

Practical Guide for EBP Implementation in Public Mental Health

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Practical Guide Goals

The goals of this guide are to provide:

- A background on EBP implementation and sustainment within the context of public mental health.
- Practical strategies for addressing common challenges to EBP implementation and sustainment.
- A foundation for continuing to build knowledge and develop additional approaches for expanding EBP availability within public mental health in Washington State and beyond.

We start by providing a background on EBP, including definition, characteristics, and research on EBP. We think this background will help organizations make the case for what they are doing, and explain what they are doing to others, as well as place the practical recommendations within a context.

Background

Evidence-based practice (EBP) can be thought of as both a general approach and as a descriptor of a specific program. EBP, as an approach, means embracing evidence-based principles and practices as the standard of care. EBPs or evidence-based programs are those that have been tested in scientific studies and shown to have outcomes that are overall more favorable than alternatives to which they have been compared such as waitlists, usual care or non-specific interventions, or the program is as effective as another EBP for the same outcome. There are many different classification schemes for assigning the level of “evidence” that a program has achieved. Of particular relevance to public mental health practice is the California Evidence-Based Clearinghouse for Child Welfare (<http://www.cebc4cw.org>) and the Washington State Institute for Public Policy Inventory of programs for children in public mental health (<http://www.wsipp.wa.gov/pub.asp?docid=E2SHB2536>).

The characteristics of the EBP general approach starts with a genuine belief that the scientific method can show that some programs work better overall than others and that clients are best served when they have access to the most effective programs. There is recognition that a shift to EBP means that providers will have to make some changes in how they have traditionally practiced. EBP is not seen as fad or as an unachievable goal for public entities even though there are many practical challenges to full implementation. Organizations that take on EBP principles recognize that EBP adoption is more than training providers in specific EBPs; in addition to training, EBP adoption involves making changes in how clinical practice is conceptualized and carried out and entails a commitment to installing organizational procedures that reinforce the principles of EBP and support sustainment of specific EBPs.

There is a science of “dissemination and implementation” that specifically focuses on how organizations can adopt EBPs and how providers can best learn, practice, and sustain EBPs over time. This science applies in many contexts including medicine, education, and criminal justice as well as mental health. There are numerous models that describe the levels and stages that are typically involved (Aarons, Hulburt, & Horowitz, 2011; Damschroeder et al., 2009; Fixen, Naaom, Blase, Friedman, & Wallace, 2005; Palinkas & Soyden, 2012; Proctor, 2012). Some dissemination and implementation scientists have specifically focused on public mental health and child welfare (Aarons et al., 2011; Glisson et al., 2008).

All models address at least two basic stages. The first stage is deciding to adopt one or more EBPs and the initial installation of the EBP within the organization. The second stage is keeping the EBP(s) going within the organization after the initial training and provider competence has occurred. Aarons et al. (2011) describe four stages: Exploration, Preparation, Implementation,

and Sustainment (EPIS). The first three EPIS elements focus on getting EBP going within an organization and the last stage focuses on *keeping* it going (i.e., sustainment). This is often a challenging stage, and we know the least about sustainment from research studies (see Wiltsey Stirman et al., 2012). A number of factors have been identified across studies that are associated with organizational change and provider uptake of the skills that are necessary for adoption and sustainment of EBP.

The **Washington State CBT+ Initiative** forms the basis for this Guide. The state mental health division (Division of Behavioral Health and Recovery) has invested in training in CBT, consultation and sustainment since 2009. CBT+ is the name used to describe an approach to teaching providers four models that cover the presenting diagnoses and clinical problems of about 80% of all children served in public mental health systems (Burley, 2009). Providers are taught CBT for anxiety, CBT for depression, Trauma-Focused CBT for the impact of trauma including Posttraumatic Stress or Posttraumatic Stress Disorder (PTS/PTSD), and Parent Management Training for behavior problems (PMT; also known as Behavioral Parent Training). All of these models appear on EBP lists (e.g., <http://www.cebc4cw.org>) and on the WSIPP Inventory (Evidence Based Practice Institute & Washington State Institute for Public Policy, 2012).

The Guide recognizes that there are various specific EBP models for these clinical targets- behavior problems, anxiety, depression, PTS and as well EBP for other targets (e.g., infant mental health, juvenile delinquency, substance abuse). Many of them are “brand name” EBPs, meaning those with a specific title and associated manual (e.g., Trauma-Focused CBT, Coping Cat, Positive Parenting Program, Parent-Child Interaction Therapy, Incredible Years, Multidimensional Treatment Foster Care, Functional Family Therapy). Brand name programs often have implementation infrastructures that provide training and varying degrees of expert consultation, ongoing supervision and quality assurance (QA). It is a benefit when organizational resources or external funding are available to support the full package of implementation and QA services for non- or brand name EBPs. Many brand name EBP companies have developed comprehensive, sophisticated implementation support services and a cadre of expert consultants.

However, a characteristic of most EBPs is that they target a specific clinical condition, problem area, or diagnosis and are evidence-based only for that specific condition. Public mental health organizations serve clients who present with the full array of mental health conditions and disorders; many clients have significant co-morbidity. This means that even when organizations select one or more brand name EBPs for a particular outcome or subgroup of clients, they still need to address the larger organizational context and find ways to install mechanisms to support EBPs for clients served throughout the organization.

This Guide is developed for public mental health organizations that have made the decision to adopt at least one EBP and have invested in training staff. The organizations are interested in making the necessary organizational changes so that the initial investment in EBP training pays off in terms of actual delivery of the EBP and positive client outcomes. According to dissemination and implementation science, the training of providers is only the beginning—the hard work, and the important aspects of increasing provider adoption, come after the training (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010). Many organizations have had the experience of discovering that they invested considerable time and financial resources into training with limited perceived benefit. Research shows that training is necessary and the first step, but not sufficient, for provider adoption and organizational sustainment (Beidas & Kendall, 2010, Herschell et al., 2010). Training alone is not enough, but yet that is where most resources and time are often spent. The research suggests that investing in training, without an investment in necessary post-training supports, is probably not worthwhile.

The Guide intends to assist organizations that are prepared to institutionalize processes to support sustainment by providing practical and feasible strategies. The emphasis is on situations where the organizations are mostly restricted to accomplishing EBP sustainment within existing resources. The Guide is also designed to be helpful for organizations that have both non- and brand name EBPs. Brand name companies may set the specific elements of training, supervision, and QA but the providers are typically situated within an overall organizational context.

The practical suggestions contained in this Guide are primarily based on the experiences and recommendations of public mental health centers in Washington State, all of whom have participated in the CBT+ Initiative and many of which also have also adopted other brand name EBPs within their organizations (e.g., Cognitive Processing Therapy, Parent-Child Interaction Therapy, Triple P Parenting Program).

Public Mental Health Context Considerations

Public mental health organizations often have a mission that encompasses far more than delivering discrete mental health interventions to children and families. Installation and sustainment of EBPs is occurring in a context in which specific mental health interventions are typically one of many services being provided to children and families. Successful adoption of EBPs and their sustainment must take into account the larger organizational context.

Public mental health refers to mental health services that are paid for by Medicaid. A majority of children receiving specialty mental health care in the US have Medicaid as the insurance. The Affordable Health Care Act that goes into effect in 2014 will expand Medicaid eligibility in most states. Typically, public mental health services are available through community-based organizations that have contracts with the state government or where the providers are state employees (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Mental-Health-Services-.html>).

The good news is that Medicaid is a comprehensive mental health insurance that is often generous by comparison to what is covered by many commercial insurance packages. It usually covers a broad array of services beyond the limited number of outpatient sessions or inpatient days that is typical for commercial insurance. For example, it can cover ancillary activities such as case management. It is common for public mental health organizations to be required or expected to provide case management, case aides, emergency crisis services, medication management, day treatment, and hospitalization. Intensive team-based approaches are common for youth with the most severe problems (e.g., Wrap Around, Systems of Care). Services are often delivered in multiple settings including clinics, home, school, juvenile justice, and the community.

In addition, many organizations have a plethora of other programs that may be available to clients to supplement mental health services. These programs may include prevention services, early interventions, educational support and tutoring, peer outreach, mentoring, skills classes, after school home work and recreational programs, etc. Organizations often also have specialized programs for specific populations that are supported by United Way, private fund raising, local, state or federal grants.

Public mental health organizations frequently encompass substance abuse services as well, although the funding streams and program structures may be separate. These services similarly include a broad array of types and intensity of services including outpatient individual or group therapy of various kinds, day programs, inpatient or residential services, hosting AA/NA type

services, urinalysis or other biological monitoring. The degree of coordination with the mental health services varies.

Each organization must consider how to install specific EBPs within their own organizational context and culture. Public mental health organizations vary in size and comprehensiveness of service array. Some organizations are large and have multiple offices and settings where they deliver services. In some cases organizations serve only children, but many serve both adults and children. For those organizations that serve adults, child services typically have fewer staff and are smaller than the adult programs. The opportunities and challenges will be different depending on the organizational context and size.

I. Organizational Climate and Leadership

The importance of organizational climate and leadership is identified by many dissemination and implementation researchers, a number of whom have addressed the issues specifically in the context of public mental health or child welfare (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009; Glisson et al., 2011; Kolko et al., 2012; Palinkas et al., 2009). A great deal of research has documented that characteristics of organizations are very influential in attitudes that providers have toward EBPs and the success of EBP implementation efforts, including the clinical outcomes for clients. Leadership from top administrators as well as mid-level managers, such as clinical supervisors, has been shown to make a big difference (Aarons & Sommerfeld, 2012).

It is important to note that adoption of EBP in an organization can actually be beneficial to the organization and the organizational climate. Aarons et al. (2009a; 2009b) found decreased staff burnout and decreased staff turnover associated with the implementation of EBP in a child welfare services context *when providers received ongoing coaching and support* in delivering the intervention (but not when providers were trained in the EBP and did not receive coaching and support).

Challenges

While the evidence shows that bringing EBP into an organization, with support, can actually lead to higher staff satisfaction and lower burnout, how the implementation is accomplished and the nature of the organizational climate is critical. Where implementation goes awry is when it is seen as yet another management band wagon or fad that is being imposed on providers with additional work load and no clear benefit. When administrators and supervisors are perceived as simply carrying out an externally imposed requirement (without buy-in or interest), buy-in at the provider level will be low. New initiatives and program imperatives are common in public human service systems. It can seem that there is an unending flow of directives mandating a new program, new way of doing business, new standards or new requirements. It is not so surprising in this context that adoption of EBP is seen as yet another initiative that will eventually go by the wayside.

A key challenge for senior leadership in organizations is to call out EBP as a change that is critical to improved client outcomes and one that will be enduring even if it takes different forms over time. It is essential that senior leadership and clinical supervisors **provide an explanation of why such a move is beneficial to clients.** In addition, the organizations must

ensure that providers have the necessary supports for learning new skills and delivering EBPs with fidelity in the context of the complex public mental health environment.

Practical Strategies

1. Senior Leaders such as the CEO, division directors, program managers and other organizational leaders make a specific decision to prefer or emphasize use of EBPs. When new opportunities or mandates arise, an EBP approach or specific EBPs are discussed. All programming is evaluated through the lens of EBP principles (evidence, measurement of change over time, outcomes).
2. Senior leaders emphasize that the reason WHY EBPs are being adopted is because they produce better outcomes overall for clients. This rationale will resonate most for providers, versus legislation or other imperatives, because helping clients is the primary professional motivation for mental health professionals.
3. Senior leaders and managers seek out opportunities to bring EBPs into the organization and speak positively about them. When EBPs are discussed there is open support expressed for the EBP approach as well as for individual EBPs. A proactive problem solving approach is modeled for how to fit EBPs into organizational practice.
4. The EBP approach and availability of EBPs in the services array is prominently mentioned in organization promotional materials, publicity efforts, fundraising activities and other community oriented initiatives.
5. Senior leaders use EBP outcomes data in annual reports, in advertizing organization services and within the organization to show the benefit to staff.
6. EBP outcomes data are used to advocate for funding, enhanced reimbursement, expansion, adding new EBPs.
7. Availability of EBPs for all eligible clients is identified as an important organization goal. It is not considered acceptable for only some eligible clients to have access to EBPs when there are trained providers within the organization.
8. Organizational leadership cultivates, encourages and supports clinical supervisors to acquire EBP supervision expertise; they become the “champions” for EBPs with clinical staff.

9. Hiring practices and announcements for staff positions—both management and clinical—specifically mention a preference or requirement for knowledge/experience in EBPs and active support for EBPs.
 - a. During interviews
 - i. Specifically ask about EBP training, certifications, experience.
 - ii. Specifically convey that EBP orientation is required and includes acceptance of ongoing feedback and coaching, openness to learning and doing new interventions.
 - b. Getting Staff Up to Speed
 - i. Require providers to read selected EBP books and manuals; take online learning courses (e.g., TF-CBT*web*).
 - ii. Begin orientation and coaching to EBP principles and practices immediately.
10. When possible, senior leaders make some direct contact with providers who are starting the EBP process (attending a training) or in the process (recently returned/just started CBT Consultation groups) to show attention to, and support of their involvement in EBP activities. Often, we wait until people are failing/not meeting expectations. Give some attention early.
 - a. This can be an email, brief meeting, or a mention in an all staff meeting
 - b. A quick email during the training/consultation process inquiring how it is going
 - c. Brief meeting or email to providers after key stages are met (finished training, completed consultation)
 - d. Senior leader “pops in” for part of in-house EBP supervision or consultation (for example, comes to a portion of a CBT+ consultation call)
 - e. Shows the senior leader is paying attention and has interest in what providers are doing at the individual level
11. Senior leaders and management provides support for EBP by ensuring that necessary resources are available to deliver EBPs within organizational capacity (e.g., purchase books and materials, identify online resources, set up a spot on the organization server to store electronic resources, therapy room set ups, etc.).
12. Senior leaders and supervisors find ways to recognize staff that is doing a good job with EBP. Recognition can take a variety of forms:
 - a. Staff acknowledgement: call-out in a meeting; feature a successful completion of a case; ask a provider who attended EBP training to present at a staff meeting.

- b. Frame the Certificates of Participation, Completion or Certification so that providers can prominently post in their offices.
 - c. Make sure that training programs provide CEUs.
 - d. Recognition in an organization newsletter or monthly email update.
 - e. Tangible rewards: Bonuses; small gift cards (even \$5 goes a long way); a notecard or email from an administrator; small, purchased reward; relief from an onerous activity.
 - f. Encourage public Rostering if available on local or national sites.
 - g. Criteria for promotion from within explicitly emphasizes commitment to and proficiency with EBP.
13. Proactively connect up with other organizations that are installing EBPs to “steal shamelessly and share relentlessly” (e.g., sharing materials like EBP progress notes or clinical materials, splitting a trainer/consultant cost across agencies, cross-site EBP discussions/calls, senior leader networking across agencies to develop a larger voice about EBPs) .

II. EBP Training

Providers and supervisors have to learn EBPs in order to deliver them. Research has clearly established that traditional training alone does not lead to change in practice or delivery of the EBPs in practice (Beidas & Kendall, 2010; Herschell et al., 2010; Wiltsley Stirman et al., 2012). The optimal training is skill-based (not just lecture on theory) and of sufficient dosage for providers and supervisors to learn and practice the new skills, as well as become familiar with the basic underlying theory and content. But the key is moving beyond initial training so that providers have an opportunity to deliver the model with actual clients while receiving expert consultation (on the job coaching). Training without follow-up case consultation and support does not result in practice changes.

The Learning Collaborative (LC) model as originally developed by the Institute for Healthcare Improvement IHI (<http://www.ihl.org/Pages/default.aspx>) has taken hold as an EBP training approach. For example, the National Child Traumatic Stress Network (<http://www.nctsn.org>) has created an LC model for EBPs that are widely used with children affected by trauma and abuse. An LC consists of several components including organizational consultation or preparation for implementation, basic learning sessions followed by an action period during which providers and supervisors do the EBP with clients while receiving expert case consultation, and subsequent learning or booster sessions.

Another more extensive but potentially more powerful approach to a LC is directed to a community, not just a single organization or a group of providers. This model incorporates learning sessions and consultation activities for the other organizations, institutions and professionals that comprise the systems of care (e.g., child welfare, CASA, juvenile court). Project Best is an example of such an approach with TF-CBT in South Carolina and other parts of the country (<http://academicdepartments.musc.edu/projectbest/partners/partners.htm>).

The other key goal of EBP training is establishing initial provider competence following the training. Studies of EBP initial trainings show that they result in changes in provider knowledge, attitudes and self-reported comfort with using EBP strategies. But this does not ensure that providers have actually acquired the skills needed to provide the EBP without supervision or coaching following training.

Methods of evaluating providers' skill acquisition include direct observation of delivery of the model with clients and structured behavioral rehearsal (role plays), observed by a trained supervisor. In behavioral rehearsal, the provider practices an EBP skill either with someone formally playing a "standard patient" or actor, or more informally in which another provider, or

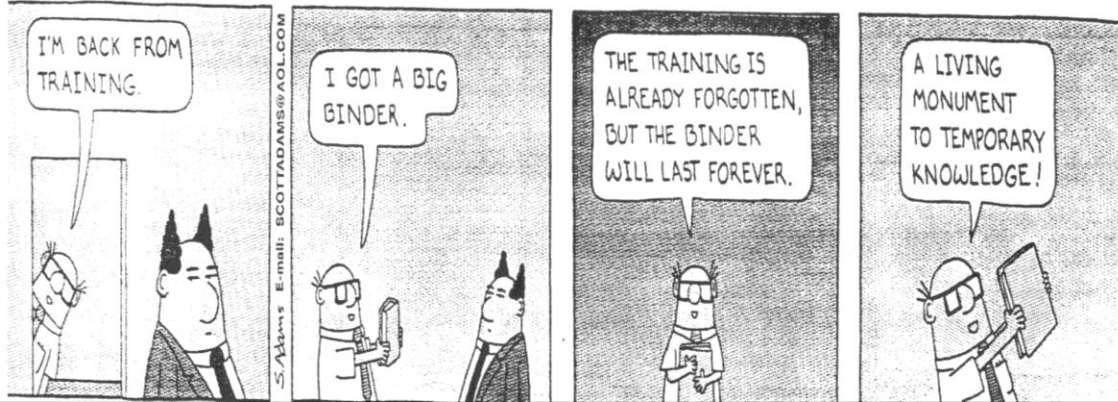
the supervisor, who plays a child who needs the skill (Beidas, Cross, & Dorsey, in press; Beidas, Edmunds, Marcus, & Kendall, 2012). Results from a 2011 CBT+ evaluation using pre and post training behavioral rehearsal (8 minute role play) over the phone objectively revealed provider competence and skill (what had the provider learned, what areas still needed improvement).

Challenges

The LC model of training plus consultation involves an explicit expectation for practice. It is more expensive because of the follow-up consultation requirement, but has a far better return than traditional methods in which providers attend workshops, lectures or conferences and incorporate bits and pieces from the training (termed “train and hope” in the dissemination literature). Commitment to the LC approach can be logistically complicated because EBP trainings using the LC model frequently involve multiple days or even weeks, limit the number of participants to facilitate a more intensive learning experience (or require multiple trainers), have requirements for consultation following the learning sessions, and expect collection of metrics to evaluate success of EBP implementation. LC trainings can engender trainee discomfort because they include a high percentage of time spent on actual practice of skills, with peer and trainer feedback. In addition to the costs of the training itself, in order to attend, providers are out of the office and not seeing clients. There may also be costs such as hotel, per diem and other expenses.

Practical Strategies

1. Shift how the organization approaches basic and continuing education. Policy is established to favor training in EBPs and support training models that are consistent with the LC approach. Establish the expectation that a change in practice is the goal of training. Continuing education moneys are devoted to training or supporting EBP. Consider fewer trainings—and prioritize those that offer consultation/supervision/coaching support to get the biggest bang for the buck.



2. Take advantage of any and all opportunities for accessing training that meets the criteria for EBP training:
 - a. Training supported by government sources either on an ad hoc or ongoing basis (e.g., WA DBHR CBT+).
 - b. Training associated with child welfare or other government contracts to provide EBPs (e.g., contracts for TF-CBT, AF-CBT, PCIT, Triple P, Incredible Years, SafeCare).
 - c. Training associated with research. Researchers seek to carry out clinical research in public mental health settings. Agree to participate as subjects or to recruit clients as subjects in exchange for access to free expert training and consultation (OK/CDC Funderburk PCIT supervision; UW Dorsey TF-CBT Supervision study; UW Dorsey TF-CBT with children in foster care, UW Spieker Promoting First Relationships).
 - d. Training associated with federal initiatives (e.g., SAMHSA NCTSN, HHS-ACF Initiative to Improve Access to Evidence-Based Behavioral Health Services in Child Welfare; DOJ Safe Start and Defending Childhood). Agree to support an application, be a participating site.
3. Seek out specific grants for EBP training, consultation, and support.
 - a. Grants that are time limited and have a specific purpose are often available from local, state and federal sources. Request funds for EBP training and provide justification for costs based on the goal of changing practice to change outcomes, not simply having providers receive training.
4. Establish a policy that if providers do attend training that is non-EBP or is not a specific LC endorsed by the organization, they will not be permitted to deliver the non-EBPs and/or

they must describe how the learning is consistent with EBP and how it would be incorporated into the organization's existing EBPs.

5. Collaborate with other local mental health organizations to contribute toward LC type training and reduce costs to individual organizations.
6. Make a decision to invest in organization-wide training in a broadly applicable EBP approach to create a fully trained work force.
 - a. Contract to bring in an expert trainer and pair them up with a qualified internal supervisor who can do the consultation and oversee providers meeting criteria.

Consider training supervisors first either internally or in collaboration with other organizations to establish commitment to the model, become internal champions and develop expertise to eventually become internal trainers.

7. Invest in and develop the training expertise of supervisors who can learn to provide ongoing internal training.
 - a. Clinical supervisors are supported to learn to do EBP training and supervision (e.g., participate in opportunities such as being a CBT+ co-consultant, join CBT+ once yearly supervisor training, participate in CBT+ monthly supervisor calls).
 - b. Clinical supervisors and experienced EBP providers deliver training on EBP skills or deliver organization-wide training on EBP components, skills to share knowledge.
 - c. Clinical supervisors learn to provide an initial EBP training for new hires before they have the opportunity to attend formal external training in specific EBPs. Such training would emphasize the key principles of EBPs (e.g., structured and focused, targets a specific outcome that is measured, skill building in the primary goal, homework for between session practice is routine, etc.) as well as the key skills (e.g., systematic assessment with feedback, teaching skills to clients).
 - d. Clinical supervisors explicitly prepare and support new providers for attending formal EBP training and follow up to create continuity and reinforcement in applying new skills.

- a. If they've been to the training themselves, prepare providers for what to expect, next steps, and how the organization will support them after the training.

- e. When possible, allow supervisors to attend EBP trainings to observe HOW the training is conducted as much as the content. Most good trainers have learned by watching other good trainers. These opportunities can improve supervisor ability to offer training and support within the organization.

III. EBP Supervision

The importance of ongoing active supervision in EBP cannot be overstated. It is widely agreed, and proven, to be necessary for successful implementation and adoption of EBP; it is extremely unlikely that providers will continue to deliver an EBP with fidelity in the absence of competent supervision. The research and the experience of supervisors in the field attest to the importance of EBP-specific supervision. By this we mean active clinical supervision on how to deliver the EBP with children and adolescents on provider caseloads, not just administrative and case management support. Supervisors need to be knowledgeable about the EBP and qualified to assist providers in acquiring and/or maintaining the skills that were learned in the training and that are necessary to deliver the model and achieve the outcomes.

There are many advantages to supervisors having direct experience delivering the EBP, either through continuing to maintain a small practice or having prior experience. Tremendous credibility and practical knowledge are gained from having had to transfer book or classroom learning into the real world context of routine practice.

The key is understanding the underlying theoretical framework and knowing the model components very well. In addition, supervisors need to be good teachers and coaches. Doing therapy involves applying skills. Some skills fall into the category of the common or non-specific factors such as forming and maintaining a therapeutic alliance, or engaging clients in the change process. Other skills involve teaching new behaviors to clients such as emotion regulation, challenging maladaptive cognitions, or positive parenting. **Skills are only learned through practice and rehearsal**, not via reading about them or hearing a verbal description of what to do. One reason why the specific skill training approach for supervision is so critical is that evidence-based therapy always involves teaching clients skills.

Challenges

Supervision is typically used to accomplish a variety of organizational objectives in addition to teaching clinical skills and monitoring direct clinical activities. Supervisors are responsible for the overall management of cases including the non-clinical activities that are common in public mental health. Typical issues that must be addressed are making child abuse reports, addressing serious crises (e.g., suicide attempts or other self harm behaviors, school suspension/expulsion, extreme family conflict, and running away). Supervision of cases of children in the child welfare system (CWS), especially foster care, frequently requires attention

to case management, attendance at staffings, writing reports, making recommendations, and care coordination across multiple systems.

Beyond the case-specific supervision activities, clinical supervisors are typically responsible for administrative oversight of providers including monitoring completion of required paperwork, doing performance evaluations, managing sick and vacation time, setting and monitoring productivity standards, checking on licensing and continuing education status, and the myriad of other workplace requirements and expectations. As well, supervisors help providers deal with stressors that interfere with work, scheduling conflicts, burnout, and vicarious traumatization. When providers are not meeting organizational standards for performance, it is supervisors who are responsible for creating and monitoring improvement plans and dealing with HR. Yet, part of supervision, if EBP is to be supported, has to be dedicated to monitoring provider practice and providing support for improved practice and fidelity to the model. This can be a very difficult balancing act for supervisors.

The other major challenge is organizational. Most EBPs establish standards of supervision that are specific to the model. For some brand names, this supervision must be purchased or is required as part of delivering the model (e.g., MST, FFT, SafeCare, MTFC). In other cases, although a requirement for model specific supervision is not imposed by the developers, it may be imposed by a local contract. Regardless of whether the developers require model specific supervision, it is a universal assumption that model specific supervision is necessary to maintain fidelity and achieve outcomes.

This presents complications for organizations where children and families come with a broad array of clinical problems and needs. Few EBPs reach more than a subset of all children entering public mental health because of the focus on specific clinical conditions. Take the example of behavior problems (e.g., ODD, CD). They account for approximately 20% of children's primary presenting problems, therefore PMT would reach only one fifth of all children seeking services. Beyond the breadth of the generic model, brand name interventions can have even more restricted criteria (e.g., PCIT is for children aged 2-7 with behavior problems). Many brand names have modifications or versions for different developmental stages or clinical contexts (e.g., Triple P, Incredible Years). This means that the list of EBPs and subtypes of EBPs that theoretically might be necessary or useful to meet the needs of all referred children is long.

Research has not explicitly addressed how many EBPs would be required to cover the array of mental health problems for which youth present to public mental health organizations, but it is likely that the number is at minimum 10 different models that address clinical problem areas excluding substance abuse disorders. The list would have to include: infant mental health, child behavior problems, anxiety, depression, PTS/PTSD, ADHD, serious family conflict, extreme emotion dysregulation, eating disorders, conduct disorder/delinquency.

Supervision is not just about supervisory skills, but also about the time it entails, both that of supervisors and providers. It is not realistic within current existing resources for organizations to support routine individual or even group supervision on every single potential EBP that might be desirable. This means that organizations will need to factor into decisions about which EBPs to adopt what would be necessary in terms of provision of active ongoing supervision and how that fits with organizational capacity.

Practical Strategies

1. Establish an organizational standard that evidence-based clinical supervision is an essential ingredient of EBP delivery. Once an EBP is adopted there will be ongoing supervision provided that is specific to the EBP and/or the relevant principles and practices.
2. Set the standard that clinical supervision on EBP must be delivered regularly and cannot be subsumed or overtaken by supervision on non-clinical concerns/issues.
 - i. Talk with other supervisors within the organization, or other organizations, about how to 'protect' part of supervision for EBP/model focus. Providers may have ideas too.
 - ii. Provide concrete and specific assistance to supervisors and providers on how to ensure that more time is devoted to focus ON clinical interventions.
3. Organize supervision around EBP principles and components:
 - a. Create a format for case presentation in supervision that emphasizes the EBP and/or EBP component (e.g., therapist provides a quick summary of client demographics and referring concerns, then states what EBP is being used and what EBP components have already been delivered). Supervision is then oriented to supporting the provider in delivering the EBP with the case.
 - b. Devote supervision sessions to specific and critical EBP skills (e.g., exposure for anxiety, selective attention for behavior problems).
 - c. Have supervisors teach, model, and then practice the basic and common skills in supervisory sessions with supervisees. True learning happens with practice. Supervisees are more comfortable practicing if the supervisor practices first.
 - d. Encourage supervisors to monitor clinical outcomes (e.g., scores on standard symptom assessments) as a routine part of case review with providers. Focus on

outcomes can help supervisors and providers identify when more intensive or directed supervisory support is needed.

4. Whenever possible combine supervision for EBPs based on the same theoretical foundation or containing common elements.
 - a. Combine all CBT or all Parent Management Training supervisions since they are based on a common theory and contain comparable elements. Focus on teaching the common skills found in all versions depending on the clinical target (e.g., selective attention and consequences for PMTs; psychoed, coping skills for anxiety, PTS, depression CBTs).
 - i. Combine non- and brand name in the same theoretical family of interventions when possible.
 - b. Organize supervision around key skills that cross EBPs (e.g., assessment, engagement, motivational enhancement, psychoeducation, assigning/reviewing homework, modeling, role playing).
 - c. Create an EBP team or supervision group that exclusively focuses on clinical delivery of EBPs (e.g., case discussions, demonstration/discussion of EBP components, reviewing treatment manual/online training components, integrating the EBP within the organization, promoting with brokers, etc).
5. Cultivate and support EBP supervisors within organizations.
 - a. Support supervisor EBP training and participation on supervision support activities (e.g., CBT+ supervisor monthly call and annual meeting; EBP specific supervision training or certification).
 - b. Specify that EBP competence is a factor in promotion, hiring and maintaining supervisor role.
 - c. Align supervisor performance evaluations to specifically address EBP supervision skills.
6. Buy outside expert supervision/consultation once a month (or some other interval).
7. Give supervisors responsibility for ensuring that providers have access to EBP resources (intranet folders with provider and client handouts, hot boxes with measures/psychoed handouts, therapeutic materials such work books, games, rewards; equipment such as recorders, observation rooms).

8. Require supervisor confirmation of provider initial competence in the EBP.
 - a. Require providers to enter cases and document that they have administered clinical measures and delivered EBP components. Use the EBP Roster Clinical Toolkit (<http://ebproster.org/roster/toolkit.php>). The Toolkit also shows whether clients report clinical change following EBP intervention and can serve as indication for increased supervisory support if client symptoms are not showing improvement.
 - b. Confirm completion of required activities such as TF-CBT*Web*.
 - c. Document initial provider competence by observing or listening to sessions, especially initially.
 - d. Align performance evaluations to contain standards regarding EBP competence and delivery to the model.

IV. Standardized Trauma Screening and Assessment of Clinical Targets

Screening for trauma. A history of trauma or abuse is associated with increased risk for many emotional and behavioral consequences. Although not all exposed children develop persisting mental health problems, when they have other risk factors such as multiple traumas, prior mental health problems, or compromised psychosocial circumstances the risk increases. Most children in public mental health have multiple traumas as well as other adversities (e.g., compromised socio-economic circumstances, parents with substance abuse or mental illness, parents who are incarcerated, foster care, etc). In other words, they are at high risk for mental health and other negative outcomes.

Screening for trauma is straightforward and highly acceptable to clients. It creates an opportunity not just to assess for trauma specific impact, but as well to make sure that children are safe, and to validate and normalize their experiences. Trauma screening can serve as an engagement strategy.

Screening for a trauma history has become a standard of care and is the essential ingredient of being a trauma-informed organization. Many settings are screening for trauma by including items about trauma or abuse on standardized intake forms or in other standardized assessment protocols and finding that clients will readily tick the boxes or respond to the questions. Unfortunately, in many instances there is no specific acknowledgment, validation or normalizing with the client, only screening. It may actually be counterproductive or even harmful to screen for trauma and not acknowledge that the client has shared this information and how it is helpful to have the information for treatment. Failure to acknowledge may be interpreted by the client as disinterest or disbelief.

Screening for trauma exposure is only clinically meaningful or useful if the information is explicitly used to provide acknowledgement, support and validation to the client and as a gateway for assessing trauma specific impact. **If an organization screens for trauma, it is necessary to institutionalize procedures for providing specific acknowledgement and feedback.**

Standardized assessment of the clinical target. EBPs target specific clinical conditions. The way they are shown to work is by (1) measuring the symptoms of the targeted conditions at baseline; (2) matching clients to an appropriate EBP for the baseline symptoms; and (3) measuring the symptoms again at one or more subsequent points to understand response/improvement. By definition, EBPs are only evidence-based for the clinical target(s) they have been tested on. This is a core characteristic of EBPs.

Although many EBPs are intended for a single or specific outcome, manyhow benefits for associated conditions. For example, TF-CBT is designed for children affected by trauma who have trauma specific impact (PST/PTSD), but it also has benefits for depression, anxiety and moderate behavior problems, if present. PCIT is designed for behavior problems but there is some evidence that it also helps with child depression and anxiety, as well as parenting stress and risk for future physical abuse in cases where physical abuse has occurred.

The key to EBP is to match the specific EBP approach to an identified clinical target(s), make sure the client is linked with a provider trained to provide that EBP, and have some way of measuring the level of the clinical target(s) at baseline and over the course of therapy. This is the mechanism for determining whether the EBP is working and whether the treatment needs to be adjusted or changed.

Mental health clinical assessments are standard practice and are intended to identify the clinical problems and needs. They routinely produce a clinical formulation, diagnosis and make treatment recommendations. The specific *addition* that is consistent with EBP is incorporating a structured, systematic and standardized method for measuring and quantifying the clinical target(s).

Challenges

There are two main challenges to incorporating standardized methods of trauma screening and clinical target(s). One has to do with the organizational usual procedures. All organizations have certain information that must be collected from clients before they can begin therapy including determining whether they meet eligibility requirements (access to care criteria, catchment area), completing required organizational paperwork including consent for care and release of information forms, filling out checklists and forms that are required by funders, and carrying out clinical assessments according to standards that are set by the organization or the government. Organizations differ in how and when these activities are completed. Some collect certain information during phone screening/intake; in some organizations there are assessment units and the client is then assigned to a provider; in other organizations the assessor will become the provider. Decisions need to be made about what point in time standardized trauma screening or clinical target assessment measures will be administered and who will provide the feedback on results to the client.

The second challenge is deciding on which trauma screening and clinical target assessment measures to use. There are many different trauma screens and many standardized measures for clinical targets. In addition, there are measures of functioning. Some standardized trauma screens and assessment measures are proprietary which means the organization has to buy

them. For some EBPs, proprietary standardized measures are required (e.g., PCIT requires the ECBI and Parenting Stress Inventory).

Fortunately, no one can copyright a list of traumas, so organizations are free to make their own list. CBT+ has developed a non-proprietary Trauma Screen. As well CBT+ makes available a number of short, reliable, valid, and free measures on the CBT+ Notebook (http://depts.washington.edu/hcsats/PDF/TF-%20CBT/CBT_Plus_NB.htm).

When an organization is ramping up to having an EBP trained work force, there are often situations where only a few providers are trained in a particular intervention. This means that a client seeking services for a condition such as PTSD may be assigned to a non-TF-CBT trained provider despite the fact that there are some trained providers within the organization. It is imperative that organizations hold discussions and have a strategy for how to handle this type of situation since the service availability will be uneven.

Practical Strategies

1. Decide how and when trauma screening will be done. Choose a method and make it part of the standard operating procedure. **Require providers who screen to give some type of acknowledging/validating response directly to the clients.** CBT+ Notebook contains simple user friendly “cheat sheets” to help the provider in how to do this with clients.
2. Incorporate standardized measures into the routine intake/assessment process.
3. Select specific clinical targets to assess during the intake/assessment process. Preferably use a standardized measure in addition to the results of clinical interview.
4. Ensure that the treating provider has the results of trauma screening and standardized measures if they do not conduct the initial assessment and provides clinical feedback prior to initiation of treatment.
5. Establish a practice standard that an EBP for the identified clinical target will be used. The provider will treat to the target until there is improvement. Adopt a systematic method of measuring progress (preferably using a standardized measure).
6. Ensure that clients are assigned to a provider who is qualified to deliver an EBP for the identified clinical target if there is a trained provider in the work force.

- a. Set intake procedures to require referral to an EBP trained provider when clients meet the clinical criteria (e.g., have clinical elevations on measures, dx).
- b. Facilitate access to an EBP trained provider when a referent or family explicitly requests a certain EBP and meets the clinical criteria for the condition.
- c. Establish organizational policies for how to make provider assignment decisions when clients meet the criteria but there are insufficient trained providers.
 - a. Require consultation with a supervisor about case assignment
 - b. Assign to providers with training in comparable interventions or those who have the basic knowledge and skills even if they have not attended a formal EBP training.
 - c. Provider higher levels of supervision in those cases.

V. Quality Assurance

QA for EBP refers to processes and procedures designed to ensure that the EBPs are being delivered in accordance with the model and measuring outcomes to confirm that the desired results are being achieved. There is extensive research documenting the importance of maintaining fidelity in order to get the results that are found in clinical trials (Schoenwald et al., 2011). The failure to achieve equivalent outcomes in real-world settings is generally attributed to the fact that the models are not being delivered faithfully as opposed to the cases being more difficult or complex (Weisz, Southam-Gerow, & McCarty, 2001). In some cases, an EBP can produce worse results when delivered by providers who are judged to not be competent in the model. For example, the recidivism rates for youth receiving Functional Family Therapy (FFT) from therapists who were evaluated as not meeting QA standards were higher than for the comparison (non-FFT) group, although FFT has been found to be an effective intervention for delinquency (Barnoski, 2004). How well the model is delivered according to the guidelines, matters.

One reason for these results may be that EBPs, when delivered by the book, are very focused on a particular outcome, are structured and involve active efforts to help clients learn and do new behaviors in the real world (e.g., via assigning homework). Careful research on usual public mental health practice has found that usual care looks quite different from that (Garland et al., 2010). Providers tend to cover many topics each session, few in much depth. Some strategies are consistent with evidence-based strategies and others are not. In usual practice, modeling or practicing skills in session, and assigning and reviewing homework practice are rare (Garland et al., 2010). These are integral parts of most EBP.

It has been established that even when providers have received high-quality training and consultation with demonstration of skill acquisition, they tend not to maintain the practice over time (Whitaker et al., 2012). **Providers tend to drift away from the model without ongoing supervision and monitoring.**

The purpose of fidelity monitoring is to go beyond supervision. Typically supervision does not involve actually learning whether or not providers are doing EBPs faithfully across their caseload. The only way to really assess drift or inept delivery of EBP treatment components is to specifically track in-session provider behavior.

It is important to keep in mind that fidelity monitoring, as part of QA, is actually a mechanism for achieving the intended client outcomes, not a goal in and of itself. Outcomes are the real goal of EBP clinical practice. There are alternative methods in use. For example, another

approach is to allow providers a certain amount of latitude in how EBP models are delivered but to require routine assessment of the clinical target at frequent intervals and require consultation/supervision if clients are not improving. A focus on outcomes can be effective (Unützer, 2012).

Challenges

Fidelity monitoring and outcome monitoring are the two strategies that ensure that EBPs are being delivered as intended and the expected outcomes achieved. Both activities require staff time to accomplish. The level of staff time required depends on the methods used.

There are three ways to monitor fidelity: observing or listening to sessions (live or recorded), provider self-reported adherence as reported via checklist or progress notes, and client report of provider fidelity to the model. Unfortunately, some studies have shown that provider self-report may not be very reliable (in comparison to observation of actual practice). This is not because providers intentionally misrepresent, but rather that it is challenging to objectively report on one's own behavior.

Given the limitations of self-report, in research studies, typically sessions are recorded (audio or video); initially the entire session is coded or reviewed for adherence, over time random tapes are coded or reviewed. Some interventions lend themselves to this methodology outside of a research setting, such as PCIT, in which sessions are recorded as part of model delivery. For most other therapies recording some or all sessions is outside of usual practice.

Buying the QA from developers or their companies is an excellent but expensive solution. Many of the most well-established brand name interventions require organizations to purchase the ongoing supervision and fidelity monitoring (e.g., MST, FFT, MTFC, SafeCare, KEEP, PMTO). In other instances these services may be available from developers but not required for advertising the service (e.g., PCIT). In some cases the QA monitoring by the company is required on an ongoing basis, whereas in other cases the model developers create a pathway to having independent internal organizational monitoring (e.g., SafeCare).

There will be many instances in which organizations will not be able to afford to buy model-specific supervision at the level and intensity that typically is associated with the brand names. As well, organizations are obligated to serve their whole client population, not only those who meet the criteria for one of a few clinical targets that a brand name intervention may address. Alternative, even if less rigorous methods, will be necessary in many cases.

Practical Strategies

Routine or periodic checkups. The key to QA is feedback to providers and assistance in improving skills, sticking with the model or tweaking strategies to address case-specific considerations. In some settings, clinical supervisors will be able to review all progress notes, provider or client self-report checklists, and outcomes measures. However, in most settings, caseload size and supervisory capacity will preclude review of all possible QA measures. Alternative strategies include creating methods for periodic or random review of tapes of sessions (to compare against self-report), progress notes or completion of provider or client self-reports. However, unless done consistently and reviewed with feedback provided to the providers, the procedures will not achieve the desired goals. Therefore they must be feasible within the extant job descriptions and the capacity to make adjustments in other duties.

1. Supervisor or consultant explicitly monitors fidelity.
When providers are initially learning an EBP it is optimal to have high levels of direct observation to ensure they have acquired the basic skills. Organizations may require supervisors to observe or listen to enough sessions to be confident that providers are competent. Once initial competence is established, supervisors may occasionally but systematically observe (or listen) to sessions or require tapes.
 - a. Supervisors sit in on sessions, observe through a one-way mirror, and/or listen in on the phone during sessions.
 - b. Providers audio or video record sessions and review with supervisors.
2. Treatment plan templates require the clinical condition and/or diagnosis to align with a specified EBP. The EBP is specifically identified on the treatment plan.
3. Progress note documentation explicitly addresses EBP and EBP components.
Providers complete progress notes for all sessions. Progress notes can be structured or templated to prompt for documentation of certain evidence-based components or activities.
 - a. Check boxes for EBP approach elements (e.g., primary treatment model; homework assignment/review and compliance monitoring; modeling, role play in session).
 - b. Check boxes for EBP session content (e.g., psychoed, exposure, behavioral activation, selective attention, rewards and consequences, etc.).
 - c. Documentation of symptoms using standardized measure score, client rating.

- d. Narrative standards such as what the EBP model is and what component was delivered, what homework was assigned, compliance with homework, etc.
 - e. End of session rating of client satisfaction or progress towards goals.
- 4. Providers complete fidelity checklists.
 - a. Providers are required to complete adherence checklists on a routine or periodic basis. Most EBPs have model specific adherence checklists that ask providers to rate whether and/or the degree to which they did the EBP components during a session.
- 5. Client Fidelity Self-Report
 - a. Clients complete checklists or respond to questions about what happened in session. These checklists are brief and comparable to provider self-report checklists. They can be administered on routine or systematic periodic basis. Some organizations have clients complete these checklists at the front desk on the way out of the appointment. Supervisors review the results.
- 6. Outcomes monitoring
 - a. Providers are required to administer standardized checklists or provide systematic assessment of clinical or functional progress at set intervals. These measures are used by the supervisor to monitor and adjust the treatment regimen. Failure to progress after a selected number (4-5) of sessions prompts a requirement for supervision/consultation.
 - b. Once the client outcomes for a specific clinical target are at non-clinical levels, clients are discharged from active therapy or from active therapy for the specific clinical target. The d/c is accompanied by explicit acknowledgement of the achievement.

VI. Technology

Technology and IT systems are critical ingredients for creating organizational QA procedures. Technology offers many possibilities for quick, attractive and meaningful presentations of data to give clients, providers and organizational senior leaders regarding the delivery of EBPs, EBP fidelity monitoring and outcomes. These data are important at the individual client feedback level, at the provider level for supervisors, and in the aggregate level for Senior Leaders and organizational administrators. Measurement of targets, provider behaviors and outcomes is a core principle of EBP.

IT systems in human service organizations most often focus on documenting activities that funders or government regulators require. There has been less attention paid to focusing on measuring the types of clinical activities and outcomes that reflect clinical change over time that can be used to provide individual or clinic wide feedback.

The ideal would be to have mechanisms that do not add additional burden, but document baseline and repeat measurement of clinical targets and adherence to the EBP at the individual provider and the aggregate clinic level. Dashboards that track use of EBP components and outcomes can be created. For example, Practicewise is a proprietary method of creating EBP dashboards for EBP components in child psychotherapy (<http://www.practicewise.com>). The Washington State Mental Health Integration Program (MHIP; <http://integratedcare-nw.org>) tracks mental health outcomes within primary care clinics where standardized mental health measures are incorporated into the electronic medical record and scores are treated like lab values that can be tracked.

Most public mental health clinics will have limitations in the ability to use technology because of funding constraints. However, there are lower tech strategies that might be incorporated within existing resources. Methods of documenting fidelity to EBP components and outcomes that require individual level review of client files or chart and that do not permit tracking are unwieldy, inefficient and do not allow for provider or clinic-level analyses. At the same time, systems that require double or triple entry are expensive and burdensome.

Practical Strategies

1. Electronic medical record.
 - a. Most organizations buy electronic medical records system off the shelf. There may be restrictions on the amount of modifying or adding that is possible. Whenever possible in decision-making, consideration should be given to how readily data can

be extracted from the EMR. The most important information for which to have access is scores on standardized measures and documentation of use of EBP components (e.g., self-report fidelity checklists).

- a. It is ideal if the EMR permits data entry/scoring of standardized measures which would then appear in the same way that lab values do.
 - b. If the EMR does not come with capacity for extracting quantitative data, it is a worthwhile investment to seek IT consultation about how to add, to modify or to incorporate repeat assessment with standardized measures and documentation of use of EBP components. Some organizations create proprietary web-based progress note systems. This approach allows for tailoring and modification but requires a substantial investment to achieve.
2. Creating dashboards.
- a. Simple dashboards can be created using an ordinary excel spreadsheet. For example, a fidelity checklist for TF-CBT is can be constructed based on the components acronym PRACTICE. Providers document which components were delivered during a session and how much time was expended. The dashboard representation shows the progression through the components and the percentage of time over the course of therapy. If this type of checklist is not incorporated into the progress note, it does require double data entry.
 - a. Supervisors can create their own dashboards to monitor provider progress with specific clients. CBT+ supervisors have created few versions that are available upon request.
3. Random review of progress notes.
- a. IT creates a list of randomly selected visits per week for supervisor review. Supervisors read the randomly selected progress notes to review how closely providers are sticking with and documenting the EBP that is being used. By randomly selecting cases for review, the supervisor is able to get an overall sense of the provider's practice approach versus relying on provider selected cases brought for discussion since most discussed cases are likely to be outliers or unusual.
4. Data entry procedures for standardized measures.
- a. The EBP Roster Clinical Toolkit (<http://ebproster.org/roster/toolkit.php>) has many different standardized measures. Providers who have participated in CBT+ or other approved EBP training can get an account that allows them to enter cases and score standardized measures. Providers or clients can enter the data.

- b. Kiosks or notepads can be set up in waiting areas and clients can enter their own data (i.e., respond to computer-administered symptom questionnaires) which are transmitted to the provider for in session review. Provider can assist client in data entry in the office and review it immediately.
- 5. Scoring of standardized measures.
 - a. The EBP Roster Clinical Toolkit (<http://ebproster.org/roster/toolkit.php>) offers automatic scoring of a variety of standardized measures. Providers who have participated in CBT+ Learning Collaborative can get an account that allows them to enter cases and score standardized measures.
 - b. Many free, reliable and valid clinical target measures are brief and easily scored. They yield a score that classifies the level of the clinical targets. Scoring programs can easily be constructed to provide visual representations (bar graphs, line graphs) that can be shown to clients as a means of providing feedback and motivating client engagement in treatment.
 - c. Purchased proprietary measures have scoring procedures that create profiles and track change over time (e.g., ECBI for PCIT; CBCL, BASC).
- 6. Monitoring outcomes.
 - a. IT can use administrative data systems to identify cases that have had a certain number of visits to create prompts for providers or supervisors to examine progress. Providers may be required to re-administer standardized measures at selected intervals. The key is initiating standardized methods for systematically identifying cases and the number of visits.

Summary and Recommendations

Public mental health organizations can undertake a variety of organizational strategies, some of which are low or no cost, to embed EBPs within their organizational structures. There are specific steps that can be taken in all of the key areas that have been identified by the dissemination and implementation science as important to keep EBPs going and flourishing within organizations. Setting, context and resources will influence the way that organizations go about these activities.

Adoption and sustainment of EBPs in public mental health settings will improve the lives of children and families. Many of these children and families suffer from a disproportionate share of adversity and are struggling to manage many aspects of their lives. High quality, effective mental health care that produces results within a relatively short period of time will not only ease their immediate distress, but can help set them on a pathway towards success in many areas of functioning. They deserve no less than the best that is available.

Appendices

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What is CBT+?

CBT+ describes a training and consultation approach that encompasses Trauma-Focused CBT (TF-CBT), CBT for anxiety, CBT for depression, and parent management training (PMT or BPT). Starting in 2009, the Washington State Division of Behavioral Health and Recovery (DBHR) supported Harborview and the University of Washington Evidence-Based Practice Institute (UW EBPI) to bring TF-CBT to public mental health organizations across the state.

TF- CBT is a well-supported and highly acceptable intervention for children affected by trauma. Public mental health settings were especially interested to have an effective therapy for the impact of trauma because most of the children they serve have complex trauma histories.

Harborview and UW EBPI are committed to the evidence-based goal that children in need have access to effective treatments for all conditions. We expanded the approach to include teaching evidence-based treatments that cover the most common clinical conditions of children in public mental health: depression, anxiety, and behavior problems as well as trauma-specific impact such as posttraumatic stress.

The program includes organization consultation, active learning sessions, and case consultation. Clinical supervisors are supported to take leadership internally to sustain the EBPs through monthly calls and an annual meeting. There are listservs, web-based resources and a web-based Toolkit that scores standardized measures and collects metrics. Providers can roster on a public web-site.

We have very high regard for our colleagues in public mental health who have embraced the evidence-based ideal and taken steps to bring effective interventions to the children and families who have the highest need. We have learned a lot about how complicated it is to successfully take research to the real world practice context. It is inspiring to see what can be accomplished with leadership, creativity and commitment. None of this would have happened if it had not been for the WA State DBHR commitment to invest in EBP and support for the Initiative. We specifically thank Robin McIlvaine and Jeannie D'Amato.

We are very grateful to TF-CBT developers Judy Cohen, MD and Tony Mannarino, PhD, Allegheny General Hospital/Drexel University College of Medicine, and Esther Deblinger, PhD, UMDNJ-School of Osteopathic Medicine for inventing an intervention that really resonates with public mental health and for being so supportive of our local variation on the theme. We appreciate so much that they have come out to train. And we thank our colleagues Michael de Arellano, PhD and Carla Danielson, PhD, Medical University (MUSC) of South Carolina; David Kolko, PhD, University of Pittsburg; and Laura Murray, PhD, Johns Hopkins University for participation in advanced training on their cultural adaptations and CBTs for violent families and high risk adolescents. Special thanks to Jason Lang, PhD Connecticut Center for Effective Practice Child Health and Development Institute (CHDI) and Rochelle Hanson PhD, MUSC for additions to the Guide.