

Child Welfare Caseworkers as Brokers of Mental Health Services: A Pilot Evaluation of Project Focus Colorado

Child Maltreatment
2015, Vol. 20(1) 37-49
© The Author(s) 2014
Reprints and permission:
sagepub.com/journalsPermissions.nav
DOI: 10.1177/1077559514562448
cmx.sagepub.com



Monica M. Fitzgerald¹, Marcela M. Torres², Kimberly Shipman¹,
Jessica Gorrone², Suzanne E.U. Kerns³, and Shannon Dorsey³

Abstract

Youth in the child welfare system (CWS) have substantially higher rates of mental health needs compared to the general population, yet they rarely receive targeted, evidence-based practices (EBPs). Caseworkers play the critically important role of “service broker” for CWS youth and families. This study examines preliminary caseworker-level outcomes of Project Focus Colorado (PF-C), a training and consultation program designed to improve access to EBPs for CWS youth. PF-C evaluation occurred in four child welfare offices (two intervention [$n = 16$ caseworkers] vs. two practice-as-usual, wait-list control [WLC; $n = 12$ caseworkers]). Receipt of PF-C was associated with significantly increased caseworker knowledge of (a) EBPs, (b) child mental health problems, (c) evidence-based treatment components targeting mental health problem areas, and (d) mental health screening instruments, compared to WLC. Dose of training and consultation was associated with greater ability to correctly classify mental health problems and match them to EBPs. These preliminary results suggest that targeted training and consultation help to improve caseworker knowledge of children’s mental health needs, EBPs for mental health, and mental health screening instruments.

Keywords

child welfare workers, evidence-based practice, mental health services, service delivery, children in child welfare

The Child Welfare System (CWS) has one of the greatest opportunities for identifying and addressing the mental health problems of youth and families who have experienced abuse and neglect, family violence, and other traumatic events. In 2012, the U.S. CWS received 3.4 million child maltreatment referrals to Child Protective Services concerning 6.3 million youth. Of those, an estimated 686,000 cases of child abuse and neglect were substantiated and/or indicated (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau, 2013). Over three fourths of youth were neglected (78%), nearly one in five (18%) were physically abused, and 9% were sexually abused, with many experiencing multiple forms of maltreatment (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau, 2012). Exposure to maltreatment places CWS youth at significant risk for developing mental health and behavioral problems, including trauma-related symptoms (Casanueva, Stambaugh, Tueller, Dolan, & Smith, 2012; Griffin et al., 2011; Leslie et al., 2005).

The presence of emotional and behavioral problems has wide-reaching negative consequences for CWS youth, including increased placement disruption and less successful reunification

for those in foster care (James, Landsverk, & Slymen, 2004; Landsverk, Davis, Ganger, Newton, & Johnson, 1996). If not properly treated, mental health problems can derail children’s typical development and have substantial social and economic impact for youth, families, and the larger community (Beaglehole, Irwin, & Prentice, 2003; Gilbert et al., 2009). Taken together, these risk factors compel us to envision and create a CWS that is better equipped to raise awareness and understanding of child mental health needs and match youth and their caregivers with targeted, effective psychosocial interventions. In addition, building a strong collaborative network between the child welfare and mental health workforces is needed to optimally meet the needs of children and families in the most parsimonious, effective manner. Project Focus

¹ University of Colorado, Boulder, CO, USA

² University of Colorado School of Medicine, Aurora, CO, USA

³ University of Washington, Seattle, WA, USA

Corresponding Author:

Monica M. Fitzgerald, University of Colorado, Boulder, Center for the Study and Prevention of Violence, Institute of Behavioral Science, UCB 483, Boulder, CO 80309, USA.

Email: monica.fitzgerald@colorado.edu

Colorado (PF-C), a CWS caseworker training and consultation program, was designed to build caseworkers' and supervisors' capacity to connect children in the CWS system to effective, trauma-informed mental health services. The current study served as a pilot evaluation of PF-C on caseworker-level outcomes. We designed our preliminary evaluation to address several issues. Specifically, we sought to examine differences in caseworkers in PF-C relative to those in a practice-as-usual group in (a) knowledge of and referrals to evidence-based practices (EBPs); (b) knowledge of primary child mental health problems, including trauma-related reactions; (c) knowledge and use of screeners to assess mental health problems; and (d) ability to match EBPs to specific mental health problem areas. Although this pilot study involves a small sample size and quasi-experimental design, the primary research questions that guide this pilot project were worth exploration.

Advancing Evidence-Supported Interventions (ESIs) in Child Service Settings

One of the major movements in mental health treatments in the past two decades is the advancement of ESIs as the recommended standard of care. ESIs are those name-brand intervention programs that have the demonstrated scientific and clinical support for their effectiveness. These treatments target a specific identified problem or problems (e.g., behavior problem and depression), are typically short term (generally under 6 months) and goal oriented, and include a well-developed evaluation component to monitor treatment progress (Kazdin & Weisz, 2003). ESI programs are well suited for service systems such as child welfare, given their focus on achieving overt changes in child and family functioning in a relatively brief amount of time (Chaffin & Friedrich, 2004; Grayson, Childress, Grayson, & Hatchett, 2012). In fact, a growing number of ESIs have demonstrated effectiveness within a child welfare population for improving child mental health and for reducing re-abuse among maltreating parents (Chaffin & Friedrich, 2004; Kolko, Iselin, & Gully, 2011; see California Evidence-Based Clearing House for Child Welfare, <http://www.cebc4cw.org>).

Although the advancement of ESIs for CWS youth is promising and the need for them is great, few CWS youth actually receive ESIs (Burns et al., 2004). This disparity exists in part due to fact that many communities across the United States still do not have access to ESIs for child mental health problems, given the cost and time (typically several years) it takes to establish and disseminate them for widespread use (Chorpita, Becker, Daleiden, & Hamilton, 2007; Fixsen, Blase, Naoom, & Wallace, 2009; Glisson & Schoenwald, 2005). Instead, CWS youth identified as needing mental health services are more often referred for general "individual" or "family" therapy that is neither evidence based nor targeted to their specific clinical needs (Dorsey, Farmer, Thompson, & Larrieu, 2007; Landsverk, Burns, Stambaugh, & Rolls Reutz, 2009).

Child welfare researchers and policy makers have called for increased access to ESI programs for child welfare-involved

youth and families (Chaffin & Friedrich, 2004; Kerker & Dore, 2006). Additionally, there has been considerable recent attention directed toward bridging the science–practice gap in child welfare and related service systems. Federal priorities and funding opportunities have highlighted CWS workforce development initiatives and targeted CWS training in ESIs for child mental health problems (e.g., Fixsen et al., 2009; Landsverk, Garland, Rolls Reutz, & Davis, 2011).

Although building capacity for specific ESIs takes time, there is much that can be done in now to ensure that CWS youth are receiving the most effective of available services. Rather than considering effectiveness from a categorical perspective (i.e., evidence supported or not), particularly in communities with limited access to ESIs, it is helpful to view interventions as having varying levels of empirical support (see Weisz & Kazdin, 2010). The term "evidence-based practice (EBP)" defined as "the integration of best research evidence with clinical expertise and patient values" (Institute of Medicine, 2001, p. 147) can be used to represent any health care practice or treatment strategy, whether packaged as part of a name-brand ESI or not, which represents best practice in the field. Applying this definition of EBP to the field of child mental health increases opportunity for children and families with specific mental health needs to receive effective and targeted mental health services. Use of an EBP framework requires a guiding set of principles for determining providers' use of outcome-oriented, evidence-based practices, as well as an understanding of the fit between child symptoms (e.g., internalizing, externalizing, attention, or trauma) and corresponding EBPs offered in the community. For example, Chorpita, Daleiden, and Weisz (2005) developed a "common elements" approach to the selection of mental health treatment strategies for practitioners based on core treatment components that are common to most existing ESIs for each specific child mental health problem area (e.g., teaching parents how to use praise for children with externalizing problems). Creating a similar approach to help child welfare workers to connect youth with the best available mental health services would present a tremendous opportunity for improving CWS youth access to effective mental health services that are matched to their unique needs.

CWS Caseworkers as Key Service Brokers

Child welfare caseworkers are key service brokers for CWS youth and are well positioned to link youth and families with services that are targeted to their specific mental health needs (Dorsey, Kerns, Trupin, Conoven, & Berliner, 2012; Stiffman et al., 2000, Stiffman, Pescosolido, & Cabassa, 2004). However, many of these caseworkers do not have graduate-level training in social work or allied professions and/or have not received specific professional training to recognize children's mental health needs or to identify the best quality services (Dorsey et al., 2012; Stiffman et al., 2000). Reflecting this gap in training, research has documented low recognition of mental health needs, few targeted referrals, and limited monitoring of treatment outcomes among caseworkers serving CWS youth

(Burns et al., 1995; Stiffman et al., 2000). Thus, a rich opportunity exists to build capacity to more effectively serve the mental health needs of child welfare-involved youth by improving training for caseworkers.

In recognition of this opportunity, the U.S. Department of Health and Human Services Administration for Children and Families recently awarded significant federal funding (HHS-2013-ACF-ACYF-CT-0595) to develop a National Center for Evidence-Based Practice in Child Welfare to develop, implement, and evaluate a new curriculum in child welfare agency settings that will support the child welfare workforce to (a) better understand the social, behavioral, and emotional needs of children and families involved in the CWS; (b) screen and assess for social and emotional needs of children and families; and (c) support the CWS workforce to learn about evidence-based interventions and how to ensure that children and families are linked to these services. Project Focus was selected to help guide the ACYF National Center's curriculum development, given its innovative approach to targeting these goals in the field, and because it is the only caseworker and supervisor model being formally developed and evaluated. The field has called for more empirical study of consultation, technical assistance, and coaching models for community practitioners applying EBPs in the field (Nadeem, Gleacher, & Beidas, 2013).

A Caseworker Training and Consultation Model: PF-C

Project Focus (Dorsey et al., 2012; Kerns, Dorsey, Trupin, & Berliner, 2010) was first developed and tested in Washington State (PF-W) to build caseworkers' capacity to serve as brokers of effective mental health services for children in foster care experiencing internalizing, externalizing, and attention problems. They conducted a small, randomized controlled trial involving four child welfare offices that demonstrated promising findings with regard to intervention impact on caseworker knowledge of ESIs for these mental health problems and referrals to ESIs for foster care youth (see Dorsey et al., 2012). PF-C was developed to extend the original PF-W caseworker training and consultation program in several key ways to build caseworkers' capacity to connect children in the CWS system to effective mental health services. First, PF-W was designed and implemented specifically for caseworkers serving youth in foster care. The curriculum was expanded for PF-C to include caseworkers in various roles (e.g., intake and ongoing services) serving all CWS youth, not only those in a foster care placement. The purpose of this expansion was to benefit a greater number of children and enhance generalizability of Project Focus concepts within each agency and across teams of caseworkers. Second, the curriculum for PF-C was expanded to include greater emphasis on identification, screening, and assessment of child trauma exposure, posttraumatic stress, and corresponding EBPs. This emphasis on childhood trauma was requested and supported by the Colorado Department of Human Services (CDHS) and current state-level incentives in Colorado to

improve trauma-informed care for CWS children. Third, PF-C included training in administering, scoring, and interpreting specific screening instruments to assess posttraumatic stress (e.g., Child PTSD Symptom Scale; Foa, Johnson, Feeny, & Treadwell, 2001), internalizing, externalizing, and attention problems (e.g., Pediatric Symptom Checklist – 17; Gardner, Lucas, Kolko, & Campo, 2007), which was not part of PF-W. This emphasis on screening was included to enhance caseworkers' ability to make targeted, evidence-based treatment referrals and to help them monitor children's progress in treatment. Fourth, given the limited availability of name-brand ESIs in counties that were selected to participate in PF-C, curriculum focus was shifted to helping caseworkers identify core intervention components or practices (EBPs) for each child mental health problem. This approach enabled caseworkers to determine key elements of effective treatments offered by a wider range of therapists, rather than being limited to referring only to treatment providers trained in name-brand ESIs.

This study sought to examine whether the PF-C increased caseworker knowledge of children's mental health needs, evidence-based practices and interventions, and mental health screening instruments. Specifically, it was hypothesized that, relative to caseworkers in a practice-as-usual condition, caseworkers receiving PF-C training and consultation would demonstrate greater (a) knowledge of and referrals to EBPs; (b) knowledge of primary child mental health problems, including trauma-related reactions; (c) knowledge and use of screeners to assess mental health problems; and (d) ability to match EBPs to specific mental health problem areas. In addition, given the preliminary nature of this work, we wanted to explore whether dose of the training or consultation was related to intervention gains in the group of caseworkers receiving PF-C.

Method

Overview

PF-C was piloted and evaluated in four counties in Colorado using a WLC design, in collaboration with the CDHS. PF-W developers used a train-the-trainer model to train our evaluation team to implement PF-C. Developers monitored fidelity to the general Project Focus model and approved the modifications.

Colorado counties were selected for participation based on (a) interest and readiness for training and consultation and (b) availability of teams of caseworker dyads and supervisors to implement the project. Offices in two counties served as the "PF-C" sites, receiving training plus consultation (April of 2012); offices in the other two counties served as the "practice-as-usual, WLC" sites. County offices were not randomized to condition. Rather, counties with close geographic proximity to each other were assigned to the same condition for ease of conducting cross training, data collection, and EBP capacity building for neighboring communities. All four counties had populations of less than 60,000 (U.S. Census

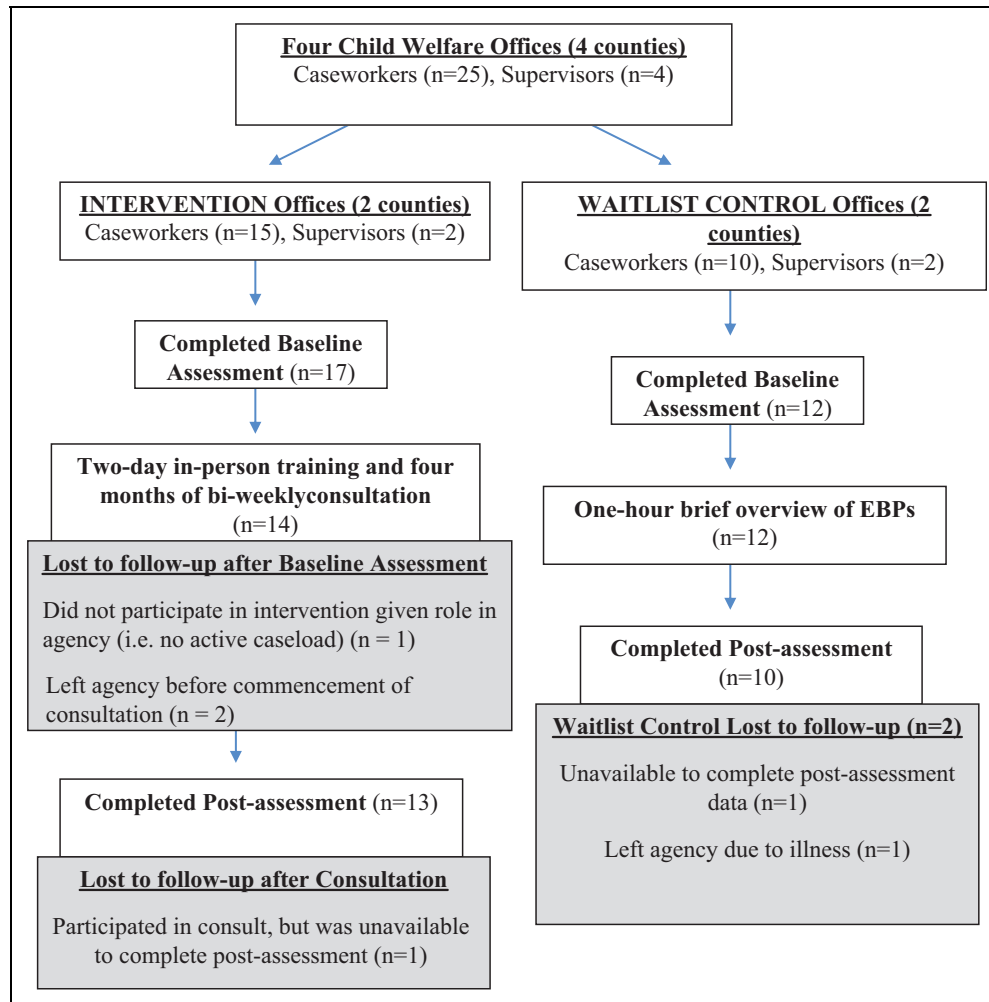


Figure 1. Flowchart depicting caseworker participation from enrollment to postassessment data collection.

Bureau, 2013), with one county in each condition classified as primarily urban and the other county in each condition classified as primarily rural (City-Data.com). The number of cases of child abuse or neglect accepted for assessment during 2012 ranged from 86 to 461 across the four counties (Colorado Department of Human Services Division of Child Welfare Services, 2012).

The caseworkers at the WLC sites completed research protocols and received a 1-hr overview of EBPs for posttraumatic stress and a list of trained providers in their community. After the evaluation period, the WLC offices received the full PF-C intervention (beginning November 2012). The Colorado Multiple Institutional Review Board approved this pilot study.

Participants

Administrators and supervisors within each county chose the teams of caseworkers for participation in the project. Participants in the intent-to-train (ITT) sample completed the baseline assessment and included 29 child welfare caseworkers with active caseloads and their supervisors. Of the 29 who

completed baseline, 23 (intervention $N = 13$, WLC $N = 10$) completed the postassessment, resulting in a 79% sample retention rate (see Figure 1). These 23 participants made up our final sample for evaluation of the intervention. Final sample participants were predominantly female (96%). Most had at least 5 years of experience (83%) and obtained a bachelor's degree or higher (91%).

PF-C Intervention

PF-C consisted of two phases, including in-person caseworker training for 9 hr over 2 days and case-based consultation for 8 hr, over 16 weeks.

Caseworker training. The PF-C in-person training was completed over 2 days and was attended by caseworkers and their supervisors. Training included lecture with PowerPoint, small group activities (e.g., reviewing assessment results using a vignette), discussion, role-play, and hands-on practice with screeners. Four main classes of child mental health problems were covered in training: internalizing (i.e., depression and

anxiety), externalizing (e.g., noncompliance, disruptive, or aggressive behavior), attention-related problems, and post-traumatic stress reactions. Although existing ESIs for each problem area were introduced in training (e.g., trauma-focused cognitive-behavioral therapy [TF-CBT] for posttraumatic stress reactions), emphasis was placed more heavily on understanding the core EBP components for each problem area (e.g., psychoeducation, coping skills, and gradual exposure for posttraumatic stress reaction). Caseworkers were given a list of questions to ask local mental health providers aimed at learning about the type of treatment utilized. Role-plays allowed caseworkers to practice conversations with providers that elicit information needed to make effective treatment referrals.

As part of in-person training, caseworkers were also taught to administer, score, and interpret brief, standardized screening instruments for each class of child mental health problems to subsequently guide targeted, evidence-based treatment referrals. Training included role playing of screener administration to children and families. Caseworkers also practiced scoring the screeners and interpreting results during the in-person training. In addition, caseworkers engaged in role-plays to practice communicating screener results and referral decisions to families and mental health professionals. In addition, evidence-based motivational engagement strategies were modeled and practiced in training to equip caseworkers with strategies for engaging hard-to-reach families and foster parents. Finally, training also included strategies for discussing treatment progress (positive or negative) with providers for children already receiving treatment, and when indicated, communicating the need for changing treatment direction.

Several user-friendly, quick-reference tools were created to facilitate each step of the referral process and facilitate application of curriculum material in real time and in the field. These tools included question lists to guide conversations with providers, visual summaries of core EBP components for each problem area, flowcharts of the referral process from start to finish, and decision trees for monitoring progress and changing treatment direction. Caseworkers were encouraged to keep these reference tools with them in the field and to bring them to PF-C consultation calls.

Consultation. Following the training, child welfare caseworkers were paired into dyads and each dyad received 4 months of biweekly, 1-hr consultation. Supervisors attended calls when possible. The goal of consultation was to increase the likelihood that training material would generalize to caseworkers' real cases and everyday practice (Dorsey et al., 2012; Joyce & Showers, 2002; Nadeem, Olin, Hill, Hoagwood, & Horwitz, 2014). Caseworkers brought descriptions of their cases at varying stages; either while assessing need for mental health treatment or evaluating effectiveness of current mental health services. Consultation involved reviewing screening results, discussing treatment referral options for individual cases, and role-playing next steps. The reference tools introduced during training were often utilized during consultation calls. "Action

steps" were assigned in between calls and followed up on during subsequent calls (e.g., administer an additional brief screening measure, have a conversation to learn about a particular clinician's treatment approach, and make a referral informed by knowledge of child's specific need for EBP components using the reference tools). In addition, caseworkers were regularly encouraged to readminister screeners to monitor treatment progress and measure change in symptom levels over time. The consultation team consisted of two PhD-level psychologists and one licensed clinical social worker; each with more than 10 years of experience in the areas of child mental health and/or child welfare.

Intervention Participation

Of the caseworkers and supervisors in the ITT intervention condition, 12 (71%) participated in the first 6-hr training and 11 (65%) participated in the second 3-hr training. Nine caseworkers participated in both training days. Caseworkers who missed any portion of the PF-C training watched a video of the portions missed. The evaluation team followed up with caseworkers and supervisors to encourage follow through; however, we were unable to verify that workers who missed training viewed the training video. Two caseworkers (12%) left the agency soon after the training and did not participate in consultation (see Figure 1).

With regard to telephone/web consultation, on average, workers attended five and a half of eight total calls ($SD = 1.74$; calls attended range = 2–8), and received an average of 330 min of consultation. Of the 15 intervention caseworkers who participated in consultation, all attended at least two consultation calls. Supervisors attended between three and four calls each. In addition to inviting supervisors to attend regular consultation calls with their caseworkers, two, hour-long video conference calls were provided exclusively for supervisors and agency administrators during the second and fourth months of consultation. The primary goal of these calls was to support ongoing implementation and generalization of core PF-C principles and integration of quick-reference tools into existing agency infrastructure. For example, administrators discussed ways to encourage caseworker use of PF-C strategies and identified caseworkers who could serve as mentors to new caseworkers learning PF-C tools and strategies. They also discussed effective ways to structure weekly supervision in order to incorporate and model strategies.

Concurrent Community ESI Efforts

Before and during the initiation of PF-C, we had been gradually increasing availability of evidence-supported trauma interventions in Colorado, primarily through providing formal training and follow-up consultation to mental health clinicians in TF-CBT (Cohen, Mannarino, & Deblinger, 2006). TF-CBT is a highly effective intervention that targets abuse and trauma sequelae in children aged 3–17 years. The

dissemination of trauma-focused ESIs is part of our ongoing work as a National Child Traumatic Stress Network site funded by Substance Abuse and Mental Health Services Administration. When we initiated PF-C in the four Colorado counties (intervention and WLC), we offered free in-person training in TF-CBT to several local mental health providers identified by each county as CWS core service providers. Training was provided to nine mental health clinicians in the intervention counties while the project was underway and to three mental health clinicians in the WLC counties (April 2012). Six months of formal TF-CBT case consultation was provided to all of these clinicians through October 2012. Specifically, clinicians received twelve 60-min telephone calls of case consultation for TF-CBT cases on a 2-week basis in a small group format. These clinicians did not have involvement as research participants in this pilot study. The caseworkers in project areas were provided with a list of the trained providers to facilitate TF-CBT referrals.

Data Collection

Caseworkers and supervisors were assessed at two time points: (a) baseline (prior to any training in April 2012) and (b) after PF-C training and 4 months of biweekly phone consultation was completed by the intervention group in October and November 2012. Measures were self-report, completed via paper and pencil. All caseworkers who participated received a gift bag (US\$10 value) after each assessment point.

Measures

Demographics. Caseworkers reported on their sex, educational degree, years of experience, role within their agency, and prior training in EBPs.

Project Focus Questionnaire (PFQ). The PFQ was adapted from The Broker Survey (Saunders, 2008), originally developed as a part of a statewide, evidence-based practice implementation initiative with brokers of services in South Carolina (Project BEST; www.musc.edu/projectbest). This measure was not used in evaluating PF-W, but we determined it would be a useful measure for PF-C to measure caseworker beliefs and knowledge. Eleven of the original 19 items were used in this study to assess caseworkers' self-reported knowledge of EBPs, knowledge of child mental health problems, treatments for child mental health problems, and familiarity with standardized screeners to assess mental health problems. Several of the items were modified or deleted because the aims and learning objectives for caseworkers in PF-C were somewhat distinct from Project Best. For example, we wanted to have language that parallels PF-C learning (e.g., using internalizing and externalizing problems instead of more generic mental health problems), so that we could assess changes in knowledge about child mental health. Some items were removed if they were not relevant to the project. Caseworkers responded to each item on a 5-point scale (0 = *strongly*

disagree to 5 = *strongly agree*); responses were collapsed to a 3-point scale for analysis (0 = *strongly disagree*, *disagree* or *neutral*; 1 = *agree*; 2 = *strongly agree*). The 11-item PFQ has a Cronbach's α of .70 calculated using baseline responses from the current sample, although each item was analyzed as a separate outcome in this study, as each mapped onto individual goals.

Evidence-based practice knowledge inventory. Three open-ended questions assessed caseworker knowledge of EBPs for specific mental health problem areas (i.e., internalizing, externalizing, and abuse/trauma). For these 3 items, caseworkers were asked to list two ESIs (e.g., Parent-Child Interaction Therapy for externalizing problems) or EBP components (e.g., praise positive behaviors for externalizing problems) for each problem area. Scores (correct or incorrect) were tallied within each type of mental health problem and ranged from 0 to 2.

Evidence-Based Practice Questionnaire (EBPQ). The EBPQ (modified from the EBPQ reported in Dorsey et al., 2012) assessed awareness of, availability, and reported referrals to 19 specific, well-established ESIs. The questionnaire asked caseworkers to respond in three ways to each of the ESIs on the list: (a) identify ESIs that they were aware/had heard of (regardless of its availability in their community), (b) identify those available in their community, and (c) provide the number of children or adolescents on their caseload referred to each ESI in the past 4 months. Each category of responses was tallied as a separate variable for analysis (EBP awareness: Cronbach's α = .70; EBP availability: Cronbach's α = .73; EBP referrals: Cronbach's α = .67).

Vignette Questionnaire. The Vignette Questionnaire (VQ; adapted from Dorsey et al., 2012) is a vignette-based knowledge test containing two mental health assessments that mirror the format of actual assessment reports of children entering the Colorado CWS. Vignettes included the required safety/risk assessment information for these children and information about emotional and behavioral functioning most pertinent to making service decisions. Vignettes were followed by nine questions, two of which were analyzed for this study. The first question ("In an overall sense, how would you characterize [youth's] emotional and behavioral health?") included four response options: mostly internalizing-type problems, mostly externalizing-type problems, a pretty even mix of internalizing and externalizing, and I'm not sure, I'd need more information. Items were scored (0 = *incorrect*, 1 = *correct*) and summed across the two vignettes creating total scores that ranged from 0 (both *incorrect*) to 2 (both *correct*). The second question was open ended: "What characteristics of treatment would you want to see for you to feel confident that [youth] is receiving appropriate treatment for emotional and/or behavioral issues?" A coding system was developed for this item based on the Project Focus quick-reference tool detailing core EBP components for each type

Table 1. Participant Demographics for Intent-to-Train and Final Samples.

Demographic variables	Intent-to-Train Sample					Final Sample				
	PF-C (n = 16)		WLC (n = 12)		Between Group Differences	PF-C (n = 13)		WLC (n = 10)		Between-Group Differences
Sex	N	%	N	%	χ^2 (df = 1) 2.52	N	%	N	%	χ^2 (df = 1) 0.80
Male	3	18.8	0	0.0		1	7.7	0	0.0	
Female	13	81.2	12	100.0		12	92.3	10	100.0	
Role					(df = 3) 2.79					(df = 3) 3.45
Supervisor	2	12.5	2	16.67		2	15.4	2	20.0	
Caseworker	14	87.5	10	83.33		11	84.6	8	80.0	
Degree					(df = 2) 0.96					(df = 2) 4.12
Bachelors	9	56.25	9	75.0		6	46.2	9	90.0	
Masters	5	31.25	2	16.7		5	38.5	1	10.0	
Other	1	6.25	1	8.3		1	7.7	0	0.0	
Did not answer	1	6.25	0	0.0		1	7.7	0	0.0	
Previous Training in EBP					(df = 1) 3.38**					(df = 1) 5.84*
Yes	8	50.0	3	25.0		8	61.5	2	20.0	
No	5	31.25	9	75.0		3	23.1	8	80.0	
Did not answer	3	18.75	0	0.0		2	15.4	0	0.0	
Years in the field					(df = 4) 0.79					(df = 4) 0.32
< 3	2	12.5	2	16.7		2	15.4	2	20.0	
3–5	3	18.75	3	25.0		2	15.4	2	20.0	
5–10	3	18.75	1	8.3		1	7.7	1	10.0	
10–15	2	12.5	2	16.7		2	15.4	2	20.0	
>15	5	31.25	4	33.3		5	38.5	3	30.0	
Did not answer	1	6.25	0	0.0		1	7.7	0	0.0	

Note. EBPs = evidence-based practices. PF-C = Project Focus Colorado; WLC = wait-list control.

* $p < .05$; ** $p < .10$.

of mental health problem (score range of 0–3 for each child; total range of 0–6 for both children). Caseworkers responses were scored accordingly: 0 = *no response*, an incorrect response, or “I don’t know,” 1 = *reference to one name-brand EBP* or one EBP component that specifically corresponds to the child’s mental health problem, or a general defining characteristic of most EBPs, 2 = *one or more general defining characteristics of most EBPs* plus one specific name-brand EBP or EBP component corresponding to the child mental health problem, and 3 = *two or more specific name-brand EBPs* or EBP components that each correspond to the child’s mental health problem. Two PF-C faculty independently coded responses, after information identifying the caseworker, condition, and assessment time point was removed. The interrater reliability for the raters indicated substantial agreement ($\kappa = 0.80$, $p < .001$; 95% CI [0.688, 0.911]). A consensus coding process was used to determine final codes where there was disagreement. The same vignettes were used at both assessment time points.

Caseload Questionnaire. The Caseload Questionnaire (CQ) has 3 items asking caseworkers to indicate the percentage of children on their caseload receiving a screen for (a) internalizing symptoms, (b) externalizing symptoms, and (c) trauma-related symptoms.

Results

Preliminary Analyses

Preliminary analyses were conducted to determine whether there were any significant differences in key demographic factors between those participants lost to follow-up versus those retained. In addition, we examined differences in key demographic factors between PF-C and WLC for the ITT sample and the final sample. Comparison of PF-C and WLC groups on demographic factors for both the ITT and final samples can be found in Table 1. For the final sample, we also examined differences between the intervention and WLC groups in the baseline scores of our primary outcome measure (see Table 2).

Considering participants lost to follow-up compared to those retained, there was a greater proportion of men than women lost, $\chi^2(1, N = 28) = 5.46$, $p < .05$. There were no other differences at baseline in those retained compared to those lost to follow-up. Furthermore, there were no significant differences between ITT participants in the PF-C versus WLC in terms of sex, years of experience, degree, or previous training in EBPs. In addition, there were no differences in caseworker caseload between ITT participants in PF-C ($M = 10.38$, $SD = 6.40$, range: 1–19) versus WLC participants ($M = 11.89$, $SD = 10.79$, range: 6–40). For the final intervention and

Table 2. Summary of Findings for PF-C Versus Waitlist Control Groups on Project Focus Questionnaire Items.

Dependent Variable (range: 0–2)	PF-C (n = 13)		Waitlist Control (n = 10)		Baseline Differences One-way ANOVA	Repeated Measures ANOVA	Effect Size
	Baseline M (SD)	Posttest M (SD)	Baseline M (SD)	Posttest M (SD)	F	(Time × Condition) F	Partial η^2
Knowledge of EBPs							
PFQ Item 1	0.75 (.62)	1.33 (.65)	1.10 (.74)	0.90 (.57)	$F(1, 20) = 1.46$	$F(1, 20) = 4.61^*$	.19
PFQ Item 2	0.33 (.49)	0.92 (.51)	0.20 (.42)	0.10 (.32)	$F(1, 20) = 0.45$	$F(1, 20) = 8.76^*$	.31
PFQ Item 3	0.83 (.58)	1.25 (.62)	1.22 (.97)	0.89 (.33)	$F(1, 20) = 1.30$	$F(1, 19) = 3.69^{**}$	.16
PFQ Item 4	0.33 (.65)	0.83 (.72)	0.20 (.42)	0.20 (.42)	$F(1, 20) = 0.31$	$F(1, 20) = 3.03^{**}$	.13
Knowledge of primary child mental health problems							
PFQ Item 5	0.33 (.49)	0.92 (.67)	1.00 (.00)	0.60 (.52)	$F(1, 20) = 18.18^*$	$F(1, 20) = 14.42^*$	.42
PFQ Item 6	0.36 (.50)	1.00 (.63)	0.70 (.67)	0.60 (.52)	$F(1, 19) = 1.69$	$F(1, 19) = 4.01^{**}$	.17
Knowledge of screening for child mental health problems							
PFQ Item 7	0.18 (.40)	0.91 (.70)	0.10 (.32)	0.10 (.32)	$F(1, 20) = 0.78$	$F(1, 19) = 5.17^*$	.21
PFQ Item 8	0.33 (.49)	0.58 (.51)	0.40 (.52)	0.20 (.42)	$F(1, 20) = 0.10$	$F(1, 20) = 3.78^{**}$	.16
Knowledge of treatment components for child mental health problems							
PFQ Item 9	0.17 (.39)	0.67 (.65)	0.10 (.32)	0.20 (.42)	$F(1, 20) = 0.19$	$F(1, 20) = 4.48^*$	.18
PFQ Item 10	0.25 (.45)	0.92 (.51)	0.10 (.32)	0.20 (.42)	$F(1, 20) = 0.78$	$F(1, 20) = 6.29^*$	.24
PFQ Item 11	0.33 (.49)	0.83 (.72)	0.10 (.32)	0.20 (.42)	$F(1, 20) = 0.46$	$F(1, 20) = 6.66^*$	.25

Note. PF-C = Project Focus Colorado; ANOVA = analysis of variance; PFQ = Project Focus Questionnaire. PFQ Item 1 = knowledge of proven and effective treatments for Child Welfare System children and families; PFQ Item 2 = knowledge of free, user-friendly resources to learn about evidence-supported interventions; PFQ Item 3 = knowledge of what evidence-based practices are; PFQ Item 4 = understanding of how to distinguish effective from ineffective treatments; PFQ Item 5 = ability to identify common trauma-related reactions and problems in children; PFQ Item 6 = ability to describe the three different types of mental health problems in children; PFQ Item 7 = familiarity with standardized screeners for assessing mental health problems and trauma symptoms in their children; PFQ Item 8 = knowledge of how to assess the benefits of services that their clients received; PFQ Item 9 = ability to describe the key characteristics of interventions for internalizing problems; PFQ Item 10 = ability to describe the key characteristics of interventions for externalizing problems; PFQ Item 11 = ability to describe the key characteristics of interventions for posttraumatic stress and other trauma reactions. Adapted from "The Broker Survey," by B. Saunders, 2008, unpublished manuscript, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, South Carolina.

* $p < .05$; ** $p < .10$.

WLC groups, there was a difference in previous training in EBPs with the intervention group reporting more training (see Table 1). There were no differences in terms of sex, years of experience, or degree. Caseworker caseloads were not significantly different for the final intervention ($M = 10.80$, $SD = 7.04$, range: 1–19) versus WLC ($M = 8.71$, $SD = 2.83$, range: 6–12) groups.

Primary Analyses

Given that there were no statistically significant differences between the intervention and WLC final groups on key demographic variables, no covariates were included in the primary analyses. Baseline group differences along with Time × Intervention results for all items on the PFQ can be found in Table 2. Additional results from the outcome measures are described in text. There was a difference in caseworker self-reported ability to identify common trauma-related reactions in children at baseline with WLC group participants reporting greater ability than PF-C group participants. It was noteworthy that more previous training did not translate to higher baseline measure performance for the intervention group on outcome measures. One-way repeated measures analyses of variance (RM-ANOVAs) were conducted to determine whether PF-C had any effect on caseworkers' knowledge and practice indicators. The

use of RM-ANOVA takes baseline levels of each measure into account in its analysis of change over time. Therefore, despite PF-C caseworkers having more previous training in EBPs at baseline and WLC caseworkers reporting greater ability to identify trauma-related reactions in children at baseline, it was not necessary to include these variables as covariates to evaluate impact of the intervention on gains in knowledge.

Knowledge of and referrals to EBPs. PF-C had a statistically significant effect on caseworker knowledge of proven and effective treatments for CWS children and families (PFQ Item 1) and on caseworker knowledge of free, user-friendly resources to learn about ESIs (PFQ Item 2). There were marginal effects of the intervention on caseworkers' knowledge of "what EBPs are" (PFQ Item 3) and caseworker understanding of how to distinguish effective from ineffective treatments (PFQ Item 4). With regard to specific, name-brand ESIs, as measured by the EBPQ, there was no effect of the intervention on the number of ESIs that caseworkers have heard of, the number of ESIs that caseworkers report as available in their local community, or the number of reported referrals to specific name-brand ESIs (all $p = ns$).

Knowledge of primary child mental health problems. PF-C caseworkers had significantly higher self-reported ability to

identify “common trauma-related reactions and problems in children” (PFQ Item 5) and marginally better self-reported ability to describe “the three different types of mental health problems in children” (PFQ Item 6). However, no significant difference between groups emerged on caseworkers’ ability to correctly classify the primary mental health problems (e.g., externalizing, internalizing, and attention) of the children on the VQ based on a description of symptoms; rather, both groups significantly improved over time, Time $F(1, 19) = 5.20, p < .05$, partial $\eta^2 = .22$. Means for the total sample at pre- and postintervention were 1.48 (.68) and 1.74 (.54), respectively.

Knowledge of screening for child mental health problems. There was a significant effect of PF-C on caseworkers’ familiarity with “standardized screeners for assessing mental health problems and trauma symptoms in children” (PFQ Item 7), and marginal effect on caseworkers’ self-reported knowledge of how to assess the benefits of services that their clients received (PFQ Item 8). With regard to use of screening instruments in practice, as measured by the CQ, there was a statistically significant effect on percentage of cases for which caseworkers reported screening for internalizing problems (Time 2 Intervention $M = 44.33, SD = 34.88$; Time 2 WLC $M = 14.75; SD = 34.88$; Time \times Condition $F(1, 15) = 6.04, p < .05$, partial $\eta^2 = .29$). No statistically significant differences were found for screening of externalizing behavior problems or trauma-related symptoms. Of note, although not significant, caseworkers in the PF-C group almost tripled the percentage of cases they reported screening for trauma-related symptoms (14% of cases at baseline; 41% at postassessment), whereas caseworkers in the WLC group did not increase (13% of cases at baseline; 11% at postassessment).

Knowledge of treatment components for child mental health problems. Caseworkers in the PF-C group had significantly higher self-reported ability to “describe the key characteristics of interventions for “internalizing problems” (PFQ Item 9), “externalizing problems” (PFQ Item 10), and for “posttraumatic stress and other trauma reactions” (PFQ Item 11). No significant group differences emerged on caseworkers’ ability to name two ESIs or core EBP treatment components for internalizing and externalizing problems, as measured by the Evidence-Based Practice Knowledge Inventory. Both the PF-C and WLC groups improved significantly over time in their ability to name two EBPs or core treatment components for all three problem areas from baseline to postassessment, externalizing: Time $F(1, 21) = 7.51, p < .05$, partial $\eta^2 = .26$; internalizing: $F(1, 21) = 6.49, p < .05$, partial $\eta^2 = .24$; trauma-related problems, Time $F(1, 21) = 11.28, p < .05$, partial $\eta^2 = .35$. Means for the total sample at pre- and postintervention were 0.43 (.66) and 1.00 (.85), respectively, for externalizing; 0.39 (.72) and 0.91 (.79), respectively, for internalizing; and 0.26 (.62) and 1.04 (.88), respectively, for trauma-related problems. Results from the VQ indicated there was no statistically significant effect on caseworkers’ ability to correctly identify the characteristics of treatment that they

would look for to treat the specific mental health problems of the children in the vignettes.

Dose of consultation. Given the small sample size, analyses examining dose are considered exploratory. The impact of dose of consultation, as measured by number of consultation calls attended (denoted by subscript a) and hours of in-person training attended (range 3–9; denoted by subscript b), on postassessment scores for the intervention group (denoted by subscript c) were examined using partial correlations controlling for baseline scores (denoted by subscript d). Dose was significantly related to caseworker ability to correctly classify the specific mental health problems of the children described in our vignettes. Specifically, the number of consultation calls that caseworkers attended was associated to correct classification, $r_{ac.d} = .66, p < .05$. Hours of in-person training was significantly related to caseworker ability to describe the characteristics of treatment that they would like to see to feel confident that the children described in our vignettes are getting appropriate and viable treatment for their mental health problems ($r_{bc.d} = .65, p < .05$). Hours of in-person training was also significantly related to caseworker ability to name two EBPs or core EBP components for internalizing problems, $r_{bc.d} = .63, p < .05$, for externalizing problems, $r_{bc.d} = .59, p < .05$, and for children who have been abused or traumatized, $r_{bc.d} = .74, p < .01$.

Discussion

Based on this small, quasi-experimental pilot study, PF-C shows promise for improving caseworker ability to serve as effective brokers of EBPs for CWS-involved children. Results indicate that receipt of PF-C was associated with significantly increased caseworker knowledge of EBPs, child mental health problems, matching of EBPs to mental health problem areas, and mental health screening instruments, compared to WLC. Dose of training and consultation was associated with greater ability to correctly classify mental health problems and match them to EBPs.

Most of the impact of the intervention appeared on self-report measures, not on practice behaviors. Additionally, it is important to note that dosage of the intervention, particularly phone consultation, did seem to matter for knowledge uptake. PF-C consultation may have been particularly helpful because practitioners value consultation approaches that are characterized by brief and direct communication, and consultants who serve as motivators and provide practical guidance in structuring, giving direction, and troubleshooting challenges (Hunter et al., 2009). This training and consultation approach is simple and with further development has potential for strong value to service providers and others who are hoping to advance the use of EBPs in resource-strapped environments. Empowering service brokers to match children in need of mental health interventions with effective treatments is critical for elevating mental health priorities in child welfare and clearly relate to safety and permanency.

Knowledge of Evidence-Based Practices (EBPs) and Referral Practices

Consistent with hypotheses, caseworkers in the PF-C group reported significantly greater knowledge of EBPs and awareness of free, user-friendly resources for learning more about specific ESIs (e.g., California Evidence-Based Clearinghouse), compared to caseworkers in the WLC group. However, PF-C caseworkers did not report increased awareness or availability of, or referrals to, name-brand ESIs in their community compared to WLC caseworkers. Because PF-C was introduced into communities with limited availability of name-brand ESIs, we emphasized EBPs over name-brand ESIs. This choice of emphasis was driven by our goal to improve CWS youth access to the best available services by training caseworkers to more effectively identify best-practice child mental health services in their local communities. Therefore, it is not surprising that knowledge of and referrals to specific ESIs were not affected by the intervention. The significant results and moderate effect sizes that emerged for caseworker knowledge of “proven and effective treatments” or EBPs suggest that caseworkers responded to training and consultation in these content areas. It is hoped that such knowledge gains would contribute to greater awareness of “what works” and create demand for effective treatments in communities. As the number of name-brand ESIs increases in Colorado, we would expect to see a corresponding increase in caseworker referrals to such specific programs.

Knowledge of Primary Child Mental Health Problems

As expected, PF-C caseworkers reported significantly greater improvement in their ability to identify common trauma-related problems in children, relative to caseworkers in the WLC condition. This finding is consistent with curriculum expansions that incorporated more trauma-focused knowledge building and is extremely relevant, given the high rates of trauma exposure and trauma symptoms in CWS youth contrary to expectations, caseworkers in both conditions improved significantly in their ability to correctly classify the mental health problems of two children described in our vignettes, perhaps because there has been increasing recognition of child mental health problems within the Colorado CWS.

Knowledge of Screening for Child Mental Health Problems

There was a significant effect of the intervention on increasing caseworker screening for internalizing problems and caseworker familiarity with standardized screeners for assessing mental health problems and posttraumatic stress in children, relative to WLC. These findings were expected, given that a considerable portion of time was spent teaching caseworkers to administer, score, and interpret standardized screeners for internalizing, externalizing, attention, and trauma-related problems. In addition, although not significant, caseworkers in the intervention

group nearly tripled the percentage of cases for which they screen for trauma-related problems, whereas there was no change in this regard for the WLC group. This trend demonstrates a promising change in caseworker practice, suggesting increased awareness of the impact of childhood trauma.

Knowledge of Treatment Components for Child Mental Health Problems

Contrary to expectation, no significant group differences emerged with regard to naming EBP components for externalizing, internalizing, or trauma-related problems. Caseworkers self-selected cases to present during consultation calls, and it was interesting that the majority of these cases involved children with severe externalizing problems, which often have a high risk for out-of-home placement and placement disruption. Therefore, caseworkers typically received a higher dose of practice and consultation around applying PF-C principles to externalizing cases, relative to internalizing or trauma cases. Unfortunately, there was only a marginal not significant effect of the intervention on caseworker ability to name EBP components for such problems.

While group differences did not emerge, there was significant improvement in both groups in caseworker ability to name core EBP components for child mental health problem areas. The 1-hr brief overview of EBPs offered to the WLC group may have, in part, contributed to their improvement in this area. In addition, there have been several recent, state-wide, trauma-informed, system-of-care initiatives in Colorado aimed at improving family well-being and child mental health by emphasizing use of EBPs and increasing the use of trauma-informed assessment and treatment. It is plausible that in light of these initiatives, WLC caseworkers became more knowledgeable about the specific mental health needs of CWS youth and corresponding EBPs during the evaluation period.

Dose of Training and Consultation

While contrary to prediction significant group differences did not emerge for most of our practice change indicators (e.g., identification of child mental health problems using case information, ability to match symptoms to needed characteristics of treatment, and self-reported screening practices), exploratory analyses with the PF-C group indicated that dose of the intervention impacted caseworker practice change indicators (e.g., ability to apply PF-C concepts when thinking about specific cases). These findings are consistent with implementation research findings examining training dose and levels of support following training and their relationship to EBP implementation outcomes (Dorsey et al., 2012; Nadeem et al., 2014; Sholomskas et al., 2005). We had a relatively wide range of participation (6 hr of training and two calls to 9 hr of training and eight calls), and it is plausible that the higher dose was needed for gains in knowledge to translate into ability to apply knowledge to cases. A larger sample of participants completing

Project Focus at the highest dose may have been necessary to detect group differences at the end of the evaluation period.

Limitations and Future Directions

The small sample size likely limited our ability to identify statistically significant differences between the two conditions (PF-C vs. WLC). Also, despite our capacity-building efforts and emphasis on EBP treatment components over name-brand ESIs, limited availability of specific EBPs in the communities we served likely reduced the potential positive impact of PF-C. A larger, more representative sample is needed to fully test the potential benefits and limitations of this model, with expanded measurement of knowledge of EBP components versus name-brand ESIs. In addition, because county offices were not randomized to condition, it is possible that differences across condition could be attributed to regional, county, or office differences.

Following training, PF-C uses a consultation approach to support knowledge and skill acquisition and implementation of concepts by caseworkers in the real world. This was deemed important, given research showing that consultation leads to significant improvements in EBP implementation as compared to manuals and/or one-day training workshops. It would be worthwhile to study methods to enhance sustainability of PF-C activities after the consultation component ends. For example, expanding the in-person training and use of video consultation with more behavioral rehearsal opportunities may strengthen caseworkers' knowledge and skills in the field and enhance the impact of the intervention (Beidas, Cross, & Dorsey, 2014). It is possible that PF-C outcomes would also be enhanced by more continuous interaction with caseworkers and their supervisors with timely feedback on applying knowledge and skills to cases (Nadeem et al., 2013). Future work is needed to identify effective consultation strategies, dosage, and mechanisms through which consultation and targeted ongoing support may impact implementation outcomes (Beidas & Kendall, 2010). Emerging approaches, such as Interactive Systems Framework (Wandersman, Chien, & Katz, 2012), can guide future work in identifying necessary evidence-based components (e.g., tools, training, technical assistance, and quality assurance) of support. Our field is moving toward trying to test different consultation and training strategies to better understand the core functions and processes (Nadeem et al., 2013). Finally, web-based courses may also help to build a foundation of PF-C concepts prior to in-person training. An interactive, web-based Project Focus training course has been developed by these authors and is currently being piloted, with a more intensive version is being developed for the national ACYF-funded project.

Similar to findings from PF-W (see Dorsey et al., 2012), PF-C demonstrated increases in caseworker knowledge, awareness, and self-reported ability with more limited evidence of actual practice change. This may have resulted in part because practice change outcomes are more difficult and take longer to achieve than increased knowledge gains (Sholomskas et al.,

2005). Also, the vignettes used in our evaluation may not have captured caseworker ability to apply PF-C principles, because caseworkers did not have use of their tools or team discussion during the evaluation. Whether or how increased knowledge translates into actual change in referral and screening practice is still largely unknown and warrants further study. Steps were taken during implementation of PF-C to pilot the feasibility of collecting behavioral change data on each conference call, which may be useful for better understanding how training and consultation can promote practice changes during future evaluations of PF-C. Tracking caseworker referral patterns using the existing agency and state database systems could also reveal changes in the types of and services families were engaged in as a result of agency involvement in PF-C. In addition, ongoing PF-C efforts include collection of child outcome data that will offer important information about the impact of broker EBP service matching on child well-being.

In sum, broker training and consultation models such as PF-C are promising for improving and sustaining EBP implementation efforts. Most EBP implementation efforts solely focus on training direct mental health service providers and do not include brokers who play a powerful role in facilitating or impeding referral and access to EBPs. To our knowledge, Project Best (www.musc.edu/projectbest) is the only other implementation effort that thoughtfully includes brokers in cross training of EBPs with mental health professionals. Fostering communication and networking among professionals serving CWS youth is critical to ensure that youth receive the highest quality services targeted to their needs. PF-C demonstrated that this model could be useful outside of Washington State, where it was created, and in communities with limited availability of name-brand EBPs, and holds promise to improve caseworkers' knowledge and self-reported ability to serve as effective brokers of mental health services for CWS-involved youth and families.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: We had two partial funding sources. **Federal funding source:** Substance Abuse and Mental Health Services Administration (Mental Health Award 2581915). **State funding source:** Colorado Department of Human Services.

References

- Beaglehole, R., Irwin, A., & Prentice, T. (2003). *World health report 2003: Shaping the future*. Retrieved from World Health Organization website: http://www.who.int/whr/2003/en/whr03_en.pdf
- Beidas, R. S., Cross, W., & Dorsey, S. (2014). Show me, don't tell me: Behavioral rehearsal as a training and analogue fidelity tool. *Cognitive and Behavioral Practice, 21*, 1–11.

- Beidas, R. S., & Kendall, P. C. (2010). Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology: Science and Practice, 17*, 1–30.
- Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M., & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs, 14*, 147–159.
- Burns, B. J., Phillips, S. D., Wagner, R. H., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Child and Adolescent Psychiatry, 43*, 960–970.
- Casanueva, C., Stambaugh, L., Tueller, S., Dolan, M., & Smith, K. (2012). *NSCAW II wave 2 report: Children's services*. OPRE Report #2012-59, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.
- Chaffin, M., & Friedrich, B. (2004). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review, 26*, 1097–1113.
- Chorpita, B. F., Becker, K. D., Daleiden, E. L., & Hamilton, J. D. (2007). Understanding the common elements of evidence-based practice: Misconceptions and clinical examples. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*, 647–652.
- Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Modularity in the design and application of therapeutic interventions. *Applied and Preventative Psychology, 11*, 141–156.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York, NY: Guilford Press.
- Colorado Department of Human Services Division of Child Welfare Services. (2012). *2012 data book*. Retrieved from <http://www.colorado.gov/cs/Satellite/CDHS-ChildYouthFam/CBON/1251586911723>
- Dorsey, S., Farmer, E. M. Z., Thompson, E., & Larrieu. (2007). Therapeutic foster care: A viable option for treating youth in families and in the community. *The Judge' Page Newsletter*. Retrieved from http://www.casaforchildren.org/atf/cf/%7B9928CF18-EDE9-4AEB-9B1B-3FAA416A6C7B%7D/0708_the_role_of_foster_parents_in_the_dependency_court_issue_0119.pdf
- Dorsey, S., Kerns, S. E., Trupin, E. W., Conover, K. L., & Berliner, L. (2012). Child welfare caseworkers as service brokers for youth in foster care findings from Project Focus. *Child Maltreatment, 17*, 22–31.
- Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531–540.
- Foa, E. B., Johnson, K., Feeny, N. C., & Treadwell, K. R. T. (2001). The Child PTSD Symptom Scale (CPSS): Preliminary psychometrics of a measure for children with PTSD. *Journal of Clinical Child Psychology, 30*, 376–384.
- Gardner, W., Lucas, A., Kolko, D., & Campo, J. (2007). Comparison of the PSC-17 and alternative mental health screens in an at-risk primary care sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*, 611–618.
- Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *The Lancet, 373*, 68–81.
- Glisson, C., & Schoenwald, S. K. (2005). The ARC Organizational and community intervention strategy for implementing evidence-based children's mental health treatments. *Mental Health Services Research, 7*, 243–259.
- Grayson, J., Childress, A., Grayson, P., & Hatchett, K. (2012). Evidence-based treatments for childhood trauma. *Virginia child protection newsletter*. Retrieved from <http://psychweb.cisat.jmu.edu/graysojh/pdfs/Volume95.pdf>
- Griffin, E., McClelland, G., Holzberg, M., Stolbach, B., Maj, N., & Kisiel, C. (2011). Addressing the impact of trauma before diagnosing mental illness in child welfare. *Child Welfare, 90*, 69–89.
- Hunter, S. B., Chinman, M., Ebener, P., Imm, P., Wandersman, A., & Ryan, G. W. (2009). Technical assistance as a prevention capacity-building tool: A demonstration using the getting to outcomes® framework. *Health Education & Behavior, 36*, 810–828.
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Retrieved from <http://www.iom.edu/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf>
- James, S., Landsverk, J., & Slymen, D. J. (2004). Placement movement in out-of-home care: Patterns and predictors. *Children and Youth Services Review, 26*, 185–206.
- Joyce, B., & Showers, B. (2002). *Student achievement through staff development*. Alexandria, VA: Association for Supervision and Curriculum Development.
- Kazdin, A. E., & Weisz, J. R. (2003). Introduction: Context and background of evidence-based psychotherapies for children and adolescents. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 3–20). New York, NY: The Guilford Press.
- Kerker, B. D., & Dore, M. M. (2006). Mental health needs and treatment of foster youth: Barriers and opportunities. *American Journal of Orthopsychiatry, 76*, 138–147.
- Kerns, S. E. U., Dorsey, S., Trupin, E. W., & Berliner, L. (2010). Project focus: Promoting emotional health and wellbeing for youth in foster care through connections to evidence-based practices. *Report on Emotional and Behavioral Disorders in Youth, 10*, 30–38.
- Kolko, D. J., Iselin, A. M. R., & Gully, K. J. (2011). Evaluation of the sustainability and clinical outcome of alternatives for families: A Cognitive-Behavioral Therapy (AF-CBT) in a child protection center. *Child Abuse & Neglect, 35*, 105–116.
- Landsverk, J. A., Burns, B. J., Stambaugh, L. F., & Rolls Reutz, J. A. (2009). Psychosocial interventions for children and adolescents in foster care: Review of research literature. *Child Welfare, 88*, 49–69.
- Landsverk, J., Davis, I., Ganger, W., Newton, R., & Johnson, I. (1996). Impact of child psychosocial functioning on reunification from out-of-home placement. *Children and Youth Services Review, 18*, 447–462.
- Landsverk, J., Garland, A., Rolls Reutz, J., & Davis, I. (2011). Bridging science and practice in child welfare and children's

- mental health service systems through a two-decade research center trajectory. *Journal of Social Work, 11*, 80.
- Leslie, L. K., Hurlburt, M. S., James, S., Landsverk, J., Slymen, D. J., & Zhang, J. (2005). Relationship between entry into child welfare and mental health service use. *Psychiatric Services, 56*, 981–987.
- Nadeem, E., Gleacher, A., & Beidas, R. S. (2013). Consultation as an implementation strategy for evidence-based practices across multiple contexts: Unpacking the black box. *Administration on Policy and Mental Health, 40*, 439–450.
- Nadeem, E., Olin, S. S., Hill, L. C., Hoagwood, K. E., & Horwitz, S. M. (2014). A literature review of learning collaboratives in mental health care: Used but untested. *Psychiatric Services, 65*, 1088–1099.
- Saunders, B. (2008). *The Broker Survey*. Unpublished manuscript, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston.
- Sholomskas, D. E., Syracuse-Siewert, G., Rounsaville, B. J., Ball, S. A., Nuro, K. F., & Carroll, K. M. (2005). We don't train in vain: A dissemination trial of three strategies of training clinicians in cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology, 73*, 106–115.
- Stiffman, A. R., Horwitz, S. M., Hoagwood, K., Compton, W., Cottler, L., & Bean, D. L., . . . Weisz, J. R. (2000). The Service Assessment for Children and Adolescents (SACA): Adult and child reports. *American Academy of Child and Adolescent Psychiatry, 39*, 1032–1039.
- Stiffman, A. R., Pescosolido, B., & Cabassa, L. J. (2004). Building a model to understand youth service access: The gateway provider model. *Mental Health Services Research, 6*, 189–198.
- U.S. Census Bureau. (2013). *State and county quickfacts from the United States census bureau*. Retrieved from <http://quickfacts.census.gov/qfd/index.html#>
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). *Child Maltreatment 2011*. Retrieved from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Child Maltreatment 2012*. Retrieved from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.
- Wandersman, A., Chien, V. H., & Katz, J. (2012). Toward an evidence-based system for innovation support for implementing innovations with quality: Tools, training, technical assistance, and quality assurance/quality improvement. *American Journal of Community Psychology, 50*, 445–459.
- Weisz, J. R., & Kazdin, A. E. (2010). *Evidence-based psychotherapies for children and adolescents*. New York, NY: The Guilford Press.