
# Road Map to Implementation

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Based on research conducted by:

Chadwick Center for Children and Families
Child and Adolescent Services Research Center (CASRC)
Evidence Based Associates (EBA)

## Introduction

Brevard Family Partnership, Inc. (BFP) seeks to improve the safety, permanence, and well-being of children served by the child welfare system in Brevard County through the further integration of evidence-based and evidence informed practice in the community service delivery continuum. To assist in this effort and to conduct an assessment of the current service delivery continuum and offer a practical roadmap to enhanced evidence-based service delivery BFP awarded a contract to Evidence Based Associates (EBA) in Charleston, South Carolina to organize the project in partnership with the Chadwick Center at Rady Children's Hospital in San Diego (RCHSD). The Chadwick Center together with the Child and Adolescent Services Research Center (CASRC) at RCHSD designed and manages the California Evidence-Based Clearinghouse for Child Welfare (www.cebc4cw.org) and has experience working with child welfare administrators in expanding the use of evidence-based practices.

The California Evidence-Based Clearinghouse for Child Welfare (CEBC) was created with the support of the California Department of Social Services as a tool for child welfare professionals, public and private organizations, academic institutions, and others who are committed to serving children and families. The primary task of the CEBC is to inform the wider child welfare community about the existing research evidence as well as to provide vital information about the child welfare related programs that are reviewed on the CEBC website. Using the definition established by the CEBC, we define evidence-based child welfare practice as the combination of: (1) the best research evidence; (2) the best clinical experience; and (3) consistent with family/client values. Individual programs are rated on a scientific scale from "1" being the highest level of peer reviewed published empirical research to "5" indicating a practice under a review may actually cause harm or make the targeted condition worse.

The project had three phases: 1) Community Assessment, Visioning, and Project Planning; 2) Data Collection (refer to Overview Report for results); and 3) Development of a Road Map based on data collection and analysis.

## Overall Impressions

The project team review found Brevard County's child welfare system has many strengths it can be proud of and that can be built upon to further expand and integrate evidence-based practices in Brevard County. There are also unique practical and philosophical factors that will shape how BFP can proceed and which evidence-based practices are a good fit with the community.

**Unique needs/situation in Brevard County – need to be considered when selecting EBPs:**

- BFP uses a Wraparound system of care that models Child and Adolescent Services Systems Program (CASSP) principles as the basis for its services, with extensive use of family team conferences and similar meetings.
- Service referrals are made largely though the team conference, with input from all involved parties.
- Approximately 50% of the BFP caseload are families who have been diverted into Brevard CARES.
- Brevard County has a very limited public transportation system, making it difficult for families to get to services. As a result, many services are delivered in the home.
- African American families are over-represented in BFP, as compared to the general population, although this is not unique to Brevard County.
- BFP has a higher than average re-entry rate and they are undertaking a project to further examine this issue and determine ways to reduce re-entry.
- Brevard providers report relatively low turnover rates, but have concerns about implementing EBPs with extensive training requirements, as it can become very expensive to provide retraining over time.

**Strengths**:

- BFP has a large and varied network of providers, ranging from large, multi-site agencies to individual providers.
- We found some providers who report they deliver well recognized evidence-based practices.
- Staff turnover among BFP staff and contracted providers is low
    - BFP currently has the lowest rate of turnover in case management in the state of Florida.
    - Statewide surveys indicate that care managers in the BFP system of care are among the highest paid, and have the lowest average caseload size.
- BFP has a strong track record of implementing innovative changes and adopting new practices to respond to the needs of their community.
- BFP has placed a large focus on prevention through Brevard CARES, resulting in fewer cases entering the dependency and out of home care system.

**Opportunities:**

- We discovered that there are providers delivering evidence-based practices currently that are not routinely used by the child welfare system and could easily expand evidence-based services to BFP and its partners in the child welfare system.
- We found a number of providers very open to delivery of evidence-based practice and willing to move in that direction but lack the resources to independently secure the training and

consultation needed to make the shift on their own. With BFP's leadership, they could retool rapidly to expand services.

## The Road Map

In order to reach its destination of fuller integration of evidence-based and evidence informed practice into the Brevard County service delivery continuum, BFP must first focus on building and strengthening the infrastructure necessary to meaningfully implement evidence-based practices. With the infrastructure in place, BFP can then strategically follow three parallel but mutually supportive paths to 1) expand the evidence-based practices already in place in Brevard County, 2) build the evidence for promising programs already in place, and 3) to add new evidence-based practices that are uniquely suited for Brevard County's service delivery needs to the service delivery continuum.

**BUILDING THE INFRASTRUCTURE:**

Successful implementation of evidence-based practices requires much more than selecting individual models or even acquiring training. BFP would be wise to ensure the infrastructure to support meaningful implementation is in place before embarking on their journey to greater evidence-based and evidence informed practice. There are several key elements to building infrastructure to support the journey outlined below:

A. **Building Assessment and Referral Pathways:** Expanding the use of evidence-based practices has little meaning to families and little impact on outcomes if the child and family are not matched with the appropriate evidence-based practice. For instance, if a six-year-old child is presenting with disruptive behaviors, this child would not benefit from Multisystemic Therapy (MST), which is designed for children between the ages of 12 and 17 with disruptive behaviors. Ensuring that children and families are properly assessed and referred is a key step in the delivery of evidence-based practices.

   BFP has a strong assessment process that can be enhanced further to help guide case managers to refer children and families to the evidence-based or informed practice that best fits their unique needs. Information collected during the assessment needs to be shared with the provider being referred to, as appropriate, in order to clarify the reason for the referral and reduce the need for duplicate collection of assessment data. The MindShare system being used by BFP would be an ideal venue for the sharing of assessment information, if the current referral information can be expanded.

The current service guide serves as a solid foundation upon which the assessment and referral pathway can be built. The service guide can be expanded to include information on all providers that are referred to in the community, along with detailed information on the types of services each provides, the populations and regions being served, and the models being used. This will give BFP a better overview of the local service system, beyond the providers that BFP has contracts and agreements with, to ensure that all available resources are being utilized appropriately. By updating this information on a periodic basis, BFP will be able to identify pieces of the services continuum that are missing, as well as specific populations or regions of the county that are underserved.

Once EBP has defined the elements of service continuum (the specific models to be used), it can define the characteristics of the children and families identified during the assessment and referral process (i.e. age, symptoms, presenting problem, safety or risk factor to be addressed, service delivery location, group or individual, etc.) that will help match the family with the practice best suited to address their needs. In doing so, it is important that BFP's service guide become more targeted and clearly match needs and symptoms to specific practice models (such as Trauma-Focused Cognitive Behavior Therapy, Coping Cat, or Dialectical Behavior Therapy) as opposed to broad service delivery mechanisms (such as individual therapy, group therapy, or parenting education). Example: a six-year-old child, with a history of trauma exposure and harsh corporal punishment occasionally escalating to minor physical abuse and with a parent or caregiver who is unable to cope with their externalizing behavior would not merely be referred to "family therapy" but a review of the expanded service delivery continuum in the revised service guide would lead the case manager to consider Parent Child Interaction Therapy, a form of treatment and parenting education rated 1 on the CEBC and well suited for the child and families with these unique needs.

This will allow for more consistent, targeted referrals to a specific service or model, as opposed to a generic referral to a broad category of services. This is already happening to an extent within the BFP network, but its likelihood could be increased by incorporating it more clearly into the referral process.

One consideration during the referral process would be whether regionalizing service referrals would be helpful. Brevard County is geographically large, has a poor public transportation system, and driving times between regions of the county can be extended. Other counties in similar situations have divided the county into regions and allocated providers accordingly, so that provider productivity, especially for providers of home based services, is maximized. Less time spent on driving can equate to more time spent with clients. Some providers in Brevard

are already doing this informally on the clinician level, but where BFP has multiple providers of the same service, it may be more efficient to divide referrals along geographic lines. Careful monitoring will need to occur as any such system is set up to adjust the referrals and/or regional lines as needed to avoid service delays.

It must also be noted during any discussion of referrals that those making the referrals need to be adequately trained on how to make effective referrals. All too often, families involved in child welfare are referred to multiple, often overlapping services, resulting in the family being overwhelmed with appointments and obligations and the system expending resources needlessly. It is important to remember that more is not always better, and referring a family to 1 or 2 services that address the most critical needs is often more effective than trying to tackle all the needs at once. A good case manager should be able to triage the family's needs and decide which referral to make when. BFP can assist with this process through development of clear guidelines and effective training of staff on an on-going basis. Quality assurance processes can be used to determine whether referrals are being made appropriately, with re-training offered as necessary.

B. **Building Implementation Pathways:** Many communities across the county have merely expanded the use of the words "evidence-based practice" rather than to focus on ensuring the change in practices represents actual implementation of evidence-based practice and real improvement. In fact, as Fixsen and colleagues wrote in their 2005 publication, Implementation Research: A Synthesis of the Literature, much implementation is in name only as "Paper Change" in which people change what they call things but don't actually change practice. To achieve what Fixsen calls "Performance" level change, BFP must be strategic in not only how it selects evidence-based practices but also how it plans the implementation of evidence-based practices. While a growing body of knowledge now exists in implementation (see Resources section) it is clear BFP must focus on organizational and community readiness for the expansion of evidence-based practice and the implementation of specific practices in individual organizations. BFP must also strategically consider the best way to transmit knowledge and skills about selected practices to the workforce who must implement the models. Once a new evidence-based model has been installed in Brevard County, BFP must consider how it will hold the provider accountable for fidelity and the range of local adaption it is willing to accept. Even once installed and being delivered with fidelity, BFP must plan how new employees entering the workforce in the future will be trained and supported in a meaningful way.

    a. **Organizational Readiness**: the good news is the review found Brevard agencies very open to the concept of evidence-based practice and many appeared very supportive. BFP is in an excellent position to provide the leadership and direction to make this change, if the resources needed to support the effort can be made available in these challenging economic times. From this foundation, BFP and community partners can

identify champions of change at all levels of the organizations who embrace the general idea of using science to inform practice and believe in the specific practices BFP seeks to expand or install in the county continuum.

There are tools and resources available to support BFP, agency administrators, and the champions of change in assessing the readiness of individual organizations and in guiding targeted readiness activities designed to build support for meaningful implementation of new practices (See resource section).

b. **Change Coordination:** System wide implementation would be enhanced by the presence of a Brevard County change coordinator whose job is to facilitate and support the change and help build a sense of mutual accountability across the service delivery continuum. This can be an internal BFP position or could be retained from outside, such as EBA. Chadwick has used this model with success in multiple California Counties in the implementation of SafeCare® (a neglect early intervention model rated 3 on the CEBC) and has seen the real benefit as compared to training and consultation alone.

c. **Training/Consultation Model:** If performance level change is to be attained, BFP must designed a system to impart the necessary knowledge and skills associated with any practice it wishes to expand or install and then ensure that knowledge and skills are woven into the culture of service delivery. There is little evidence that training alone will result in meaningful change. Rather, most evidence-based practices appear to be best implemented when training is paired with ongoing consultation and clinical supervision as part of a learning community where peer support and accountability support actual implementation. For example, when training on Trauma-Focused Cognitive Behavioral Therapy, we typically require participants first take a 10 hour web base introduction course (TF-CBT Web) to acquire basic knowledge, followed by a 2 day interactive classroom training, followed by at least 15 group consultation calls spread over 8-12 months and punctuated by 1 or 2 "booster sessions." This combination of training and consultation spread over a period of months and supported by a community of learners allows the user to understand and integrate the practice change in a meaningful way that simply would not occur on a large scale for a one off training.

d. **Role of Clinical Supervision:** Trainers and outside consultants, no matter how knowledgeable about a new practice, lack the impact of effective day to day clinical supervision. It is key that clinical supervisors be trained in any new practice and prepared to act as clinical supervisor. This is challenging if they are not themselves implementing the new model. In fact, a supervisor who lacks comfort and experience

with the new model can ultimately undermine the implementation if they feel they lack competence and prefer to revert to more comfortable practices they know from their days on the front lines. BFP would be wise to ensure supervisors receive special attention and support and recognition in planning and implementing any new or expanded practices, even if they will not be delivering it directly.

C. **Implementation/Fidelity Monitoring:** It will be important that BFP ensures the implementation of any new or expanded models is on the right track. This requires fidelity monitoring of some sort and is enhanced by the use of metrics that measure key variables of implementation. In a study of the SafeCare home visiting intervention in Oklahoma, Chaffin and colleagues found that individuals taught an evidence-based practice without any monitoring, tended to return to old ways within in a year while those monitored were more likely to implement the model as designed. Monitoring and metrics proved to be the most effective way to ensure the change in practice was woven into everyday practice and became the new way of doing business.

This monitoring needs to occur on several levels. First, BFP and its partners need to monitor if agencies receiving referrals make contact and concur that the selected practice is the best fit for the family (or offer alterative suggestions). This would serve as an important check on the referral process described above, ensuring that families are being referred to appropriate services and then are actually receiving them. There needs to be a clear two-way communication link between staff making the referrals and the providers being referred to, to ensure that any concerns are addressed quickly. In addition, providers receiving referrals should have a limited number of days to respond to a referral and any referrals not addressed in a timely fashion should be routed back to BFP for action, so that families are not left without needed services.

Second, BFP must also track the degree in which families engage in the selected practice. Without sufficient dosage, even the best practice will be ineffectual. Engagement is often a difficult piece of the puzzle when working with child welfare populations, and BFP may want to institute certain standards for engagement levels (e.g. the percentage of authorized therapy sessions that should be used) or provide training on concrete strategies to improve client and family engagement, with a focus on the types of services that may have lower engagement levels. In addition, when low engagement levels are found, BFP may want to work with clients to determine the reasoning and how BFP can help encourage engagement. In some counties, parent peer partners (families who have previously been involved in child welfare services) are being used to reach out to families who do not engage in services and try to determine what barriers exist and how the local services system can help address them.

Finally, once children and families are engaged, key fidelity measures should be selected for each selected practice and collected in the most efficient and least intrusive way possible that

both holds the provider accountable and provides feedback on implementation to BFP. Most EBPs have developed fidelity tools that should be used periodically during the delivery process; most of these measures are brief and user friendly. These may be completed by the service provider (to ensure that the components of the practice are being followed as prescribed), the service recipient (to provide feedback on what has been delivered), or a combination of the two. BFP could choose to integrate this monitoring with an ongoing assessment process that also provides clinical feedback and outcome data on case and system performance. MindShare may also be an ideal venue for the collection of this data.

**INTEGRATION OF EVIDENCE-BASED AND EVIDENCE INFORMED PRACTICE IN COMMUNITY SERVICE DELIVERY CONTINUUM:**

With the infrastructure described above in place, we recommend BFP pursue three paths to further integration of evidence-based and evidence informed practice in community service delivery continuum.

**Path 1: Expand Upon What Currently Exists in Brevard:**

The review uncovered pockets of evidence-based practices already in place in Brevard County. This is a real strength that can be built upon. It appeared that BFP was not routinely accessing some of these existing evidence-based services (they were being delivered to other, non-BFP client populations or at the request of other referral sources). We noted the presence of at least eight models that are highly rated on the CEBC in Brevard County and four others who are rated a 3 on CEBC. Most, however, are only being provided by a single agency and as such may not be having the impact they might if strategically supported and expanded. Note: The review did not test whether these evidence-based practices were being delivered with fidelity, and few providers reported using fidelity measures.

The 8 programs rated as a 1 (Well-Supported by Research Evidence) or 2 (Supported by Research Evidence) on the CEBC and therefore considered as evidence-based include:

- **Brief Strategic Family Therapy (BSFT)** (1 provider, not currently being delivered to BFP clients)
    - The BSFT™ Program targets children and adolescents between the ages of 6 and 17 who are displaying or are at risk for developing behavior problems, including substance abuse, conduct problems and delinquency. BSFT is based on three basic principles: First, BSFT is a family systems approach. Second, patterns of interaction in the family influence the behavior of each family member. The role of the BSFT counselor is to identify the patterns of family interaction that are associated with the adolescent's behavior problems. Third, plan interventions that carefully target and provide practical ways to change those patterns of interaction that are directly linked to the problem

behaviors. BSFT is typically delivered in 12 to 16 family sessions, depending on the severity of the communication and management problems within the family.

- **Child Parent Psychotherapy (CPP)** (1 provider)
  - CPP is a treatment for trauma-exposed children aged 0-5. Typically, the child is seen with his or her primary caregiver, and the dyad is the unit of treatment. CPP examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.

- **Coping Cat** (1 provider)
  - Coping Cat is a cognitive-behavioral treatment for children with anxiety. The program incorporates 4 components: 1) Recognizing and understanding emotional and physical reactions to anxiety, 2) Clarifying thoughts and feelings in anxious situations, 3) Developing plans for effective coping, and 4) Evaluating performance and giving self-reinforcement. Coping Cat also has a version for adolescents, ages 14-17, known as the C.A.T. Project. The C.A.T. Project has not been tested separately, but has the same elements as Coping Cat except that it contains materials more developmentally appropriate for older adolescents.

- **Eye Movement Desensitization Reprocessing (EMDR)** (2 providers)
  - EMDR is an 8-phase psychotherapy treatment that was originally designed to alleviate the symptoms of trauma. During the EMDR trauma processing phases, the client attends to emotionally disturbing material in brief sequential doses that include the client's beliefs, emotions, and body sensations associated with the traumatic event while simultaneously focusing on an external stimulus. Therapist directed bilateral eye movements are the most commonly used external stimulus but a variety of other stimuli including hand-tapping and audio bilateral stimulation are often used. EMDR has primarily been studied for use with single event traumas.

- **Mindfulness-Based Cognitive Therapy (MBCT)** (1 provider)
  - MBCT is an adult depression intervention that includes simple meditation techniques to help participants become more aware of their experience in the present moment, by

tuning into moment-to-moment changes in the mind and the body. Participants learn the practice of mindfulness meditation through a course of eight weekly classes (the atmosphere is that of a class, rather than a therapy group), and through daily practice of meditation skills while listening to tapes at home. MBCT also includes basic education about depression and suicidality, and a number of exercises derived from cognitive therapy. These exercises demonstrate the links between thinking and feeling and demonstrate ways that participants can care for themselves when they notice their mood changing or a crisis threatens to overwhelm them.

- **Motivational Interviewing (MI)** (2 providers)
  - MI is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. Although originally developed for use in substance abusing populations, it is increasingly being used in other areas, such as child welfare.

- **Parent Child Interaction Therapy (PCIT)** (1 provider, not currently being delivered to BFP clients)
  - PCIT was developed for families with young children experiencing behavioral and emotional problems. Therapists coach parents during interactions with their child to teach new parenting skills. These skills are designed to strengthen the parent-child bond; decrease harsh and ineffective discipline control tactics; improve child social skills and cooperation; and reduce child negative or maladaptive behaviors. PCIT is an empirically supported treatment for child disruptive behavior and is a recommended treatment for physically abusive parents.

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** (4 providers)
  - ***TF-CBT*** is a child and parent psychotherapy model for children, ages 3-18, who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. The overall goal of ***TF-CBT*** is to address symptoms resulting from a specific traumatic experience or experiences. This includes: Improving child PTSD, depressive and anxiety symptoms; Improving child externalizing behavior problems (including sexual behavior problems if related to trauma); Improving parenting skills and parental support of the child, and reducing parental distress; Enhancing parent-child communication, attachment, and ability to maintain safety; Improving child's adaptive functioning; and Reducing shame and embarrassment related to the traumatic experiences.

We also noted the following programs rated a 3 (Promising Research Evidence) and therefore evidence informed; some are being used widely with BFP clients:

- **Wraparound**
  - Wraparound is a team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g. mental health, child welfare, juvenile justice, special education, etc.); who are at risk of placement in institutional settings; and who experience emotional, behavioral, or mental health difficulties. The Wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal Wraparound process is no longer needed. The values associated with Wraparound require that the planning process itself, as well as the services and supports provided, should be individualized, family driven, culturally competent and community-based. Additionally, the Wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, Wraparound should be "strengths-based," helping the child and family recognize, utilize, and build talents, assets, and positive capacities. Wraparound services have been shown to increase placement stability for children in the child welfare system.

- **Family Group Decision Making (FGDM)**

  FDGM is an innovative approach that positions the "family group" as leaders in decision making about their children's safety, permanency, and well-being. Children and their parents are nested in a broader family group: those people to whom they are connected through kinship and other relationships. Agency decision-making practices that are planned and dominated by professionals and focused narrowly on children and parents can deprive those children and parents of the support and assistance of their family group — and can deprive agencies of key partners in the child welfare process. FGDM recognizes the importance of involving family groups in decision making about children who need protection or care, and it can be initiated by child welfare agencies whenever a critical decision about a child is required. In FGDM processes, a trained coordinator who is independent of the case brings together the family group and the agency personnel to create and carry out a plan to safeguard children and other family members. FGDM processes position the family group to lead decision making, and the statutory authorities agree to support family group plans that adequately address

agency concerns. The statutory authorities also organize service providers from governmental and non-governmental agencies to access resources for implementing the plans. FGDM processes are not conflict-resolution approaches, therapeutic interventions or forums for ratifying professionally crafted decisions. Rather, FGDM processes actively seek the collaboration and leadership of family groups in crafting and implementing plans that support the safety, permanency and well-being of their children.

- **Domestic Abuse Intervention Project (DAIP), also known as the Duluth Model**
  - The DAIP was designed in 1981 as a Coordinated Community Response (CCR) to domestic violence and includes law enforcement, the criminal and civil courts, and human service providers working together to make communities safer for victims. The DAIP includes a 28-week education program for offenders using the curriculum "Creating a Process of Change for Men Who Batter". Participants are adult males who are either court-ordered (civil or criminal) or voluntary participants. Advocates contact the partners of men court-ordered to the program to offer advocacy, community resources, and education groups for women.

- **Theraplay**
  - Theraplay is a structured play therapy for children and their parents. Its goal is to enhance attachment, self-esteem, trust in others, and joyful engagement. The sessions are designed to be fun, physical, personal, and interactive and replicate the natural, healthy interaction between parents and young children. Children have been referred for a wide variety of problems including withdrawn or depressed behavior, overactive-aggressive behavior, temper tantrums, phobias, and difficulty socializing and making friends. Children also are referred for various behavior and interpersonal problems resulting from learning disabilities, developmental delays, and pervasive developmental disorders. Because of its focus on attachment and relationship development, Theraplay has been used for many years with foster and adoptive families.

We recommend BFP examine the populations these existing models are designed to serve (see attached resources) and assess if children and families with Brevard County's child welfare system would benefit from expanded availability of these services. BFP may conclude some of these evidence-based models are actually not a good fit with BFP's service population and service priorities and not appropriate for expansion. On the other hand, BFP may find some of these programs should be expanded within the current agency or spread across the county and among multiple providers. BFP may find some of these models may represent a duplication on the service delivery continuum and select only one for strategic expansion. For example, EMDR and TF-CBT both address trauma in children and it may not be wise to

invest resources in strategic expansion of both. Rather, BFP may want to consider the attributes of both and the strength of the research for each with BFP's target population and select one for expansion.

We also encourage BFP to assess the fidelity of the current providers of these models and how and where training and consultation was obtained. Then, using the infrastructure described above, BPF can oversee the strategic expansion of the existing models to best fit the needs, volume, and or geographic location within the county. The existing provider may have the capacity to lead that expansion or it may be necessary to bring in outside training and consultation support. At a minimum, different providers who are delivering the same model can be linked up for mutual support and consultation, and encouraged to serve as a resource for others with interest in the model.

**Path 2: Determine the Evidence Base for Current Services:**

The review identified several practices in the BFP service continuum that appear to be based on a solid theory and well-respected in the community. This group of services, however, lacks any peer reviewed published research to support the belief they are effective and thus cannot be considered "evidence-based." This lack of a research base does not mean they don't work. Quite the contrary, they could be superior to some similar practices widely considered evidence-based. We encourage BFP to identify and work with academic partners and progressive elements of the provider community to begin to collect and disseminate data and empirical analysis of the impact of these untested models, especially those locally designed and delivered. In fact, some providers have been collecting and analyzing outcome data that could support this effort. With research, BFP may find they can develop the evidence to consider these models evidence-based in the future and spread them to other communities. If BFP does so, we encourage submitting the findings for publication. Programs that appear to fall into this category include:

- **Brevard C.A.R.E.S.**
    - Brevard C.A.R.E.S. is a family-centered, strength-based, and community-driven approach to child abuse prevention. Using a Wraparound and Family Team Conferencing approach, they offer a full continuum of care and support services to families experiencing stressors that may lead to neglect, abuse, or abandonment. Originally used for Prevention cases, CARES was expanded to the Dependency population in January 2011. Services are being delivered to over 400 families each month.
    - This model, which is a central component of the BFP service continuum, has been tested in an unpublished comparison study and found to be effective at preventing future abuse and neglect reports. We recommend that results from the completed study be published, so that information on the program is able to reach a larger audience. In addition, additional studies should be conducted, perhaps in a new county interested in implementing C.A.R.E.S., to determine the effectiveness of the model outside of the BFP system. Ideally, randomization would be used during the effectiveness trial.

- **Community Outreach and Mentoring Program (COMP) – CHANGES**
  - The COMP model is a structured treatment program designed to treat youth, ages 7-17, in the foster care system who have displayed serious levels of emotional and/or behavioral challenges. Services will be provided by degreed and highly-trained professionals, who will teach daily living skills, social skills, and provide therapeutic interventions. These therapeutic support specialists will work closely with youth and their families, meeting with youth each week and developing a Personal Improvement Plan with each youth to address his/her identified risks. Participants in the program have both a counselor and a therapeutic support specialist, utilizing a team approach, with the counselor focusing on the emotional issues and the therapeutic support specialists on the behavior / social issues and life skills.
  - This locally developed model has not been tested, but given its focus on youth in the foster care system, an evaluation should be conducted to determine whether it is more effective than existing interventions for youth with emotional and behavioral difficulties. CHANGES is currently developing the evaluation framework.

- **Mentoring program – Coastal Behavioral Therapy**
  - Coastal Behavioral Therapy delivers mentoring services to BFP clients with a goal of getting the child involved in new activities and expanding the child's and family's support system. Mentors meet with the child weekly for approximately 2 hours. Mentors allow children access to home or community-based instruction related to health, personal development, social development, and life skills. These activities may include connecting them to local community centers to build peer relationships, access sports, fishing, and/or other similar activities. An important function is to help the family access free community resources so that they may continue to receive assistance after closure of the case. Positive role modeling is also a crucial part of the mentoring program. The service is not intended to be therapeutic, but rather a positive experience for the child and family.
  - This model is based on the Big Brother Big Sister model which does have a research base. An evaluation should be conducted to determine whether the local adaptation is effective with a child welfare population.

- **Parent Aide Model – Yellow Umbrella**
  - The National Exchange Club Foundation's Parent Aide Model evolved from knowledge and experience of the dynamics surrounding child abuse and neglect. The Parent Aide's role is to act as a mentor who assists parents by providing intensive support and information, and modeling effective parenting. The Parent Aide works with parents in their home. This provides an atmosphere of greater comfort and allows a parent to more readily develop a trusting, dependable relationship. The Parent Aide relationship

with the parent provides a model for the parent in developing a trusting relationship with their own child and a safe environment to demonstrate new and effective parenting techniques based on child development information. In addition, the Parent Aide facilitates parent's problem solving skills and strengthening their network of social supports. The Parent Aide relationship with parents occurs through intensive and long term home visitation. Continuity and consistency of service are key to success. Ideally the home visits occur one to two times per week and continue for at least one year.

- The Parent Aide model has a clear research base, and while not currently listed on the CEBC, appears to meet criteria for a rating of 3. BFP should support the program's efforts to increase the evidence base. In addition, BFP should examine how it is currently using the model, as the provider felt that the model was not being delivered to BFP clients in its entirety, which may reduce its effectiveness.

- **Supervised Visitation program – Eckerd**
  - The Eckerd supervised visitation model serves 25 families at any given time, with an emphasis on coaching and mentoring parents on communication and bonding with their children. The goals are to reunify families within 12 months of removal and to reduce recidivism. Visitations occur twice a week for 2 hours each for approximately 6 months.
  - This program is based on a combination of two existing models / guidelines for supervised visitation. A study of the model's effectiveness should be completed to determine whether it is having a positive effect. An initial study could utilize a wait list control or matched control group.

**Path 3: Build the Evidence-based Continuum:**

While Brevard County has a strong service continuum, the review failed to find examples of some key evidence-based practices that typically would be a strong addition to any child welfare system continuum of care. BFP could use its influence and contracting resources to strategically introduce selected evidence-based models to the community. We found providers very receptive to new practices (and some had clear ideas which new evidence-based models they hoped to implement) if BFP or another entity could reduce the financial barriers related to implementation. This approach gives BFP a central role in strategic installation of new evidence-based practices that fit the BFP client's needs and community characteristics. We encourage BFP to review the CEBC and related resources, such as SAMHSA's National Registry of Evidence-based Programs, and identify a limited number of models that fill needs or gaps on the Brevard service delivery continuum. As described by Greenhalgh and colleagues in 2004 and summarized in the CEBC's Selection Guide for EBPs in Child Welfare (http://www.cebc4cw.org/implementation-resources/tools/ and in the Resources Section), there are several factors that should be taken into account when selecting a new program for installation to increase the likelihood of success.

Based on our understanding of Brevard County's child welfare population and service delivery system, we would encourage BFP to consider the following models:

1. A **home visiting model** that has documented outcomes on child abuse and neglect prevention while also targeting the skills that many families in the child welfare system are lacking, such as basic child care and household management. These programs typically target young or first time parents. Models to consider include:
    a. **Nurse - Family Partnership** (Rated a 1 on CEBC)
        i. The Nurse-Family Partnership (NFP) program provides home visits by registered nurses to first-time, low-income mothers, ideally beginning during pregnancy and continuing through the child's second birthday. The program has three primary goals: (1) to improve pregnancy outcomes by promoting health-related behaviors; (2) to improve child health, development and safety by promoting competent care-giving; and (3) to enhance parent life-course development by promoting pregnancy planning, educational achievement, and employment. The program also has two secondary goals: to enhance families' material support by providing links with needed health and social services, and to promote supportive relationships among family and friends.
        ii. Target: young, first time mothers, and children ages 0-3
    b. **SafeCare®** (rated a 3 on the CEBC)
        i. SafeCare is an in-home parenting model program that provides direct skill training to parents in child behavior management and planned activities training, home safety training, and child health care skills to prevent child maltreatment.
        ii. Target: Parents at-risk for or with a history of child neglect and/or abuse, and children ages 0-5.

2. **Interventions for children with emotional and behavioral problems.** Effective interventions typically involve both the parent and the child in treatment, as the parent is often the mediator of behavior change.
    a. **Parent Child Interaction Therapy (PCIT)** (rated a 1 on the CEBC)
        i. PCIT was developed for families with young children experiencing behavioral and emotional problems. Therapists coach parents during interactions with their child to teach new parenting skills. These skills are designed to strengthen the parent-child bond; decrease harsh and ineffective discipline control tactics; improve child social skills and cooperation; and reduce child negative or maladaptive behaviors. PCIT is an empirically supported treatment for child

disruptive behavior and is a recommended treatment for physically abusive parents.

ii. Target: Children ages 2-8 with behavior and parent-child relationship problems. May be conducted with parents, foster parents, or other caretakers. Adaptation available for physically abusive parents with children ages 4-12.

b. **Functional Family Therapy (FFT)** (rated a 2 on the CEBC)

i. FFT is a family intervention program for dysfunctional youth. FFT has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Target populations range from at-risk pre-adolescents to youth with very serious problems such as conduct disorder, violent acting-out, and substance abuse. While FFT targets youth aged 11-18, younger siblings of referred adolescents often become part of the intervention process. Intervention ranges from, on average, 8 to 12 one-hour sessions for mild cases and up to 30 sessions of direct service for more difficult situations. In most programs, sessions are spread over a three-month period. FFT has been conducted both in clinic settings as an outpatient therapy and as a home-based model.

ii. Target: Youth, ages 11-18, with disruptive behavior problems

3. **Parent training programs** that can be used with a wide variety of populations and can function as either prevention or intervention for abuse, neglect, and behavior problems.

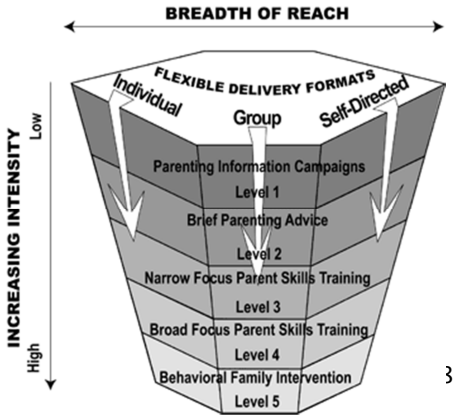
a. **Incredible Years** (Rated a 1 on the CEBC)

i. The Incredible Years is a series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. This series is designed to promote emotional and social competence; and to prevent, reduce, and treat behavior and emotional problems in young children. It has also been shown to reduce child maltreatment. The parent, teacher, and child programs can be used separately or in combination. There are treatment versions of the parent and child programs as well as prevention versions for high-risk populations.

ii. Target: Children, ages 0-12, with conduct problems, their parents, and teachers

b. **Positive Parenting Program** (Triple P) (rated a 1 on the CEBC)

i. The Triple P-Positive Parenting Program is a multi-level system of parenting and family support. It aims to prevent severe behavioral, emotional and developmental problems in children by enhancing the knowledge, skills, and confidence of parents. It has also been shown to reduce child maltreatment. It can be provided individually, in a group,



or a self-directed format. It incorporates five levels of intervention on a tiered continuum of increasing strength. The multi-disciplinary nature of the program allows utilization of the existing professional workforce in the task of promoting competent parenting. The program targets five different developmental periods from infancy to adolescence. Within each developmental period, the reach of the intervention can vary from being very broad (targeting an entire population) to quite narrow (targeting only high-risk children). Triple P enables practitioners to determine the scope of the intervention given their own service priorities and funding.

ii. Target: Parents of children and adolescents from birth to age 16

4. **Treatment foster care** models to prevent placement disruptions and reduce the use of higher level placements
    a. **Multidimensional Treatment Foster Care (MTFC)** (Rated a 1 for ages 12-18 and a 2 for ages 3-6 on the CEBC)
        i. **MTFC for Adolescents (MTFC-A)** is a model of treatment foster care for children 12-18 years old with severe emotional and behavioral disorders and/or severe delinquency. MTFC-A aims to create opportunities for youths to successfully live in families rather than in group or institutional settings, and to simultaneously prepare their parents (or other long-term placement) to provide youth with effective parenting. Four key elements of treatment are (1) providing youths with a consistent reinforcing environment where he or she is mentored and encouraged to develop academic and positive living skills, (2) providing daily structure with clear expectations and limits, with well-specified consequences delivered in a teaching-oriented manner, (3) providing close supervision of youths' whereabouts, and (4) helping youth to avoid deviant peer associations while providing them with the support and assistance needed to establish pro-social peer relationships. MTFC-C (for children) has not been tested separately, but has the same elements as MFTC-A except it includes materials more developmentally appropriate for younger children.
        ii. **MTFC for Preschoolers (MTFC-P)** is a treatment foster care model specifically tailored to the needs of 3 to 6-year-old foster children. MTFC-P is effective at promoting secure attachments in foster care and facilitating successful permanent placements. MTFC-P is delivered through a treatment team approach in which foster parents receive training and ongoing consultation and support; children receive individual skills training and participate in a therapeutic playgroup; and birth parents (or other permanent placement caregivers) receive family therapy. MTFC-P emphasizes the use of concrete encouragement for pro-social behavior; consistent, non-abusive limit-setting to address disruptive behavior; and close supervision of the child. In addition, the

MTFC-P intervention employs a developmental framework in which the challenges of foster preschoolers are viewed from the perspective of delayed maturation.

5. Interventions to increase **successful reunification** for families whose children have been placed in out of home care.

   a. **Homebuilders®** (rated a 2 on the CEBC)
      i. Homebuilder is a home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The goals of Homebuilders® are to reduce child abuse and neglect, family conflict, and child behavior problems; and to teach families the skills they need to prevent placement or successfully reunify with their children. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports or other community groups. Child neglect referrals often require case activities related to improving the physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports.
      ii. Target: Families with children (birth to 18) at imminent risk of placement into, or needing intensive services to return from, out of home care.
   b. **Project Connect** (rated a 3 on the CEBC)
      i. Project Connect works with high-risk families who are affected by parental substance abuse and are involved in the child welfare system. The program offers home-based counseling, substance abuse monitoring, nursing, and referrals for other services. The program also offers home-based parent education, parenting groups, and an ongoing support group for mothers in recovery. While the goal for most Project Connect families is maintaining children safely in their homes, when this is not possible, the program works to facilitate reunification.
      ii. Target: High-risk, substance-affected families involved in the child welfare system. Family risks may include the following: Poly-substance abuse and

dependence, domestic violence, child abuse and neglect, criminal involvement and behavior, poverty, inappropriate housing, lack of education, poor employment skills, and impaired parenting. Most of the families served are ethnically diverse, have a low household income, and are headed by single mothers.

6. Interventions to increase **family engagement** in services.
    a. **Supporting Father Involvement** (rated a 2 on the CEBC)
        i. SFI is a preventive intervention designed to enhance fathers' positive involvement with their children. The curriculum is based on an empirically-validated family risk model. This model predicts that children's development is predicted by risks and buffers in five interconnected domains: 1) family members' characteristics, 2) 3-generational expectations and relationship patterns, 3) quality of parent-child relationship, 4) quality of parents' relationship, and 5) balance of stressors versus social support for the family. The curriculum highlights the potential contributions fathers make to the family. The program is aimed at strengthening fathers' involvement in the family, promoting healthy child development, and preventing key factors implicated in child abuse.
        ii. Target: Fathers of children ages 0-11.
7. Interventions to address **substance abuse disorders in caregivers**. As with many child welfare systems, caregiver substance abuse is a primary reason for entry to services and/or out of home care. Effective treatments exist for substance abuse (more information can be found at www.cebc4cw.org), but few are designed to address the specific needs of substance abusers who are also parenting. The following interventions utilize a family centered approach.
    a. **Families Facing the Future** (rated a 2 on the CEBC)
        i. The Families Facing the Future program was developed for parents receiving methadone treatment and for their children. The primary goals of the project were to reduce parents' use of illegal drugs and to reduce risk factors for their children's future drug use while enhancing protective factors. The curriculum consists of one five-hour family retreat and 32 hour-and-a-half parent training sessions. Sessions are conducted twice a week over a 16-week period. Children attend 12 of these sessions to practice the skills with their parents. Session topics are targeted at specific risk and protective factors and include topics such as Family Goal Setting, Relapse Prevention, Family Communication Skills, and Family Management Skills.
        ii. Target: Mothers, fathers, and children ages 5-14.
    b. **Family Behavior Therapy for Adults (FBT)** (rated a 2 on the CEBC)
        i. FBT for Adults includes more than a dozen treatments including management of emergencies, treatment planning, behavioral goals, contingency management skills training, communication skills training, child management skills training,

job-getting skills training, financial management, self-control, stimulus control, home safety tours, and tele-therapy to improve session attendance. Therapies are consumer-driven and culturally sensitive. FBT for Adults' goal is to result in positive outcomes in such areas as alcohol and drug use, depression, conduct problems, family dysfunction, and days absent from work/school. FBT for Adults is designed to be used with adults, multiple ethnicities, differing types of substance abuse (alcohol, marijuana, and hard drugs), and across genders. Drafts of standardized client record keeping forms and quality assurance may be customized to fit agency needs.

ii. Target: Adults with drug abuse and dependence, as well as other co-existing problems such as depression, family dysfunction, trauma, child maltreatment, noncompliance, and poor communication skills.

c. **Parent-Child Assistance Program (PCAP)** (rated a 2 on the CEBC)

i. PCAP serves high-risk mothers who abuse alcohol/drugs during pregnancy, and their families, using a theory-based model (relational theory; stages of change; and harm reduction). PCAP intervention activities are conducted by trained and supervised case managers who each work with 16 families for 3 years, beginning during pregnancy or postpartum. PCAP case managers have experienced similar adverse life circumstances as clients, have subsequently achieved success in important ways, are positive role models, and offer hope from a realistic perspective. They provide regular home visitation, and help clients obtain treatment and stay in recovery. They connect families with comprehensive services including health, housing, parenting, and vocational services.

ii. Target: Women who used alcohol or drugs heavily during pregnancy. Women are enrolled during pregnancy or up to 6 months postpartum.

Note: There are a few but important elements of the child welfare continuum where no evidence-based practice models yet developed and where there is simply no peer reviewed published research that shows one model works better than another, such as in the area of youth in foster care transitioning to adulthood.

**CLOSING SUMMARY**

BFP's proactive steps taken to critically examine and enhance their delivery of EBPs and services to their community, families and children, as evidenced by this assessment effort, has the potential to lead to numerous positive outcomes. This document has provided a multi-stage framework for modifications to the BFP system to enhance evidence-based practices in the Brevard County child welfare system.

By building the infrastructure to support evidence-based practice delivery, BFP will have achieved a key part of its vision and do so in a way other communities can seek to emulate. Enhancing the assessment and referral process, and then strategically expanding the array of evidence-based practices in Brevard County will ensure that that needed services are implemented with fidelity and that successful sustainment and spread would follow.

It will be important for BFP to clearly identify the issues that will be addressed by any new or expanded programs, as a key tenant of evidence-based practice is that the intervention must be designed to address the specific need. Before selecting a practice, BFP will need to carefully examine the existing data on the issue and try to identify the underlying cause. It is this underlying cause that must be addressed in order to achieve the desired outcomes. For example, concerns about re-entry to child welfare services have been identified by BFP as an area of concern. Re-entry can have many causes, but usually stem from reunification or case closure occurring before the family's issues were adequately addressed. BFP will need to identify where the system is not functioning correctly, so they can determine if the root cause is procedural (e.g. closing cases prematurely) or treatment related (e.g. families complete substance abuse treatment successfully but begin using substances again within a few months), and determine how to best address the problem.

Finally, appropriate selection of any new practice will be critical to its success. All too often, programs are selected based on glossy packaging or the persuasive language of the program developer, without an assessment of whether the program will both address the system's needs and fit within the existing service system. In such cases, the program is often unsuccessful, as it was never a good fit in the first place. As discussed on page 15, the selection process must be done in a thorough and thoughtful manner to provide a solid footing for the implementation of a new EBP.

**Resource Section Contents:**

- CEBC Scientific Rating Scale
- CEBC EBP Selection Guide for Child Welfare
- Detailed summaries of the Existing CEBC EBPs and Recommended CEBC EBPs