Everyday Competence and Fidelity for EBP Organizations: Practical Guide

Sponsored by

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Introduction

Organizations that embrace evidence-based practices (EBPs) need a work force that is competent to deliver EBPs and consistently delivers EBPs when possible. A growing literature details frameworks for adoption and sustainment of EBPs. The dissemination and implementation science (DI) documents the importance of a number of key organizational factors that are necessary for adoption and sustainment. This includes an agency climate and leadership that actively endorses and supports EBPs, ensuring access to training in EBP, and ongoing clinical supervision in EBP. The Washington State's Practical Guide for EBP Implementation in Public Mental Health (Berliner, Dorsey, Merchant, Jungbluth, Sedlar, 2013) details these organizational factors, their scientific support, the real world challenges, and described numerous practical strategies.

Everyday Competence and Fidelity for EBP Organizations: A Practical Guide is a companion to the *EBP Organization Practical Guide.* This guide focuses specifically on steps organizations can take to determine that:

1. Providers are competent in a specific EBP and EBP elements ("CAN they do it?").

2. Providers are delivering the models with fidelity, or have adherence to the EBP ("Are they DOING it?").

Assessing competence and fidelity goes beyond attendance at training, participation in consultation/supervision, favorable attitudes toward EBP, and increased familiarity with the theory, principles, and elements of the EBP. While important, these aspects do not assure that providers have acquired or can use the specific necessary skills or can use the skills with their clients, and they do not establish whether providers are delivering the models as intended (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010). The emphasis in both guides is on practical strategies that organizations can use to adopt and sustain EBPs even when there is minimal or no outside funding.

Why do Competence and Fidelity Matter?

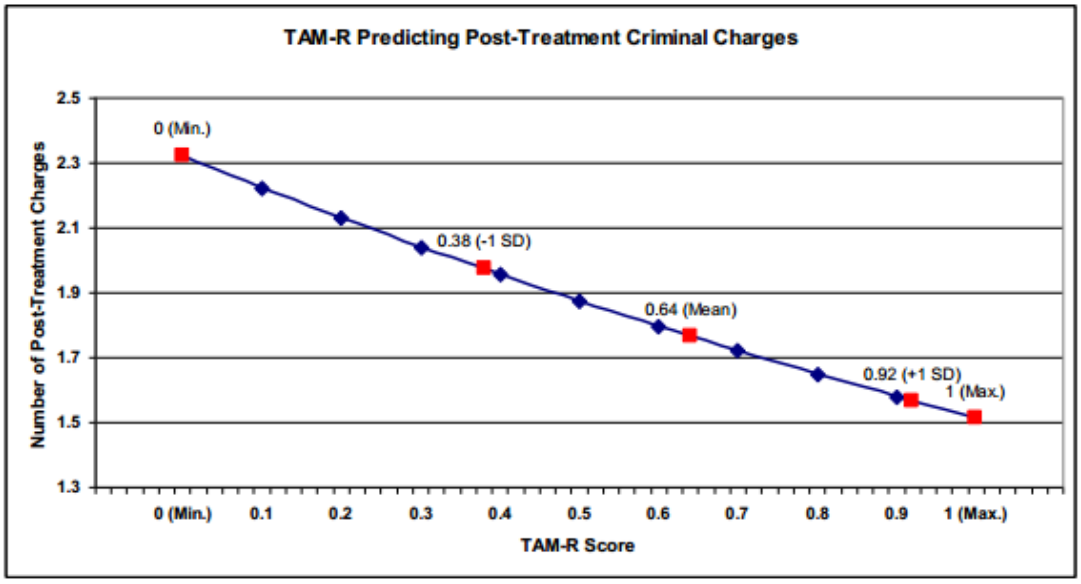
The reason why competence and fidelity matter is because research has shown that competently and faithfully delivered EBPs produce overall superior mental health outcomes in clinical trials. Mental health therapy aims to help clients with mental health conditions improve in the best and most efficient course of intervention. Fidelity to a specific EBP manual or model is not in and of itself the goal; it is a proxy for better outcomes. The mental health enterprise is not in the business of delivering EBPs per se; it is dedicated to alleviating suffering from mental health conditions.

In public mental health, there is a special obligation to ensure that clients receive competent care. These clients are low income or struggling with multiple challenges, which is why they must rely on publicly funded services. They have fewer options in terms of where and from whom they can receive their mental health care. Additionally, they are less likely to have access to information and knowledge about scientific developments in mental health, changing standards of care or new approaches. In many cases, they cannot even choose their provider; because they receive services in an organizational setting in which will assign them to a provider.

The DI literature has strongly emphasized the necessity of competent delivery and fidelity. For example, the Washington State Institute for Public Policy (Barnowski, 2004) showed that non-competence can produce even worse results than usual care. Non-competent providers of Functional Family Therapy, an EBP, had higher rates of juvenile delinquency recidivism compared to youth on a waiting list (e.g., no services). Many researchers have shown that providers tend to stray from an EBP model over time and when they do, the beneficial results of the EBP tend to be reduced (e.g., Schoenwald, Henggeler, Brondion, & Rowland, 2000). In sum, providers who are not competent will not be able to deliver EBPs, and without some support for adherence to the contents of the EBP, it is likely that providers will drift away from the EBP model.

The figure below illustrates how the higher (better) the score on the MST Therapist Adherence Measure (TAM), the lower the criminal charges.

Relationship between TAM-R and Youth Criminal Outcomes*



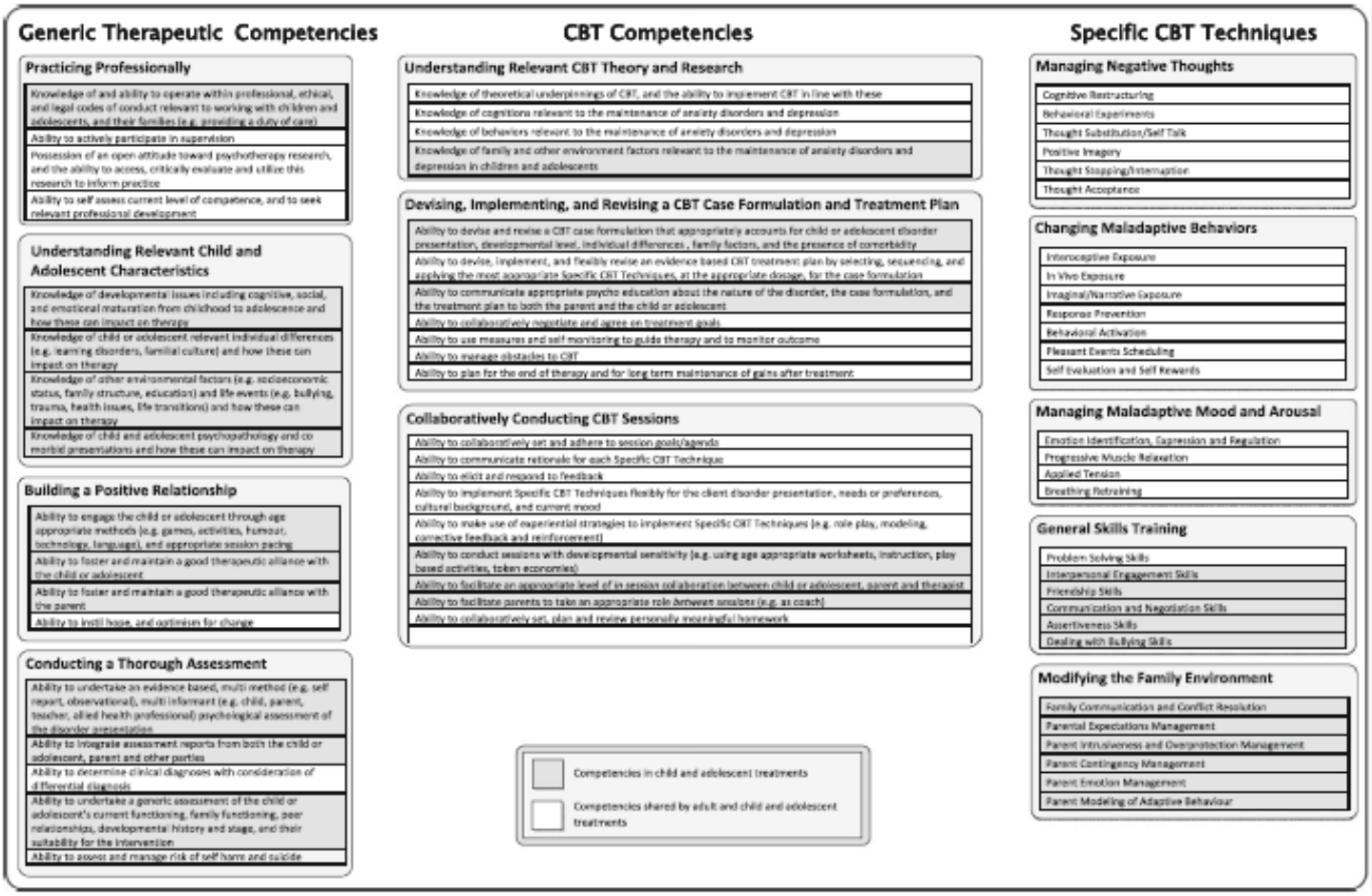
At follow-up (average of 2.3 years), the number of youth criminal charges was 36% lower for families with a maximum TAM-R score (i.e., 1) than for families with a minimum TAM-R score (i.e., 0).

Research (e.g., Chaffin, Hecht, Bard, Silovsky, & Howard, 2012) has now shown that it is possible to implement EBPs in usual care, public mental health settings and even to scale them up to statewide

levels and get good outcomes. However, this empirical research invariably focuses on a single EBP that targets a single outcome. In addition, the studies typically involve full funding by research grants and/or other outside funding. Public mental health organizations will have to deliver a wide array of interventions and services, some EBP and others probably not EBP, to target the many different conditions affecting their clients. The organizations may or may not have outside funding to support the implementation and sustainment activities for EBPs. Therefore, practical strategies and recommendations are needed.

Training and Supervision as Necessary Prerequisites

Increasingly professional education is focusing on identifying and describing the key competencies associated with different professions and areas of practice. Training programs and ongoing supervision are intended to lead to the acquisition and maintenance of the competencies. Sburlati, Schniering, Lyneham, and Rapee (2012) provide an excellent illustration of EBP competencies for the CBT treatment of child and adolescent depressive and anxiety disorders.



In order to become competent delivering EBPs, providers first must be trained in them. Attention has been paid to the nature of the training experience, with recommendations for incorporating adult learning principles and an emphasis on modeling and role playing/behavioral rehearsal of expected skills (Beidas, Koerner, Weingardt, & Kendall, 2011). However, regardless of how interactive and practice-based, training alone is not sufficient for competence in the skills or fidelity in delivery (Beidas & Kendall, 2010; Herschell et al., 2010). For this reason, training programs/packages now usually incorporate a period of post-training expert consultation while providers are learning to use the EBP with their clients. The evidence shows that more consultation is linked to better learning and client outcomes (Beidas Edmunds, Marcus, & Kendall, 2012). Presumably, this is because learning to do the skills competently, particularly with actual clients in public mental health settings, is very different than attitude change or knowledge acquisition (outcomes most frequently examined).

However, while receiving expert case consultation following training does improve provider skills and client outcomes, other methods may be even more effective. For example, in a randomized trial of Parent Child Interaction Therapy (PCIT) training methods (Chaffin, Funderburk, Bard, Balle, & Gurwitch, 2011), two different training methods were compared: expert case consultation and live real-time coaching of providers. The results showed that live coaching produced superior outcomes. Of course, PCIT lends itself to this method of skill acquisition because the intervention itself is delivered via live coaching of parents by the provider; however, the study clearly makes the point, as have some others, that coaching of actual practice in the delivery setting may be most effective (e.g., Showers & Joyce, 1996).

Expert consultation currently reigns as the dominant method (over live coaching) used in widely disseminated training models (e.g., TF-CBT, AF-CBT). However, it has not yet been determined what the qualifications are for expert consultants/supervisors or the best methods for doing initial case consultation to achieve competence and ongoing supervision to maintain fidelity. Nadeem, Gleacher, and Beidas (2013) have developed a consultation model, but it remains untested. When considering expert consultation, there a number of important questions to resolve. For example, do consultants/supervisors themselves have to be competent in delivering the model or have an active clinical practice in order to provide effective supervision? In terms of credibility, having experience delivering the EBP, or even better, continuing to maintain at least a small caseload, likely are advantageous. Beyond consultant/supervisor competence in the model, even more questions exist about what constitutes an effective consultation or supervision session (e.g., all case discussion? Some teaching/didactic? Incorporating modeling and role plays?).

Although ongoing supervision is considered critical, surprisingly little is known about the actual content and strategies used in supervision, in public mental health, by community-based supervisors (Accurso, Taylor, & Garland, 2011; Dorsey et al., 2013). For example, how much of supervision focuses on the EBP (e.g., delivery of key skills, CBT competencies—like therapeutic homework assignment) versus how

much focuses on administrative or case management topics? Additionally, how often do supervisors use “gold standard” supervision strategies from the research literature, reviewing audio or video tapes, conducting role plays, or monitoring clinician fidelity to the EBP or client outcomes (i.e., symptom response over time)? Supervision in most organizational contexts has many goals, not simply teaching and monitoring the use of skills or adherence to an EBP. However, supervisors will likely play a critical role in assessing and maintaining competency and fidelity of providers. Limited knowledge about whether and how supervision affects provider skill and practice is available, but increasing research attention is focused on supervision, and should yield information on what currently happens in supervision and which “gold standard” elements might be most feasible in public mental health and have an impact on clinician practice (see Dorsey et al., 2013).

In sum, EBP training packages that include consultation and ongoing EBP supervision increase the probability of provider competence and fidelity to the model, but do not guarantee competence and fidelity These elements can be viewed as *supports* for competence and fidelity, but are not considered competence or fidelity assessment or evaluation strategies. The only way to know if providers are competent or are delivering the model adherently is to assess competence and fidelity in some fashion. This is the dilemma for organizations and the focus of this guide.

Gold Standard Measurement of Competence and Fidelity

In scientific studies (e.g., clinical trials), competence and fidelity are typically assessed together and in a systematic, regular, and ongoing way. The gold standard virtually always involves "direct methods" of observation (i.e., observing providers exhibiting the skills in a structured exercise or while delivering the model). Providers are rated and receive specific feedback. Initial competence may be evaluated during the training period through live coaching or practice cases until providers reach criterion for competence. In most cases, sessions are taped (video or audio) and coded. Coding schemes exist for many specific EBPs, and there are more general coding schemes as well. Raters watch (or listen) to tapes and code every few minutes for dozens of specific elements. In many research contexts, coding involves examining not only whether the element has been delivered (fidelity), but how well it has been delivered (competence).

Measuring competence and fidelity using gold standard measures is time intensive and expensive. Raters have to be trained and monitored. They must watch (or listen) to tapes and make ratings. In order to check for reliability, a certain number of sessions must be double-coded to ensure that the raters are rating reliably and consistently, and not drifting themselves. Principle investigators also monitor the providers and the raters by listening to a certain number or percentage of tapes. Over time, in research studies, fidelity may be monitored more by watching/listening to tapes or sessions than actually coding every session. But some direct method of knowing what providers are actually doing in session typically continues for the duration of the study. While these methods provide the level and specificity of information that is necessary to do statistical analyses and draw conclusions in a randomized clinical trial, they are not feasible in real world settings.

Proprietary EBP companies or purveyors approximate the gold standard by setting requirements for establishing competency and/or maintaining fidelity. A few EBPs require that the model (MST, FFT, MDTFC, SafeCare, etc.) be adopted in whole to be carried out as a program to which clients are referred only to receive that specific service. Typically, these EBPs are delivered in the context of a team or a separate program and must adhere to certain requirements for documentation, supervision, and monitoring. Some EBP companies/developers require this link to the purveyor on an indefinite basis (e.g., MST, FFT, MTFC, KEEP), whereas others have provisions by which the local organizations can become qualified to do the ongoing training, supervision, and monitoring of fidelity (e.g., SafeCare). In most cases, some ongoing connection to the EBP company/developer is maintained, but most EBPs do not have companies that control distribution. Most have less rigorous requirements that range from provider behavioral rehearsal (e.g., role play) of key skills, to provider self-report of delivery of EBP delivery, to observation (or listening) of a certain number of cases. When EBP companies/developers set requirements, there is a great deal of variability in the intensity and longevity of these requirements.

The table below contains examples from various EBP.

EBP	Purveyor Controlled	Initial Competence	Ongoing Fidelity Monitoring	Ongoing Purveyor Requirement
SafeCare	Yes	Standard training + live coaching with feedback to criterion	Once a month tape review and provider self-report checklists	Yes: procedure for local trainer/ consultant
MST	Yes	Standard training + weekly on-site team supervision and weekly telephone consultation with MST expert	Ongoing weekly supervision on-site and MST expert periodically surveys 1) clients about the providers re: 9 principles 2) provider about supervisors and consultant Recidivism outcomes reporting	Yes: training and fidelity monitoring
FFT	Yes	Standard training + trainee ratings by FFT trainer	FFT Consultant weekly consultation, quarterly provider ratings, providers enter standard progress note data, and Recidivism outcomes reporting	Yes: training and fidelity monitoring
Triple P	Yes: training and competence	Standard training + knowledge test and role play	No	No
PCIT	No: PCIT Int'l sets standards	Standard training + expert case consultation and tape review; trainer rates provider on mastery of PCIT skills	No: PCIT Int'l sets standards. Monthly case consultation with PCIT expert, provider self-report session integrity checklist	No: PCIT Int'l sets standards including annual; attendee at national conference
AF-CBT	Yes: training, competence	Standard training + 12 expert consultation sessions + 2 tapes	No	Yes: establishing procedures for local trainer/consultants.

Focus on Outcomes

Focusing on outcomes is another approach that is gaining currency and can be employed instead of—or in addition to—extensive monitoring of fidelity. There is growing support for the benefit of providing routine feedback on outcomes as the mechanism for achieving positive results. Bickman, Kelley, Breda, de Andrade, and Riemer (2011) found that by implementing a routine assessment measure and providing feedback on results to providers, client outcomes improved even without changing the usual care intervention. The clients of providers who received the results in a user-friendly report on a weekly basis improved significantly more than the clients of providers who received the feedback on a quarterly basis.

Below is an example of the abbreviated youth self-report measure.

	IN THE LAST TWO WEEKS, HOW OFTEN DID YOU:	Never	Hardly Ever	Some-times	Often	Very Often
1.	. . . feel unhappy or sad?	☐	☐	☐	☐	☐
2.	. . . get into trouble?	☐	☐	☐	☐	☐
3.	. . . have little or no energy?	☐	☐	☐	☐	☐
4.	. . . disobey adults? (not do what adults told you to do)	☐	☐	☐	☐	☐
5.	. . . threaten or bully others?	☐	☐	☐	☐	☐
6.	. . . feel afraid that other kids would laugh at you?	☐	☐	☐	☐	☐
7.	. . . have a hard time waiting your turn?	☐	☐	☐	☐	☐
8.	. . . feel nervous and/or shy around other people?	☐	☐	☐	☐	☐
9.	. . . have a hard time sitting still?	☐	☐	☐	☐	☐
10.	. . . cry easily?	☐	☐	☐	☐	☐
11.	. . . annoy other people on purpose?	☐	☐	☐	☐	☐
12.	. . . argue with adults?	☐	☐	☐	☐	☐
13.	. . . drink alcohol (beer, wine, hard liquor)?	☐	☐	☐	☐	☐

An EBP example of the use of coding and feedback is the system used in PCIT, which combines two different types of outcome measurement: repeat administration of a standardized measure that assesses children's behavior problems (ECBI) and direct observation of parental behavior. The intervention is delivered in two stages: the Child Directed Intervention (CDI) and the Parent Directed Intervention (PDI). At baseline and at each session or at the end of the each stage, a standardized outcome measure is completed. At the beginning of each session, there is a 5-minute structured interaction between the parent and child that is coded by the provider (e.g., essentially counting certain parent behaviors taught in PCIT). Results of the coding are shared with the parent and used to engage and motivate parents so that they can progress to the next stage. In order for clients to move to the second stage (PDI) or to graduate successfully from both phases, they must demonstrate mastery of the key skills as assessed by provider coding. Therefore, in PCIT, changes in a behavior checklist and observed changes in parent behavior are measured. In this example, the provider is faithful to the EBP by measuring the outcome behavior before proceeding with the next phase or successfully discharging the client from therapy.

The Hawaii Example

The state of Hawaii has the only statewide system for fidelity monitoring within a large system of care. The model has a predominant focus on improvement of clinical practice through an emphasis on outcomes versus adherence to the content of individual EBPs. Fidelity is viewed as a data driven decision making process. If clinical progress is documented with *objective measurement,* there is no case review. Only in the absence of documented progress does the focus shift to the following questions: Was the appropriate intervention used? Was it delivered with fidelity?

Hawaii has established two distinct yet complementary ways of monitoring practitioner fidelity and client outcomes. The first occurs at the individual provider level and involves monthly provider reports of services, setting, and clinical progress. The second involves a state-wide method of standardized performance evaluation, by assessing provider fidelity and client outcomes.

Provider-level: Monthly Treatment and Progress Summary

This first method involves provider ratings that are completed on a monthly basis through a Monthly Treatment and Progress Summary form (MTPS; see Appendices) (Hawaii Child and Adolescent Mental Health Division, 2003). The MTPS measures the service format and setting, treatment targets, clinical progress, intervention strategies (e.g., exposure, logical consequences, emotional processing), and outcomes on a monthly basis. In addition to providing structured response options from which clinicians select, the MTPS includes fields for each domain in which clinicians can write open-ended responses.

For the format and setting questions, clinicians are asked to indicate all formats (individual, group, parent, family, teacher, or other) and settings (home, school, community, out of home, clinic/office, or other) in which the youth received services during the reporting month. Clinicians are then asked to indicate up to 10 target competencies or concerns which were the focus of treatment during that month. The targets are selected from a list of 48 predefined competencies and concerns and two additional open-response fields. Clinicians provide a progress rating for each target that describes the degree of progress achieved from baseline level of functioning toward the goal specified for the target. Progress ratings are on a 7-point Likert scale (anchors of *Deterioration < 0%, No Significant changes 0 – 10%, Minimal Improvement 10 – 30%, Some Improvement 31 – 50%, Moderate Improvement 51 – 70%, Significant Improvement 71 – 90%,* and *Complete Improvement 91 – 100%)*. Next, clinicians are asked to indicate all of the specific intervention strategies (a.k.a., practice elements) that were used with the child and family during the month. The MTPS records 55 predefined intervention practice elements (e.g., exposure, time out, modeling, etc.) and allows for the write-in of up to three additional intervention practice elements per month.

The aforementioned information is entered into a management information system that can produce "Dashboards" on demand with user-friendly graphics-based clinical reports (see Appendices). These dashboard clinical reports are available at the individual client level on a day-to-day basis for clinical directors and other staff to support decision-making. Data are also available on a monthly basis to monitor agency performance, and/or rolled-up across various levels (e.g., individual, county) or inclusion in reports (e.g., annual performance report) that inform policy and strategic planning. In the near future, Hawaii will be transferring to an electronic health system and planning is underway to change from the clinical dashboard and incorporate the above mentioned fidelity information into an electronic health record.

Below is an example of a clinical dashboard from MAP.

State-wide Performance Evaluation: Monthly Treatment and Progress Summary

The second method of monitoring provider fidelity and client outcomes involves a state-initiated and developed standardized measure of performance. The MTPS has optional fields that allow providers to report other outcomes measures (e.g., several functional measures, whether the youth was arrested during the month, percent of school days attended; Daleiden, Lee, & Tolman, 2004). Standardized assessment measures include the CAFAS (a measure of global functioning), the CALOCUS (a measure of restrictiveness of service needs), and the Achenbach scales (i.e., CBCL, YSR, and TRF). These measures are administered by public-funded case managers at 3-month intervals as part of a broader statewide outcome monitoring system. However, the results of these standardized measures are not available at the individual client, provider, or organization level; they are used primarily at the state level.

It is important to keep in mind that there are significant costs and infrastructure needs associated with outcomes-based approaches. The cost of implementing the infrastructure for data entry, tracking and routine feedback and monitoring, and reports production is not trivial. These costs are in addition to other EBP installation and sustainment costs such as training/consultation and ongoing supervision.

The optimal model may be one in which the fidelity monitoring content (e.g., treatment activities) and outcome measures are incorporated into the electronic medical record (EMR). Exemplars of this approach include the behavioral progress monitoring procedures approach recently implemented by Group Health Cooperative in WA for their behavioral health clinics (Steinfeld, 2013). Patients 12 years and older complete a one-page symptom monitoring form that assesses depression (PHQ9), anxiety

(GAD2), and substance abuse (AUDIT) at each encounter. Results are entered into the EMR by providers along with progress notes (see Appendices). A version of this approach is used in an integrated behavioral health program in Washington State for adults on disability. Care managers flexibly deliver components of evidence-based care for depression that is monitored at each encounter with a depression measure entered into the EMR. Consultation is required after four sessions without improvement. A payment approach where a certain amount of reimbursement is withheld based on fidelity to the model has shown that not only does fidelity increase, but patient outcomes do as well (Unützer et al., 2012).

Ways of Measuring Competence and Fidelity

There are direct and indirect methods of determining competence and monitoring fidelity. Direct methods involve seeing (or hearing) providers demonstrate the essential skills or elements of the EBP. Indirect methods involve provider or client self-report about what the provider did in session. For competence, the indirect method consists of questionnaires asking providers specifically about their confidence or comfort doing the specific skills or components of an EBP. This is a weak method because it relies on providers evaluating their own competence. For fidelity, indirect methods generally mean some kind of provider-completed checklist that is completed after every session or at periodic intervals about was done in sessions (e.g., the content of the intervention). Client report about provider behavior is another indirect method. For example, MST queries clients at periodic intervals about provider adherence to the nine principles of MST.

Direct observation is clearly the best, most reliable, and accurate method for ascertaining both competence and fidelity. With direct observation, it is possible to know exactly what providers actually did without interpretation or bias. There is evidence that provider self-report frequently does not correspond with more objective measures. For example, there is little agreement between provider diagnoses and standardized measures (Jenson-Doss, Osterberg, Hickey, & Crossley, 2013) and providers inflate how often they use EBP components compared to direct coding of sessions (Hurlburt Garland, Nguyen, & Brookman-Frazee, 2010) .

Direct Methods

1. Tapes of sessions [Competence; Fidelity if rating over time for a case]

   Sessions are audio or videotaped, reviewed and rated, and then feedback is given to providers. In research, typically all sessions are taped whereas purveyors or organizations may only require a certain number of tapes for establishing competence or monitoring ongoing fidelity. For example, AF-CBT requires two tapes and PCIT requires three with at least one from the CDI stage of the model and one from the PDI stage. Tapes may be required of sessions in which certain specific evidence-based techniques are used (e.g., exposure, addressing maladaptive cognitions). The key to tapes being useful is the feedback to providers. Feedback may be done through written summary and critique, rating on a checklist, or discussion in a supervision session.

2. Live observation [Competence; Fidelity if rating over time for a specific case]

   Sessions are observed or listened to as they are happening. Low-technology methods include sitting in on sessions while providers are delivering the intervention or calling into providers' offices and listening in over the phone ("observer" is on speakerphone in the session room, phone on

mute). Live streaming of video can now be done at reasonable cost. A camera on a laptop or computer can transmit the video using basic technology. Skype, Google Hangout, or Macintosh FaceTime applications can be accessed for free. If recording is desired, low-cost programs like Pamela (http://www.pamela.biz/en/) can be purchased to record the streamed session. Additional low-cost options include purchasing a subscription to video conferencing programs (e.g., WebEx, GoTo Meeting). A supervisor can observe from another location within the same office or remotely at another site. This method has the advantage of permitting live coaching to enhance the skills in the moment.

3. Role play/behavioral rehearsal [Competence]

   Providers demonstrate a specific skill required by the EBP model. The demonstration may involve a scenario that is provided such as the Triple P post-training role plays. Alternatively, supervisors can informally ask providers to demonstrate a skill they might use with a client either generically or as applied to specific clinical cases. Behavioral rehearsal is being tested as a specific supervision strategy in a Washington State study of "gold standard" supervision methods, infused into usual care settings, by community-based supervisors (Dorsey, Pullmann, et al., 2013). A method of promoting skill learning is to model the skill first; however, by modeling first, the observer does not get a sense of the provider's baseline skills. During the behavioral rehearsal practice, it is useful to incorporate some client resistance or objection so that providers learn to deliver the skill in more difficult situations.

   Behavioral rehearsals have been used as an indirect method to examine participant competency in CBT general competencies and specific CBT techniques (Beidas, Cross, & Dorsey, in press). In Washington State, CBT+ participants in the 2011 cohort were asked to participate in two behavioral rehearsals pre-training, immediately post-training, and at the end of the 6-month consultation period. The behavioral rehearsals focused on important CBT competencies: 1) explaining the CBT model and 2) assigning CBT homework. Based on objective coding of the first behavioral rehearsal, participants demonstrated significantly improved skills from pre-training to post-training, and skills were maintained at the post-consultation follow-up (Dorsey, Beidas, et al., 2013). Analyses of the second behavioral rehearsal are underway.

   Some behavioral rehearsal methods incorporate responses to the provider role play that are either reinforcing of EBP-consistent behaviors or not. For example, behavioral rehearsal with a trained "standard patient" actor has been tested for a brief suicide intervention (Cross et al., 2010) and a Motivational Interviewing (Baer et al., 2009). In the MI example, when providers stray from key MI skills (e.g., giving advice, arguing), the standard patient resists and defends the status quo, whereas when the provider presents options and choices in a non-judgmental way, the standard patient exhibits change talk.

Indirect Methods

1. Provider report: Detailed written or verbal report of in-session activities [Fidelity]

   Providers describe in detail exactly what they did in the session and how the client responded. The description may be contained in the progress note or occur via self-report during supervision. In order for the report to mostly closely resemble what actually happened, the description must be objective, behaviorally specific, and detailed. Supervisors are instrumental in focusing the discussion on provider activities versus general descriptions of the intervention procedures or interpretations of client behavior. Supporting documentation can be used such as showing handouts or other materials that were used or completed during the session (e.g., for a clinician who reports completion of a Trauma Narrative (TN) with a child client, showing the TN provides nice corroboration of self-report).

2. Provider report: Fidelity/adherence checklists [Fidelity]

   Providers complete checklists following sessions or at periodic intervals documenting the activities that were done during sessions. Many specific EBPs have intervention specific checklists. Some EBPs have checklists that cover the basic components of the intervention (e.g., the TF-CBT "PRACTICE" acronym for the treatment elements; see attachment), whereas other EBPs have checklists for the content that is expected to be covered at each session or during each section of the intervention. The checklist can be incorporated into routine progress notes or be separate within an organization or required by purveyors.

3. Client report [Fidelity]

   In MST, clients are periodically called by MST, Inc. staff (independent of the provider and provider's organization) and queried about the degree to which the nine principles of MST are reflected in their experience with their providers. In this way, the client is providing information about the provider's fidelity to the model.

A variety of methods have been developed for asking clients about provider behavior, though most of these do not assess fidelity, but rather patient perception of the session more generally. One approach is asking clients at the end of sessions about the degree to which the session was helpful, the degree to which it addressed the problems they considered important, or to rate their perception of the working alliance. An example of this approach is a brief rating scales of the clients' perceptions of the therapeutic relationship (e.g., Miller's SRS: http://scottdmiller.com/srs-ors-license/). A suite of client rating scales that yield individual and aggregate reports can be purchased (http://www.myoutcomes.com/).

Below is a table comparing methods of direct and indirect observations of competence and fidelity.

Method	Competence	Fidelity
Direct	1) Role play/Behavioral Rehearsal 2) Tapes 3) Live observation	1) Tapes 2) Live observation
Indirect	1) Provider self-report of competence.	1) Detailed case discussion 2) Provider checklists/progress notes 3) Client checklists/surveys

Practical Strategies for Every Day Evaluation of Competence and Fidelity

This section provides recommendations for organizations to consider to work toward establishing goals that 1) providers are competent in specific EBPs or meet general EBP competencies, 2) providers are delivering EBPs in accordance with the respective models, and 3) clients are improving on the clinical target of the individual EBPs. Organizations may install different procedures depending on their setting and circumstances. In many cases, organizations will have different methods for different EBPs. This will not just depend on the specific competencies, content, and outcomes for different EBPs, but will be determined by the selection of EBPs. Proprietary EBPs often have their own required methods of determining competence and monitoring fidelity to which organizations must adhere. Additionally, governmental agencies or insurance companies may also impose certain requirements. The intent here is to present a framework for how to think about competence and fidelity and to offer practical suggestions for those EBPs that are not controlled by proprietary companies.

Direct methods that involve observation (seeing or hearing) are obviously the most desirable, as they are the most accurate. However, they are most important for establishing competence since fidelity without competence is of little value. Currently, there is no substitute for observing providers actually doing a skill to learn whether they are competent. Although observation may be the best method, it is also the most expensive because it requires minute for minute/hour for hour supervisor time to observe tapes or participate in live observation of sessions. In addition, there is the time spent reviewing and giving feedback to providers, which is the purpose of having direct method accurate information about what providers actually do—so that they can receive feedback from the observation and improve. Feedback reinforces competence or to allows for highlighting/reviewing areas that need improvement and subsequent skill building. Because observation is expensive, it makes sense to use it in highly strategic ways.

Fidelity to every specific element or number of sessions described in an EBP manual may or may not be necessary for achieving positive outcomes. Randomized trials are about overall group differences between those receiving the intervention and those receiving a comparison condition (e.g., usual care). Not everyone receiving the tested intervention gets better, and many clients in usual care conditions get better. Usual care is not always significantly less effective than EBPs delivered in real world settings (Spielmans, Gatlin, & McFall, 2010). In addition, randomized trials do not show that every client needs to complete every session of a tested intervention to achieve the full benefit or that clients may need a different number of sessions for one outcome than for another. For example, a dismantling study of TF-CBT (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2010) found that fewer sessions were needed to achieve improvement on posttraumatic stress versus the optimal number of sessions for improvement on behavior problems. This is important and good news because direct methods of fidelity monitoring (the gold standard way to ensure every component is delivered) are not feasible in

real world practice as the primary method of monitoring. Therefore, indirect methods are preferable for ongoing fidelity with direct methods reserved for use on a periodic basis or for use around the most challenging techniques (exposure, cognitive reprocessing) and general competencies (assigning/reviewing homework, engaging clients).

Recommendations for Organizations

I. Invest in establishing initial competence.

Organizations should use direct methods to ensure that providers actually acquire the necessary skills for EBP (those that in-house supervisors train to or those that are taught in evidence-based training/consultation). This can be done in a variety of ways including: role play/behavioral rehearsal, review of taped sessions, and live observation via sitting in on sessions or video streaming. For newly hired providers or interns, supervisors should absolutely observe the providers delivering interventions and not only observe role plays. Use of indirect methods is important as a supplement to the direct observation. For example, it is important to have documentation that providers have actually delivered the EBPs that are on the service menu even if supervisors do not have the time to observe every session for every individual intervention.

Organizations can set in-house procedures for direct and indirect methods of establishing initial competence:

1. Role plays of "key skills" (detailed below) in supervision;
2. Sitting in on, listening to, or reviewing tapes of a certain number of session to strategically target particular skills/challenges;
3. Requiring providers to document delivery of at least one full course of each EBP on the service menu, preferably very early on in the provider's use of the model (i.e., first case);
4. Setting a requirement for Rostering on the EBP Roster, and reviewing of clinician entry (which documents delivery of one of the four CBT+ interventions including the use of standardized measurement).

Key Clinical Skills.

There are skills associated with EBP in general and with achieving optimal results for certain types of target conditions. Organizations should prioritize establishing competence in the key skills that have been shown in research to rarely occur in usual care or are difficult for providers to do (e.g., homework assignment/review; exposure).

1. Engagement

Many clients do not attend more than a few sessions or attend therapy only sporadically. These utilization patterns would not be expected to lead to improvements in outcomes. In cases where children have externalizing behavior problems, research strongly suggests that active caregiver participation in learning new skills, especially in the case of younger children, and changing the external contingencies within the family or at school or in the community are very important. There is research showing that certain skills and provider activities can increase initial attendance, return, and ongoing participation in therapy (Chaffin, et al., 2011; Dorsey et al., under review; McKay & Bannon, 2004; Nock & Kazdin, 2005; Szapocznik et al., 1989).

2. Skill teaching

   EBPs are typically active treatments that involve learning new skills to use in real life. Skills are best acquired through observing them performed (modeling), practicing them (behavioral rehearsal), and trying them out in real life settings (homework assignment/review). Garland et al. (2010) showed that usual care providers rarely do any of these three activities. Skill teaching is a general EBP competency since learning new skills is the essence of most active treatments.

3. Exposure

   Effective treatments for anxiety conditions including posttraumatic stress involve exposure, imaginal, and in vivo. Research has found that providers who do TF-CBT are least likely to report doing the Trauma Narrative (exposure) which is the key ingredient of the model (Allen & Johnson, 2012). This is also the case for other anxiety disorders where providers are less likely to do exposure compared to other elements (McLeod & Weisz, 2010; Borntrager, Chorpita, Higa-McMillan, Daleiden, & Starace, 2013).

4. Changing maladaptive cognitions

   Untrue or unhelpful thoughts, beliefs, and attitudes in children and their caregivers are associated with both internalizing and externalizing mental health conditions. Giving psychoeducation (new information) is a straightforward and relatively easy clinical activity. However, many clients, both children and adults, have “stuck cognitions” that do not respond to the simple presentation of alternative information. Changing stuck cognitions that are untrue or unhelpful often requires the skillful application of Socratic questioning or other complex methods of helping clients reconsider or reevaluate their own cognitions.

5. Delivering rewards and consequences

   When negative child behaviors persist even when caregivers have increased positive time and are attending selectively to positive behaviors, it is often necessary to teach caregivers to implement a rewards or consequences plan (e.g., Time Out, behavior contract). Engaging caregivers and

teaching them the components of these procedures is often tricky because if the plan is not realistic or followed through with at home, it is likely to fail and lead to caregiver loss of confidence in therapy as well as continuation or escalation of the negative child behavior. In session, practice and careful construction of a plan with active support is often necessary for success.

Practical strategies.

1. Pay very close attention to the first case for providers because a success will be the best advertisement for the EBP as well as a confidence builder for providers using new skills. When possible, select a case that is not very complicated and is more likely to be successful. Give high levels of supervision for the full course of the therapy, pay close attention to assessing and building competency, and make a point to celebrate successful completion of the case through praise and acknowledgement.

2. Incorporate role play and tapes into routine supervision. Require tapes for initial competence and at periodic intervals.

3. Adopt the peer review model for group supervision in which providers bring tapes or clips of tapes to demonstrate specific skill use and get group feedback.

II. Emphasize outcomes as the goal.

Organizations should communicate that the goal of EBP is positive outcomes for clients. This can be achieved by establishing organizational standards for baseline assessment using some type of standardized measure. Research shows that more frequent administration of standardized measures with feedback is what improves outcomes versus having lengthy intervals between administrations (Bickman, et al, 2011). Preferably, organizations should require:

1. Identification and measurement of a specific clinical target that can be tied to a specific EBP (e.g., PSC-17 for behavior problems; Moods and Feelings or PHQ9 for depression; CPSS or UCLA RI for PTS; SCARED or GAD for anxiety, etc.; see Appendices);
2. Some periodic administration of a standardized measure to document progress. The emphasis should be on re-administration at regular intervals even including at every session. Post treatment measurement is neither useful nor practical. Most clients leave therapy without a planned final session to complete a post measure. As well, the value of repeat administration is the ongoing review of whether treatment is working so that adjustments can be made if necessary and so that progress can be reinforced.

3. The key to the added value of standardized measurement is that the results are actively used, whether at the individual client level, in evaluating providers (e.g., identifying additional supervision/training needs), or at the organizational level for showing overall outcomes.

Key Assessment Skills.

1. Clients

   - Results of standardized measures are always discussed with clients. They are given an explanation of what the clinical scores mean. The feedback process has multiple clinical benefits including engagement, validation, normalization, joint identification of—and agreement on—treatment targets, foundation for psychoeducation about the clinical condition and its associated symptoms, and measurement of progress.
   - Collaborative clinical decision-making regarding the clinical target, assessing whether treatment is working, and discharge from therapy incorporates results of the baseline and ongoing administrations.

2. Providers

   - Standardized measures are used as part of establishing diagnosis and identifying a primary clinical target. Discrepancies must be justified.
   - Achieving non-clinical scores on a standardized measure is incorporated into treatment plans and is used as a basis for making clinical decisions. Once the score is in the non-clinical range, the client is discharged from active therapy or from the specific therapy focused on that outcome unless there is clinical justification.

3. Organizations

   - Supervisors use results of standardized measures as part of quality assurance. They review results of standardized measures in approving initial diagnosis and treatment plans. Re-administration of measures is used at routine intervals to determine whether treatment is working. Lack of documented change prompts review of the treatment regimen.
   - Administrators use aggregate results of standardized measures to show overall organizational progress and achievement of goals.

Practical strategies.

1. Use brief measures, preferably those that are free, reliable, valid, and can be scored immediately.

2. When possible and feasible, incorporate standardized measures into the EMR and document on treatment plans.

III. Use indirect methods as the primary way of monitoring ongoing fidelity

Key skills.

1. In supervision:

    - When reviewing what providers have already done, prompt for detailed description of the specific skills they used in a session and have them specify what component they were doing and why.
    - Have providers specify what the component is and show through role play or other concrete demonstration (e.g., actual therapy materials such as a fear ladder, behavioral contract, TN) what happened in session.
    - Always ask what the clinical target is, how it has been measured, what component of the EBP was the focus of the session. Inquire about homework given and compliance.
    - Use behavioral rehearsal to have providers demonstrate how they will deliver a component in the upcoming session.

2. Progress note documentation:

    - Establish standards for narrative description of session activities to include explicit description of the specific activities and skills taught.
    - Have a progress note that prompts for EBP components, including structural elements such as reviewing and giving homework and setting an agenda and content that corresponds to specific EBPs.
    - Randomly review progress notes to ascertain what EBP is being used, what the component is, and how the treatment is progressing.
    - Use checklists or other materials such as the CBT+ Notebook materials (Treatment Descriptions, Treatment Cheat Sheets, Need to Know Sheets (N2Ks)) at periodic intervals to document use of EBP skills, treatment components, or adherence to a specific EBP model.

Documenting Competence using the EBP Roster Toolkit

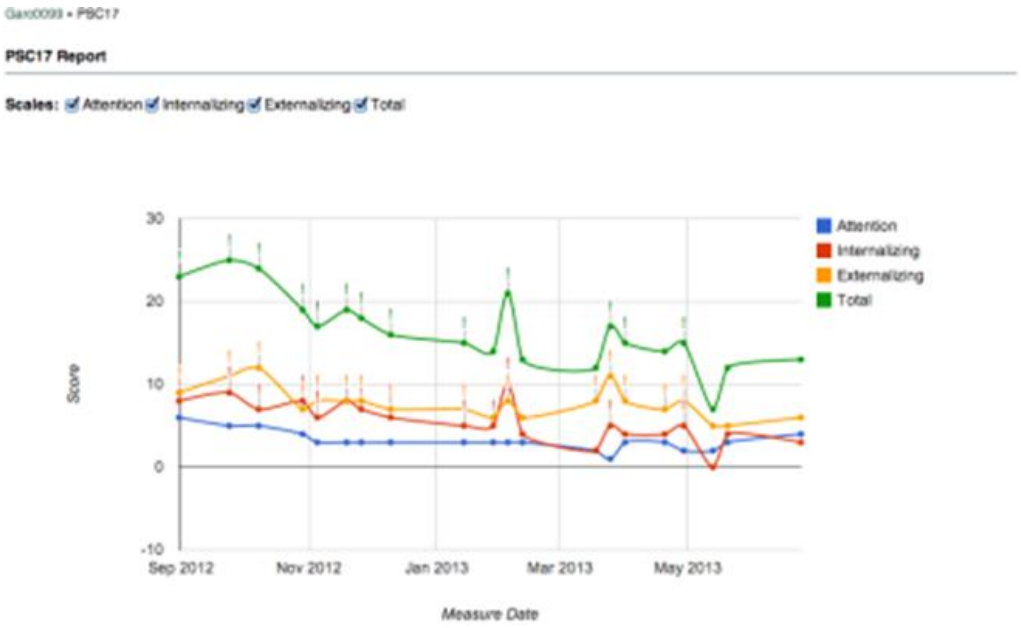
The EBP Roster Toolkit (http://ebproster.org/roster/toolkit.php) is a web-based method for organizations and supervisors to document that their providers have met basic requirements for an EBP, including attending EBP training, completing consultation, and delivering the models with actual clients. There are EBP Rostering websites associated with various EBPs. For example, Project Best (Duke Foundation supported TF-CBT Learning Collaborative) maintains a TF-CBT Roster (http://academicdepartments.musc.edu/projectbest/roster/roster.htm).

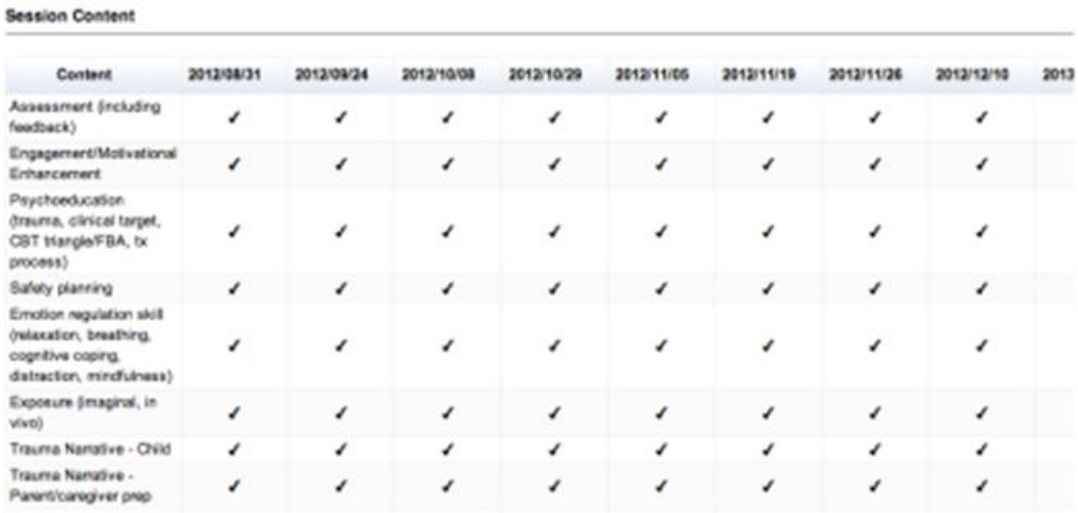
The EBP Roster Toolkit provides numerous resources for providers, supervisors, and organizations to document EBP competence, fidelity, and client outcomes. Providers have accounts that allow them to enter and track cases by:

1. Identifying the clinical target and primary EBP;
2. Entering and scoring a variety of standardized measures;
3. Marking the session structure and session content.

A graphical representation of standardized measures and session content is displayed in a dashboard format. In addition, providers can document the requirements they meet to be Rostered or acquirea n EBP training certificate of completion. In order to be Rostered, providers must demonstrate that they have met the requirements and on-site supervisors must confirm that their provider has actually completed the requirements before the provider can be Rostered. Once Rostered, the provider creates a profile that is viewable to the public.

Below is an example of the EBP Roster Toolkit Dashboard.





Session Content

Content	2012/08/31	2012/09/24	2012/10/08	2012/10/29	2012/11/05	2012/11/19	2012/11/26	2012/12/10	2013
Assessment (including feedback)	✓	✓	✓	✓	✓	✓	✓	✓	
Engagement/Motivational Enhancement	✓	✓	✓	✓	✓	✓	✓	✓	
Psychoeducation (trauma, clinical target, CBT triangle/FBA, tx process)	✓	✓	✓	✓	✓	✓	✓	✓	
Safety planning	✓	✓	✓	✓	✓	✓	✓	✓	
Emotion regulation skill (relaxation, breathing, cognitive coping, distraction, mindfulness)	✓	✓	✓	✓	✓	✓	✓	✓	
Exposure (imaginal, in vivo)	✓	✓	✓	✓	✓	✓	✓	✓	
Trauma Narrative - Child	✓	✓	✓	✓	✓	✓	✓	✓	
Trauma Narrative - Parent/caregiver prep	✓	✓	✓	✓	✓	✓	✓	✓	

Use of the Toolkit

1. Providers

    - Use with clients to show scores and progress over time on standardized measures.
    - Provide documentation of delivery of EBP models.
    - Meet requirement for receiving a certificate of completion of consultation for CBT+ or other EBP.
    - Become Rostered.

2. Supervisors and Administrators

    - Confirmation that providers meet requirements for a certificate of completion of consultation or Rostering.
    - QA with individual providers of documentation of delivery of EBPs. Organizations may set requirements regarding delivering a certain number of courses of an EBP, meeting CBT+ or other EBP training/consultation requirements, request on an ad hoc basis for performance improvement, etc.
    - Access to scoring for standardized measures with exportable reports.
    - Exportable reports of an organization's providers showing whether they have delivered CBT+ or other EBPs to clients, their status on completion of certificate of completion of CBT+ or other EBP consultation, whether they are Rostered.

Summary

Competence and fidelity are key considerations for organizations adopting EBPs. In order to realize the potential benefit of EBP for clients, providers must be competent to deliver the EBPs and must actually be delivering them in accordance with the model. Research has confirmed these conclusions. However, research does not provide much guidance on how to achieve these goals in every day settings, especially in contexts like public mental health where there is a need to serve all clients who may suffer from a range of clinical conditions. It is prohibitive to evaluate and monitor competence and fidelity as is done in research contexts or on the fee for service basis of EBP companies. Therefore, organizations must arrive at solutions that approximate the goals of competence and fidelity to the degree that is possible within resources.

Organizations should target the bulk of their efforts and investment in ensuring that the workforce is competent to deliver the EBPs that are available within the organization. There is really no substitute for direct methods in assessing competence; however, indirect methods can be efficiently used to monitor fidelity to models by embedding requirements for identifying the EBP models and comments into the usual care progress note to both prompt providers to stick to the model and afford supervisors a method of monitoring fidelity.

The second most important step is to establish measurement of the proximate outcomes that should show change when an EBP is delivered by competent providers with fidelity. One important point about fidelity is that fidelity is not the goal in itself. Fidelity is important because it has been shown to be associated with superior outcomes. However, the goal is the good outcomes, not necessarily the faithful delivery of EBPs. Focusing on measurement and feedback is another strategy to achieve good outcomes. Mechanisms to prompt for case review, supervision, and modification of treatment plans should be put in place when progress in not occurring. This type of approach has a high degree of utility, can potentially be incorporated into routine practice, and could promote a system where supervision efforts are more efficiently targeted to situations where clients are not making progress.

Appendices

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Service Provider Monthly Treatment & Progress Summary
Child and Adolescent Mental Health Division (CAMHD)

Instructions: Please complete and electronically submit this form to CAMHD by the 5th working day of each month (summarizing the time period of 1st to the last day of the previous month). The information will be used in service review, monitoring, planning and coordination in accordance with CAMHD policies and standards. Mahalo!

Client Name:	CR #:	DOB:
Month/Year of Services:	Eligibility Status:	Level of Care (one per form):
Axis I Primary Diagnosis:	Axis I Secondary Diagnosis:	Axis I Tertiary Diagnosis:
Axis II Primary Diagnosis:	Axis II Secondary Diagnosis:	

Service Format (circle all that apply):

Individual Group Parent Family Teacher Other: _____

Service Setting (circle all that apply):

Home School Community Out of Home Clinic/Office Other: _____

Service Dates:																

Targets Addressed This Month (*number* up to 10):

	Activity Involvement		Community Involvement		Hyperactivity		Positive Peer Interaction		Shyness
	Academic Achievement		Contentment, Enjoyment, Happiness		Learning Disorder, Underachievement		Phobia/Fears		Sleep Disturbance
	Adaptive Behavior/Living Skills		Depressed Mood		Low Self-Esteem		Positive Thinking/Attitude		Social Skills
	Adjustment to Change		Eating, Feeding Problems		Mania		Pregnancy Education/ Adjustment		Speech and Language Problems
	Aggression		Empathy		Medical Regimen Adherence		Psychosis		Substance Use
	Anger		Enuresis, Encopresis		Occupational Functioning/Stress		Runaway		Suicidality
	Anxiety		Fire Setting		Oppositional/Non-Compliant Behavior		School Involvement		Traumatic Stress
	Assertiveness		Gender Identity Problems		Peer Involvement		School Refusal/Truancy		Treatment Engagement
	Attention Problems		Grief		Peer/Sibling Conflict		Self-control		Willful Misconduct, Delinquency
	Avoidance		Health Management		Personal Hygiene		Self-Injurious Behavior		Other:
	Cognitive-Intellectual Functioning		Housing/Living Situation		Positive Family Functioning		Sexual Misconduct		Other:

CR # _____ (please repeat number here)

Progress Ratings This Month (check appropriate rating for any target numbers endorsed as targets):

#	Deterioration < 0%	No Significant Changes 0%-10%	Minimal Improvement 11-30%	Some Improvement 31%-50%	Moderate Improvement 51%-70%	Significant Improvement 71%-90%	Complete Improvement 91%-100%	Date (If Complete)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Intervention Strategies Used This Month (check all that apply):

	Activity Scheduling		Emotional Processing		Line of Sight Supervision		Personal Safety Skills		Stimulus or Antecedent Control
	Assertiveness Training		Exposure		Maintenance or Relapse Prevention		Physical Exercise		Supportive Listening
	Attending		Eye Movement, Tapping		Marital Therapy		Play Therapy		Tangible Rewards
	Behavioral Contracting		Family Engagement		Medication/ Pharmacotherapy		Problem Solving		Therapist Praise/Rewards
	Biofeedback, Neurofeedback		Family Therapy		Mentoring		Psychoeducation, Child		Thought Field Therapy
	Care Coordination		Free Association		Milieu Therapy		Psychoeducation, Parent		Time Out
	Catharsis		Functional Analysis		Mindfulness		Relationship or Rapport Building		Twelve-Step Program
	Cognitive		Goal Setting		Modeling		Relaxation		Other:
	Commands		Guided Imagery		Motivational Interviewing		Response Cost		Other:
	Communication Skills		Hypnosis		Natural and Logical Consequences		Response Prevention		Other:
	Crisis Management		Ignoring/Differential Reinforcement of Other Behavior		Parent Coping		Self-Monitoring		
	Cultural Training		Individual Therapy for Caregiver		Parent/Teacher Monitoring		Self-Reward/ Self-Praise		
	Discreet Trial Training		Insight Building		Parent/Teacher Praise		Skill Building		
	Educational Support		Interpretation		Peer Pairing		Social Skills Training		

CR # _____ (please repeat number here)

Psychiatric Medications (List All)	Total Daily Dose	Dose Schedule	Check if Change	Description of Change
_____	_____	_____	☐	_____
_____	_____	_____	☐	_____
_____	_____	_____	☐	_____
_____	_____	_____	☐	_____
_____	_____	_____	☐	_____

Project Discharge Date: _____ ☐ Check if Discharged During Current Month

IF YOU WAS DISCHARGED THS MONTH, PLEASE COMPLETE ITEMS A & B:

A. Discharge Living Situation (check one):

☐ Home ☐ Foster Home ☐ Group Care ☐ Residential Treatment

☐ Institution/Hospital ☐ Jail/Correctional Facility ☐ Homeless/Shelter ☐ Other: _____

B. Reason(s) for Discharge (check all that apply):

☐ Success/Goals Met ☐ Insufficient Progress ☐ Family Relocation

☐ Runaway/Elopement ☐ Refuse/Withdraw ☐ Eligibility Change ☐ Other: _____

Outcome Measures: Optional. If you have any of the following data, please report the most recent scores:

CAFAS (8 Scales): (1-School:) (2-Home:) (3-Community:) (4-Behavior Towards Others:) (6-Self-Harm:) (7-Substance:) (8-Thinking:) (Total:)			Date:
CASII/CALOCUS (Total):	CASII/CALOCUS (Level of Care):		Date:
CBCL (Total Problem T):	CBCL (Internalizing T):	CBCL (Externalizing T):	Date:
YSR (Total Problems T):	YSR (Internalizing T):	YSR (Externalizing T):	Date:
TRF (Total Problems T):	TRF (Internalizing T):	TRF (Externalizing T):	Date:
Arrested During Month? (Y/N):	School attendance (% of days):		

Comments/Suggestions (*attach additional sheets if necessary*):

AF-CBT Full Practice Checklist

Therapist Identifier: _____

AF-CBT Treatment Component	Session #:	1	2	3	4	5	6	7	8	9	10
	Date:	/	/	/	/	/	/	/	/	/	/
PHASE 1: ENGAGEMENT AND PSYCHOEDUCATION											
Topic 1: Caregiver: Orientation											
I. Introductions and Guidelines											
1. Introduce self and do family introductions (who's at home, who in treatment?)											
2. Briefly describe AF-CBT (name, pop, benefits)											
3. Explain rules and regulations (confide, reporting, releases, info sharing concerns)											
II. Caregiver Treatment Experiences											
1. Learn about the caregiver/family (living situation, roles, strengths, decision making)											
2. Review previous treatment history and clinician experiences (highlight differences)											
3. Brief discussion of family status/referral (reason for referral, normalize situation)											
III. Preparing Family for Sessions											
1. Treatment structure/participation (basic psychoeducation, outline session structure)											
2. Facilitators/Barriers to treatment (attendance, barriers/solutions, appt. times/places)											
3. Review weekly safety check-in (rationale, review wrksht, summarize, questions)											
IV. Home Practice											
1. Rationale for home practice assignments (link learning and practice)											
2. Potential Assignments (treatment goals, follow safety plan if developed)											
Topic 1: Child: Orientation											
I. Introductions and Guidelines											
1. Introduce self and do family introductions (who's at home, who in treatment?)											
2. Briefly describe AF-CBT (name, pop, benefits)											
3. Explain rules and regulations (confide, reporting, releases, info sharing concerns)											
II. Establishing Rapport/Goals with Child											
1. Build therapeutic alliance (use Learning About Each Other wrksht, ask Q's)											
2. Clarify treatment expectations (estab. rules, explain confidentiality, secret vs. private)											
3. Review previous treatment history and clinician experiences (highlight differences)											
4. Determine understanding of referral (child explanation of referral, benefits of treat.)											
5. Child's Goals (Goal Setting wrksht, goals/outcomes of AF-CBT)											
III. Preparing Family for Sessions											
1. Treatment structure/participation (participation (basic psychoeducation, outline session structure)											
2. Facilitators/Barriers to treatment (attendance, barriers/solutions, appt times/places)											
3. Review weekly safety check-in (rationale, review wrksht, summarize, questions)											
IV. Home Practice											
1. Rationale for home practice assignments (link learning and practice)											
2. Potential Assignments (treatment goals, follow safety plan if developed)											
Topic 2: Caregiver: Alliance Building and Engagement											
I. Personal Coping Skills and Stressors											
1. Rationale for discussing coping skills/stressors (rationale, check-in)											
2. Positive life experiences (identify, summarize & validate responses)											
3. Stressful life experiences (handout, identify stressors/coping skills, summarize)											

4. Caregivers' Experience w/ stress (use handout, in relation to family of origin)											
II. Pros and Cons of Treatment Participation											
1. Discuss treatment investment (rationale, Dec. balance sheet, concerns/obstacles)											
III. Review of Assessment Results and Identification of Goals											
1. Review relevant assessment results (pretreatment assessment findings)											
2. Identify treatment targets/goals (rationale for goals, My Goals for Treatment wrksht)											
Topic 3: Child: Learning about Feelings and Family Experiences											
I. Explaining Feelings and identifying the Child's Feelings											
1. Common feelings children experience (define/discuss, feelings identification game)											
2. Identifying others' feelings (Look, Listen, Ask handout /Identifying Feelings handout)											
3. Identifying child's own feelings (discuss, explore)											
4. OPTIONAL: Additional feeling identification activities (use handouts, games)											
II. Understanding Positive/Negative Family Interactions and Referral Incident											
1. Understand routine caregiver/child interactions (My Pos. Exp. At Home wrksht, My Upsetting Exp. At Home wrksht, summarize)											
2. Child's perspective on referral incident (child describe incident, relate to other experiences)											
III. Psychoeducation on Use and Impact of Family Abuse/Conflict											
1. Educate about words/actions that hurt (normalize, support, rationale for treatment)											
IV. Alternatives for Families Plan (Personal Skill Log)											
1. Introduce/initiate the plan (explain AFP, identify positive words, add them to AFP)											
Topic 4: Caregiver: Talking about Family Experiences and Psychoeducation											
I. Caregiver's Family of Origin and Caregiver Letter											
1. Discuss family of origin (experiences, views/emotion, discipline)											
2. Develop caregiver letter (summarize, help draft letter, read aloud)											
II. Child's Exposure to Positive and Negative Family Interactions											
1. Exposure to positive/negative talk (rationale, exposure to each, summarize)											
III. Exposure to Force											
1. Explore exposure to physical force (caregivers' use of, risks of physical force)											
2. Summarize discussion (pos/neg words/force, normalize, responsible for own actions)											
IV. The Referral Incident/Other Conflicts											
1. Summarize incident based on caregiver reports (summarize/reframe, understand classification)											
V. Psychoeducation on Use and Impact of Family Abuse/Conflict											
1. CPS involved (psychoeducation, referral incident, provide context for report/what happens next)											
2. CPS uninvolved (psychoeducation, conflict situations)											
VI. Alternative for Families Plan (Persona Skill Log)											
1. Introduce/initiate plan (explain AFP, identify positive words, add them to AFP)											
PHASE II: INDIVIDUAL SKILL BUILDING (SKILLS TRAINING)											
Topic 5: Caregiver: Emotional Regulation											
I. ABC Model and Reaction Triangle											
1. Explain ABC model (rationale, ABC/reaction tri handout, apply to real-life situation)											
II. Anger and Anxiety Reaction, Cues & SUDS											

1. Explain role/impact of anger/anxiety (use reaction triangle, feeling vs. responses)											
2. Identify physical cues of anger/anxiety (Response to Anger/Anxiety wrksht, what cues they experience)											
3. Describe SUDS (Feelings thermometer wrksht)											
4. Identify anger warning signals (external/internal triggers, Anger/Anxiety Warning Signs sheet)											
5. Identify anxiety warning signals (external/internal triggers, Anger/Anxiety Warning Signs sheet)											
6. Review (psychoeducation on anger vs. anxiety)											
III. Controlling Anger and Anxiety: Physiological Skills											
1. Introduce Anger/Anxiety control (rational, discuss already used methods)											
2. Controlled Breathing (rationale, model, instruct shallow vs. deep breathing)											
3. Progressive muscle relaxation (rationale, explain PMR, handout, practice)											
IV. Practice and Relaxation Plan Development											
1. Practice using upsetting experience (recall experience and practice breathing/PMR)											
2. Develop relaxation plan (Relaxation Practice wrksht)											
V. Developing Materials for Clarification Letter											
1. Document material (summarize, meaningful statements and lessons learned)											
Topic 6: Child: Emotional Regulation											
I. ABC Model and Reaction Triangle											
1. Explain the ABC Model (rationale, ABC model handout, reaction triangle)											
II. Getting Angry and Anxious, Cues & SUDS											
1. Role of anger/anxiety (reaction triangle)											
2. Common physical cues (define, Response to Anger/Anxiety wrksht)											
3. SUDS (feelings thermometer, wrksht, identify child's SUDS)											
4. Anger warning signals (external/internal triggers, Anger/Anxiety Warning Signs sheet)											
5. Anxiety warning signals (external/internal triggers, Anger/Anxiety Warning Signs sheet)											
6. Review SUDS and warning signals (psychoeducation on anger vs. anxiety)											
III. Controlling Anger and Anxiety: Physiological Skills											
1. Introduce Anger/Anxiety control (rational, discuss already used methods)											
2. Controlled Breathing (rationale, model, instruct shallow vs. deep breathing)											
3. Progressive muscle relaxation (rationale, explain PMR, handout, practice)											
IV. Practice and Relaxation Plan Development											
1. Practice using upsetting experience (recall experience and practice breathing/PMR)											
2. Develop relaxation plan (Relaxation Practice wrksht)											
Topic 7: Caregiver: Restructuring Thoughts											
I. Session Overview & Reaction Triangle											
1. Provide Rationale for understanding role of cognition (purpose, agenda)											
II. Using a Clinician Example to Illustrate the ABC Model Pathway and Role of Cognition											
1. Explain key steps of cognitive coping (ABC model, automatic thoughts, pathways of thinking)											
III. Model Application to Recent Experience											
1. Discuss a recent upsetting experience (ABC model pathway, develop alt thoughts)											
IV. Model Application to Referral Incident or Conflict Situation											

1. Identify key contributing thoughts/beliefs (auto. Thoughts, ABC model pathway)											
2. Explore possible alternative thoughts (finish ABC model pathway)											
3. Review suggestions to increase awareness of cognitive reactions (develop plan)											
V. Optional: Challenging Key Problematic Thoughts											
1. Unrealistic or high child expectations (explore in-depth, suggest adjustment if need)											
2. Attribution of negative intent to child's behavior (address using ABC model)											
VI. Developing Materials for Clarification Letter											
1. Document material (summarize, meaningful statements and lessons learned)											
Topic 8: Child: Restructuring Thoughts											
I. Session Overview & Reaction Triangle											
1. Provide Rationale for understanding role of cognition (purpose, agenda)											
II. Using a Clinician Example to Illustrate the ABC Model Pathway: Self Statements and Coping											
1. Positive self-statements (explain, list for child, child repeat aloud)											
2. Key steps to cognitive coping (ABC model, automatic thoughts, pathways of thinking)											
III. Model Application to Recent Experience											
1. Discuss a recent upsetting experience (ABC model pathway, develop alt thoughts)											
IV. Model Application to Referral Incident or Conflict Situation											
1. Identify key contributing thoughts/beliefs (auto. Thoughts, ABC model pathway)											
2. Explore appropriate alternative thoughts (finish ABC model pathway)											
3. Review suggestions to increase awareness of cognitive reactions (develop plan)											
V. Optional: Challenging Key Problematic Thoughts											
1. Reluctance to altering thoughts: self-blame (explore and challenge)											
2. Reluctance to altering thoughts: dangerous world (explore and challenge)											
VI. Meaning Making of the Referral Incident & Other Experiences of Abuse/Conflict											
1. Explore meaning making of the abuse/conflict (summarize, explore themes, ABC)											
VII. Optional: Cognitive Coping: Positive Imagery											
1. Develop positive imagery (guide child through process)											
Topic 9: Caregiver: Noticing Positive Behavior											
I. Review the ABC Model											
II. Importance of Parenting Style and Role											
1. Introduce concept: parenting styles (discuss caregiver's style)											
2. Introduce topic: parent training (rationale, importance, wrksht)											
III. Child's Positive Behaviors											
1. Identify pos. behaviors and characteristics (rationale, funct. analysis, parent strategies)											
IV. Role of Caregiver as Coach											
1. Discuss roles of caregiver (coaching, importance, obstacles)											
V. Consistency											
1. Importance of consistency (rationale, difficulties/obstacles, minimizing obstacles)											
VI. Attending											
1. Provide rationale (define, describe benefits)											
2. Teach the skill (steps, active listening, facilitate practice)											
VII. Praise											
1. Provide rationale (define types of praise, explain benefits)											
2. Teach the skill (two types, sample praise handout, concerns)											

VIII.	Rewards (Positive Reinforcement)										
1.	Provide a rationale (benefits/types of rewards, pros/cons, concerns)										
2.	Teach the skill (when-then statement wrksht)										
3.	Practice the skills (develop a plan, model giving rewards)										
IX.	A Positive Instructions and Approving Statements										
1.	Provide rationale (define, discuss benefits)										
2.	Teach the skill (instruction vs. request, Giving Effective Instructions handout, model)										
X.	Developing Materials for Clarification Letter										
1.	Document material (summarize, meaningful statements and lessons learned)										
Topic 10: Child: Assertiveness and Social Skills											
I.	Social Skills with Friends and Family										
1.	Understand child's friendships (explore and discuss child's peer interactions)										
2.	Rationale: Social skills/Why use them? (importance, benefits, problems w/o skills)										
3.	Review (ways to show good social skills w/ friends and family)										
II.	Assertiveness: Making Requests										
1.	Ways people get along with others (illustrate differences, passive/aggressive/etc.)										
2.	Teach how to make requests (rationale, examples, skills, practice)										
III.	Assertiveness: Standing Up for Yourself										
1.	Why/When to stand up for yourself (rationale, importance, when/why)										
2.	Teach the skills (thinks of situations, identify what to say, review skills)										
IV.	Social Support Plans										
1.	Rationale for social supports (generate list of possible supports, address concerns)										
V.	Optional: Brief Check-In with Caregiver & Child										
Topic 11: Caregiver: Techniques for Managing Behavior											
I.	Matching the Method to the Problem Behavior										
1.	Review types of behavior/potential strategies (rationale, annoying vs. dangerous, handout)										
II.	Guidelines for Effective Discipline										
1.	General rules for using consequences (relate to behavior, reasonable, meaning)										
2.	Natural and Logical consequences (role, concerns, rationale for both)										
3.	Review "when-then" statements (rationale, examples)										
III.	A Positive Approach to Managing Children's Annoying Behaviors										
1.	Identify annoying behaviors (rationale, identify/list, pos/neg effects)										
2.	Strategies to manage annoying behaviors (to decrease annoying behaviors)										
3.	Positive opposites (define, rationale, positive opposites wrksht)										
4.	Active ignoring (define, rationale, active ignoring handout, model)										
IV.	Removing Privileges										
1.	Review purpose/skill (rationale, rules, removing privileges plan)										
2.	Practice the procedure										
V.	Time Out from Positive Reinforcement										
1.	Teach steps (rationale, time out wrksht, develop plan, what happens after)										
2.	Practice the procedure										
VI.	Contracts										
1.	Discuss purpose/skills (rationale, components, potential problems, contracts wrksht)										

VII. Developing Materials for the Clarification Letter											
1. Document material (summarize, meaningful statements and lessons learned)											
Topic 12: Child: Imaginal Exposure and Preparation for Clarification											
I. Imaginal Exposure											
1. Introduce rationale/key concepts (re-experience/avoidance, habituation)											
2. Take anticipatory SUDS (feelings thermometer wrksht)											
3. Begin imaginal exposure process (SUDS, active listening, open ended Q's)											
4. Post-process the imaginal exposure (praise/thank, use coping skills)											
5. Review SUDS (SUDs graph, hot spots, conclusions)											
6. Psychoeducation about response to imaginal exposure (symptom increase, motivate to return)											
7. Discussion about imaginal exposure statement (expand hot spots, SUDs)											
8. Return to the end of topic 8 (cognitive coping)											
II. Discussion of Clarification Process											
1. Introduce clarification (rationale, discuss letter, address concerns)											
2. Prepare for clarification process											
Topic 13: Caregiver: Preparation for Clarification											
I. Review of Caregiver Training											
1. Discuss caregiver progress during parent management skills training (Alt. Fam Plan)											
II. Preparation for Discussion of Conflict/Abuse											
1. Purpose/highlight steps to discussion (rationale, assess readiness, potential steps)											
2. Highlight potential content to be shared											
III. Drafting the Clarification letter											
1. Introduce/describe the letter (rationale, sections, process, procedure of session)											
2. Begin to draft letter (Clarification Letter Sections wrksht, psychoeducation)											
PHASE III: FAMILY APPLICATIONS (JOINT: CAREGIVER & CHILD)											
Topic 14: Verbalizing Health Communication											
I. Identifying the Family's Communication Patterns/Preferences											
1. Rationale for enhancing communication/explain session rules											
2. Identify positive communication strategies used by each party											
3. Assess use of communication obstacles and preferences (Comm. Obst. wrksht)											
II. Teaching Alternative Communication Skills											
1. Identify communication alternatives (rationale)											
2. Review list of alternative methods (Comm. Alt. wrksht)											
III. Communication Skills Practice											
1. Explain benefit of practice											
2. Practice skills/give feedback											
Topic 15: Enhancing Safety through Clarification											
I. Brief Preparation for Clarification											
1. Meet with caregiver/child to prepare for session											
2. Meet with child to prepare for session (review child's plan, SUDs)											
3. Meet with caregiver to prepare for session (review questions, practice reading letter)											
II. The Clarification Meeting											
1. Conducting clarification (review structure of session and then conduct)											

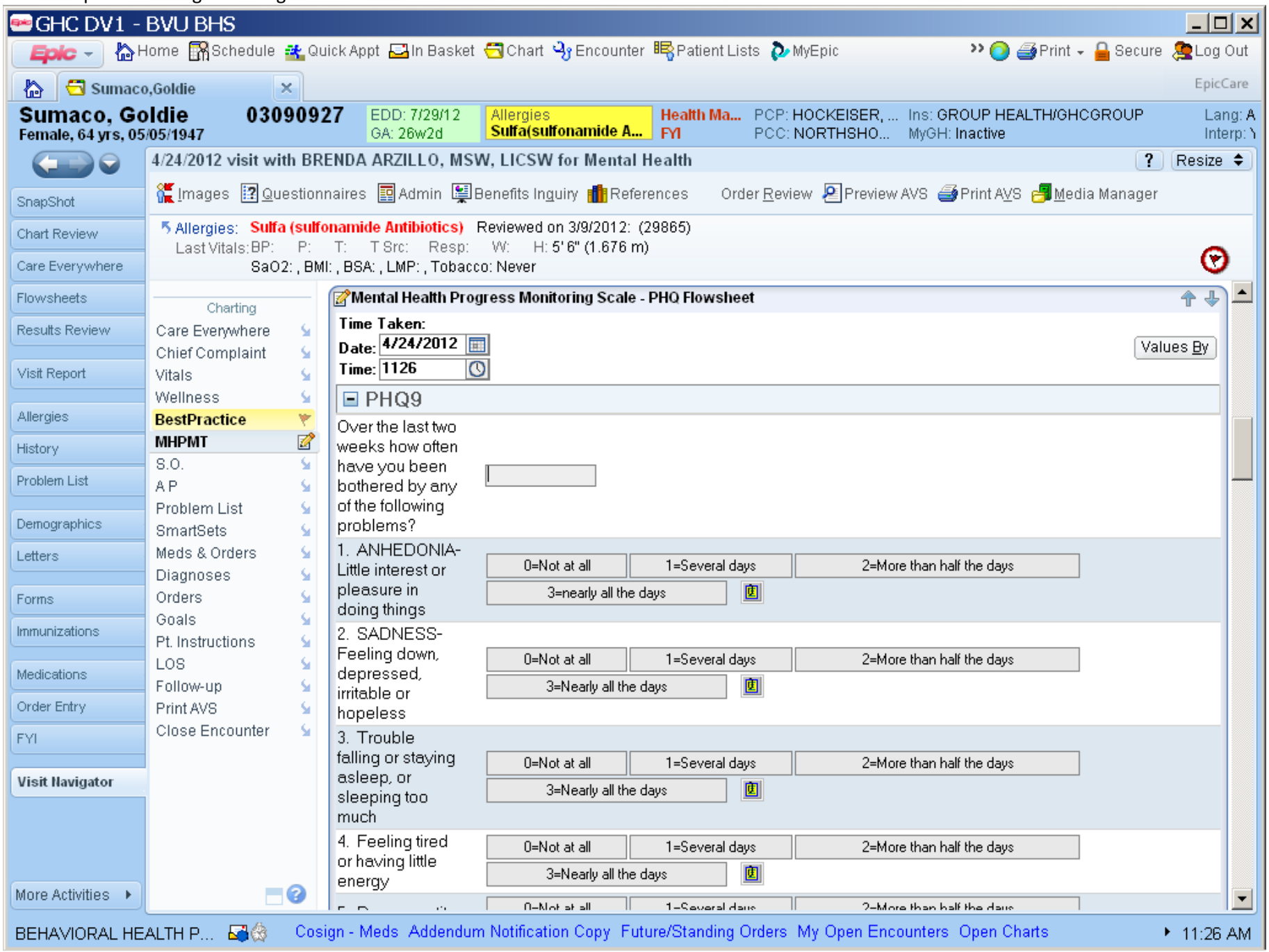
III. Post-Processing the Clarification										
1. Meet with child (discuss reaction and use methods as needed, praise)										
2. Meet with caregiver (discuss reaction and use methods as needed, praise)										
Topic 16: Solving Family Problems										
I. Reviewing the Six Problem-Solving Steps										
1. Provide rationale										
2. Review model and steps (both list problem behaviors, prioritize, Prob. Solv. wrksht)										
II. Practice Using the Six Problem-Solving Steps										
1. Step 1: Identify problem (what is the problem?)										
2. Step 2: Identify goal (what do we want to happen? Realistic, achievable)										
3. Step 3: Brainstorm (identify possible solutions)										
4. Step 4: Evaluate solutions (positive and negative consequences?)										
5. Step 5: Make/carry out a plan to try a solution (when/where/how to carry out)										
6. Step 6: Evaluate outcome/revise plan (evaluate outcome at next session)										
III. Application and Review of the Problem-Solving Model										
1. Review the use of the model tried in the home										
2. Continue discussions for successful problem solving										
Topic 17: Graduation										
I. Current Applications										
1. Review individual/family applications (Use AFP, explore skills learned)										
II. Relapse Prevention Plans										
1. Identify/address potential family problems (potential upcoming problems or obstacles)										
III. Termination Plans										
1. Encourage persistence in using new skills										
2. Optional: Discuss any recommended referral options										
IV. Graduation										
1. Final comments/graduation rituals										

Adapted from version prepared by Mt. Hope Family Center (7/2012) – V2.

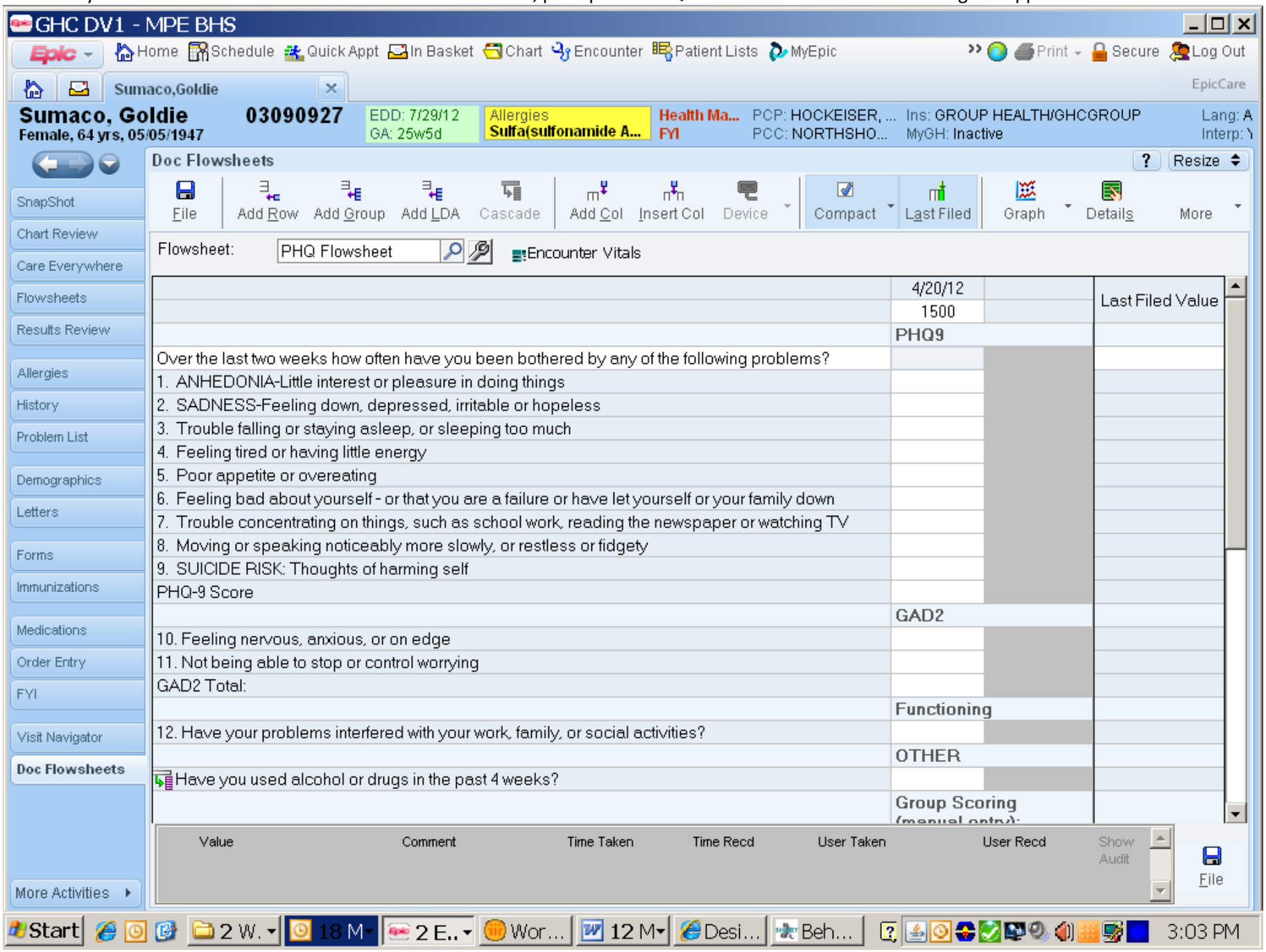
Entering and Graphing Progress Monitoring Tool (PMT) into EPIC

Individual Patients

- Open visit navigator and go to MHPMT site and click on it

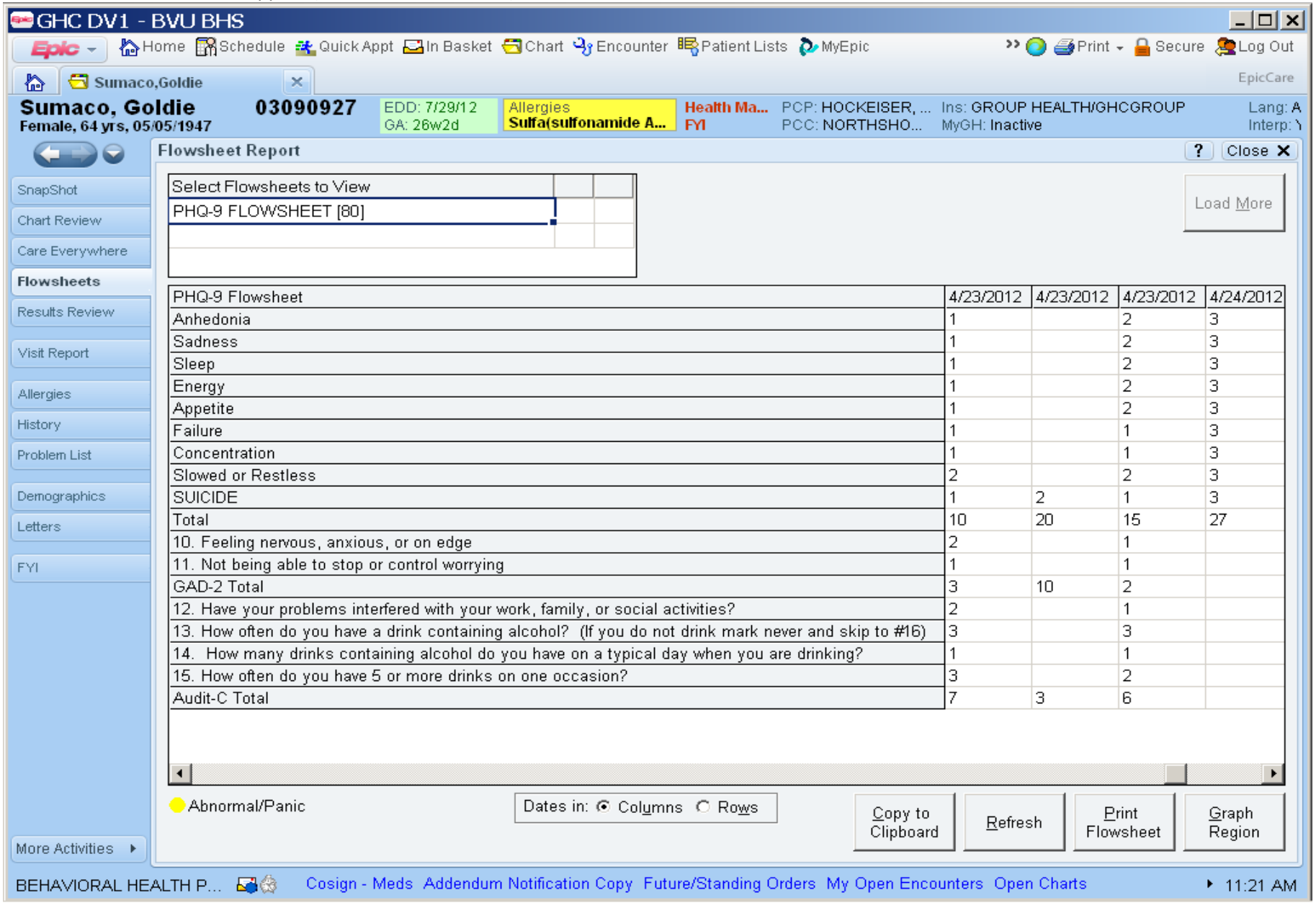


- Enter in first 12 items of questionnaire
- If all responses on AUDIT C substance used questions (questions 13-16) are zero, respond “NO” to other questions and hit file button to complete entry
- If not, respond “YES” to other question and enter in responses for questions 13-16
- If you want to use flow sheet function to enter into EPIC, pull up “BHSPHQ-9” in flow sheet and the following will appear

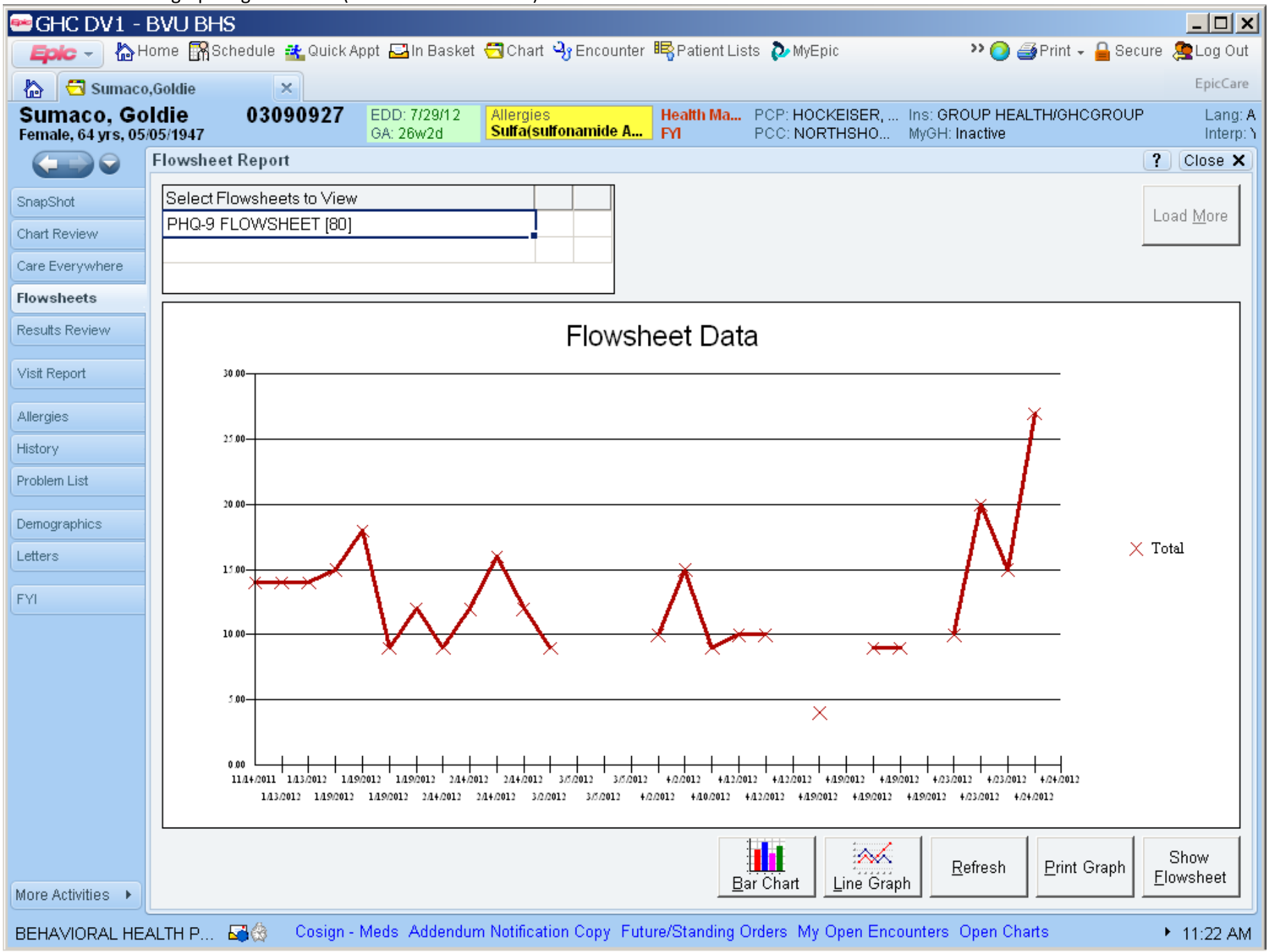


Graphing Progress Monitoring Tool (PMT) in EPIC

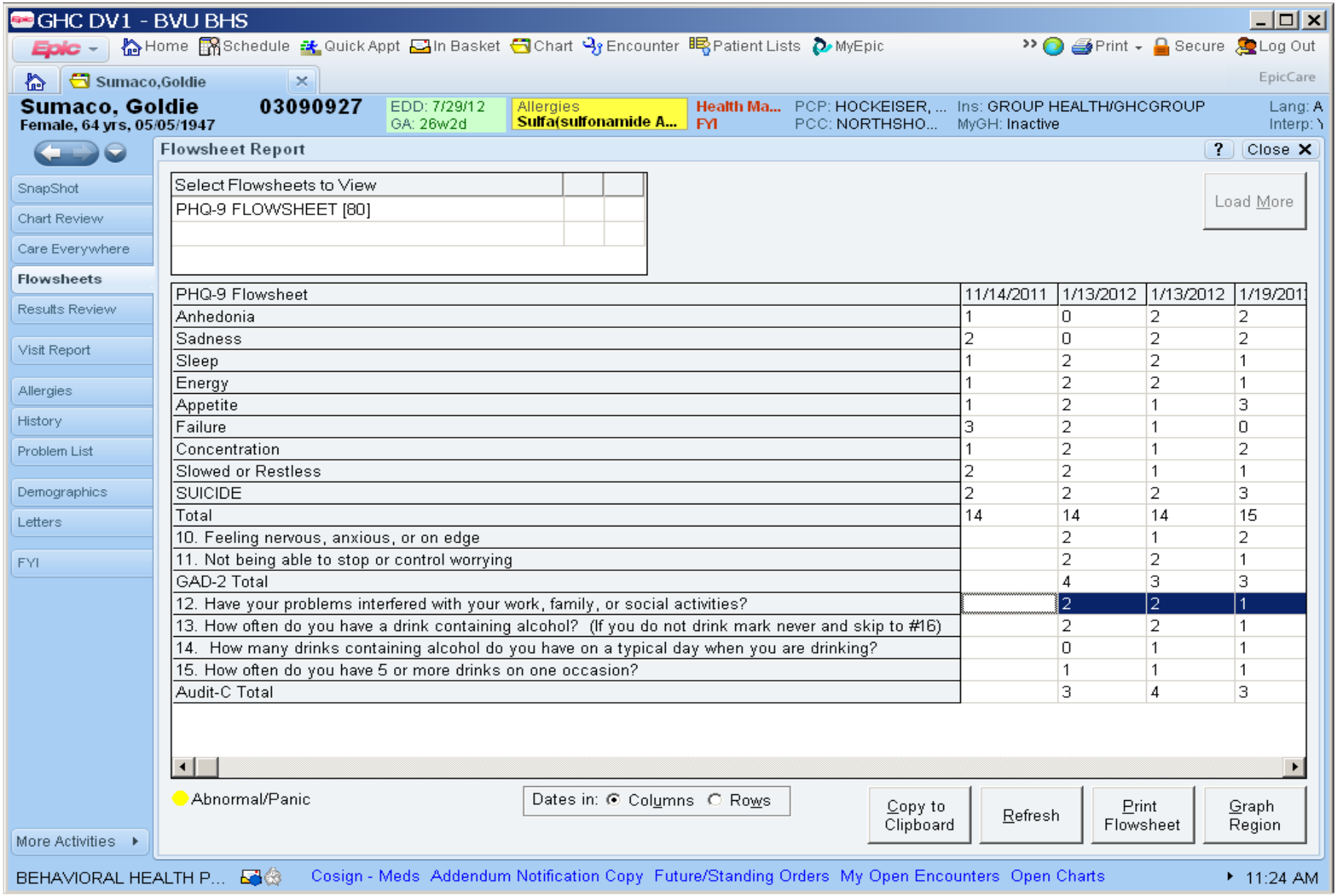
- Identify patient in EPIC for whom you want to review graphed PMT scores
- Pull up Chart Review screen on patient
- Click on the flow sheets tab and enter PHQ-9 under flow sheet name
- The PMT scores will appear (see screen shot below)



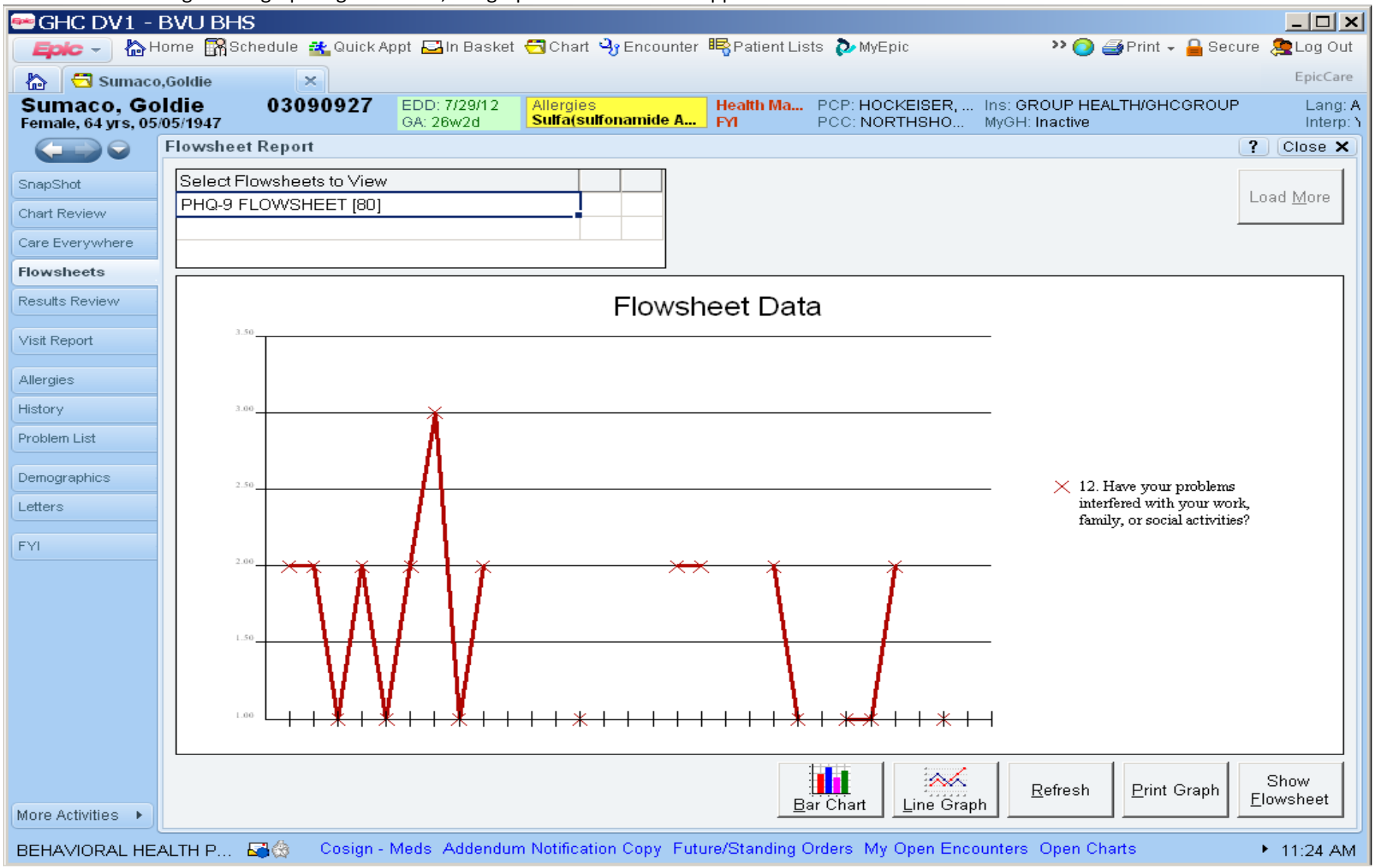
- Highlight the scores you want to dray (typically total PHQ-9) by click and dragging on scores you want to graph
- Click on the graph region button (see screen shot below)



- You can also graph other targeted areas such as functioning (question 12) from the same flow sheet doing the same process as noted above (see screen shot below)



- After clicking on the graph region button, the graph of the scores will appear as follows:



Behavioral Health Progress Tool Process
Provider Job Breakdown

Selected Process: **Progress Tool Administration**	**Job: Incorporation of Behavioral Health Progress into Patient Visit**
Needed equipment and Materials for operation: Progress Tool, EPIC, job aid	
Material for Instruction: Needed equipment, job breakdown	

Important Step: "Why"	**Key Point: "How"**	**Reason: "Why"**
Prepare for visit	• Review past note for most recent patient Progress Tool Scores • Review EPIC PHQ-9 flow sheet • See job aid for flow sheet	• Track patient's progress over time which will inform focus and direction of upcoming visit
Discuss Progress Tool results with patient	• If intake visit: explain purpose and rationale for Progress Tool to patient and it will be occurring each visit • For intake visit, patient completes first 12 questions of tool (not audit C and drug question) and also completes Audit and Dast. • For all other visits, complete full tool. • For all visits: look at current score in terms of level of distress • See Desktop job aid for details  G:\MPE-ADMIN\ BHS-Admin\Project\O • Additional information also can be found on PMT (Progress Monitoring Tool) Script Tips	• Increase patient compliance in completing tools and facilitating understanding of why it is used. • Research shows that asking patient's for feedback about their clinical status results and better treatment outcomes. • Helps the provider stay focused on the episode of care in addition to the current concern. • Helps promote a positive therapeutic relationship by incorporating patient's perspective into treatment.

Discuss Alliance Questions at the beginning of session	• Review and discuss alliance questions specifics with patient in session • Additional information also can be found on PMT Script Tips	• Research shows that provider's perceptions of the relationship often do not match patient's perceptions • Research shows the patients of providers who use a tool to measure the therapeutic alliance have better clinical outcomes than those who use an outcome tool alone • Using a feedback tool ensures the provider assess patient perception at every visit • Any score less than "very often" may indicate a therapeutic rupture and repairing of therapeutic rupture is key to re-engaging the patient and often leads to a stronger therapeutic alliance
Record Progress Tool results in EPIC	• Select MHPMT on visit navigator • Enter progress tool data into MHPMT (flow sheet)	• Keep track of past progress and look for trends
Shred	• Use confidential shred box	

Team:

Manager or Supervisor:

Date Worksheet Completed:

06/25/10

04/17/12 – rev.

GroupHealth

Behavioral Health Progress Tool

Date Completed: _____

Consumer: _____

Clinician ID: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
10. Feeling nervous, anxious or on edge	0	1	2	3
11. Not being able to stop or control worrying	0	1	2	3
12. Have your problems interfered with your work, family or social activities?	0	1	2	3

	Never	Monthly or less	2-4 times/month	2-3 times/week	≥4 days/week
13. How often did you have a drink containing alcohol in the past month? ***If you answer "Never" please skip to question #16***	0	1	2	2	4
14. How many drinks containing alcohol did you have on a typical day when you were drinking in the past month?	0	1	2	2	4
15. How often did you have 5 or more drinks on one occasion in the past month?	0	1	2	3	4
16. How often did you use drugs or prescription medications for non medical reasons in the past month?	0	1	2	3	4
If you have had a visit with this provider before, circle the response that best matches your feelings about your most recent visit	**Never**	**Seldom**	**Fairly often**	**Very often**	**Always**
17. This Clinician and I are working on mutually agreed upon goals	0	1	2	3	4
18. This Clinician treats me with care and compassion	0	1	2	3	4

Depression: PHQ-9
0-5 Normal
6-10 Mild
11-15 Moderate
16-20 Moderately Severe
21-27 Severe

Suicide:
2-3 do suicide risk Assessment

Anxiety: GAD2
0-3 Normal
4-6 Clinical

Functioning check:
0-1 Normal
2-3 Clinical

Alcohol: Audit C
0-3 Normal
4 – 12 Clinical

Drug Use:
0 Normal
1-4 Clinical

Alliance:
Anything less than 8 indicates relationship issue

Progress Monitoring Tool Desktop
Job Aid

Prior to Visit:

- Look up PHQ-9 flow sheet, graph score or see previous sessions results

Start of Visit:

- Look at the first 12 questions. If there are mostly 2's and 3's, this indicates patient is in some degree of distress (may indicate patient is worse, explore reasons). If mostly 1's and 2's, indicates less distress (patient may be doing better, explore what's going well).
- Look at suicide question (#9) of PHQ-9. If 2 or 3, do suicide risk assessment.
- Look at alliance questions (17 and 18). If "always" boxes are checked, acknowledge and validate appreciate that this is working for you). If total less than 8, indicate possible relationship issue and inquire (what's not working, what could be better).
- Look at questions 12 – 16, if anything greater than zero is checked, inquire about status of substance use.