for the positions. Subsequently, other jurisdictions implementing SBC as a practice model (e.g. New York City, New Hampshire, Florida, Kentucky, and Kansas) chose to use their Supervisors and Program Managers as ongoing coaches, so it is clear that implementation of a comprehensive practice model does not require new or re-assigned positions solely dedicated to the implementation process. However, in Washington State, the legislature agreed that this approach would be optimal for CA in their efforts to build internal capacity to improve practice. A barrier encountered at this stage was that, although the legislature agreed to fund new positions, they only agreed to fund a limited allotment of dollars on the condition that CA find another organization to match the funds. The PMIT investigated several private funding agencies, and eventually was successful in obtaining matching funds from the Casey Family Programs, which became an equal and vital partner in the implementation of SBC. The funding provided by Casey Family Programs was allocated for implementation of the practice, training resources, consultation fees, and also salary and benefits for five contract practice model coaches. In addition, due to this contractual agreement with Casey Family Programs, Washington State was able to hire six additional state-employed practice model coaches and one lead coach. By November 2007, the Practice Model Coaching Team was in place. This team received intensive training on SBC that same month.

Once the coaching team was in place, the Implementation Team was able to expand its members and begin the planning. The practice model Lead Coach and a representative from Casey Family Programs were two additional members to this team. Prior to the initiation of training, CA, through the assistance from the Boeing project manager, began the steps to assess organizational readiness. Initially, several small workgroups were held statewide that were limited to headquarter leadership, upper management, and regional management. These workgroups were facilitated by the Boeing representative and included activities to ensure leadership's readiness for change and steps

they would implement for their staff to prepare to follow the new model. A survey was then developed for all staff to gauge their readiness for change. This survey was developed in collaboration with the Boeing representative and Partners for Our Children (POC), a child welfare research organization out of the University of Washington.

During this assessing capacities stage, the focus was on the training element and quality assurance. Infrastructure elements, such as policies, information system, were discussed but not at great detail. These areas became the central focal point of assessment much later in the implementation process. In addition, this stage continued to evolve throughout the implementation process due to lessons learned, leadership changes, budget reductions, and other project initiatives. From the beginning phases, a quality assurance plan was instituted that first measured knowledge growth for the coaching team, quality of the training, quality of coaching, and local offices' strengths and needs for staff understanding.

2.6. Implementation planning steps

The 6th step of the GTO process involves planning the details of how the implementation will occur (Barbee et al., 2011; Wandersman et al., 2000, 2012). Two areas are crucial for the planning stage: a plan for training staff and a plan for infrastructure changes that will sustain the practice changes. A critical component of implementing a practice model is the development of a clear plan that guides all activities and tasks, serves as the blueprint for success, and is specific as to roles and responsibilities, both for internal as well as external players.

For Washington State, early efforts and planning for implementation centered mainly on developing training and communication plans. The Implementation Team and CA Leadership thought it best to train and coach to the practice model concepts, including focusing on family strengths, planning ways to successfully manage daily tasks, and relapse prevention, prior to having any new tools or policies set forth. Therefore, infrastructure areas were identified as needing to be modified, a plan was not put in place to address these areas until two years after implementation began. In retrospect, this decision delayed the transfer of learning and created doubt in some staff's minds regarding whether the administration was committed to the long term establishment of the model. This is a consistent threat in agencies that see new initiatives come and go with each new administration or legislative session.

In response to the delay in the transfer of knowledge to new staff, the PMIT developed a Practice Model Implementation Project Charter, a tool that facilitated long term planning as a hedge against system drift. This document described the framework for the development of an organized structure with project experts and resources to implement SBC as the practice model for Washington State's CA. This charter outlined and defined specific techniques and disciplines to be applied including planning, tracking, reporting, scope, assumptions, constraints, stakeholders, required resources, and criteria for project success. The Project Charter also defined its purpose, deliverables, decision-making process, and roles and responsibilities of each member. The hope was to get a higher degree of system commitment to future infrastructure change.

Once the Project Charter was approved by CA leadership, the PMIT had a wider and deeper base of support to begin planning the next stage of the implementation plan. The purpose of this plan was to describe the activities and objectives for further project implementation, including activities to assist CA in preparing for and accepting the change. The Implementation Plan addressed several critical components: 1) the readiness assessment activities to support successful implementation of the practice model; 2) the vital communication activities to promote acceptance and understanding of the change; 3) training activities and supports for SBC; and 4) a plan to review how well the practice model had been implemented throughout CA. Also, this plan included a sustainability plan that described how CA would

ensure the casework management model would be supported and sustained over time. The four components are described below.

2.6.1. Readiness assessment activities to support successful implementation of the practice model

The first activity the PMIT addressed and planned for was organizational readiness. Implementation success of any project or model depends heavily on the organization being ready for the planned change. “People resist coercion much more strenuously than they resist change” (Block, 2003, pg.21). Good change management plans work on the heart (commitment) as much as they work on the head (training). The PMIT developed a readiness for change plan that included five elements, assessment, presentations to field staff, meetings involving PMIT staff and regional management staff, “managed transitions plans workshops,” and “how to change” information. To assess readiness for change, the PMIT sent an online survey to agency staff prior to the pilot training. Follow up conversations were held in person at the regional level and sometimes office level to help better understand survey results and develop action plans to address areas of low acceptance. Next, the PMIT made presentations to field staff to inform those impacted (directly and indirectly) about SBC. It demonstrated the benefits of adopting a new practice model versus the costs of continuing with current practice. These presentations also educated staff on the basic principles and concepts of SBC, a sense of what will be different with families and social workers, and provided some hands on experimental exercises with SBC.

The final three elements included planned meetings between PMIT leads and Regional Management staff, “managed transitions planned workshops” facilitated by the Boeing project manager and provided to CA leadership, and “how to manage change” information. These elements provided opportunities to discuss the impact the change would have on staff and agreed upon steps to assist and support the change. Information from these meetings and other areas were made available by CA leadership in the form of tip sheets, reference materials, tools, and other forms. This information was openly disseminated to all CA staff through emails, website, SharePoint, additional trainings, and hard copy materials.

2.6.2. Communication activities to promote acceptance and understanding of the change

The second area addressed in the Project Charter and Implementation Plan was the communication plan. This plan described the approach for communicating the practice model changes to all levels in CA and to community stakeholders. It outlined communication activities, frequency, individuals responsible for communication, and communication tools used to ensure delivery of consistent, timely, and targeted communications. The plan was considered successful if the communication methods and tools described in the plan were consistently followed by team members, the plan provided routine channels for the appropriate dissemination of clear, accurate, and relevant information, appropriate stakeholders were identified on a routine basis, staff were supported in developing and distributing communications according to the plan, and websites and shared information repositories were available to all CA staff and routinely updated with appropriate content. The communication plan included three major components: 1) marketing; 2) outreach; and 3) monitoring.

2.6.2.1. Marketing. The marketing approach centered on key message themes that were communicated and reinforced at every available opportunity. The PMIT developed two tables to capture and plan for delivery. The first table was the communication audience. This table listed the stakeholders/audience and identified their area of interest, the communication method, frequency, and person(s) responsible for communication delivery. The second table was the communication event. This table listed the available communication events held throughout the state, person(s) responsible for delivery, and the audience. Messages were delivered through a wide variety of delivery channels including

one-way and two-way methods. The communications were designed to be delivered repeatedly, consistently, and by a trusted, credible source. Communication occurred via direct contact, as well as through other tools such as a website, brochures, and a newsletter.

2.6.2.2. Outreach. The second component of the communication plan was outreach in the form of face-to-face opportunities to communicate project progress and encourage adoption of the practice model. Outreach events were conducted throughout the project and were intended to reach all CA staff and management repeatedly using multiple delivery mechanisms, convenient to each stakeholder group, and with carefully allocated usage of resources. These events included an introduction to staff and management about the practice model and presentations at regularly scheduled administrator, program manager, and staff meetings. Objectives of the outreach included identifying effects of the change on the organization and staff, increasing understanding of the forthcoming changes through information sharing, promoting acceptance by lowering the anxiety caused by change, and managing expectations by stating realistic benefits and acknowledging challenges. The PMIT Team evaluated feedback from outreach events to determine what information was lacking, where resistance was occurring and to refine the communication plan accordingly. An Outreach Event Log was maintained to keep track of events and follow-up activities, if any. At each outreach event an evaluation form was provided. In addition, presenters and other project representatives recorded questions raised at these events. These questions were logged and included into the Practice Model Frequently Asked Questions (FAQ).

2.6.2.3. Monitoring. Finally, regarding monitoring, the organization awareness and acceptance levels were assessed through communications with the field, the inputs of readiness assessments, and feedback collected at outreach events. Feedback was collected through surveys, evaluation forms, and informal methods such as emails. Communication after the clinical practice model has been fully implemented and integrated will become the responsibility of the Practice Model Coaches and their lead.

2.6.3. Planned training activities and supports for SBC

The third element of the project charter was the plan for training. The PMIT, through consultation with external partners, decided to pilot the three-day SBC training in three sites prior to a statewide rollout. The offices selected represented a small, medium, and large population ratio. The pilot trainings began in April 2008 and concluded the last week of July 2008 with 82 staff and 14 supervisors. Pilot planning meetings were scheduled and held with each of the three offices prior to the trainings occurring.

These meetings provided all staff in an office an overview of the pilot and allowed the PMIT to answer staff questions. In addition, these meetings were used to identify office strengths, office challenges, the training and coaching plan, quality assurance, and the plan for research on outcomes. A meeting was also held shortly after the conclusion of a pilot training to review evaluations, feedback, and next steps.

The overall training plan and schedule included separate trainings for supervisors/managers and field staff. The supervisor trainings were held during the rollout of the pilot sites. The original training plan, which was implemented during the pilot and supervisor training phase, consisted of a seven-week cycle. The first week consisted of classroom training. The second, fourth, and sixth weeks were the designated times that workers applied SBC principles to their day-to-day work. During the third, fifth, and seventh week, each worker partnered with a Practice Model Coach to gain more knowledge in SBC. Credit for completing the training was granted after a worker received three coaching sessions. Supervisors followed the same schedule, however, their time was shortened to five weeks.

Partners for Our Children (POC) an organization that collaborates with the University of Washington and Washington State Department

of Social and Health Services in providing research to identify areas to improve child welfare practice, conducted an evaluation of the training, including interviews with members of the practice model implementation team, focus groups with social workers and supervisors directly following the pilot trainings, pre and post-tests to trainees, and observations of SBC trainings across the state. Regarding the three pilot trainings with caseworkers, the average rating for increasing knowledge of SBC for caseworker trainings across the sites was 7.3 (range = 6.90 to 7.70), on a scale of 1 to 10. The average rating for increasing knowledge of SBC was lower among supervisor trainings, 6.32 (range = 4.92 to 8). In addition to the quantitative measures, five focus groups with workers were held involving 13 supervisors, 15 caseworkers, and 5 other staff members. Overall participants reported having gained a good understanding of SBC concepts and that it reflects their professional social work values. However, they also reported they were not completely sure of the motivation of the CA for adopting SBC, that the case examples used during the training did not reflect the complexity of their actual cases, and they were concerned that the on-going coaching would be insufficient to meet their needs. In addition, supervisors reported some confusion about their role in helping to implement SBC. These data were used to redesign the statewide training schedule, edit portions of the curriculum, and develop a more structured process for providing coaching and consultation after training (Lyons, Courtney, Newby, & Lee, 2009).

The statewide rollout training, following the pilot training, was originally approved to follow this same seven week training cycle, and to begin in the summer of 2008. However, during this same year, CA also began utilizing a new information system. CA management decided to not train staff to the new computer system and SBC at the same time. This decision delayed the training of SBC to social workers until early 2009. The estimated timeline to complete intensive training and coaching statewide was two years, and involved a mix of offices from different regions in each series of training.

2.6.4. A plan to review how well the practice model has been implemented throughout CA once fully implemented

At the conclusion of the pilot and supervisor training, the PMIT reviewed the training plan and identified strengths and barriers to the process. Overwhelmingly, all members identified the strength in providing coaching to field staff in addition to classroom training. However, they also identified the resource impact of the 11 Practice Model Coaches, particularly their attempts to provide one-on-one coaching to service providers. Though they were able to meet with each worker and supervisor during the pilot phase, the statewide rollout presented a challenge, due to the large number, over 2000, of staff yet to be trained. In addition, the PMIT discovered there was the potential of the two-year training timeline to extend beyond the time-line provided by Casey Family Programs (hereafter referred to as Casey). Casey was contracted to provide funding on a yearly basis and to review the need for funds each fiscal year. The statewide training plan was revised to reflect these barriers. The new training plan continued to provide both classroom training and coaching for staff. However, this new plan was separated into two phases. In the first phase the Practice Model Coaches provided classroom training to all staff. A schedule was developed that incorporated a mix of offices from each region receiving training simultaneously each week. In the second phase the Practice Model Coaches provided coaching and consultation to units of workers. The coaching element was expanded from one-on-one assistance to a more holistic approach through case consultation provided to a supervisor's unit. Case consultation and coaching will be discussed further in the sustainability step. Coaching did not begin with units until phase one classroom training was completed statewide.

This revised statewide training plan provided a new approach in the transfer of learning to staff. This "train and coach" method is one that has been replicated in other initiatives set forth by CA. Another benefit of this revised training plan was that it reduced the training timeline

from two years to one year. The statewide training began in March 2009 and was concluded by January 2010.

Barbee et al. (2011) identified, related to this step, that a plan for infrastructure changes are to be included in the overall implementation plan. These infrastructure changes include forms, policies, procedures, information systems, CQI tools, case reviews, and changes to pre-service academies and ongoing trainings. The Washington State PMIT discussed and identified future changes in infrastructure that needed to occur to support practice. However, the process and timeline for making such changes were not included in the original implementation plan, but instead became an addendum to the original implementation plan. This will be discussed in detail below.

2.7. Process evaluation/8. Outcome evaluation

The final four steps in the GTO process are centered on the evaluation, improvement, and sustainability of an implemented project (Barbee et al., 2011; Wandersman et al., 2000). In step 7, process evaluation tracks whether the project was implemented as intended and helps to identify ways to improve program delivery. Step 8 outlines the need for an outcome evaluation which assesses whether an implemented practice improves outcomes for children and families. For Washington State, these steps did not occur sequentially but occurred in an iterative fashion, such that process and outcome evaluation informed changes for improvement and sustainability which then went through additional rounds of process and outcome evaluations.

POC designed a baseline evaluation early in the implementation of the practice model. The evaluation was developed to measure caseworker and family perceptions of child and parent functioning and current casework practices. POC recruited a random sample of parents with a newly opened CA case between July and December 2008. The evaluators achieved a response rate of 82% for a total of 809 parents interviewed. Parents in the study were predominately single (41%), unemployed (67%) women (92%), with an annual income of less than \$20,000 (69%). Regarding risk factors for child maltreatment, 87% of the parents reported that they experienced at least one of four risk factors, including domestic violence, sexual abuse, substance abuse/dependence, or mental health conditions. Parents were somewhat neutral on whether their case workers had an engagement style that was inclusive of families $M = 3.07$ (1 = strongly disagree, 5 = strongly agree). They had a slightly positive attitude towards their social worker in regard to feeling respected, $M = 3.25$ (1 = strongly disagree, 5 = strongly agree) and slightly disagreed with the statement that it is hard to work with their caseworker $M = 3.25$ (1 = strongly disagree, 5 = strongly agree). On the other hand, parents slightly agreed that their worker saw more problems than strengths in their family, $M = 3.25$ (1 = strongly disagree, 5 = strongly agree) (POC, 2009). A total of 1420 caseworkers participated in POCs baseline evaluation of caseworker perceptions of casework practices and caseload characteristics. Overall, caseworkers reported having face-to-face contact with the primary caregiver about 3 times in the previous month and about 3.5 times with the children involved in the case. Caseworkers indicated that the primary caregiver was "somewhat involved" in creating the service plan, $M = 2.1$ (1 = very involved, 4 = not involved at all) but virtually, "not involved at all" with regard to playing a central role in identifying service needs and goals in case plans, $M = 3.7$ (1 = very involved, 4 = not involved at all). Caseworkers were somewhat neutral regarding the idea that families served often have more problems than strengths, $M = 2.5$ (1 = strongly disagree, 4 = strongly agree) but did agree that all parents have strengths and resources they can use to solve problems $M = 3.5$ (1 = strongly disagree, 5 = strongly agree) (Marcenko, Newby, Lee, Courtney, & Brennan, 2009; POC, 2009).

Due to budget constraints, changes in personnel, introduction of other CA initiatives, and other factors, the full post-implementation evaluation has not yet occurred, but is scheduled for completion by the end of 2013. Although the outcome evaluation process is on-going,

a Solution Based Quality Assurance and Improvement team, created to monitor implementation and outcomes on an on-going basis, has gathered preliminary outcome data with regard to both worker practice and child outcomes through a central case review process and from the CA electronic case management system, FamLink. For example, in 2012, a central case review revealed that family, providers and natural supports were involved in the assessment and planning process in 92% of cases reviewed ($n = 50$ cases). In addition, actions were taken to involve 76% of mothers ($n = 351$ cases) and 50% of fathers ($n = 279$ cases) in case planning. Although the questions asked as part of the Quality Assurance process were somewhat different than those asked in the POC base-line evaluation, given that at base-line the primary caregivers on average were viewed as almost “not involved at all” in case planning and were somewhat neutral on whether their workers were inclusive of families, these are promising findings. Regarding child outcomes, initial findings indicate that the rate of re-victimization of children according to statewide data dropped from 7.1% in 2007, the year when implementation of SBC began, to 6.3% at the end of 2011. Consistent with this drop, the number of dependencies filed dropped from 4454 in 2007 to 3628 in 2011. An important caveat is that multiple practice initiatives, besides SBC, were instituted in Washington's child welfare system during this time, and thus it is not possible to completely disentangle changes solely associated with the implementation of SBC.

2.8. Continuous quality improvement

Questions asked during this phase include “How can the practice model be improved?” and, “How can implementation of and model fidelity to the practice model be improved?” The CQI process involves assessing and feeding back evaluation information about implementation and outcomes to improve the practice model. This step involves a continuous review of data and ensuring that this information is used to revise strategies and activities (Wandersman et al., 2000).

From 2008 to the time of this writing, the PMIT has met monthly to review data and information from numerous sources: training evaluations, coaches' reports, tracking reports on elements of practice (case consultations, case plan development, etc.), feedback from regional management. Over time, the practice model became integrated with all levels of CA including policies, information system, other program areas, and CFSR. In addition, as mentioned above, beginning in June 2012, the Solution Based Quality Assurance and Improvement Team began meeting, with the purpose of the team being to collect, organize, and present data related to the implementation of SBC. One challenge noted was that data collected as part of Quality Assurance, although measuring inclusion of family members in case planning and other over-arching aspects of the SBC approach to case management, did not include objectives generated by the family tied to threats of child safety and/or maltreatment, an important part of the SBC model. In response to this short-coming, the Quality Assurance team is revising the tool used for central case reviews and also plans to provide case reviewers with additional training in reviewing documentation pertaining to more fine-grained aspects of the SBC model.

2.9. Sustaining the practice

The final step of the GTO framework is to ensure that the practice model is sustained for long term success (Wandersman et al., 2000). This is particularly important in the public child welfare arena where there can be constant change in leadership, supervisors, and workers (Barbee et al., 2011). For a practice model to continue, the agency must develop a process and administer measurable indicators of both short-term and long-term positive outcomes, as well as model fidelity. Without this information and data, it can be challenging for new leaders to understand the purpose and intent of a practice model. The SBC model developer has recently set national standards and a procedure for agency certification in SBC, a helpful step to help agencies self-

assess and monitor model fidelity. Because empirical outcomes are tied to model fidelity (Antle et al., 2012), this will be an important final and ongoing step for any jurisdiction implementing a practice change process. Without ongoing fidelity measures, there are simply too many other pressures on child welfare systems for them to maintain a consistent course of action.

In Washington State, sustainability was facilitated through both processes which were part of the Implementation Plan and developments that unfolded as part of CA activities. During the training phase, the PMIT developed a statewide quality assurance plan. This plan outlined the elements that could be initiated and measured in local offices in lieu of supporting infrastructure changes including a process for case consultations, a family feedback survey, learning contracts for supervisors and social workers, supervisor learning groups, and local office implementation assessments. The practice model coaches assisted each local office in developing their QA plan and strategies to achieve each element. Though this process set the groundwork for a more formal QA plan later in the implementation process, it was a challenging undertaking due to much of the information collected was anecdotal and not quantitative.

In 2010, CA contracted with the National Resource for Child Protective Services to review the current safety assessment and planning process. The practice model was included in this partnership with a shared goal of improving CA's process for assessing child safety. After a year of consulting and planning, CA embarked on the implementation of a Child Safety Framework. The significant time spent in planning was necessary to fully integrate the introduction of the Child Safety Framework with the practice model. This provided an opportunity to not only train staff on this framework, but to revisit the concepts and principles of CA's practice model of SBC. In order to successfully integrate the Safety Framework initiative within the SBC practice model architecture, CA made overdue changes to the infrastructure including: new policies and procedures related to practice, redesign of CA's information system to include specific assessment and case planning tools, revision of the statewide case review system, changes to new worker academy, inclusion of practice model strategies to the Program Improvement Plan (PIP), and a formal QA system.

With these changes to the infrastructure, the inclusion of SBC on the PIP, and the continued use of practice model coaches, SBC gained the elements and supports needed for long-term sustainability. In addition, CA developed processes for where tangible data can be collected, evaluated, and disseminated.

3. Conclusion

Washington State's experience with implementing a significant change in child welfare practice illustrates the challenges in large public systems that are routinely buffeted by forces internal and external. Even with significant internal and external supports, including funding, consultant expertise, initial legislative and administrative support, without investments of time and energy in planning, the road to full implementation can be challenging. Paradoxically, in large systems, as illustrated in this article, these challenges and barriers can be magnified by the time spent planning (vs. action). In other words, the longer the implementation planning occurs without decisive supportive action, the more potential distractions may occur. Once off course, even temporarily, the momentum for change can be threatened by either fatigue, diffusion of purpose, or disorganization.

Given these dynamics, an implementation structure such as the Getting to Outcomes framework may prove to be a useful guide for the state-wide implementation of a practice change initiative. In Washington's experience, the GTO process did not prevent unintended or unanticipated outcomes in the process, but it did provide a guide for returning the change process to its proper course when these occur. Additionally, extensive planning and system involvement early on can help sustain a system when faced with implementation challenges.

The wider and deeper that involvement, the more resources are available when needed to rally the effort back to its goals and objectives.

Additional lessons learned in the process of implementation of SBC in Washington State are many, and have been discussed above. However, there are two critical and related lessons that deserve highlighting as they may serve to be pivotal in future efforts to implement an empirically based practice model in child welfare. These two lessons involve the role of two separate levels of the system, upper management and the line supervisor.

The importance of senior leadership's active participation in managing the implementation process cannot be overstated. In large public systems, senior leadership tends to delegate "these projects" to a subordinate, so that they can focus on the "ongoing work" of the agency, thus assuming their normal work practice pattern as if this practice change was just another project. However, it could be fairly argued that a practice model change is fully central to the "ongoing work" of the agency, and touches every aspect and every decision that is made by leadership. Leadership may assume that this is not something they need to be trained on, that others can learn the details of the model and they can just manage. However, when senior leadership is not expert in the model, critical decisions in the life of the system that affect practice are not noticed as critical. Similarly, when new initiatives are introduced internally or externally, leadership is not able to see the benefits or barriers they might present to the practice of the agency. Based on Washington's experience, as well as the experience of other large jurisdictions with whom we communicate, we suggest agency heads consider: 1) attending the initial trainings, 2) reading all relevant literature on the model, 3) using regular senior lines of authority to manage the project (vs. assigning to lower level training branch for example), 4) scheduling regular quarterly meetings with the model consultant for updates, and 5) finding ways to be personally visible and vocal about the project, particularly supporting a process of recognizing practice model champions at all levels of the system.

The decision in Washington to build internal staff expertise (Coaches) dedicated to the model implementation was a significant accomplishment. The lesson learned however is that there is a danger in relegating the responsibility of ensuring model implementation to individuals in the Coach position. An unintended consequence of this process is that line supervisors may feel disempowered. The Washington experience with gaining the buy-in of the supervisors has been challenging, as too many supervisors saw the task of changing practice as that of the dedicated Coaches positions. In other jurisdictions where SBC has since been implemented, the engine of change is squarely with the supervisor and their direct management of practice.

Given these two lessons learned as a backdrop, much can be said for the GTO process helping overcome these issues. Having a formal structure to help direct the next step can allow for an accurate assessment of the current challenge, a revisiting of goals and objectives, and then problem-solving efforts designed to overcome the challenge or barrier. Because of the extensive early strategic planning support internally and externally, the Washington Implementation Team continues to solve problems with implementation, and is now in a position to return to the task of bringing the supervisors fully on board by beginning a process of certifying their and their caseworker's skill sets in Solution Based Casework. This process, though ideally done earlier in the process, is now better positioned to be successful because the larger system has made the time to make the changes in infrastructure (i.e. information systems, policy, performance review, and Quality Assurance) that are needed to support a practice change.

As has been demonstrated in this paper, the GTO framework may prove to be a useful tool to assist a variety of organizations that are entering a change process or to study retroactively a system that has completed a change process. As such, it fills an important niche in the implementation of best practices in large, complex organizations, particularly when the desire for implementation originates in those organizations. Following such a structured, practical approach to implementation

can help facilitate the more rapid and broader adoption of practices that may lead to improved outcomes among children and families.

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