Child Abuse & Neglect 36 (2012) 342–353

Contents lists available at SciVerse ScienceDirect

Child Abuse & Neglect

The impact of the Solution Based Casework (SBC) practice model on federal outcomes in public child welfare

Becky F. Antle*, Dana N. Christensen, Michiel A. van Zyl, Anita P. Barbee

University of Louisville, Kent School of Social Work, Louisville, KY, USA

ARTICLE INFO

Article history:
Received 6 August 2009
Received in revised form 6 October 2011
Accepted 12 October 2011
Available online 11 April 2012

Keywords:
Child welfare
Practice model
Solution Based Casework
Safety
Permanency
Well-being

ABSTRACT

Objective: To test the effects of the Solution-Based Casework practice model on federal outcomes of safety, permanency and well-being. The Solution-Based Casework model combines family development theory, solution-focused skills and relapse prevention for the casework process in child protection.
Method: 4,559 public child welfare cases were reviewed through a CQI case review process.
Results: This study found that cases with high levels of fidelity to the model demonstrated significantly better outcomes in the areas of child safety, permanency and well-being and exceeded federal standards, while cases with low fidelity to the model failed to meet federal standards.
Conclusion: Components of the Solution-Based Casework were significant predictors of these federal outcomes and accounted for variance in these outcomes better than any other casework process factors.

The field of child welfare has long been charged with the responsibility of protecting children from abuse and neglect. However, there has been a growing emphasis on documenting the outcome of those efforts, specifically in the areas of child safety, permanency, and well-being due to the passage of the Adoption and Safe Families Act (ASFA) of 1997 (Gendell, 2001) and the Government Performance and Results Act of 1993 (Kautz, Netting, Huber, Borders, & Davis, 1997). When ASFA identified key outcomes of child safety, permanency, and well-being for state child welfare agencies, the federal government implemented the Child and Family Service Review (CFSR) process to monitor compliance with these outcomes.

The Child and Family Services Reviews (CFSRs), authorized by the 1994 Amendment to the Social Security Act (SSA) and administered by the Administration for Children and Families (ACF), require the federal government and state child welfare agencies to work as a team in assessing states' capacities to promote positive outcomes for children and families being served in the child welfare system. The CFSRs emphasize 4 areas: family-centered practice, community-based practice, individualized services, and strengthening parental capacity (http://www.acf.hhs.gov/programs/cb/cwmonitoring/tools_guide/hand-2.htm). This process includes: (1) statewide assessment prepared by the state child welfare agency; (2) state data profile prepared by the Children's Bureau of the US Department of Health and Human Services; (3) reviews of 65 cases at 3 sites throughout the state; and (4) interviews or focus groups (conducted at all 3 sites and the state-level) with stakeholders including, but not limited to children, youth, parents, foster parents, all levels of child welfare agency personnel, collaborating agency personnel, service providers, court personnel, and attorneys.

Results from the first round of CFSRs between 2001 and 2004 indicate that there were only 6 states that were in substantial conformity with the 2 federal safety outcomes, which measure the protection of children from abuse and neglect (http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/genfindings04/ch1.htm). While no states were in substantial conformity with the federal permanency outcome that centered on permanent and stable living situations for children, there

* Corresponding author.

0145-2134/$ – see front matter © 2012 Elsevier Ltd. All rights reserved.
doi:10.1016/j.chiabu.2011.10.009

were 7 states that met the criteria for preserving family relationships and connections. There was also wide variability in states' conformity with the federal well being outcomes. Although 17 states were in substantial conformity with the well being outcome that focused on children's educational needs, there was only 1 state that met the criteria for providing for children's physical and mental health needs and there were no states that met the criteria for enhancing family capacity to provide for children's needs.

Evidence based child welfare practice

Despite the prevalence of a federal focus on child maltreatment and outcomes of efforts to prevent and ameliorate child maltreatment, effective and enduring child welfare interventions remain elusive. Although the National Association of Public Child Welfare Administrators has recognized the call to evidence-based approaches in child welfare, they caution that the research base in child welfare is still in its early development, and the pace of science may not be adequate to meet the urgent needs of families in the system (APHSA, 2005). Gira, Kessler, and Poetner (2005) have argued that not only is there a paucity of evidence on effective interventions in child welfare, but the evidence that is available is difficult to generalize because of the diversity of the client population. It should also be noted that evidence based treatment/intervention models do not specifically address the primary *case management* responsibilities of public child welfare agencies.

Evidence-based treatment programs

Nevertheless, there are a few *treatment* programs that have established a base of evidentiary support for their effectiveness to promote child welfare outcomes of safety, permanency, and well-being. One such program, Family Preservation Services, has been shown to significantly reduce the re-occurrence of child abuse and neglect and out of home placements for children (Walton, 1998). Various home visitation models (e.g., Duggan et al., 2004; Holton & Harding, 2007; Olds, 1997) have been used to prevent the initial occurrence and recidivism of child maltreatment as well. Although there is substantial evidence demonstrating the effectiveness of this approach for the primary prevention of child maltreatment (e.g., Gonzalez & MacMillan, 2008; Harder, 2005), there is conflicting evidence on the effectiveness of such approaches for key ASFA indicators such as repeat maltreatment. MacMillan et al. (2005) evaluated the effectiveness of a nurse home visiting program for disadvantaged parents, they did not find a significant impact on recidivism of child abuse/neglect.

In addition to these home-visiting approaches, Gershater-Molko, Lutzker, and Wesch (2002) evaluated a parent training program focused on health care, bonding and environmental safety, Project SafeCare, to prevent child maltreatment recidivism. Those who received the Project SafeCare services had significantly lower reports of child abuse and neglect than families in the comparison group. Another parent training approach, Parent–Child Interaction Therapy (PCIT), utilizes parent coaching and it has been shown that parents who receive PCIT are significantly less likely to abuse or neglect their children (Chaffin et al., 2004).

Evidence-based case management

Although there is some research on promising *treatment programs* to promote child safety and well-being, none of these studies has focused specifically on *case management strategies* or the casework practices of the entire public child welfare agency itself. Family Preservation Services are used for a targeted sub-group of child welfare clients to prevent out of home placements and are typically provided by staff from private providers outside the public child welfare agency. Programs such as home visitation, Project SafeCare, and Parent–Child Interaction Therapy are also outside treatment programs to which child welfare clients can be referred. Furthermore, there has been no systematic research conducted on other public child welfare practice models used in such states as Utah, Alabama, and New Jersey (National Resource Center for Organizational Improvement, 2008). Hence, while some treatment programs have demonstrated positive impacts on child welfare outcomes such as the prevention of recidivism and removal of children from their homes, they do not provide guidance to the field on best practice for assessment, case planning, and casework management for those families that are served by public child welfare workers to address the federally mandated outcomes.

Overview of the Solution Based Casework model

One practice model that has been developed for and tested within the public child welfare system is Solution-Based Casework. Solution-Based Casework (SBC) (Christensen & Todahl, 1998; Christensen, Todahl, & Barrett, 1999) is a child welfare practice model based on three theoretical foundations: family life cycle theory (Carter & McGoldrick, 1980), relapse prevention/CBT theory (Irvin, Bowers, Dunn, & Wang, 1999; Marlatt & Gordon, 1985; Parks & Marlatt, 1999), and solution-focused family therapy (Berg, 1994; DeShazer, 1988; Kelly & Berg, 2000). These theoretical foundations translate to the following assumptions of casework: (1) that full partnership with the family is a critical and vital goal for each and every family case, (2) that the partnership for protection should focus on the patterns of everyday life of the family, and (3) that solutions should target the prevention skills needed to reduce the risk in those everyday life situations. When applied to the child welfare population, a SBC assessment utilizes the family life cycle to frame and locate the "problem" in the difficult developmental challenges that create safety threats to the family in their everyday life (*supervising young children*, *keeping*

the house clean and safe, *teaching the children right from wrong*). SBC case planning organizes those challenges into efforts (specific plans of action) the whole family can work on (Family Level Objectives), and those efforts (plans) that certain individuals in the family need to work on (Individual Level Objectives) so that the family can address these challenges more successfully. These specific plans of action are not the typical service delivery plans that measure service compliance, but are behaviorally specific plans of action that are co-developed by the family, provider, and caseworker. These plans target needed skills in critical risk areas that can then be demonstrated, documented, and celebrated. Throughout assessment, case planning, and casework management, SBC builds on solution-focused tenets (see Berg, 1994; Christensen et al., 1999) that child welfare clients (1) need significant encouragement to combat discouragement, and that (2) they possess unnoticed and unrecognized skills that can be used in the anticipation and prevention of child maltreatment. Clients are assisted within a forward looking partnership that searches for exceptions to problems in everyday life and recreates or builds upon their social network with supportive others (Berg, 1994; DeShazer, 1991; O'Hanlon & Weiner-Davis, 1989).

Previous research on the SBC model

There have been several published studies on the effectiveness of the SBC model of practice. The purpose of the first study was to evaluate the implementation and short-term outcomes of SBC through a review of 148 child welfare cases (Antle, Barbee, Christensen, & Martin, 2008). This research found that SBC can be implemented across cases differing in type of maltreatment, co-morbid factors, and other demographic variables. Results indicated that workers were more actively involved in case planning and service acquisition for families when SBC was implemented. Families were significantly more compliant with casework requirements and achieved more case goals and objectives. The model was particularly effective for families with a history of chronic involvement with the child welfare system. The purpose of the second research study was to evaluate worker and client experiences with the SBC model. In-depth qualitative interviews were conducted with 12 workers and 8 clients in the public child welfare system (Antle, 2000; Martin, Barbee, Antle, Sar & Hanna, 2002). Workers identified challenges of the shift from a pathology-orientation to a solution-focused and strengths-based perspective, the importance of supervisory support, and the struggle to understand complex elements of the model. Clients reported positive experiences with workers who viewed them from a strengths-perspective and engaged them in a collaborative relationship.

A third study was used to develop and test a comprehensive theoretical model for training child welfare workers in the SBC model (Antle, Barbee, & van Zyl, 2008). The training was evaluated through an experimental-control group pre- and multiple-post test design with 72 supervisors and 331 case workers in public child welfare. Supervisors and workers in the experimental group participated in a 5-day training on skills for effective casework practice and federally mandated outcomes for child welfare. Subjects completed a number of standardized scales to measure the constructs in the model pre-training, immediately post-training, and 2 months post-training. The data were analyzed using structural equation modeling. Results indicated that individual learning readiness, supervisor support of learning, and knowledge gain were predictive of transfer of the SBC model.

A final study evaluated the impact of the SBC model on the prevention of child maltreatment recidivism among families involved with the public child welfare system (Antle, Barbee, Sullivan, & Christensen, 2010; van Zyl, Antle, & Barbee, 2010). In this research, cases were assigned to a SBC group or control group based upon degree of implementation of the SBC model. There were 339 cases in the SBC group and 421 cases in the control group tracked over a 6 month time period for recidivism referrals, or reports for subsequent maltreatment for cases with previously substantiated maltreatment. In addition to state level management data on recidivism referrals, surveys were also administered to examine individual and organizational mediators of model effectiveness. The data showed that there significantly fewer recidivism referrals for the SBC group than the control group, and the variables of learning readiness, team and organizational learning conditions were found to be mediators of this outcome.

Current research on Solution Based Casework

Previous research was helpful in establishing whether the model had potential to impact child welfare outcomes and in establishing the optimal training procedures for implementing the model in large state-wide agency settings. These studies did not, however, address whether or not the SBC practice model had an impact on the specific criteria used for assessing a state's capacity to promote positive outcomes for children and families being served in the child welfare system. The current study sought to address three key questions:

(1) What is the relationship between SBC use and performance on federal review items and outcomes?
(2) What are the relative contributions of SBC and other elements of casework to these outcomes?
(3) What are the most critical points in the child welfare casework process to use SBC in order to promote positive outcomes?

Method

Design

This study utilized a quasi-experimental design. For certain analyses, cases were assigned to a high adherence-SBC implementation group and a low adherence-SBC implementation group based upon their scores on a number of items from the public child welfare system's Continuous Quality Improvement tool.

Sample

The sample consisted of 4,559 public child welfare cases from the state of Kentucky. All cases that were selected for the target state's Continuous Quality Improvement (CQI) process during a 4 year time period (2004–2008) were used for this research. The CQI cases were randomly selected from all 9 service regions of the state on a monthly basis.

Variables and measurement

The key variables for this research included the use of SBC, as well as the outcomes of safety, permanency, and well-being. The use of *Solution-Based Casework* was measured using 33 items specific to SBC from the CQI review tool. These 33 items were originally developed by the practice model team and represented core elements of the SBC model. These items have previously been used in supervisor management processes and prior chart file review studies on the model (Antle et al., 2008). These items were related to the identification of the stage of family development, high-risk patterns of behavior, and the involvement of the family in the case planning process. This well-formulated plan and procedure was essential to ensure content validity (adequacy of sampling the items that represent core SBC components) in the initial stages of the project to ease the task of validation later. Adherence to SBC was calculated as a total percentage score, corresponding to the percentage of items for which the casework on the case met the evaluative criteria. In addition to the total SBC score, there were also sub-scale scores for intake/investigation, ongoing services, case planning, and case management. An example of an item from the intake/investigation sub-scale was "In the initial assessment, was the documentation of Individual Adult Patterns of Behavior, including strengths, thorough and rated correctly?" For the ongoing services sub-scale, a sample item included "In the ongoing assessment, was the documentation of Family Support or Systems of Support thorough and documented correctly?" A sample item for the case planning sub-scale was the following: "Was the individual/family, child/ren, and foster parents/relative/kinship engaged in the case planning and decision-making process?" Finally, the case management sub-scale included items such as "Was the progress or lack of progress toward achieving EACH objective (every family, individual and child level objective) documented in contacts?"

The outcome of safety was operationalized according to the federal definitions of Safety 1 and 2. Safety 1 refers to the protection of children from abuse and neglect and includes specific criteria such as timeliness of investigations and the prevention of recidivism. Safety 2 is defined as the maintenance of children in their own homes and includes services to prevent removal and risk of harm. The state child welfare agency of this study worked in collaboration with federal program officers to link items on the Continuous Quality Improvement (CQI) tool to the federal review items and outcomes of safety, permanency and well being. Therefore, for the purposes of this study, the CQI items linked to the federal definitions were used. Scores were reported as a percentage score, corresponding to the percentage of items for which the casework on the case met the evaluative criteria for these review items and outcomes.

The outcome of permanency was also operationalized according to the federal definitions of Permanency 1 and 2. Permanency 1 refers to children having permanency and stability in their living situations and includes elements of foster care, reunification, permanency goals, and adoption of children. Permanency 2 refers to the preservation of family relationships and connections such as proximity of placement and placement with siblings.

The outcome of well being was operationalized according to the federal definitions of Well-being 1, 2, and 3. Well-being 1 refers to enhancing families' abilities to meet the needs of their children through worker visits and involvement of the family in case planning. Well-being 2 refers to children receiving services to meet their educational needs, and Well-being 3 refers to children receiving services to meet their physical and mental health needs.

Procedure

These cases included in the sample were reviewed by independent, trained review specialists using the 178 item review tool. These review specialists were employees of the state child welfare agency whose primary responsibility was the collection and monitoring of quality improvement data. Specialists were hired from each region to review cases randomly selected from that region. However, they did not have personal knowledge of the caseworkers or cases that they were assigned to review. These specialists were aware that the data they collected was to be used in the Continuous Quality Improvement process, including the generation of regional reports with summary data on key process and outcome variables that could be used to identify training and other resource needs for the region. Prior to beginning their positions, reviewers were provided with intensive training through which their reliability in use of the CQI tool was established. The review tool contained items that measured both process and outcome elements in the child welfare case with possible ratings of "Yes,"

"No," or "Not Applicable." (The latter was utilized for sections of the review tool that did not fit the type of case, such as the application of out of home care items to cases were children were not removed from the home). The process elements were either assigned to the SBC adherence score or the non-SBC process variables, while the outcome elements were assigned to the safety, permanency, and well being outcomes per the guidance of the federal program officers who worked with the state in this study. There was no item overlap for the SBC factors and the safety, permanency, and well-being outcomes (no items appeared on both the SBC measure and the outcome measures). Hard copies of each case were reviewed by the independent review specialists and entered into an on-line data management system that was maintained by the first author on this manuscript. Data were downloaded by this on-line management system and analyzed per the following plan.

Data analysis

Correlation and regression analyses were conducted in order to address the following: (i) how do the factors derived from 33 items that represent SBC, selected from the CQI Review Instrument, correlate with the outcome related items, (ii) are the SBC factors strong predictors of outcomes, (iii) how do the SBC factors correlate with the other dimensions of the CQI Review Instrument, and (iv) are the SBC factors strong predictors of the CQI dimensions or factors. The last 2 questions attempt to identify the relationship of SBC with other factors in the CQI Review Instrument. In addition to these analyses, *t*-tests were conducted to analyze the difference in outcomes between high and low SBC adherence groups.

Criteria for high correlations and strong predictors. 'High correlations" were defined as those that were significant at the $p < 0.001$ level and with a Pearson correlation of $r > 0.40$. "Strong predictors" in linear regression models were defined as having a R square > 0.45, significant *t*-tests of each b coefficient, maximum centered leverage value and Cook's distance of less than 0.1, and the Variance Inflation Factors (VIF) should be <4.

Three other aspects were also considered in the regression analysis: skewed distributions, linearity and homoscedasticity. In the case reviews included in the sample and often found in practice, the majority of cases met CQI requirements. Consequently both dependent and independent variables were positively skewed. Square root transformations were conducted and resulted in distributions that were closer to normal. Partial regression plots between the response variable and the predictors were examined and nonlinearity was not a problem in any of the analyses. Mild homoscedasticity was observed in most of the residuals plots. The criteria for residual score distributions, as outlined above, was fairly conservative to compensate for the homoscedasticity problem.

Results

Analysis of the reliability of the instruments

Reliability of the 33 SBC items in the CQI Review Instrument. A principal component factor analysis with Varimax rotation on the 33 SBC items yielded 4 factors that corresponded almost completely with the 4 previously defined domains, with the exception of 2 items. [Two items in the *ongoing casework* subscale had slightly higher loadings on other domains. Both items correlated higher with *the ongoing casework* scale total score than with the total scale scores of the other factors they had high loadings on (item 42, 0.340 with *ongoing casework* and 0.316 with *case management*; item 51, 0.612 with *ongoing casework*, 0.549 with *case management*, and 0.577 with *case planning*). The intent of the 2 items relates to the *ongoing casework* factor, and the results of correlation analysis also support them being part of the *ongoing casework* factor.] Example items for each of the factors are: Factor 1—intake/investigation "Is the documentation of the Sequence of Events thorough and rated correctly?"; Factor 2—ongoing "Is the documentation of the Family Development Stages, including strengths, thorough and rated correctly?"; Factor 3—case planning "Does the case plan reflect the needs identified in the assessment to protect family members and prevent maltreatment?"; Factor 4—case management "Is the need for continued comprehensive services documented, at least monthly?" the Cronbach alpha coefficients of the four factors are high (intake/investigation 0.83), ongoing 0.96, case planning 0.98, and case management 0.92 and cumulatively they explained 84% of the variance. A corrected mean item-total correlation to get a coefficient of *content validity* was computed for each scale. Content validity coefficients of 0.60 and higher are usually seen as very good. Content validity of the 4 SBC scales are exceptional with coefficients ranging from 0.64 to 0.85.

Factors and the CQI Instrument. The CQI Review Instrument consisted of 5 main sections: targeted case management, intake/investigation, ongoing, adult protection, and out of home care. After removing the 33 SBC items, each of the 8 sections was factor analyzed separately using Principal Component Analysis and Varimax Rotation if more than 1 factor was extracted. The data structure did not merit an analysis of all the items simultaneously due to "Not Applicable" response options and subsequent low response rate on some questions. Two sections were excluded from the analysis after no factor could be extracted either due to insufficient focus in the section (APS and General Adult) or insufficient number of cases (Status Offenders Only). In addition 15 items were excluded in another section due to low case numbers. The 7 additional factors, beyond the SBC factors represented by 33 items, that were extracted represented 116 items out of a total of 151 or 77% of remaining items.

Table 1
Pearson correlation coefficients of Solution Based Casework factors with seven factors in the CQI Review Instrument.

Factors in the CQI Review Instrument	Solution Based Casework				
	Intake & investigation	Ongoing	Case planning	Case management	Mean
Factor 1 –TCM	0.084**	0.269**	0.300**	**0.526****	0.295
Factor 2 –intake & investigation	**0.644****	0.263**	0.237**	0.264**	0.352
Factor 3 – ongoing	0.212**	0.734**	**0.743****	0.707**	0.599
Factor 4 – out of home care: child focused	0.264**	0.396**	0.457**	**0.510****	0.407
Factor 5 – out of home care: permanency issues	0.197**	0.429**	0.464**	**0.490****	0.395
Factor 6 – out of home care: parent involvement	0.191**	0.374**	0.401**	**0.466****	0.358
Factor 7 – out of home care: objectives & tasks	0.255**	0.508**	0.464**	**0.537****	0.441
Mean	0.264	0.425	0.438	0.500	0.407

Bold values represent the highest correlation coefficient in each row.
** Correlation is significant at the 0.01 level (2-tailed).

Correlations between the 4 SBC factors and the seven other CQI factors extracted were all significant at the .001 level. The highest correlation between any 1 of the SBC factors and the 7 CQI factors ranged from 0.466 to 0.743 (see Table 1). In other words at least 1 SBC factor correlated highly (greater than 0.465) with a CQI factor. Factor 5, out of home care-permanency issues (0.490) and Factor 6, out of home care-parent involvement (0.466) highest correlation were slightly under the 0.50 mark, but still higher than the target correlation of 0.40 set out in the criteria for high correlations. Factor 1, targeted case management, had the lowest mean correlation of 0.294. Intake and investigation correlated highly with Factor 2, the corresponding domain in the CQI Instrument. Mean correlations for the other 3 factors were 0.425, 0.438 and 0.500. In conclusion, SBC correlates significantly and highly with all the outcome variables as well as with all factors contained in the CQI.

Regression analysis was conducted to answer the question if SBC factors are predictors of the different factors or constructs contained in the CQI Review Instrument. The factor analysis assisted in identifying domains contained in the CQI. If the 4 SBC factors are predictive of all the domains (factors) extracted from the CQI Review Instrument, it would mean that SBC accounts for the spectrum of expectations represented by the CQI Review Instrument. From Table 2 it can be concluded that the 4 SBC factors, or combinations of these factors, are predictors of factors in the CQI Review Instrument. All models of predictions were significant at the .001 level and the significance explained ranged from moderate (22%) to very high (78%). SBC was least predictive of the factor representing the fewest number of items (4) on the CQI, and most predictive of the factor with the most number (55) of items.

Correlations of SBC factors with outcomes

All Pearson correlations between the 4 SBC factors and the ten outcome scores were significant at the .001 level. As previously stated, there was no item overlap for the SBC factors and the safety, permanency, and well-being outcomes (no items appeared on both the SBC measure and the outcome measures). The highest correlation between any 1 of the 4 SBC factors and each of the 10 outcomes ranged from 0.524 and 0.756 (see Table 3). This means that at least 1 category of the SBC correlated significantly and highly with an outcome. Safety correlated highly with intake and investigation, and the mean correlations for all 3 other SBC factors were very similar (0.531, 0.530, and 0.525).

Regression models for safety, permanency and well-being

A standard multiple regression was performed between the SBC factors and the CSFR outcome measures. No cases had missing data. From Table 4, it is clear that regression models were computed that predicted overall safety, permanency, and well-being from the 4 SBC factors significantly at the .001 level, and that all the criteria identified for strong predictors were met. The variance explained by the models ranged from 50% to 64%. Different factors of SBC contributed differently to the outcomes, with SBC-intake and investigation being a major factor in predicting overall safety, SBC-case management and SBC-case planning dominant factors in overall permanency prediction, while SBC-ongoing, SBC-case management and SBC-case planning, all made substantial contributions to predicting overall well-being scores. At the subscale level, all models were highly significant and all the criteria for strong predictors were met, except in 2 cases for the percentage variance explained. Safety subscales were strongly predicted by SBC factors, and variance explained were 47% and 57% respectively. The same was true for Permanency 1 with 55% variance explained, but only 30% of variance was explained by 3 of the SBC factors, with SBC-ongoing not contributing to the prediction. Well-being 1 is very well predicted by SBC factors with 73% of variance explained. The model for Well-being 3 explained 47% of the variance by three predictors, SBC-ongoing, SBC-case management and SBC-case planning. The same predictors were included in the model for Well-being 2 and 36% of variance was explained. In conclusion, the 4 SBC factors were found to be strong predictors of overall safety, permanency, and well-being and combinations of the SBC factors also adequately predicted Safety 1, Safety 2, Permanency 1, Permanency 2, Well-being 1, Well-being 2, and Well-being 3.

Table 2
Regression model statistics using SBC factors to predict factors in the CQI Review Instrument.

Dependent variable	R^2	F (p<)	Predictors	B (unstandardized)	Beta	t (p<)	95% Confidence Interval for B		VIF	Maximum centered leverage value	Cook's distance
							Lower bound	Upper bound			
Factor 1 – targeted case management $n = 3043$	0.221	860.3 (.001)	(Constant)	0.558		48.8 (.001)	0.535	0.580		0.003	.001
			SBC CM	0.394	0.470	29.3 (.001)	0.368	0.420	1.0		
Factor 2 – intake & investigation $n = 2659$	0.546	1062 (.001)	(Constant)	0.395		41.0 (.001)	0.376	0.414		0.013	.001
			SBC I&I	0.501	0.704	53.1 (.001)	0.482	0.519	1.0		
			SBC CP	0.020	0.051	3.2 (.001)	0.008	0.032	1.5		
			SBC CM	0.049	0.104	6.5 (.001)	0.034	0.064	1.5		
Factor 3 – ongoing $n = 3252$	0.793	4137 (.001)	(Constant)	0.292		53.6 (.001)	0.281	0.303		0.007	.001
			SBC ongoing	0.279	0.423	42.2 (.001)	0.266	0.291	1.6		
			SBC CP	0.169	0.293	27.8 (.001)	0.157	0.181	1.7		
			SBC CM	0.246	0.352	35.2 (.001)	0.232	0.260	1.6		
Factor 4 – out of home care (child focused) $n = 871$	0.319	135.6 (.001)	(Constant)	0.502		20.0 (.001)	0.453	0.552		0.039	.003
			SBC I&I	0.137	0.164	5.7 (.001)	0.090	0.185	1.1		
			SBC CP	0.135	0.259	7.9 (.001)	0.102	0.169	1.4		
			SBC CM	0.216	0.322	9.7 (.001)	0.172	0.260	1.4		
Factor 5 – out of home care (permanency issues) $n = 1365$	0.331	224.9 (.001)	(Constant)	0.347		18.1 (.001)	0.309	0.384		0.015	.001
			SBC ongoing	0.157	0.201	7.3 (.001)	0.114	0.199	1.6		
			SBC CP	0.124	0.172	6.1 (.001)	0.084	0.163	1.6		
			SBC CM	0.286	0.322	11.9 (.001)	0.239	0.333	1.5		
Factor 6 – out of home care (parent involvement) $n = 1354$	0.263	160.8 (.001)	(Constant)	0.695		60.9 (.001)	0.672	0.717		0.016	.002
			SBC ongoing	0.068	0.155	5.3 (.001)	0.043	0.093	1.6		
			SBC CP	0.044	0.108	3.6 (.001)	0.020	0.068	1.6		
			SBC CM	0.174	0.344	12.1 (.001)	0.146	0.202	1.5		
Factor 7 – out of home care: objectives & tasks $n = 864$	0.487	272.2 (.001)	(Constant)	0.274		9.3 (.001)	0.216	0.331		0.041	.003
			SBC I&I	0.140	0.124	5.0 (.001)	0.085	0.196	1.1		
			SBC CP	0.331	0.477	16.6 (.001)	0.292	0.370	1.4		
			SBC CM	0.242	0.272	9.4 (.001)	0.192	0.292	1.4		

Table 3
Pearson correlation coefficients of Solution Based Casework factors with outcome measures.

Outcomes	Solution Based Casework				
	Intake & investigation	Ongoing	Case planning	Case management	Mean
Safety 1	**0.564****	0.464**	0.350**	0.332**	0.428
Safety 2	**0.609****	0.552**	0.418**	0.452**	0.508
Safety total	**0.620****	0.552**	0.417**	0.424**	0.503
Permanency 1	0.163**	0.514**	0.559**	**0.632****	0.467
Permanency 2	0.225**	0.425**	0.507**	**0.527****	0.421
Permanency total	0.260**	0.486**	0.569**	**0.596****	0.478
Well-being 1	0.265**	0.608**	0.686**	**0.756****	0.579
Well-being 2	0.175**	**0.524****	0.520**	0.427**	0.412
Well-being 3	0.169**	0.543**	**0.590****	0.486**	0.447
Well-being total	0.228**	0.643**	**0.680****	0.618**	0.542
Mean	0.328	0.531	0.530	0.525	0.478

Bold values represent the highest correlation coefficient in each row.
** Correlation is significant at the 0.01 level (2-tailed).

t-Tests

Safety. There was a significant difference between high adherence and low adherence SBC groups for all federal outcomes. There was a significant difference between high adherence and low adherence SBC groups for Safety 1, $t(4417) = -20.20$, $p < .0001$. For Safety 1, the federal goal was 83.7%. The mean percentage score for low adherence SBC group was 76.50% and the mean percentage score for the high adherence SBC group was 89.98% (exceeding the federal standard). There was a significant difference between high adherence and low adherence SBC groups for Safety 2, $t(4405) = -23.40$, $p < .0001$. For Safety 2, the federal goal was 89%. The mean percentage score for the low adherence SBC group was 80.66%, and the mean percentage score for the high adherence SBC group was 95.53%. See Fig. 1 for means by group compared to federal standard for all outcomes.

Permanency. There was a significant difference between high adherence and low adherence SBC groups for Permanency 1, $t(3513) = -24.62$, $p < .0001$. For Permanency 1, the federal goal was 32%. The mean percentage score for the low adherence SBC group was 70.07% and the mean percentage score for the high adherence SBC group was 92.72%. There was a significant difference between high adherence and low adherence SBC groups for Permanency 2, $t(1533) = -14.54$, $p < .0001$. For Permanency 2, the federal goal was 74%. The mean for the low adherence SBC group was 66.89% and the mean for the high adherence SBC group was 89.57%.

Well-being. There was a significant difference between high adherence and low adherence SBC groups for Well-being 1, $t(4336) = -35.22$, $p < .0001$. For Well-being 1, the federal goal was 67%. The mean for the low adherence SBC group was 66.01% and the mean for the high adherence SBC group was 94.29%. There was a significant difference between high adherence and low adherence SBC groups for Well-being 2, $t(2988) = -19.5$, $p < .0001$. For Well-being 2, the federal goal was not established in the reports. The mean for the low adherence SBC group was 61.59% and the mean for the high adherence SBC group was 90.58%. There is a significant difference between high adherence and low adherence SBC groups for Well-being 3, $t(3467) = -23.93$, $p < .0001$. For Well-being 3, the federal goal was 78%. The mean for the low adherence SBC group was 60.38% and the mean for the high adherence SBC group was 88.81%.

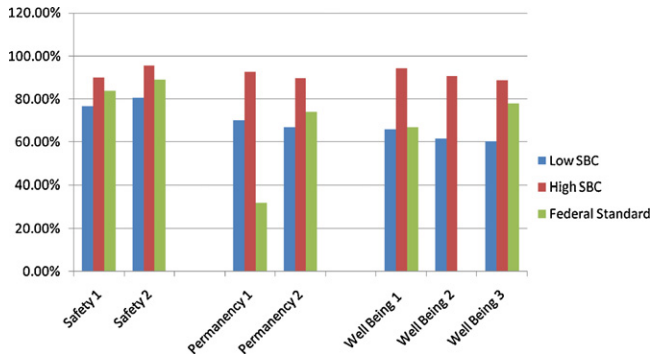

Fig. 1. Mean outcome scores by use of SBC compared to federal standard.

Table 4
Regression model statistics using SBC factors to predict CQI outcomes.

Dependent variable	R^2	F (p<)	Predictors	B (unstandardized)	Beta	t (Sig.)	95% Confidence Interval for B		VIF	Maximum centered leverage value	Cook's distance
							Lower bound	Upper bound			
Safety (combined safety score) n = 2472	0.564	798.4 (.001)	(Constant)	0.642		51.1 (.001)	0.618	0.665		0.017	.001
			SBC intake & investigation (I&I)	0.505	0.592	43.3 (.001)	0.482	0.528	1.1		
			SBC ongoing	0.104	0.189	11.2 (.001)	0.085	0.122	1.6		
			SBC case planning (CP)	0.029	0.062	3.5 (.001)	0.013	0.046	1.8		
			SBC case management (CM)	0.096	0.166	9.9 (.001)	0.077	0.116	1.6		
Permanency (combined permanency score) n = 902	0.498	222.5 (.001)	(Constant)	0.668		25.2 (.001)	0.616	0.721		0.017	.002
			SBC I&I	0.107	0.102	4.1 (.001)	0.056	0.158	1.1		
			SBC ongoing	0.049	0.070	2.3 (.001)	0.008	0.091	1.6		
			SBC CP	0.195	0.303	10.3 (.001)	0.157	0.232	1.6		
			SBC CM	0.350	0.418	14.2 (.001)	0.302	0.399	1.6		
Well-being (combined well-being score) n = 2134	0.639	941.7 (.001)	(Constant)	0.500		20.0 (.001)	0.451	0.549		0.19	.001
			SBC I&I	0.098	0.053	4.0 (.001)	0.050	0.147	1.1		
			SBC ongoing	0.0376	0.323	19.4 (.001)	0.338	0.414	1.6		
			SBC CP	0.330	0.319	18.4 (.001)	0.295	0.365	1.8		
			SBC CM	0.377	0.299	18.1 (.001)	0.337	0.418	1.6		

Discussion

This research found that the use of the SBC model is associated with significantly better scores on all 23 CFSR review items and the 7 federal outcomes of Safety 1 and 2, Permanency 1 and 2, and Well-being 1, 2, and 3. As the SBC adherence implementation score for cases increased, the compliance score for the CFSR review items and outcomes also increased. There were differential effects of SBC on outcomes based upon the stage of the case. The strongest SBC predictors of safety outcomes were the SBC intake/investigation skills. On the contrary, the strongest SBC predictors of permanency outcomes were case management and case planning skills. Lastly, SBC skills of case planning, case management, and ongoing casework were important for well-being outcomes. The SBC scales account for very high percentages of the variance in these outcomes.

There were also significant group differences in each of the 7 outcomes between high adherence and low adherence SBC implementation groups. When cases were assigned to these high adherence and low adherence implementation groups based upon their score on the 33 SBC items from the CQI review tool, significant group differences in each of the federal outcomes were detected. The higher degree of use of the SBC model (across all stages of the case) results in exceeding federal standards for each of the key outcomes of safety, permanency, and well being. When the model is not used or used to a lesser degree, cases fail to meet these federal standards for most outcomes.

Strengths and limitations

There were several strengths of the current research, including the large sample size, use of federal definitions/standards for review, and a clearly operationalized practice model with reliable and valid measures of implementation. The sample size of 4,559 cases is quite large compared to other studies on practice model effectiveness for child welfare. Most research studies of this magnitude rely exclusively on administrative data instead of direct chart file review of cases. These chart file reviews of cases included the collection of data along 178 dimensions (items). Another strength of the study was the use of federal definitions and from child welfare CFSR processes and ASFA outcomes. Other research on promising practice models to promote child welfare outcomes has not relied upon these federal definitions, but instead has asserted study-specific definitions of child safety and well being (e.g., Chaffin et al., 2004; DePanfilis & Dubowitz, 2005). Lastly, this study assesses a clearly operationalized practice model with reliable/valid measures of adherence to implementation of the practice model. The measurement of adherence to the SBC practice model within this study utilizes comparable criteria to those set forth in previous research on the model (e.g., see Antle et al., 2008). Data analyses confirmed the factorial soundness, content validity and reliability of the SBC review criteria from the CQI tool.

Despite these strengths, there were also several limitations of this research. There was no random assignment to conditions. However, this was managed by focusing on the level of adherence to implementing the SBC practice model which accounted for worker differences in implementation. While there had been statewide training of the SBC model, this study demonstrates that there was much variability in the extent of fidelity to the model and this variability had a significant effect on outcomes. This variability in adherence may be due to differences in training quality and reinforcement, as well as middle management support of the model, which have been shown to be related to transfer of the model (Antle et al., 2010). There was also limited data on case characteristics, such as race and other family factors, that may have influenced outcomes, but because the cases were randomly chosen each month for a period of 4 years, it is unlikely that there would be great differences in case characteristics across those that were high versus low adherents to the SBC practice model.

Future research

Future research should address the aforementioned limitations. There is a need to conduct a randomized controlled trial on the SBC model in child welfare. Yet, this type of study is difficult in a state where implementation of the practice model is statewide. Other states have begun to explore the use of the model and might offer appropriate venues for a randomized controlled trial to contribute to the growing body of evidence on SBC, yet even in such situations the research may be complicated by factors related to model support such as training, information systems, policy and procedures, all elements currently considered critical to the definition of a casework practice model and its successful implementation (Barbee, Christensen, Antle, Wandersman, & Cahn, 2011).

There is also the possibility to use the current data set to identify the most critical elements of the SBC model to promote positive outcomes. While this research established that the use of the model is associated with positive outcomes and this association varies based upon the stage of casework, there is a need to identify which specific SBC practice skills at what dosage are most predictive of child safety, permanency, and well being. Other research can continue to explore worker and case variables that mediate outcomes of the SBC model. Previous research by this team found that SBC can be implemented across types of maltreatment, racial groups, and with various comorbid factors (Antle et al., 2008). However, there is a need to explore differences in SBC outcomes based upon these characteristics, particularly in light of the growing emphasis of the field of racial disproportionality and disparate outcomes in child welfare (e.g., Harris & Courtney, 2003; Hill, 2006). Other past research by this team has identified the impact of worker learning readiness, organizational support of learning, and training methods on implementation of the model (Antle et al., 2008, 2010). Future research could explore differences in

SBC outcomes based upon supervisor and worker characteristics. Such research would provide additional direction for the field as child welfare systems consider this theoretically and empirically based practice model.

Implications

There are numerous implications of this study, including the need to operationalize practice models, the challenges of fully implementing an evidence-based practice model, and the potential for improving child welfare services through outcome accountability (see also Barbee et al., 2011). This study is the first to establish that an operationalized casework practice model can be used to achieve federal outcomes in the areas of safety, well-being and permanency.

Practice models need operational specificity. A state agency's statement of service philosophy, or principles of casework, is not specific enough to be considered a practice model. If these practice principles are not operationalized, they cannot be measured for effectiveness, much of the early development of Solution Based Casework was focused on operationalizing the model in an existing public child welfare system. Operationalization of a practice model encompasses the agency's standards of practice, policy and procedures. This specificity affects agency forms, case data collection, time-lines, progress reporting, collateral contacts, community engagement, and management strategies. Because there are so many competing needs in large child welfare agencies, the practice model needs enough operational definition that when decisions need to be made that might affect the best practice of the model, agency personnel can look to the model for fidelity of practice (Barbee et al., 2011). As states consider how to achieve the federal outcome standards, this study lends support to efforts that operational specificity of their practice so that its effectiveness can be measured.

Challenges to fully implementing an evidence based practice model. At the time that data collection for this study began, Solution Based Casework had been in various stages of implementation for almost a decade. Structural changes in policy, training, information systems, practice procedures, supervisor mentoring and quality assurance all took time to work their way through the system. The authors do not see this as unique to this implementation, but generic to large system change. Despite the time already invested in the model, these data demonstrate there is more work to do in this service delivery system to achieve higher rates of model transfer. It is hoped that the lessons learned in this study, and the previous studies of SBC, assist other large and small systems in their efforts to achieve good outcomes in a timely manner.

The potential for improving child welfare services through outcome accountability. The use of quality assurance or improvement data such as that utilized in this study offers the opportunity to promote "best practice" and associated positive outcomes for families involved with the public child welfare system. This type of quality assurance data is gathered by most state child welfare agencies and can be utilized to inform supervision, adherence to a practice model such as Solution Based Casework, if one is present in the system, and a focus on federal outcomes that are to frame work with families.

In summary, this study addresses an important gap in the child welfare literature on the impact of an operationalized model of casework practice (Solution Based Casework). Given the significant concern in the field about improving child welfare services as measured through the CFSR process, there was a need to assess the impact of a practice model on these outcomes. This study provides data to suggest the positive impact of Solution Based Casework on meeting the federal CFSR standards for safety, well-being, and permanency and describes a number of practice implications for the field.

References

Adoption and Safe Families Act of 1997. Pub. L. No. 105-89.
Antle, B. F. (2000). *Client and worker perception of the solution-based casework model*. Unpublished manuscript.
Antle, B. F., Barbee, A. P., Christensen, D. N., & Martin, M. (2008). Solution-based casework in child welfare: Preliminary evaluation research. *Journal of Public Child Welfare*, *2*(2), 197–227.
Antle, B. F., Barbee, A. P., & van Zyl, M. A. (2008). A comprehensive model for child welfare training evaluation. *Child and Youth Services Review*, *30*(9), 1063–1080.
Antle, B. F., Barbee, A. P., Sullivan, D. J., & Christensen, D. N. (2010). The effects of training reinforcement on training transfer in child welfare. *Child Welfare*, *32*(2), 223–230.
Barbee, A. P., Christensen, D., Antle, B. D., Wandersman, A., & Cahn, K. (2011). System, organizational, team and individual changes that need to accompany adoption and implementation of a comprehensive practice model into a public child welfare agency. *Children and Youth Services Review*, *33*, 622–633.
Berg, I. K. (1994). *Family-based services: A solution-focused approach*. New York: Springer Publishing.
Carter, B., & McGoldrick, M. (1980). *The family life cycle*. New York: Gardner.
Chaffin, M., Silovski, J. F., Funderburk, B., Valle, L. A., Vestan, E. V., & Balachova, T. (2004). Parent–child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, *2*(3), 500–510.
Christensen, D. N., & Todahl, J. (1998). Solution based casework. *Family Social Work Journal*, *6*(1), 38–52.
Christensen, D. N., Todahl, J., & Barrett, W. G. (1999). *Solution-based casework: An introduction to clinical and case management skills in casework practice*. New York: Aldine DeGruyter.
DePanfilis, D., & Dubowitz, H. (2005). Family connections: A program for preventing child neglect. *Child Maltreatment*, *10*(2), 108–123.
DeShazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York: Norton.
DeShazer, S. (1991). *Putting difference to work*. New York: W.W. Norton.
Duggan, A., McFarlane, E., Fuddy, L., Burrell, L., Higman, S., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program: Impact in preventing child abuse and neglect. *Child Abuse & Neglect*, *28*, 597–622.
Gendell, S. J. (2001). In search of permanency: A reflection on the first 3 years of the Adoption and Safe Families Act. *Family Court Review*, *39*, 25–42.
Gershater-Molko, R. M., Lutzker, J. R., & Wesch, D. (2002). Using recidivism data to evaluate Project Safecare: Teaching bonding, safety, and health care skills to parents. *Child Maltreatment*, *7*(3), 277–285.

Gira, E., Kessler, M., & Poetner, J. (2005). Moving best practice to evidence-based practice in child welfare. *Families in Society*, *86*(2), 244–250.
Gonzalez, A., & MacMillan, H. L. (2008). Preventing child maltreatment: An evidence-based update. *Journal of Postgraduate Medicine*, *54*(4), 280–286.
Harder, J. (2005). Prevention of child abuse and neglect: An evaluation of a home visitation parent aide program using recidivism data. *Research on Social Work Practice*, *15*(4), 246–256.
Harris, M. S., & Courtney, M. E. (2003). The interaction of, race, ethnicity, and family structure with respect to the timing of family reunification. *Children and Youth Services Review*, *25*(5/6), 409–429.
Hill, R. B. (2006). *Synthesis of research on disproportionality in child welfare: An update*. Seattle, WA: Casey Family Programs.
Holton, J., & Harding, K. (2007). Health Families America: Ruminations on implementing a home visitation program to prevent child maltreatment. *Journal of Prevention and Intervention in the Community*, *34*, 13–38.
Irvin, J. E., Bowers, C. A., Dunn, M. E., & Wang, M. C. (1999). Efficacy of relapse prevention: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *67*(4), 563.570
Kautz, J. R., Netting, F. E., Huber, R., Borders, K., & Davis, T. (1997). The Government Performance and Results Act of 1993: Implications for social work practice. *Social Work*, *22*, 364–373.
Kelly, S., & Berg, I. (2000). *Building solutions in child protective services*. New York: Norton.
MacMillan, H. L., Thomas, B. H., Jamieson, E., Walsh, C. A., Boyle, M. H., Shannon, H. S., & Gafni, A. (2005). Effectiveness of home visitation by public-health nurses in prevention of the recurrence of child physical abuse and neglect: A randomized controlled trial. *Lancet*, *365*(9473), 1786–1793.
Marlatt, G. A., & Gordon, J. R. (Eds.). (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.
Martin, M. H., Barbee, A. P., Antle, B., Sar, B., & Hanna, S. (2002). Expedited permanency planning: Evaluation of the Kentucky Adoptions Opportunities Project (KAOP). *Child Welfare: Special Issue on Permanency Planning*, *81*, 203–224.
National Association of Public Child Welfare Administrators. (2005). *Guide for child welfare administrators on evidence based practice*. Washington, DC: APHSA.
National Resource Center for Organizational Improvement. (2008). *An introduction to the practice model framework: A working document series*. Portland, ME: NRCOI.
Olds, D. (1997). The prenatal early infancy project: Preventing child abuse and neglect in context of promoting maternal and child health. In *Child abuse: New directions in prevention and treatment across the lifespan*. Thousand Oaks, CA: Sage Publications, Inc. (pp. 130–154).
O'Hanlon, W., & Weiner-Davis, M. (1989). *In search of solutions: A new direction in psychotherapy*. New York: Norton.
van Zyl, M. A., Antle, B. F., & Barbee, A. P. (2010). Organizational change in child welfare agencies. In S. Fogel, & M. Roberts-DeGennero (Eds.), *Empirically supported interventions for community and organizational change*. New York: Lyceum Books.
Parks, G. A., & Marlatt, G. A. (1999). Relapse prevention therapy for substance-abusing offenders: A cognitive-behavioral approach in what works. In E. Latessa (Ed.), *Strategic solutions: The international community corrections association examines substance abuse* (pp. 161–233). Lanham, MD: American Correctional Association.
Walton, E. (1998). In-home family focused reunification: A six year follow-up of a successful experiment. *Social Work Research*, *22*(4), 205–214.

Children and Youth Services Review 33 (2011) 622–633

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

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

Anita P. Barbee [a,*,1], Dana Christensen [a,*], Becky Antle [a,*], Abraham Wandersman [b,*], Katharine Cahn [c]

[a] Kent School of Social Work, University of Louisville, United States
[b] Department of Psychology, University of South Carolina, United States
[c] Child Welfare Partnership, School of Social Work, Portland State University, United States

ARTICLE INFO

Article history:
Received 29 June 2010
Received in revised form 4 November 2010
Accepted 6 November 2010
Available online 12 November 2010

Keywords:
Casework practice model
Getting to outcomes
Organizational change

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.

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,

* Corresponding authors. Barbee, Christensen, Antle are to be contacted at Kent School of Social Work, University of Louisville, Louisville, KY 40292, United States. Wandersman, Department of Psychology, University of South Carolina, Columbia, S.C. 29208, United States.
E-mail addresses: anita.barbee@louisville.edu (A.P. Barbee), dana.christensen@louisville.edu (D. Christensen), becky.antle@louisville.edu (B. Antle), wandersman@sc.edu (A. Wandersman).
[1] Tel.: +1 502 245 1861; fax: +1 502 553 4575.

0190-7409/$ – see front matter © 2010 Elsevier Ltd. All rights reserved.
doi:10.1016/j.childyouth.2010.11.008

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

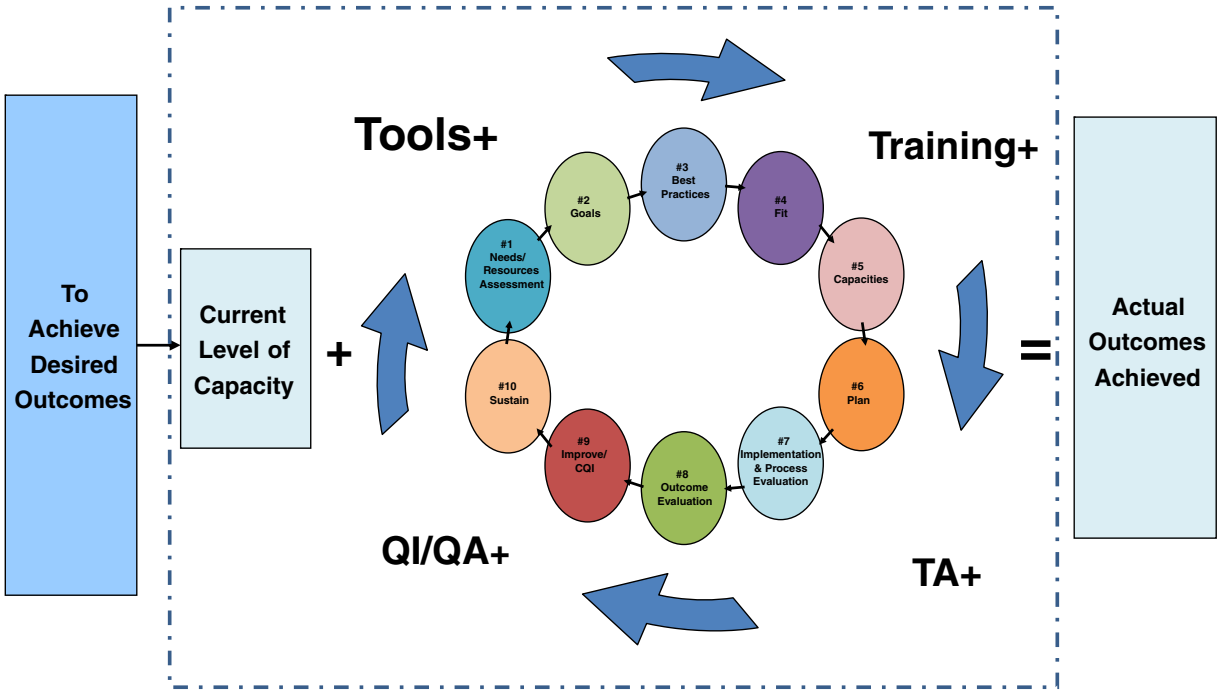

Fig. 1. GTO Support System Model.

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 bureaucracies, 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 committees 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 identification 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

Special thanks to Eli Karam and three anonymous reviewers for comments on an earlier draft of this paper.

References

Aarons, G. A. (2004). Mental health provider attitudes toward adoption of evidence-based-practice: The evidence based practice attitude scale (EBPAS). *Mental Health Services Research*, *6*, 61—74.

Aarons, G. A. (2006). Transformational and transactional leadership: Association with attitudes toward evidence-based practice in mental health services. *Psychiatric Services*, *57*, 1162—1169.

Ajzen, I., & Fishbein, M. (1977). Attitude–behavior relations: A theoretical analysis and review of empirical research. *Psychological Bulletin*, *84*, 888—918.

Altshuler, A. A., & Behn, R. D. (Eds.). (1997). *Innovation in American government: Challenges, opportunities, and dilemmas*. Washington, DC: Brookings Institution.

Anderson, A. (2005). An introduction to theory of change. *Evaluation Exchange, Summer, Volume XI, 2* http://www.hfrp.org/evaluation/the-evaluation-exhange/issue-archive/evaluaton-methodology/an-introduction-to-theory-of-change

Antle, B. F., Barbee, A. P., Christensen, D. N., & Sullivan, D. (2010). The prevention of child maltreatment recidivism through the Solution-Based Casework model of child welfare practice. *Children and Youth Services Review*, *31*, 1346—1351.

Antle, B. F., Barbee, A. P., Sullivan, D. J., & Christensen, D. N. (2008). The effects of training reinforcement on training transfer. *Child Welfare*, *88*, 5—26.

Antle, B. F., Barbee, A. P., & van Zyl, M. A. (2008). A comprehensive model for child welfare training evaluation. *Children and Youth Services Review*, *30*, 1063—1080.

Antle, B. F., Barbee, A. P., & Van Zyl, M. A. (2009). Supervision in child welfare practice. In C., & C. (Eds.), *Supervision in child welfare*. Oxford Press.

Antle, B. F., Christensen, D., Barbee, A. P., & Martin, M. (2008). Solution-based casework: A paradigm shift to effective, strengths-based practice for child protection. *Journal of Public Child Welfare*, *2*, 197—227.

Antle, B. F., Christensen, D. J., van Zyl, M.A., & Barbee, A. P. (in press). The impact of the solution based casework (SBC) practice model on federal outcomes in public child welfare. *Child Abuse and Neglect*.

Argyris, C., & Schön, D. (1978). *Organizational learning: A theory of action perspective*. Reading MA: Addition Wesley.

Argyris, C., & Schön, D. (1996). *Organizational learning II: Theory and method and practice*. Reading, MA: Addison-Wesley.

Bandura, A. (2004). Health promotion by social cognitive means. *Health Education & Behavior*, *31*, 143—164.

Barbee, A. P., Antle, B., Sullivan, D., Huebner, R., & Fox, S. (2009). Recruiting and Retaining Child Welfare Workers: Is Preparing Social Work Students Enough for Sustained Commitment to the Field? *Child Welfare*, *88*, 69—86.

Barbee, A. P., Sullivan, D. J., Antle, B. F., Hall, J. C., & Fox, S. (2009). The public child welfare certification program: Worker retention and impact on practice. *Journal of Social Work Education*, *45*, 427—444.

Barbee, A. P., Yankeelov, P. A., Antle, B. F., Fox, S., Harmon, D., Evans, S. & Black, P. (in press). The importance of training reinforcement in child welfare: Kentucky's field training specialist model. Child Welfare.

Bass, B. M. (1990). *Bass and Stogdill's handbook of leadership: Theory, research and managerial applications* (3rd Ed.). New York: Free Press.

Beck, A. T., & Alford, B. (2009). *Depression: Causes and treatment* (*2nd Ed.*). Baltimore, MD: University of Pennsylvania Press.

Budd, K. S. (2005). Assessing parenting capacity in a child welfare context. *Children and Youth Services Review*, *27*, 429—444.

Cahn, K. (2010). Innovations in child welfare: Dynamics of adoption and implementation — Introduction to Special Issue on Innovations in Child Welfare. *Protecting Children*, *25*, 1—5.

Chaffin, M., & Friedrich, B. (2004). Evidence based treatments in child abuse and neglect. *Children and Youth Services Review*, *26*, 1097—1113.

Child Welfare Policy and Practice Group (2010). www.childwelfaregroup.org

Child Welfare League of America (2008). *Child Welfare League of America Standards of Excellence*. Washington, D.C.: CWLA Press.

Chinman, M., Imm, P., & Wandersman, A. (2004). *Getting to Outcomes 2004: Promoting Accountability Through Methods and Tools for Planning, Implementation, and Evaluation.*Santa Monica, CA: RAND Corporation TRTR101.Available at http://www.rand.org/publications/TR/TR101/

Chinman, M., Hunter, S. B., Ebener, P., Paddock, S. M., Stillman, L., Imm, P., & Wandersman, A. (2008). The Getting to Outcomes demonstration and evaluation: An illustration of the prevention support system. *American Journal of Community Psychology*, *41*, 206—224.

Christensen, D. N., Todahl, J., & Barrett, W. G. (1999). *Solution-based casework: An introduction to clinical and case management skills in casework practice.* New York: Aldine DeGruyter.

Coetsee, W. J. (1998). An evaluation model for human resources interventions. Unpublished dissertation. Rand Afrikaans University, Johannesburg.

Collins, J. (2004). *Good to great.* New York: HarperCollins Publishers.

Cooperrider, D. L. (1996). Resources for getting appreciative inquiry stared: An example OD proposal. *Organizational Development Practitioner*, *28*, 23—33.

Corbett, T., & Noyes, J. (2008). *Human service integration.* Institute for Research on Poverty: University of Wisconsin-Madison.

Courtney, M. (2009). *Evaluating practice models.* Washington, D. C: Children's Bureau Evaluation Summit.

Covey, S. R. (1989). *The seven habits of highly effective people.* New York: Simon & Schuster.

Comer, D. P., & Vassar, D. (2008). Six principles of partnership: Building and sustaining system-wide change. *Protecting Children*, *23*(1 & 2), 96—104.

Deming, W. E. (1986). *Out of the crisis.* Cambridge, MA: MIT Press.

Fetterman, D. M., & Wandersman, A. (2005). *Empowerment evaluation principles in practice.* New York: Guilford Press.

Fisher, D., Imm, P., Chinman, M., & Wandersman, A. (2007). *Getting to outcomes with developmental assets: Ten steps to measuring success in youth programs and communities.* Minneapolis: Search Institute.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Folaron, G. (2009). Report to Office of Juvenile Justice and Delinquency Prevention.

Fox, S., Burnham, D., Barbee, A. P., & Yankeelov, P. (2000). Public school to work: Social work that is! Maximizing agency/university partnerships in preparing child welfare workers. *Training and Development in Human Services*, *1*, 13—20.

Fox, S., Miller, V., & Barbee, A. P. (2003). Finding and keeping child welfare workers: Effective use of Title IV-E training funds. *Journal of Human Behavior in the Social Environment, 7,* 67-82. Also a chapter in *Charting the Impacts of University-Child Welfare Collaboration*. Ed. Katherine Briar-Lawson & Joan Levy Zlotnick. Haworth Social Work Practice Press.

Gleeson, J. P., & Philbin, C. M. (1996). Preparing caseworkers for practice in kinship foster care: The supervisor's dilemma. *The Clinical Supervisor*, *14*, 19—34.

Glisson, C., & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect*, *22*(5).

Goldsmith, S., & Eggers, W. D. (2004). *Governing by network: The new shape of the public sector.* Washington, D. C.: Brookings Institute.

Horwath, J. (2001). Child care practice innovations: Using a model of change to develop training strategies. *Child Abuse Review*, *10*, 18—24.

Johnson, L. M., Antle, B. F., & Barbee, A. P. (2009). Addressing disproportionality and disparity in child welfare: Evaluation of an anti-racism training for community services providers. *Children and Youth Services Review*, *31*, 688—696.

Kelman, S. (2005). *Unleashing change: A study of organizational renewal in government.* Washington, D. C.: Brookings Institute.

Kotter, J. P. (1996). *Leading change.* Boston: Harvard Business School Press.

Lehman, W. E. K., Greener, J. M., & Simpson, D. D. (2002). Assessing organizational readiness for change. *Journal of Substance Abuse Treatment*, *22*(4), 197—209.

Lesesne, C. A., Lewis, K. M., White, C. P., Green, D. C, Duffy, J. L., & Wandersman, A. (2008). Promoting science-based approaches to teen pregnancy prevention: Proactively engaging the three systems of the interactive systems framework. *American Journal of Community Psychology*, *41*, 379—392.

Lewin, K. (1951). *Field theory in social science.* New York: Harper & Row.

Liese, L. H., Anderson, J. L., & Evans, R. P. (2003). The Christmas Box House: Developing a best practice model for emergency shelter care and assessment. *Journal of Family Social Work*, *7*, 39—48.

Martin, M. H., Barbee, A. P., Antle, B., Sar, B., & Hanna, S. (2002). Expedited Permanency planning: Evaluation of the Kentucky Adoptions Opportunities Project (KAOP). *Child Welfare: Special Issue on Permanency Planning*, *81*, 203—224.

McMillen, J. C. (1997). A practice model for enhancing effective coping in child welfare families. *Child Welfare*, *126*, 781—799.

National Child Welfare Resource Center on Organizational Improvement (2008). *An introduction to the practice model framework: A working document series.* Portland, Maine: NRCOI.

Pettigrew, A. M., Woodman, R. W., & Cameron, K. S. (2001). Studying organizational change and development: Challenges for future research. *Academy of Management Journal*, *44*, 697—713.

Preskill, H., & Torres, D. T. (1999). Building capacity for organizational learning through evaluative inquiry. *Evaluation*, *5*(1), 42—60.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, *51*, 390—395.

Quinn, R. E. (1988). *Beyond rational management: Mastering the paradoxes and competing demands of high performance.* San Francisco: Jossey-Bass.

Rivaux, S. L., James, J., Wittenstrom, K., Baumann, D., Sheets, J., Henry, J., & Jeffries, V. (2008). The intersection of race, poverty, and risk: Understanding the decision to provide services to clients and to remove children. *Child Welfare*, *87*, 151—168.

Rogers, E. M. (1995). *Diffusion of innovations.* New York: The Free Press.

Sholnsky, A., & Wagner, D. (2005). The next step: Integrating actuarial risk assessment and clinical judgment into an evidence-based practice framework in CPS case management. *Children and Youth Services Review*, *27*, 409—427.

Senge, P. M. (1994). *The fifth discipline: The art and practice of a learning organization.* New York: Doubleday.

Senge, P., Scharmer, C. O., Jaworski, J., & Flowers, B. S. (2005). *Presence: An exploration of profound change in people, organizations, and society.* New York: Doubleday.

Schein, E. (2001). Organizational culture and leadership. In Jay, & J. Steven (Eds.), *Classics of Organization Theory*. Fort Worth: Harcourt College Publishers.

Schein, E. (2004). *Organizational culture and leadership.* New York: Jossey-Bass.

Sirkin, H. L., Keenan, P., & Jackson, A. (October, 2005). Hard side of change management. *Harvard Business Review*, 1—13.

Smale, G. (1998). *Managing change through innovation.* London: Stationery Office Books.

Sprinson, J. S., & Berrick, K. (2010). *Unconditional care: Relationship-Based, behavioral intervention with vulnerable children and families.* New York: Oxford University Press.

Sullivan, D. J., Antle, B. F., Barbee, A. P., & Egbert, R. (2009). The use of training for best practice in public welfare. *Administration in Social Work*, *33*, 278—296.

van Zyl, M. A., Antle, B. F., & Barbee, A. P. (2010). Organizational change in child welfare agencies. In S. Fogel, & M. Roberts-DeGennero (Eds.), *Empirically supported interventions for community and organizational change*. New York: Lyceum Books.

Van Zyl, K. & van Zyl, M. A. (2000). Re-conceptualizing learning readiness and standardizing the Learning Benefit Inventory. *Unpublished manuscript.*

Wandersman, A., Imm, P., Chinman, M., & Kaftarian, S. (2000). Getting to outcomes: A results-based approach to accountability. *Evaluation and Program Planning*, *23*, 389—395.

Wandersman, A. (2009). Four keys to success (theory, implementation, evaluation, and resource/system support): High hopes and challenges in participation. *American Journal of Community Psychology*, *43*, 3—21.

Wandersman, A., Snell-Johns, J., Lentz, B., Fetterman, D., Keener, D., & Livet, M. (2005). The principles of empowerment evaluation. In D. Fetterman, & A. Wandersman (Eds.), *Empowerment evaluation principles in practice*. New York: Guilford Press.

Wheatley, M. J., & Frieze, D. (2006). Using emergence to take social innovations to scale. Retrieved January 7, 2010, from http://www.berkana.org/pdf/emergence_web.pdf

Weick, K. E., & Quinn, R. E. (1999). Organizational change and development. *Annual Review of Psychology*, *50*, 361—386.

Yankeelov, P. A., Barbee, A. P., Barber, G., & Fox, S. (2000). Timing isn't everything, but it can be important. *Training and Development in Human Services*, *1*, 67—81.

Yankeelov, P. A., Barbee, A. P., Sullivan, D. J., & Antle, B. (2009). Retention of child welfare workers. *Children and Youth Services Review*, *31*, 547—554.

LESSONS LEARNED FROM PAST IMPLEMENTATIONS:

ADMINISTRATIVE / MANAGEMENT:

- Lead Implementation Team stays involved, and continues to meet periodically through the process.
- Funding is a mix of internal and external resources and adequate to the scope of the project.
- Top leadership has a presence at each stage of rollout, and has some sort of direct communication with the line teams regarding the practice.
- Engaging Managers in practice skill building (i.e. avoid thinking they are administrators, not really casework oriented, therefore not critical to practice).
- Monitoring the amount and nature of Supervisors individual and group supervision meetings.

TRAINING:

- Prevent the overloading of training sessions with extra participants to "speed things up".
- Prevent overloading the training schedule (pace), i.e. prevent trainers from burning out early.
- Take concrete steps to integrate the practice model with existing training curriculum, i.e. recognizing that SBC is the architecture that holds all curriculum together (versus treating SBC as a stand alone or add-on).
- Role out training only when trainers and coaches can not only train but also answer difficult complex questions as well.
- Hold Supervisors accountable during Case Consultations, and hold Managers accountable for their Supervisors scheduling and completing the Case Consultations.
- Support Supervisors and Managers with Field Coaching during the Case Consultation Process.
- Designate enough Field Coaches, to provide ongoing coaching and provide them access to an SBC mentor.
- Hiring/using internal resource Coaches who have a strong base (and reputation) of having good clinical or casework skills.
- Recognizing the importance of your internal counsel (AG's) by offering (requiring) training, listening to their concerns, solving problems early before they face using the new forms and practices in the courtroom.

INFORMATION SYSTEMS & FORMS:

- Place a high priority around integration of the practice model into the current assessment and case planning procedures and expectations(i.e. Forms for assessments, case transfer summary, case planning, ongoing progress notes, contact notes, and Action Planning
- Make the forms (or temporary work-a-rounds) fit the conceptual map of the practice model.
- Accomplish form and information system changes prior or very near the beginning of training.

POLICY:

- Roll out the training with policy and clear direction in place that supports the practice, particularly in the area of assessment, case transfer summary, case planning, ongoing progress notes, contact notes, and Action Planning
- Establish a vehicle or procedure for policy review regarding issues that emerge as potential hindrances to the practice change
- Set policy regarding Supervision with Caseworkers, i.e., how often group, how often individual, nature of supervision (administrative or professional mentoring).

QA AND PERFORMANCE REVIEW:

- Recognize the need for and the differences between the Certification Process, ongoing QA, and Performance Review.
- SBC Certification is about Foundation Skills (they have shown they can do it once), so reviewing and modifying the QA process as designed is critical to continuing where the SBC Certification process leaves off.
- Reviewing and modifying the Performance Review process in order to integrate the new practice skill expectation of staff and supervisors

CULTURE (INTERNAL):

- Focus attention on early adopters (champions) rather than preoccupation with the late adopters
- Management embracing the parallel process of noticing and celebrating change (excellence); developing or utilizing a vehicle for expanding the audience of change (Newsletter, "From the Director's Desk" monthly email, regular Q& A from DC re: clarifying questions from the field, etc.)
- Establish a SharePoint site, or internal website for Practice, with tools and resources. This internal drive would also be used for uploading work product documents during Certification.

CULTURE (EXTERNAL):

- Leadership makes specific plans to value external communication and messaging with judiciary, provider network, foster care families, etc.
- The organization addresses wording (performance expectations) in their contracts with their provider network as soon as possible.
- The organization formally encourages (or requires) their provider network to become at least SBC familiar, if not fully SBC trained and certified.

Solution Based Casework®
Sometimes the simple things are the most radical.

June 16, 2019

Hello!

Thank you for your interest in *Solution Based Casework*®! I have enclosed some initial information for you about the model, and about training and implementation. Costs are related to the number of casework and supervisory staff in your program, but with that information we could quickly give you a general idea. I don't know if you are aware that SBC has had a presence in NYC going back to about 2010 and there are a number of agencies there that have successfully implemented the model. In partnership with these SBC agencies, we have been able to form the *NYC SBC Collaboration* for the purpose of conducting year-round joint new-worker training, training new trainers, and generally mentoring each other. We continue to provide ongoing agency support to the Collaboration to this day. That means much lower costs to agencies for keeping new workers trained and maintaining model continuity and fidelity.

After reviewing these materials, feel free to contact me with any questions that come up for you and your agency. If you could send me the scope of your Family Prevention program and staff numbers, I can also get back to you with some preliminary cost estimates for you to consider. The website *www.solutionbasedcasework.com* has some short videos that might be a quick way to get a feel for the model. The first one is a whiteboard (also linked under my signature below) of only about 4 minutes is on the HOME page, and a NYC based video created by the NYC Collaboration is on the ABOUT page.

In the meantime, I have included 2 research articles, and a short Overview of *Solution Based Casework* Training and Implementation. If you wish to move further with your consideration of SBC for your agency, it might be helpful to set up a phone call with Dr. Christensen. If so, I can set that up for you, however we would need your staff numbers to make that meeting most useful to you. Thank you again for you interest and don't hesitate to reach out with questions as they come up!

Regards,

Natalie Bowlds, LCSW

Natalie Bowlds, LCSW
Director of Operations and Special Projects
Solution Based Casework Training and Consultation
natalieb@solutionbasedcasework.com

Watch our SBC whiteboard animation!

Solution Based Casework®
Sometimes the simple things are the most radical

Overview of Solution Based Casework Training and Implementation

Full implementation of the SBC Practice Model is best seen as being accomplished in four phases: 1) the Training phase, 2) the Case Consultation phase, 3) the Field Practice/Certification phase, and 4) the On-going Quality Assurance/Fidelity phase.

Preparation Phase

- ***SBC Reading Groups:*** Supervisors and managers are provided readings and discussion guides to complete. Discussion groups are held internally and with the assigned SBC Lead Trainer to address reactions and questions raised to ensure a successful implementation
- ***Agency specific practice tools*:** SBC tools for practice are cross-walked with existing agency tools and forms to anticipate duplication or potential areas requiring better integration.
- ***SBC Coordinator is Assigned by Agency:*** The agency is assisted in selecting an ***SBC Coordinator*** to help manage the training and implementation of the practice model. This person will be the point of contact between SBC and the Agency.

Training Phase

- ***SBC Initial Training***: This is a 3-day training with a focus on the basic concepts of the model with practice on applications to assessment and case planning skills. All front-line staff and their supervisors (team leaders) attend this training.
- ***SBC Supervisor Training***: This is a follow-up 2-day advanced training, with a more in-depth review of the practice model concepts with a focus on their role as supervisors (team leaders) and mentors. Part of this time is spent on issues of coaching and mentoring staff toward implementing the ideas on new and existing cases. *Case Consultations* and concept integration are the primary focus. Supervisors and Coaches/Managers take the *SBC Qualifying Exam (QE)* at the end of this training. When the Supervisor completes this training, they are ready to begin mentoring their Caseworkers in their own learning process.
- ***SBC Refresher Training***: Typically, a 1-day refresher training 2-3 months post Initial Training.

Case Consultation Phase

- Supervisors facilitate weekly *Case Consultation* meetings with their team where the SBC concepts are applied to a different case each week. Supervisors are provided training in how to use a provided agenda that walks each case through the major concepts, thus providing good learning transfer across the whole team. After each *Case Consultation*, the Supervisor will meet with the Caseworker that presented the case and review the meeting, review the team's suggestions, and help reinforce the learning issues that came out of the consultation. *(Typically, about 6 weeks long)*

Field Practice / Certification Phase

- The third phase begins as Caseworkers are assigned their first new case (early during the *Case Consultation* Phase) to start applying the new practice skills. Learning the practice model skills should be a day-to-day activity and part of each supervisory session. Progress is monitored using the *SBC Implementation Website*.
- This *SBC Certification Manual* is used by the Supervisor to familiarize themselves with examples of the work product standards that will used in the mentoring process leading to.
- Progress of each worker and supervisor on skill acquisition is tracked on a provided agency website designed specific to each supervisor and their worker. The website generates monthly reports to Agency leadership on demonstrated skill proficiency.

On-going Quality Assurance/Fidelity Phase

- The Agency builds the practice model skills into their ongoing agency QA program and Performance Review standards to ensure model fidelity over time. The SBC Certification Process for new workers is provided to the Agency to ensure that new workers and supervisors are quickly oriented and model fidelity is maintained. This contracted service begins at the end of the first contract year at a nominal cost.

Solution Based Casework®
Sometimes the simple things are the most radical.

Jurisdictional Readiness

When a jurisdiction chooses to implement the *Solution Based Casework™* practice model, there are some key criteria that are considered critical to the success of the implementation process. The following elements should therefore be planned for and addressed during implementation in order for the agencies practice model to eventually achieve model fidelity in a large system.

Management:
Intention and initial plans to do the following:

1. *The establishment of an Implementation Team to manage the practice model roll out and to charter and delegate sub-committees activity (eg. culture, communication, policy and forms, QA and performance review).*
2. *An initial model overview training for all management with time to plan strategically for implementation.*
3. *A decision of central leadership to provide their presence and support to the practice change and a task plan to demonstrate their support.*
4. *A plan to provide direct contact with the model developer for input around challenges, barriers, and noticing successes.*

Area of Training and Learning Transfer:
Intention and initial plans to do the following:

1. *Provide an initial overview training of all staff (caseworkers, supervisors,support personnel, management).*
2. *Establish the Case Consultation process to help workers and supervisors transfer learning from the Initial training to their casework.*
3. *Ensure that their Supervisors lead Case Consultations with their teams and are coached and reviewed for the ability to lead a successful Case Consultation Meeting.*
4. *Ensure that their Coaches use direct consultation with a designated Lead Coach until they achieve competence in the Coaching process and are Proficient as SBC Coaches.*
5. *Plan long term for new employee training through 1) revision of their existing curriculums to incorporate the agency's practice model tenets, 2) utilization of the SBC eLearning tool as a lead in to the SBC Initial Training, and 3) establishing their own adaptation of the SBC Initial Training for new employees who are hired post implementation.*
6. *Additional training modules are developed by the agency that focus on task specific SBC interviewing skills (also available from the model) to assist workers in enhancing their skills once they have become comfortable with the overall approach of SBC.*
7. *A Training Overview that summarizes SBC is developed and offered to system partners, ie. the judiciary, treatment providers, advocacy groups, and related stakeholders.*

Area of Policy:
Intention and initial plans to do the following:

1. *Initial Policy is put into place that supports the practice and eventually is detailed in a Standards of Practice document. Typically, the Standards of Practice focus on Intake, Assessment, Case Planning, and Casework Management. Once policy in place that*

supports full implementation of the practice, then the expectations of performance review and quality assurance have a foundation to build upon

2. *Leadership recognises that after a period of phased in practice in the concepts and their application, staff will not only be encouraged toward best practice, but will need to be held accountable for key milemarkers of the practice. This means that existing policy will need to be brought up to date with new parameters that ensure that key elements and expectations of the practice model are operationalized.*

Areas of Performance Review:
Intention and initial plans to do the following:

1. *Outcome performance review of field skills is first measured by the success of the SBC Proficiency process[1], and then measured through practice related Performance Review conducted annually. Performance Review should include direct observation of practice skills as well as Case File Review, each using standardized instruments tied to the Quality Assurance criteria.*
2. *Core skills of caseworkers and supervisors must be identified and a consensus built within the agency around their relevance to the Standards of Practice. A phased in schedule for Performance Review of practice skills is recommended. This phased in approach begins with mentorship and model familarity, and progresses to mock reviews, then finally folded into annual or bi-annual performance reviews tied to merit and retention policy.*

Area of Quality Assurance:
Intention and initial plans to do the following:

1. *Once policy and performance reviews have been initially established, outcome criteria for quality assurance and program effectiveness must be established and readied for use.*
2. *A Quality Assurance mock review to test the criteria and focus management on performance shortfalls is a helpful next step, followed by full implementation of practice based QA review.*
3. *The practice criteria shown to account for successful outcomes must be incorporated and measured to be considered consistent with the research base of the model, and to hope to achieve comparable results.*

Area of Community Network and Collaboration:
Intention and initial plans to do the following:

1. *Community partners that share a common conceptual map for addressing child protection should be an early strategy addressed by leadership.*
2. *This process can begin at the upper management levels with key stakeholders, but should proceed quickly to lower level collaborative meeting with Clinical Directors of provider agencies, administrative office of the courts, judges, internal legal cousels, victim advocacy groups, and other partners and community stakeholders.*

---

[1] *The acceptable threshold for Agency SBC Proficiency rating is 80 % of active Coaches and Supervisors reaching SBC Proficiency status.*

Solution Based Casework®
Sometimes the simple things are the most radical.

What is Solution Based Casework all about?

As model developer of *Solution Based Casework® (SBC),* I'm often asked to give a brief overview of what the practice model is all about. Specific training followed by application in the field will allow you to go into much more depth, however I hope this brief primer will give you a feel for the practice.

You might not be familiar with the idea of a *practice model*; they are not that common in Child Welfare. The child welfare field has primarily relied on policy and procedure to guide practice, and while some states (and agencies) have come up with guiding principles and values, it has been difficult for jurisdictions to operationalize those values in the field. Starting about 25 years ago, we began to study best practice casework in an effort to distill key factors that led to positive outcomes. We wanted to know if there were some common factors that our most successful staff demonstrated on a consistent basis that were getting the best results for children and families. The short answer was that there were common factors, and that they were fairly simple and based on what we thought made common sense. To establish an evidence base for these initial findings, we started doing research on those factors to see if we could provide the field with some clarity about what worker skills produced the best results in terms of safety, well-being, and permanency for kids. We also were interested in whether those common factors could be taught to others, on a reliable basis, so that everyone in the agency could be doing "best practice".

Thirty published articles later, we can confirm that indeed some very simple caseworker characteristics do make a huge difference in our outcomes, as long as we do them consistently and with fidelity. So, what are these common-sense skills that really do make a difference? Well, they are probably skills that you and your colleagues are doing on a frequent basis, maybe not in a consistent or organized way, and maybe not as a whole team, but they are already in your "practice tool bag". Here is a brief introduction to the factors that correlate highest with successful practice in child welfare:

- The first major factor that we found was the ability to **PARTNER** with clients around safety concerns. Not always the easiest to achieve, but when we take time to really understand our clients' life and struggles, we are in a better position to reach some consensus about what is not working, what is working, and what we need to do keep the kids safe and well cared for. Partnering it turns out is key, and through the research we have learned the sub-skills of partnering that can help all staff partner on a more consistent basis.

- The second major factor we found, and this shouldn't come as a big surprise, is that we need to use that partnership to **GET ORGANIZED** around a specific plan of action that will help the partnership stay focused on the important and critical safety outcomes for change. The plan needs to make sense in terms of the everyday life of the family, because that is where change must take place. An organized focus on behavioral change turns out to be more effective than just focusing on service compliance.

- The last big factor that our best practice workers have, is that they have found a way to combine clear and reasonable expectations for change with a lot of hope, support, and recognition of small steps of change. They are specifically able to help their clients **NOTICE, DOCUMENT and CELEBRATE** their behavioral change.

SBC is an evidence based practice model that helps everyone focus on caseworker skills that have been shown to improve our outcomes. Many staff believe it is an opportunity to really do the kind of casework they hoped to do when they came into the profession, and now feel supported to do. I hope this brief overview is helpful; I've included a link to a short video as well if you would like more information.

Thank you for your interest,

Dana N Christensen, PhD
Model Developer
Solution Based Casework

www.solutionbasedcasework.com

Want to learn more? Watch a brief ***Whiteboard on SBC*** by checking out this link: https://vimeo.com/136861716 .