

Session 5.14 – Understanding and Identifying Evidence-Based Practices in Child Welfare: A Focus on Dissemination and Implementation Research

Panelists:

Jennifer Rolls Reutz

Blake Zimmet

Please note: The following is a direct transcription and has not been edited.

Blake Zimmet: Just in the interest of time I think we'll just go ahead and get started here. And I'm supposed to read this as a reminder, the audio for this session will be digitally recorded and once formatted for accessibility standards will be made available to the summit website and deliver and consent participants who ask questions or provide comments during the session will be giving their permission or consent to this recording. If you have any questions about this recording please feel free to talk with someone who is on the support side.

Gregory Aarons: Counselors are standing by.

Blake Zimmet: Alright. So we'll just go ahead and jump right in there. My name is Blake Zimmet I'm the trainee coordinator with The California Evidence-Based Clearinghouse for Child Welfare and I'm usually not stuck behind the podium here so but I'll work my best here. My colleague and our research coordinator Jennifer Rolls Reutz is here with us in spirit and I've had nothing bad happened to her, she is just one of those people that was unable make it due to the flight stuff. And then, but telling then for her we have our implementation consultant Dr. Greg Aarons, so yeah.

I'll just jump right in here with understanding and identifying evidence-based, excuse me, practices and child welfare focused on dissemination, implementation and research.

Gregory Aarons: And maybe since we have kind of small group we just make it interactive with questions come up as we go.

Speaker 1: Yeah, the only thing is as I'm going to ask with the moderator piece is it makes it difficult but I can run the microphone around if that make, if we can just make sure that conversation is recorded and stuff.

Gregory Aarons: Great.

Speaker 1: So I'll be looking out as the folks talk, just indicate to me and I'll run the microphone...

Blake Zimmet: Okay. Could I get a show hands besides for our plug, the plug that we got from Dr. Rick Barth, which is really nice, I didn't see that one coming. So I'm just wondering how many people have, who are familiar with the website prior to him mentioning it and talking about science and recreating, okay. And how many people have been to the website, actually been through it, okay great. Alright, so what we're

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going to go through that in really quick and understand the purpose and the background of the California Evidence-Based Clearinghouse for Child Welfare, understand practical applications of the CEBC web-based tool for those working with child welfare populations, provide more specialized focused in the areas of dissemination and implementation research and identify some of the challenges with implementation EVPs and learn successful strategies to overcome them.

So I threw in this little quote here, it is easier to build strong shoulder than to repair a broken man, and I really think it's important that even though we're talking about a website here what goes on behind, all of this effort is for the children and the families that were working so hard to serve. So and I make sure that with all of the direct service providers and the people through CPS that I've worked within the past that that message isn't lost, so throughout the trainings and the work on dissemination that we do.

So the purpose of the CEBC I think this is something that it's different for everyone, depends on what perspective you bring to child welfare, what your area of expertise is and I want to start off by telling a quick story, this picture is actually taken almost a year ago, I work through Rady Children's Hospital, San Diego and through the Chadwick Center and I was prior this position a trauma therapist and what we're working towards doing is partnering up with a another agency called Arthur Outreach, and trying to integrate sports and other activities into our trauma treatment model, which was trauma-focused cognitive behavioral therapy. How many people are familiar with TF-CBT? Okay and we're trying to do that and bring therapy outside the office.

Now I was all excited about it and getting all like worked out like this is easy we can just get it funded and this won't be a problem at all I don't say how this going to work out, we have the people to partner up with and who are going to provide all the equipment, the surf boards and we can take it to another level and do rock climb and all that stuff. And throughout this process what I learned was a really valuable lesson is that this all looks great and in theory it sounds really good but is it really doing what we're hoping to achieve, will it be something that is better than the therapy that we're currently providing or is it just something that's really cool and fine and something that looks really attractive but it's not achieved in those results that we're starting out to do.

And so what I hope to do with this project is try and work towards getting other people, no matter what their perspective is to really understand that, it's so important that we're testing and evaluating and seeing what we want to achieve and that we're getting the results that we set out to do. So, and it's really important and this is, this would be an incredible project I think but I definitely would want to make sure that it worked prior to going full into it.

So anyway, so this is our homepage and we will be able to do a little demo later on and we're actually trying to make it a little less text study, which should hopefully be done in two to three months and make it little more inviting to the first time user.

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So a quick overview of the CEBC, it's funded by the California Department of Social Services and OCAP, the Office of Child Abuse Prevention, the Chadwick Center at Rady Children's Hospital, San Diego had partnered up with Child and Adolescent Services Research Center, CASRC and that took place that was a grant that we went back in 2005 and in 2006 the website was officially launched with only two topic areas and I think it was 15 programs listed within it and currently we have 32 topic areas with 204 programs listed within it, so we're kind of hard there.

The goal of the CEBC is to provide easy access to information about child welfare related programs through a user-friendly website, so we're trying to make it so that whether or not, whether you just have 5, 10 minutes to look up something real quick or you're interested in looking at the extensive research that we have on there and it's really practical for anyone who wants to use it. So we are both brief and detail summaries for each review program, each user can determine the level that they want, and the programs are rated on level scientific support if it's possible, so we'll go through that later.

Guidance for the CEBC, this was something else that Rick Barth had mentioned earlier during the planetary, he is on our scientific panel, we also have an advisory committee and it's, at this point there is, I believe there is 18 members on it and they all vary from adolescent-child welfare professionals, child welfare directors to public and private community partners and community based organizations and they were pretty much, they provide for us a lot of guidance, they're also critical in terms of they're the ones that provide us with information and also steer us in that direction and giving us those five different topic areas that we're setting out to look into every year, so and I'll – we'll go more into that later.

So our scientific director Dr. John Landsverk, I believe many of you might be familiar with him and also many of the people here on this list. So, and they also make sure that we're up to date with the latest emerging trends and research and they're just familiar with everything that's out there, all the things to look at. They also do a lot of speaking out there nationally and trying to make sure other people are interested on board and I really like something that I heard one of the people in our scientific panel talk about Dr. Ben Saunders, he does, he gives a great talk at one point and sharing about something called that's like a chicken therapy, I don't know how many people have heard of, yeah, mean either or for him.

Anyway that's basically sharing that it's great if the children are coming out therapy laughing and having a good time with their therapist because they've been doing dance like a chicken therapy for the last 45 to 50 minutes but is it really achieving those results, is there really trauma treatment going on in there? So these are important things that people need to be familiar with and really be looking at.

So this is everyone else on our team, so Charles Wilson, our executive director, our project manager Cambria Rose Walsh and yeah these are some of the people behind the scenes. And we also through CASRC right there and we also, we work in the same building so we're able to check in with each other and go through everything together,

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Jennifer Rolls Reutz, Jordan, Emily Trask, and of course Greg Aarons here, our implementation resources consultant.

So just really quick, why evidence-based practice now, hopefully is something now that a lot of people are really familiar with, just when I worked as an emergency response CPS worker from 2001 to 2006 there was never any talk about evidence-based practices and all those years I was there, except for when I was in graduate school and I got to hear about it. So I just thought as far as it goes on the front line for the most part they're not talking about it much and that was pretty reason, so it depends on the agency but I know back then through San Diego County Health and Human Services Agency there wasn't something that that a lot of people are familiar with.

So some great thoughts about evidence-based practice, this one by Gandhi's Great, what do I think about western civilization? I think it would be a very good idea. So this is pretty much to me just as the same, we have the capabilities to really look at all the research and check out the programs out there and make sure that we're doing what we're doing is helping and creating results and so we might just want to be doing it. And then new ideas passed through three periods, it can't be done, it probably can be done but it's not worth doing and I knew it was a good idea all along. So this one also is a great one, a lot of people would say that there is programs out there that just might not work out but why not just go for it and tested it and who knows what will come of it. So just then keeping in mind though that from the get-go, we're really looking at what's out there and whether or not we're making a difference and we're familiar with everything that takes to run a successful program.

So this large gap between scientific knowledge and frontline practice, this is something else that Rick Barth had mentioned and talked about and this came from back in an article 2001 through the institute of medicine that 17 years that gap and what we're hoping to do here is to reduce that gap. So, and with of course this process it takes time but it seems obviously with a big conference like this and so many great minds coming together that we're working towards that.

So the CEBC's definition of evidence-based practice for child welfare, what we hope to bring here is that circle right there with best research evidence and this is adapted from Dr. David Sackett's model through the Institute of Medicine and what we're hoping to do here with that consistency with family and client values and that best clinical practice that that center sort of provides there pulls it all together and creates that evidence-based practice.

So with all sorts of treatment out there and it's important ethically that we're providing services to clients that work and are safe and what we often find at least on the front line is that if they aren't working and they're not effective we're showing some sort of results and if we're not communicating this with the families that we're working with and giving them those real ideas of, okay how many weeks until they see results or months and lining then though being upfront they will go somewhere else most likely and unfortunately this is sometimes where they go to Brussels Stress Management Clinic or

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they'll find somewhere else to go or they'll just start using some sort of, some sort of program or treatment out there that looks really flashy and grey but it just hasn't been tested, it's not – even though if it's working or even worse it could be doing some harm.

So EBPs and child welfare less as known about EBPs and child welfare than any other, than other area such as medicine and mental health, I know of course this is due mainly, often times to funding issues but it is possible I think to make it work and get through this. And no one else is looking specifically at those best practices for child welfare services and populations and this is, this was spoken about at various points during our plenary this morning, it's really a unique population here with many complex needs so we have to keep that in mind as well.

So I'm going to go through this really quick an overview of the CEBC process, alright. So basically what happens is our – with our advisory committee there is five different topic areas that are identified and then they really take a deep look at all the research programs in that topic area, everything that has research and what exists out there. They narrow down that program list, the research for each program and they work with the developer on that and have the developer fill out everything and then when it comes back to our team at all the marketing language is taken out of it, it's been edited and it's – we have some really good people there that do their best to make sure that all of that, all the marketing talk is taken out and it's just giving the fact saying exactly what's out there and I'll show you on the website exactly what is on there.

They review and rate each program and post the program information eventually on the website once it's ready. Any questions about that? So hopefully you got, if you didn't get the handout they're right there at the front, I have a handout here in the scientific rating scale and you can just take a look at, I'm just going to go through it really quick and you guys can refer back to it at any point.

So a well-supported program and well supported by research evidence, these programs have multiple side replication, two or more rigorous RCTs in different settings have been found the practice to be superior to an appropriate comparison practice. The RCTs have been recorded in published peer-review literature so this is key right there and at least one RCT has shown that there is a sustained effect for at least one year beyond the end of treatment. So that's in order to make need that one. Two is at least one RCT or one, we have one RCT also in peer-review literature and sustain effect for at least 6 months beyond the end of treatment.

Promising research evidence is a three, at least one study utilizing some form of control has found the program to work better and the placebo are to be comparable to better than an appropriate comparison practice and also it's reported and published to review literature. And some additional criteria here, all these practices there has to be a manual or training or some other valuable, available materials either online or on some sort of paper form that the overall weight of evidence supports the efficacy of the practice. No evidence that the practice constitutes a substantial risk of harm to those receiving it

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compared to its likely benefits and that there is reliable value and consistent outcome measures.

Four, where the evidence fails and demonstrate effect, there is two or more RCTs that I found in the practice has not resulted and improved outcomes when compared to usual care and the overall weight of evidence does not support the efficacy of the practice. And five is a concerning practice, if multiple outcome studies have been conducted the overall weight of evidence suggest the intervention as a negative effect on client served or there are some sort of risk or harm by those receiving it. A good example if, I don't know how many of you are familiar with those scared straight programs out there, so I think this reason is what 5 to 6 months ago they come out with research that this program was actually increasing the children adolescents' delinquent and aggressive behavior by 28% and so, and this is the research that they did and they had completed on it. And when you, and at first a lot of people were really like, it's really weird and it doesn't make sense why that is and what they found was happening were that these children, adolescents have typically have more of a – often times fall victim to that bullying type of attitude and take on that persona were identifying with those inmates and those people that were – that were doing this operating here and as the mentors or counselors for this scared straight program.

So yeah it's, once that research is done and out there and there is other stuff out there that has also been found to not show positive results and actually causes harm and these, many of these programs have been funded by big governmental agencies and it's a lot of money that goes into them before they've actually tested and seen the results, so.

Speaker 1: From that and in that example, it's really vital...

Blake Zimmet: It would have been rated, if it was within our topic areas we haven't dealt it quite yet, it's on our list though not that one specifically but mentoring programs is one of our topic areas that we're going to be looking into over the next year.

Speaker 2: A lot of studies with multiple outcomes with that study of what you're looking at singular outcome or what do you do or what is significant for one outcome for an announcement...

Gregory Aarons: Yes, so for the recording the question is, what do you – what does the CEBC do when you have a study that parses out its outcome to different published papers I think, right.

Blake Zimmet: Yeah I mean Greg is very familiar with that and what happens I think but when if, can you ask me one more time, I'm sorry.

Gregory Aarons: So the issue is, so say X, Y, Z treatment there is a big randomized trial typically people have lots of different things they measure. They usually becomes if the criteria for a number one rating the highest rating in the CEBC is to have two randomized control trials, can they publish two studies or two papers from that reporting different

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outcomes and the answer is no that the randomized clinical trial has to be a completely separate study rather than, and it has to be focused on the primary outcomes relevant for, well I guess the relevant scale, which we'll talk about in a minute talks about the relevance of the outcomes for child welfare but this study wouldn't qualify as having two if they just published multiple findings from the same.

So sometimes we have to go back and look at the literature carefully to see well exactly what they did is, this is the same sample or is it a sub-sample of the larger study and other rating criteria also limit sub-sample analysis that has to be the major sample that the study was designed to assess.

Blake Zimmet: Okay that, yeah it makes sense. I'm not little self-disclosure here, I'm not a researcher just as one of our plenary speakers this morning. So fortunately Greg was able to come around and then help me out with the tougher questions like that. So not able to be rated and I'll show a breakdown of all the different programs that we have on our website, this is a majority of them. When the practice lacks out adequate published peer-review researched and peer determined its efficacy or the efficacy and then the practice is generally accepted and clinical practice as appropriate for use. We have 9 different programs under the topic area of youth transitioning into adulthood and all 9 of them are unable to be rated at this time, so you can tell there is a real need for that.

Gregory Aarons: So it's somewhat controversial I think with any of these rating skills. So what about on publish research, what about doctoral dissertations and those sorts of things? What about the issue of negative findings that often don't get published or lack of effects they're more difficult to get published and I know the scientific advisory committee wrestles with those issues as well and how to either include or not for now, it's what appears in the published literature, the assumption being that there is more rigor if it's subject to the peer-review process. So that is the case for any of the rated programs that the CEBC looks at.

Blake Zimmet: Yes.

Speaker 3: Is there ever been inspiration changing [indiscernible] [0:25:07]? Does that make sense, I don't know if it's in that level...

Gregory Aarons: Yeah so the question is, has there, is there another approach for rating the NR those without enough publishing.

Speaker 3: Right and is there a way, especially since the NR category seems to be so large, since I've been on the website, it's hard to kind of cipher through that because it is divided category now so how any of the inspiration that you have taken in the literature or not and...

Blake Zimmet: Yeah. Our scientific panel has, they design and came up with this one type rating scale which actually used to be 1 to 6 and so there wasn't not able to rated and

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they found that it was, just wasn't possible, it wasn't working out. There are so many they were not able to be rating though and coming up, we did some consulting work in Florida and Jennifer Rolls Reutz who was supposed to be here actually shared, she shared what was a version of what you were just talking about during our meeting of trying to develop something like that but of course that's something that we would have to take back to our scientific panel and it's a great idea, it's something that might be even the next direction that the CEBC needs to go at some point but I think in the mean time they've just come up with the standard of peer-review literature.

Gregory Aarons: Yeah and it's an interesting process which is I mean I'm not part of the advisory committee but the, it's not just what sort out in the literature but intervention developers and communities and folks who want to get there name up here contact the CEBC as well to have their programs rated and so that's a matter at some cases of educating about what research evidence is required.

Blake Zimmet: Yeah and we mentioned that too and there is strengths and limitations coming up and so we'll talk a little bit about that. It's okay, no that's good.

Gregory Aarons: Yeah.

Blake Zimmet: This is adapted actually from Dr. Richard Barth and so I don't want to say it's the scientific rating scale for dummies or anything like that but that's trying to work off of a metaphor, an analogy to make it so that it's a little more user friendly for possibly like some child welfare professionals or direct service providers that might not get so heavy into the research that's out there. And so well in rock solid foundation not likely it shift overtime to, and we – Jennifer and I, when we adapted this from his, from what Dr. Barth had put together is kind of the foundation of a good strong home. So I'm gravel less stable but still forms decent foundation, sand more likely a shift overtime. And lot of our three is eventually, if they're keeping in mind really evaluating and looking at the work that they're doing along them raise up to a two or one eventually, so four, water may flow for some time than in the long run likely it sink and gas full of hot air are worse, and ours not able but we rated unknown foundation so we get the engineers.

Alright, as far as out of the 205 programs that we have rated at this time 20 are ones so that's less than 10%, 62 are threes that's 30% and then we have 94 that are not able to be rated at this time so that's almost 50%. So there really is a need for a lot of these programs out there to be looking at and working towards testing and evaluating and research, and doing some real research there. This relevance to child welfare scale, this was something that Rick Barth had mentioned earlier, the high designed or commonly used for child welfare clients, medium design are commonly used for population similar to child welfare clients.

So for the most part a high is most likely the children that have – that this program works towards are children that have, children or families that have been involved in the child welfare system. And medium is more those that are at risk and then well it would be

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more of possibly some school based programs or the ones out there that might not be very similar to child welfare populations.

So their husband talk also about us and I don't know when this will happen but taking the – currently on the website also there is one for high, two for medium and three for low and what some programs are doing when their marketing are saying that their rate at one on the CEBC but they might not be able to be rated or scientific rating scale but they have a high relevance to child welfare, so just really being able to look at what's been said.

Speaker 4: So I just speak with this mic or not?

Blake Zimmet: We could repeat what you want to say but she felt like moving around.

Speaker 4: Yeah just speaking about the last five, I know one of the topics that to be tackled is prevention and so you take if it's programs that are progressing the needs of parents are being involved in child welfare system that could be I would hope highly relevant to child welfare but it looks like it would just get a medium relevance on what you're showing here rather than high. So I guess the question is, is it relevance to child welfare as a field or relevance to child welfare clients and so not the same.

Blake Zimmet: So the question is, is it relevance, is it relevant child welfare as the field or relevant child welfare as a client or just specifically relate to the clients.

Gregory Aarons: Yeah, I don't know if you have some insight information I don't know. I think each practice would be evaluated based on the potential, so if the high risk population that in a prevention program focuses on is at risk for child welfare involvement I would see that as relevant, I'm not again part of the group that does the...

Speaker 4: Right but the potential medium that is looking at...

Gregory Aarons: Potentially and I think that's a great...

Speaker 4: If prevention is a goal, which hopefully it is, for a child welfare system it could be high or very high, highly relevant.

Gregory Aarons: Yeah, I'm wondering the – if the outcome of the studies of the prevention program if one of the key outcomes that was tested was future involvement with the child welfare system it seems like that would be highly relevant, so that could have something to say about the design of a study to demonstrate relevance to child welfare, right, so designing it in a way that you could show prevention of involvement in the child welfare system for families involved in your prevention program. So I'm just kind through on this out of the discussion at this point.

Blake Zimmet: Yeah, I just wrote down your question so it's something I'll bring up and we'll talk about.

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Gregory Aarons: Yeah I'm just thinking I mean if the outcome or child behavioral problems or delinquency then that would be related but not the same as actual child welfare system involvement an open case referral to child welfare. It's a great, great question though, it will be transmitted to the powers that be...

Blake Zimmet: Definitely.

Gregory Aarons: No but I do think that the scientific advisors struggle with these issues too and discuss them in the ratings.

Blake Zimmet: Okay we touched on this one already with the strengths and limitations. The rating scale at this point we try to make it as a clear cut and as objective as possible and the numbering system is easy to follow and that's I think that's a major strength that our clearinghouse or website has. It may miss high quality research and studies, so by the line on peer unpublished peer-reviewed research. So yeah we definitely knowledge that and yeah.

Speaker 5: After a program has been reviewed do you feel that periodically the safe is doing research or new evidence?

Blake Zimmet: Yeah average is, ever as the website increases and gets busier with all the programs out there that we, every year or a year and a half when I go back and then look at what's been updated, there has been new research and we also – we often ask that the developers keep us posted this and that. Alright, so lessons learned, the rating scale needs to be as concrete and objective as possible so but as going back to your question I feel like that unable to be rated I'm wondering if it's possible to bring some objectivity into that by having almost subsets there and looking at other studies or other things that might exist out there, non-peer-reviewed research and literature.

The rating scale needs to allow for changes over time as issues arise, so there is some flexibility there and we are trying to make it better as any program should or would hopefully and include all identified programs, including non-responders and refusals as the website gains in some popularity or just the CEBC we have some programs that are getting upset with their rating or, and involve wares and so that's definitely coming up. And then at that point the hospital just gets its legal pin number, so yeah...

Gregory Aarons: So all of this is not without controversy.

Blake Zimmet: Right.

Gregory Aarons: Why did we get that rating what is it mean, also if people are on the site regardless of their rating they might put it in their promotional materials listed on the CEBC for California website without saying what the rating is, things like that.

Blake Zimmet: Yeah or being misleading and saying there are one or two on the child welfare relevance rating, yeah exactly.

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Gregory Aarons: And they may sincerely believe that also.

Blake Zimmet: And then need process for self-nominated programs, so this is also something that I'm just, lessons learned as we go. So just going to try and take a quick moment here with the – so like here just a demo on the website, we have all these different topic areas. If anyone has one that they really want to see or curious about otherwise I could just go with something that I'm familiar with, so does anyone have anything that they...

Interviewer: Stabilization placement...

Blake Zimmet: What was that placement, stabilization?

Interviewer: Placement stabilization.

Gregory Aarons: Hit it again.

Blake Zimmet: It's loading, it's also an issue that comes up with some technical difficulties at time. I did take screenshots in case when we ended up so okay.

Gregory Aarons: Could you just scroll up a second? So something the interesting to notice there is this bar right under the description why was placement stabilization chosen as a topic by the advisory committee. So there is links for the practices that kind of discuss the rationale for that can be informative as well.

Blake Zimmet: Thank you Greg, yeah and this is something that our topic expert would do before we go and delve into a topic area, we do have someone on topic expert that works with us on this. So yeah, so it would be, yeah we'll click on that and why it was chosen. And, so within everything here we have, as you can see we have that multidimensional treatment of foster care for adolescents, which has a one, rating number one and then for preschoolers as a rating number two. So and then we have all these with the rating number three, so we can just go and then there is not able to be rated at this time by the various others and now we'll just go strength based here with the one, you can see the scientific rating here along with the child welfare relevance rating. So there is a brief description where you can find the child welfare outcomes, permanency, child and family well-being, types of maltreatment, target population and then contact information, Patty Chamberlain, who many of you might know.

And then to view a detailed report simply click on view detailed report, we have all the central components. So basically all the work has been done for you, this is – I've been presenting more at San Diego State University and we're working more with CalSWEC and the students both graduate and undergraduate just love this or when papers are coming out because what we have here is a breakdown of everything here just the way it's built, child component, caregiver component, group format, delivery settings, homework, languages it's offered in, the resources and get to run the program, yes sir.

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Speaker 6: Is there a place that where it explains why it's two in terms of relevance rather than one in terms of relevance?

Blake Zimmet: Yeah, it only referred to back to the scale so that's...

Speaker 6: So that was saying why does particular program is always somewhat relevant, it doesn't say that anywhere else.

Blake Zimmet: Right.

Gregory Aarons: But...

Speaker 6: So you seem like that might be in interest.

Gregory Aarons: Yeah. No I agree because I was looking at it going, no, why is that a two, I don't remember because I think MTFCP had a relevance of one, is that correct?

Blake Zimmet: With the...

Gregory Aarons: For the younger kids.

Blake Zimmet: For the younger kids. So yeah, it's a high relevance there, so lots of good questions been asked about the child welfare relevance rating so...

Gregory Aarons: No but I think it's a great point something that should go back to the advisory committee because you want an explanation about what the deliberation was that led to that.

Blake Zimmet: Yeah.

Speaker 4: Actually one could add the same point about the scientific panel could be I think by interest and to summarize the thinking that this is collaborating...

Blake Zimmet: The explanation for the...

Speaker 4: Summarized, yeah.

Blake Zimmet: ...for the scientific panel.

Speaker 4: Rather than just take his our word.

Speaker 3: Well let me think it'll be helpful from [Question inaudible] [0:42:52 - 0:43:29].

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Gregory Aarons: Right. So the comment is to maybe provide more information not only about the deliberation process for the ratings and how the conclusion was drawn but also information for case work staff as well. I think for the scientific rating scale the criteria are little more clear getting some thoughtful nods back, maybe I'm seeing some maybes out there but yeah.

Speaker 7: The general topic area of the placement stabilization, is there a literature review or any sort for the topic like stuff...

Blake Zimmet: Oh for the entire topic area? No, I mean if you, within each program...

Speaker 7: I saw that.

Blake Zimmet: We have the...

Speaker 7: Those are resources where the study was published...

Blake Zimmet: Yeah, right.

Gregory Aarons: I mean it sounds like what you're referring to is like a Cochrane collaboration type review, a systematic review of all the literature and I think that is not available on the CEBC website but it would be very nice to have.

Blake Zimmet: We do have...

Gregory Aarons: But then I'm wondering how often would that need to be updated like every three years, I mean systematic review like that is a three months.

Blake Zimmet: Okay, three months.

Speaker 7: Resources development...

Blake Zimmet: Well also here we can go through it, if we have time later with the various resources there are various articles that we have focusing on a real quick though before I forget in terms of programs that are rated either one or two have implementation information. So that's all there on the website as well.

Speaker 8: Yeah I think I have a question on that, all these are programs, projects, are they also industries I mean are they, I've seen a lot of models become something that moves in you have to purchase, so you need a profane...

Gregory Aarons: Right, yeah.

Speaker 8: Versus someone that says, you know what we really need to improve placements, how do we go about doing that and then giving them ideas for what they

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might do on a day-to-day practice it's more of a self-contained model that someone has a business...

Gregory Aarons: Yeah, so the question is how formalized are some of these models in terms of being able to apply them in your own setting, do you have to purchase the entire program or can you learn about it and apply some pieces, which is I think an ongoing issue especially for agencies, child welfare programs, community based organizations, what if we can't afford the catalog, what if we want to apply – I think the answer is that, the ratings are on the programs as designed. Now some of intervention developers have moved to more of a model with their own organization, multi systematic therapy, MTFC is going there, IY Incredible Years as to some extent, PCIT not so much. There is variability PPP is at globalization level but so I think there really are referring with going about now anyone can come to the website and use the resources to learn about what aspects of models at least the intervention developers believe are responsible for the effects and to use that in whatever way they wish.

I think the hope is that the practice as designed would be implemented with appropriate adaptations for whatever particular service contacts but I think that was the main hope and intent of the ratings.

Blake Zimmet: Alright. And that's something else we provide that education and training resources, contact information. So a lot of people ask if we have, if we threw costs on there and have looked at that and we – I think we tried that years back at various depending on a costs, it's very different to run something out of California versus maybe Oklahoma or Kansas City...

Gregory Aarons: Well I mean there is going to different variables in any service system that you have to take into account.

Speaker 8: Well lot of these you could read them and replicate, is that right? And would that be one results or would that be read the material and replicate [question inaudible] [0:48:35]?

Gregory Aarons: Well I think it's a start, the side is to learn about the practices, their scientific evidence, their fit with child welfare and then make decisions about how you want to proceed or how a system will proceed how an agency would proceed. So say an RFB comes out from SAMSA and says or from the children's bureau or wherever you must do an evidence-based practice and you want to target a certain population so you could come and research the scientific evidence without having to review every intervention yourself. So the ground work is done.

Blake Zimmet: Yes.

Speaker 9: You mentioned at the beginning, you mentioned sort of process for the review and research, I was wondering if you could speak a little bit more to probably

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universal program is selected at the initial level in terms about being, making it on their list to where it go.

Blake Zimmet: So the question, how are the topic areas selected those, is that?

Gregory Aarons: No.

Speaker 9: Well the actual programs within those topic areas?

Gregory Aarons: How are the interventions, how do they come to the attention of the CEBC.

Blake Zimmet: Okay, yeah.

Gregory Aarons: How do they decide which ones they're going to rate?

Blake Zimmet: Yeah excellent question, I may have forgotten to share that. Since our funding source is California we're primarily looking at those being heavily marketed within the state of California however it's also ones that are brought to the attention of our scientific panel and our advisory committee. So if any programs that are really out there and people, they just know that this is one we really need to take a look at that's how we're getting that information.

Gregory Aarons: Yeah and if fortunately there are many interventions being done in California but it really you know starting with the Office of Child Abuse Prevention funding in the state of California really has broadened. So I think originally it was a much smaller world and now it's national and even international in scope.

Blake Zimmet: Right, yes.

Speaker 10: On the website I'm able to narrow down the search to specific program is that targeted specific nature, so if you could just wanted to search [question inaudible] [0:51:00].

Blake Zimmet: No you know, there is that search feature as well on the website however there are, they're still working out the bugs to it like, so within our search engine or that feature with do like a keyword search. It does struggle a bit with that and so that's something that we still need to work with our IT personnel.

Gregory Aarons: So it's yes, but it's not perfect.

Speaker 4: ...when you say that this priority things of California programs is that and I think it's not widely understood, aren't they? A lot of people from around the country and elsewhere in the world I think that they don't get, and that's a real bias. If that is really shaping the selection of which programs to look at, I don't know I need to take a fresh look at the homepage.

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Gregory Aarons: Yeah, well this...

Interviewer: ...there involved...

Blake Zimmet: Yeah okay.

Gregory Aarons: Yeah this was the first time I have heard that from you Blake. So can you back that up with evidence?

Blake Zimmet: No it's fine. Yeah it is something I've shared previously and other training so and I was taught that because that is our funding source and we are at the California evidence-based clearinghouse for child welfare those are the ones that are given priority. However...

Speaker 4: Priority for review?

Blake Zimmet: Right, priority for review to be really looked.

Speaker 6: Which is far as that with developing California or that are being used in California?

Blake Zimmet: That are being used in California they're not all developed in California.

Gregory Aarons: So MTFC was developed in Oregon, PPP in Australia, and credible years in Florida or I mean in Washington State, PCIT in Florida.

Blake Zimmet: Okay. Just really quick, I wanted us to get to the implementation I know we have about a half hour here left. So just with those practical applications of the website for administrators it really helps them to look out whether or not it's a good fit for their agency. And so we do have a whole resource within there on implementation and looking at all those things that make up that implementation, so we'll have this high level of evidence all those programs that are on there, again the implementation and many of these – many different grants and they're asking for specific information related to evidence based practices. So it's something great for influence in funding sources and for direct service providers, just learning more about different EVPs out there. So and really giving them just a snapshot if that's all they want or all they're looking for, and then likes the information about training as well. So this really helps many different professionals out there, direct service providers who are also in private practice.

This is something that my colleague Jennifer Rolls Reutz has been more familiar with but we're trying to do right now evaluation piece on the CEBC, so we're really looking at how we're helping them and what we can improve, what we can work on. So we're out of all the 58 counties in the state of California where we're going to various child welfare directors and really trying to look at how they're using the CEBC and really getting some data on how it's been helpful and how they're using it.

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Alright so, Jennifer and I had worked out this little journey to, through to this road implementation and hopefully what gets you there is really nice kind of paradise, so Greg is going to take us there now.

Gregory Aarons: Yes, implementation is paradise, you feel by that. So yeah, so Jen was going to talk about implementation, I've worked with the CEBC a little bit, some issues around implementation just way – by way of background I've been doing implementation research in child welfare and mental health for about the last 12 years or so, obviously founded by the NINH and CDC.

So if only if we're walking to Lash Gardens towards an ideal since we had at the beach I'd be a happy camper and I've been warned that there are some little clip art graphics in here that in animation.

Blake Zimmet: If they need explanation I could...

Gregory Aarons: Definitely. So I don't know what they all are but the idea is that the roadmap to your implementation that it runs through phases and so I published a paper and administration policy in mental health earlier this year that lays out kind of the topography of the way I think about implementation, which is through a kind of few phases kind of exploration which would be in the practice selection to the adoption decision when planning then begins once you decide you're going to adopt. You better start planning and plan thoroughly in group and looking at community and organization readiness and then on to active implementation which would be the training and fidelity monitoring peace and hopefully on to sustainability to being able to sustain practice.

And it's really been interesting in number of implementations that I've been involved with and had research projects looking at that some of the common, I think lower about implementation is it takes 2 to 5 years to effectively implement, we have a project going now actually in conjunction with the Chadwick Center where we're doing a complete scale up implementation including training trainers so that they can be self-sustaining in one year and that's been a very interesting process trying to accelerate implementation and really having a very focused engagement with our counties and community based organizations to make that happen.

So I'm going to be seeing these lives for the first time I think, so practice selection there is that car again. The way I'd like to think about this out of the organization and management literature and some of the diffusion of innovation literature there is this idea of innovation organization or innovation context fit. All right, so to the degree that whatever practices you're selecting fits with when we think of a multilevel nature of the service system what we call out of context which is more kind of system and inter context organizations and providers. The fit of the innovation with that system, an example of good fit is implementing a child neglect intervention in a child welfare system, the prevalence of neglecting child welfare system ranges from about 65 to 85% of incoming cases depending on the system.

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So if the intervention targets that predominant presenting issue that's a good fit for the service system and also a good fit for the families. Does the practice also fit with the way providers think about delivering services, there are theoretical orientations, they review about how you interact with clients to the degree that you have that fit. So thinking about this values innovation fit during practice selection can be critical and the funding streams are also critical, we are involved within implementation. It's a child welfare maltreatment intervention, it's being implemented in the middle health system and lo and behold one of the issues that we're struggling with is that the agencies that are implementing use medical health funding which is mental health funding but neglect interventions and maltreatment interventions aren't necessarily considered mental health and they don't meet criteria for Medicaid billing. Questions?

Speaker 6: I can't remember do the CEBC website have a information that would help organizations make this decision about what are the practices is a good fit for their county or their legislation...

Blake Zimmet: Yes we have that information on there under the implementation on the left hand side when you go to the homepage. So under implementation we have the whole selection guide and it's based of the work, Trisha Greenhalgh and we also, a lot of the information and the things that Greg has helped us work on.

Gregory Aarons: Yeah, so Greenhalgh, and her colleagues in 2004, 2005 did a really comprehensive systematic review of diffusion of innovations into community based organizations is the best that's out there, it beats any other review today. So that's a big piece of it and she goes back to kind of Roger's diffusion of innovations, trial ability, observe ability of the interventions to the degree that when you're thinking about intervention you can either try it out or you can talk to people who've used it in a similar setting and get a sense for what the challenges were or it's easy to implement, I can help you with your practice selection as well.

So again clearly defining the problem I was just talking about neglect as the particular problem, if it's trauma and then something like trauma focused CBT or another intervention like that but the target population, the goals for change. So the example for the Incredible Years is promote emotional and social competence, prevent, reduce and treat behavior and emotion problems in young children. So if the evidence for IY is around those outcomes if you're trying to reduce maltreatment recidivism IY may or may not be what you're looking for. So again thinking about the fit with the goals what you're trying to accomplish, so here is the Incredible Years, scientific rating one, child welfare relevance two and there is descriptions of...

Blake Zimmet: Yeah sorry, that's just the screenshot.

Gregory Aarons: That's just a screenshot, okay but you can see that the child welfare outcomes or safety child and family well being types of maltreatment that has been

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looked out for our physical abuse, physical neglect and emotional abuse and being used with parents, teachers and children, so it has been tested in those settings.

Okay so other things to think about in terms of fit or how complex is the intervention. We talked about fit with the system and with organizations, how much knowledge skill set, what's the training that's required I think Rick this morning was talking about some – somebody was talking about some training that takes two weeks, taking clinicians or case managers offline for two weeks for training and then putting them in the field is a big expense for organizations, so will that fit, would an intervention with the shorter training and in vivo coaching be something that could work as well or better or can you work with intervention developers to modify how the training and then ongoing support go.

Blake Zimmet: If you're live on the website if you clicked on any of those they have a full description of all those things to look at and examples.

Gregory Aarons: Each of these.

Blake Zimmet: Yeah this is just a snapshot.

Gregory Aarons: Okay. So this looks like a reification of that, imagine the skill set internal or external complexity, absorbability of benefits. And support is going to be critical so you were talking about are there organizations that support you. Well there is support and there is different levels of support, so some intervention developers will have support and training and you can kind of tailor that, some interventions really have their set criteria and if you're going to do their practice then you use their fidelity tools, you will use their web-based tools coaching has to be done X amount of time, their fidelity monitoring is done in certain way and you're essentially developing a long-term relationship with the intervention developer. So that can vary quite a bit depending on what intervention you select.

Speaker 11: So on the website does it explicate for each program what type of support is provided or some of these pieces are such as any general definitions.

Blake Zimmet: You mean on the website if there is specific within each program if they've looked at those things, yeah I mean they – within the website we've broken it down into like central components and the minimum provider qualifications, languages, all of those that information to get specific information about some of these things, yes you would have to call the contact information.

Gregory Aarons: Intervention developers.

Speaker 11: Okay.

Blake Zimmet: But sorry, the ones that are rated, a one or two offer like implementation support, so and we'll get to that.

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Gregory Aarons: Okay. This is what I think talking about earlier I was talking to someone in the hall before we came in about how do you measure organizational readiness or system readiness, say well you can measure it but you're not going to know what you are actually going in and I've done some work with Nolan Proctor at a pro-center on developing a measure of organizational receptivity that having best practice and we looked at comprehensive measures we came up with like 2,500 items and started to narrow it down. Well we eventually settled down for this one CBEC project that I'm doing now is to take the domains that we identified and do a semi-structured to interview around those domains with multiple stack holders to try and get that sense of readiness or the relationships, right relationships in place or the funding sources in place, do they apply to the intervention that we're going to use or staff available or staff ready, your staff, can they be moved from one service to another or can this be implemented right into existing services.

So there are whole range of things that we ask about, that said, even with a comprehensive review there is always surprises, sometimes pleasant surprises when people really do go above and beyond to iron out issues and develop relationships and smooth way and then sometimes hurdles that we work with organizations and it's like organ. So keeping with the conceptual model we think about both the internal and external environment when we talk about the outer context or external environment really thinking about that system level, so our service is funded under a child welfare agency that provides contracts to community based organizations or the policies in place to support the type of services that you want to implement, can contracts be issued or can contracts be modified and we've seen both of those scenarios in implementations of evidence based practices where some counties try to do things under existing funding streams and just modify contracts and others with issue whole new RFPs get the services provided.

In terms of internal environment there are lots of ways to look at that internal environment, it could be looked at very kind of subjectively in terms of our staff available, is the appropriate supervision available, if there were going to be more demands related to the evidence based practices there are ability to have staffs do that or do productivity requirements demand that certain amount of cases be seen, all of those issues need to considered. The other piece that we're doing a lot of work on in my research program is looking at the issues of leadership in organizational dynamics in implementation. So how do leaders at multiple levels in organizations prepare the organizations for moving forward, what kinds of leadership are most effective, what kinds of leader behaviors support implementation of evidence based practice and I'm talking both at leaders of case management teams, middle managers and executive staff but also what kinds of multi-level strategies within organizations support that implementation, so how can capitalize on that?

So the internal environment of the organization and there is the culture, traditions and history of organizations. And so if you're going to start home visitation with clinicians who do kind of psychodynamic process oriented psychotherapy and you want to do interventions that are going and looking for safety as it is in the home that could be seen

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as very intrusive. It wouldn't fit with the tradition and culture of that agency, so some training work would need to be done. I talked about leadership, supervision, support of opinion leaders both in upper management but also your team leaders and what we found is sometimes within case management teams or treatment teams and informal leader emergence who can really be capitalized on during the implementation process.

So connections with other supportive organization, individuals of technology to support change, we're working with different types of technology now to assess fidelity in the field or we'll have home visitors go in and at the end of the session it have a net book that they will set up and then turn around and give to the client to rate what's been done for that particular session of module in home. And so we're trying to get more real time data that can then be fed back to our case management teams to use in supporting the implementation process. We're – we just ordered a couple of things, Samsung notepads, we're going to try using those because if we use those we found, well we think that we'll be able to also put support materials for our home visitors on the notepad so that they can use those other delivering services. So there are lots of different things to think about in implementation in ways you can get creative to support that.

I think I already talked about most of these things in the external environment, yeah and this is one of my pet keys, this is a deliberate comment. So since I'm back from training I got a big binder, the training is already forgotten but the binder will last forever, a living monument to temporary knowledge. I think this really has implications both for training our providers in evidence based models that it's not just that one day workshop or a week or even a two week workshop if there is not ongoing support practice coaching building the teams, working together on this but also the work that we're doing in training leaders and how to apply best leadership practices and create a climate free implementation we use a 6 to 9 month coaching model with them with behavioral targets to also support their learning about how to implement effectively.

Okay so yeah, we know this doesn't work.

Blake Zimmet: So yeah keep going.

Gregory Aarons: Is there other one?

Blake Zimmet: Yeah.

Gregory Aarons: Okay, alright.

Gregory Aarons: So this is, I think this expert consultation over here is really should be a little more prominent in this. The training in the model is one thing you're having the materials available those are kind of the basics that you need to understand but I think if you look at the literature on expert knowledge and development of expertise kind of the ongoing consultation, hitting targets, going alive, being corrected supportively can really go a long way towards creating that therapist provider excellent. And we're finding that that not only does it help with fidelity of the model but when you have a model that fits

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the service system and the providers and the needs of the clients along with supportive coaching we've seen staff burnout significantly reduced and staff turnover reduced significantly and we published that paper one or two years ago on the state wide implementation trial where we actually thought that the implementation would lead to higher rates of turnover because of the reduction in job autonomy, especially when you say to coach out to observe the case managers interacting with our clients but it was really the opposite.

So we're seeing that implementation can be an opportunity for really supporting staff and supporting staff expertise but also supporting them in their work and develop them more generally. This piece here obtain client customer feedback is something that we've been struggling with in my research program how to do that more efficiently. So as I mentioned, I have 10 minutes, as I mentioned we're working with more real time feedback or at least feedback within a week or so that we can give to providers and I know there were discussions earlier today about in a session that I was in about if you just provide a dashboard, if you provide data to case managers and clinicians well they'll use that and we've seen an number of cases where that gets provided but they don't use it, that goes into the case file so the challenge is how to really incorporate that data, those data in a meaningful way that will get used. So like we have 10 minutes left you know the whole...

Blake Zimmet: Yeah, if you want to fly through and then make sure we saved at least 5 minutes for questions or if anyone.

Gregory Aarons: Yeah, so we talked about fidelity and monitoring, this idea of spread, some implementations are going to be very targeted for an agency but in others what you're trying to do is create the capacity. So in thinking about that there had been a few studies that have looked at what's called the cascading diffusion or cascading dissemination model. We've now – we've paid Chamberlain and had one in San Diego county with multidimensional treatment foster care where they moved the expertise from organization social learning center to a larger service system in San Diego county. And then move that to community based organization that now help support the fidelity and retraining of staff and training new staff of MTFC.

We are trying the cascading diffusion model little bit differently in a couple areas, in Mexico we have a 12 city and 8 state HIV prevention study that we're doing where we're doing a train to train the model and community based organizations that's agency similar to Planned Parenthood up here to doing outreach to high risk women for HIV prevention. So these kind of cascading models and spread models can be done in a number of ways through kind of distributing expertise out and then creating a network to support that or there is another study in San Diego County where seed team had a community based organization was trained in safe care and then that team holds the expertise and trains other teams in the county.

And so the idea there is to start with that central team but distribute expertise throughout these individual teams that are made up of providers for multiple organization, so you

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might have 3 CBOs contributing case managers to a team that delivers the evidence-based intervention. So there is a number of ways to think about that and hopefully we'll be doing more with the CEBC website around and ideas for how to do that effectively as we learn now. And then sustainability, I don't think you can have the assumption that once you implement the practices it's going to self-sustain that as with the cascading diffusion models you create local expertise if possible some intervention developers don't really allow that they want to keep it in their own house so that they can kind of monitor the fidelity with which their intervention continues to go out. But it can become part of the culture of the organization and we're seeing a really interesting experiment in Los Angeles county right now on the middle health side, they changed over with their mental health services administration and funds that's approximately \$63 million air tax familiar with that.

So in the state of California, anyone who makes over million dollars there is a one percent tax that goes towards mental health. With those funds this year they came up with a list of 10 evidence-based practices and any agencies or community based organizations that want to receive those funds must do an evidence-based practice. So this is a first step, this is like super top down, we can't give much more top down in this but the question is will it build a culture of evidence-based practice across the service system as agency struggle with this and start to do it.

The CEBC has implementation resources on the site that you can go and look at definitions, implementation tools, some different implementation approaches and implementation resources. We talked about doing ratings of implementation approaches but randomized trials of implementation approaches are few and far between. So we're settling for those with some good evidence in the literature and good support but putting them out there as examples and ways to think about implementation challenges.

So for each program rated one or two we're also trying to provide pre-implementation assessments relative to that intervention and implementation tools and fidelity tools if they're available. So I'm doing the wrong way.

Blake Zimmet: Yeah that's just more...

Gregory Aarons: Okay. Yeah so here is an example, yeah for TF-CBT you just scroll down pre-implementation assessments organization readiness and capacity assessment, so it's a 29 item that are specific to TF-CBT we don't know if they've actually tested or validated these measures but they're provided by the intervention developer. And so there is an example of one of the measures for implementation support, clinicians and our agency agree with rationale for using new practice, we already have many clients we will benefit usual suspect.

So future directions to provide real technical assistance with dissemination and implementation, so I and others as the science of dissemination and implementation around these issues becomes more solid, we're thinking about ways to improve that support on the website, doing webinars and EBPs on implementation issues and then one

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papers or summaries of highly rated programs that can be shared. So way to disseminate information and help prepare the way for implementation as you go.

Blake Zimmet: Yeah please try this at the website and signup for email alerts and feel free to contact or write, call me or write me if you had any other questions or concerns. And does anyone have any questions, I think we have a minute or two left or we might be out of time.

Gregory Aarons: Yeah, I think we're able to answer a lot of questions as we went. So thanks for your time...

Blake Zimmet: Thanks for...

Gregory Aarons: ...if anyone has any other thing...