

Higher Education Reform on Evidence-Based Practices: The Connecticut Transformation Initiative

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For more than a decade, there has been a national movement to improve the behavioral health service delivery system through investment in the development and effective implementation of empirically supported interventions. The call to action has been to promote evidence-based practice through expanded research of both specific treatment paradigms and the most effective mechanisms for training and dissemination of manualized evidence-based treatments. In 2000, for example, the Surgeon General's Conference on Children's Mental Health National Action Agenda led to the identification of nine goals to improve the service system for youth with behavioral health concerns. These included the continued development, implementation, and dissemination of scientifically proven treatments and the prioritization of training

mental health providers in these practices (U.S. Public Health Service, 2000).

Similarly, in 2002 the Annapolis Coalition on the Behavioral Health Workforce highlighted the ongoing concern that despite the growing movement within the behavioral health service delivery system toward evidence-based practice, the training focus within graduate programs was not keeping pace with this paradigm shift (Hoge et al., 2002). The Annapolis Coalition developed 15 recommendations for improving graduate education for behavioral health. Among these was the call for graduate programs to teach students how to use an evidence-based practice approach to working with clients, as well as for students to learn specific evidence-based treatments while still in school. In 2003, the President's New Freedom Commission Report identified six goals to "transform" the mental health system. Again, a core recommendation was to expand both dissemination of evidence-based treatments and training to develop an effective workforce for delivering those treatments.

Despite these calls to action, it would appear that graduate school curricula have continued to lag behind demands for a workforce better prepared to implement evidence-based practice. A recent survey of 589 North American senior managers and supervisors within the behavioral health service system for children and youth, for example, indicated 57% of clinicians entering the workforce were either *barely* or *minimally* prepared for evidence-based practice and fewer than 3% were *very prepared* (Barwick, 2011). The findings of this survey were similar to Connecticut's own experience over a 10-year period of significant expansion of empirically supported in-home treatment programs, with providers frequently lamenting the challenge of finding staff with foundational training that adequately prepared them for this kind of work.

This paper presents an overview of a successful initiative that has partnered behavioral health providers and graduate training programs across Connecticut and

in neighboring states to bridge the divide between pre-service education and practice. The program provides an example of a collaborative effort to expand new clinician awareness and readiness for evidence-based treatment.

System Reform in Connecticut

In 2000, parallel to the national warning sounded by the surgeon general regarding the crisis in children's mental health (U.S. Public Health Service, 2000), the Connecticut State Legislature commissioned a study of the segment of Connecticut's service system for children with behavioral health concerns that was funded through the child welfare system and Medicaid. The findings revealed that 70% of the state's behavioral health dollars were spent on serving only a small portion (19%) of the child population that was receiving mental health services (Meyers, 2000). These dollars were being spent on inpatient and residential care, often out of state, with kids separated from their families for long periods because of a shortage of community-based treatment options. The subsequent recommendations developed to address these concerns by the Governor's Blue Ribbon Commission on Mental Health (2000) included redirection and expansion in funding to develop community-based services for children with serious behavioral health concerns. A greater emphasis on family involvement in the design and delivery of services was also emphasized.

Through a similar process of system review, significant attention to the behavioral health treatment needs of youth involved with the juvenile justice system began to emerge in the mid-1990s. In part, this focus was triggered by a class action lawsuit filed in 1993, alleging that children were languishing in detention centers across the state without services to address their significant mental health needs. The result was a consent decree in 1997 that mandated reforms and ongoing court oversight. The subsequent commitment of funding to expand community-based treatments for court-involved youth followed

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a 2002 motion for non-compliance with the consent decree (**Emily J., et al. v John G. Rowland et al.**, 2002) and the findings and recommendations of a 2003 report issued by the Connecticut Health and Development Institute, which summarized the mental health needs of this population and called for greater emphasis on implementation of evidence-based community treatment programs (Ford et al., 2003).

During this period of system reform, two centers were established to help guide the selection of evidence-based treatments and oversee assessment of the impact of these initiatives. These were the Connecticut Center for Effective Practice, which operates under the Child Health and Development Institute, and the Center for Best Practices, which is in the Court Support Services Division of the Judicial Branch. The activities of both of these entities helped to strengthen Connecticut's commitment to the dissemination of evidence-based treatments and to improve its infrastructure to promote effective implementation of these models (Court Support Services Division, 2002; Franks, 2010).

Resulting Workforce Demands

As a result of these reform directives and funding increases, the number of empirically supported in-home family intervention programs and treatment teams grew dramatically over the next few years through funding by Connecticut's Department of Children and Families and Court Support Services Division. By 2008, there were 22 provider agencies across Connecticut offering one or more of the following empirically supported treatment programs:

- Multisystemic Therapy (MST);
- MST for Problem Sexual Behavior (MST PSB);
- MST Building Stronger Families (MST BSF);
- Multidimensional Family Therapy (MDFT);
- Functional Family Therapy (FFT);
- Brief Strategic Family Therapy (BSFT);
- Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS); and
- Family-Based Recovery (FBR).

The substantial dissemination of these programs across the state had profound workforce implications, creating a large demand for clinicians who were interested

in and capable of providing model-adherent services. By 2008, there were more than 341 masters level clinician positions for therapists and supervisors connected to these programs. In a small state, this represented a sizable demand on the total behavioral health workforce. Program managers and administrators across Connecticut consistently reported challenges in hiring clinicians who had the relevant foundational training to prepare them for this type of clinical practice, let alone prior knowledge or exposure to any of the models. Leaders in the provider community noted that despite the large number of graduate training programs in social work, marriage and family therapy, counseling, and psychology serving as the pipeline for the Connecticut workforce, most of the students coming out of these programs had not been exposed to any of the specific evidence-based treatment models being used in the state. Moreover, many had misconceptions about in-home clinical work and about evidence-based treatments in general. Discussions with faculty from these training programs often revealed similar misconceptions or a lack of awareness of the different models, as well as negative views about manualized treatments. It was hypothesized that this disconnect between practice demands and graduate training was contributing to the difficulty in hiring new graduates for the in-home evidence-based treatment programs, with positions often remaining vacant for several months, limiting program capacity, clinical impact, and cost/benefit.

In an ongoing effort to address these concerns, several strategies were adopted. Already in 2003, for example, practitioners, treatment model consultants, and funders had joined forces to bring together directors of clinical training programs to provide an overview of the various in-home models. The presentation highlighted the opportunity these treatment programs represented for new graduates, both in terms of jobs and clinical skill development, given the intensive level of training and supervision that clinicians receive when employed in these programs. The response of many faculty members was lukewarm, with some indicating that they had been teaching "this kind" of approach already (i.e., providing service in people's homes) and others expressing concerns about evidence-based treatments or about the lack of attention within the models to the unique professional identities of clinicians from different disciplines (i.e., social work, professional

counseling, marriage and family therapy, and psychology).

During the next few years, some of the graduate school representatives did become interested in expanding their students' awareness about service trends and began to participate in workgroup meetings to address the disconnect between graduate curriculum and the specific in-home models. The opportunity to influence course content was limited, however, because faculty did not have training in the models and providers did not have the time or teaching expertise to develop curricula for the graduate programs. The best outcome of this early collaboration was a modest increase in in-home internship and practicum opportunities, and an early draft of a graduate course syllabus on evidence-based in-home treatment (Franks, 2006).

Window of Opportunity

In 2005, Connecticut was awarded a Mental Health Transformation State Incentive Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) targeting statewide enhancement of the mental health service delivery system. One of the workgroups launched under the grant was charged with the task of identifying the most pressing workforce development needs within the child and family service sector. This group identified the challenge of finding an adequate, well-trained pool of clinicians to fill the large number of empirically supported in-home treatment models, and funding was allocated to the development, dissemination, and broad-scale adoption of a graduate level course.

The funding for the curriculum development was awarded to Wheeler Clinic through a competitive request-for-proposals process. Wheeler Clinic, a private nonprofit behavioral health agency and the largest provider of evidence-based and promising practice models of in-home family treatment in Connecticut, had an optimal foundation from which to build the curriculum. Specifically, the clinic operated eight of the nine in-home intervention models within the state and therefore had staff with the knowledge base and clinical experience to develop the course content. The clinic also had credibility and relationships with the model developers, with other provider agencies, and—as a prominent employer of newly graduated clinicians—with the graduate training programs, all of which were useful in promoting partnerships. With its large number of in-home teams,

the clinic was highly invested in developing strategies to address the ongoing challenges of hiring clinicians with well-matched foundational skill sets.

The vision for the course curriculum, which was titled “Current Trends in Family Intervention: Evidence-Based and Promising Practice Models of In-Home Treatment in Connecticut,” was to expose as many clinicians-in-training as possible to the state’s array of specific, empirically supported in-home family treatment programs. The overarching goal was to promote student interest and expand the pool of graduates pursuing in-home job opportunities following graduation. The course was also viewed as providing a vehicle to promote greater collaboration between the provider community and universities in training the workforce beyond the traditional partnership around practicum and internship placements.

In order to ensure sustainability of a training focus on evidence-based and promising practice models of in-home treatment in graduate schools after the grant-funded period, it was clear that there needed to be a focus on creating course content that would be integrated in a formal, ongoing way within the curricula of participating graduate training programs. Given that the targeted course content was generally quite divergent from the curricula of all graduate training programs at the time when the project was initiated, it appeared prudent to assume that any faculty identified to teach the course would need to be trained “from scratch,” particularly with regard to each of the specific models. Faculty would also need to be given in-depth knowledge, beyond the content delivered to students, to ensure their confidence in teaching the course, to promote accurate representation of the models, and to ensure faculty preparedness to respond accurately to student questions. At the same time, it was recognized that the course would fit differently into each graduate program in relation to its specific curriculum. In marriage and family therapy programs, for example, it was a reasonable assumption that students who would take the course would have already been exposed to certain family therapy concepts that are at the foundation of the different in-home models. Social work students, however, might not have taken a family therapy course before receiving the in-home curriculum, but might have had coursework that exposed them to an ecological perspective and had a strong focus on case management. An additional consideration

in constructing the course was to ensure enough flexibility that it could be adapted to the broader curriculum of each program where the course would be offered.

Curriculum Design

The Current Trends curriculum is a 14-week, three-credit graduate level course designed to provide an overview of nine evidence-based and promising practice models of in-home family treatment that have been disseminated in Connecticut. The course also provides an understanding of, and positive framework for, evidence-based practice and empirically supported interventions. Because all of the models covered require an extensive level of initial training by expert trainers, the goal is not to have students become certified to deliver the models. Rather, it is to ensure that they have an accurate understanding of each of the models and of some of the shared core competencies, with the goal of promoting interest in pursuing internships or employment in one of the in-home programs.

The structure of class time for each of the models includes a didactic presentation covering the theoretical foundation and core principles of the model, empirical evidence of effectiveness, and practical details about team composition, essential elements of service delivery, and required training and supervision. Each session also includes active learning activities (e.g., through role playing, small-group discussions, and paper and pencil tasks) to introduce students to particular clinical concepts and/or tools representative of the specific model. Over the course of the semester, students also hear first-hand from local providers of several of the models about what it is like to do this work, with illustration of the models’ application through case presentations.

Families as Educators

Principles of family engagement and family-driven treatment planning are fundamental to all of the models included in the Current Trends course. To reinforce the importance of listening to and actively involving families in treatment decisions, the curriculum design includes a session in which a panel of parents who have received one or more of the in-home treatment models come to the classroom to talk about their experiences. The inclusion of families as educators is also aligned with the recommendations for best practices in behavioral health workforce education identified by the Annapolis Coalition (Hoge et al. 2004).

Potential family member participants are identified by providers and then contacted by the curriculum developer to explore their interest, support them in preparing their presentations, and assign them to a specific university or universities at which to speak to students. To help families prepare their “talking points,” a set of questions was developed to elicit thought about their experience with in-home services in general and what stands out for them in particular about the model of care that they received. Families are encouraged to focus their presentation on what they believe would be most important for “therapists in training” to understand about being helpful to families.

Mechanisms to Promote Instructor Competency and Quality Improvement

To facilitate course implementation, an Instructors’ Toolkit was developed to provide faculty with all of the components necessary to successfully offer a typical semester course. This toolkit includes:

- Background reading lists (for faculty and students);
- All books and articles for “required” reading assignments;
- A sample syllabus;
- A flash drive with PowerPoint presentations to use in the classroom to guide instruction;
- Lesson plans and teaching strategies that include topics for in-class discussions to highlight the most important content from assigned readings and distinguish between the different treatment models;
- Detailed instructions and tools for skill-building activities;
- Videos for classroom instructional enhancement;
- Sample exam questions;
- Suggested topics for semester projects, with all instructions for students and scoring guidelines for faculty; and
- Certificates of course completion for students.

To ensure course content accuracy, the modules for each specific treatment program were either reviewed or written by the model developers or expert consultants. Important considerations in developing the curriculum were designing course content and materials that would be engaging for students, would be accurate regarding

specific treatment models, and could be taught by professors who do not necessarily have first-hand experience with any of the programs. To ensure that faculty have a solid grasp of course content, a train-the-trainer paradigm was adopted. This consists of a required faculty fellowship training program for all faculty interested in teaching the course. The fellowship provides 24 hours of instruction for professors during the semester prior to teaching the course, with emphasis on expanding foundational knowledge about evidence-based practice and about each of the particular models. Attention is also given to familiarizing faculty with the different tools in the toolkit. During the subsequent semester, while the course is being delivered by faculty fellows at their respective graduate programs, fellows attend two additional training sessions (six hours total) to assist with successful course implementation by addressing questions or challenges that arise as the course is first taught. At the end of the semester, the faculty fellows attend a final session to share their experiences teaching the course. This feedback has been critical to improving the Current Trends curriculum and to the development of a revised second edition of the Instructors' Toolkit.

In an effort to obtain some empirical evidence of faculty competency vis-à-vis accurate understanding and representation of the models, fellows are required to complete the student exam from the Instructors' Toolkit. The opportunity to assess faculty accuracy in presenting the models is also provided by the incorporation of the clinician guest speakers in the class design. Using a collaborative teaching approach, these clinicians observe the professor's didactic lecture about a specific model before discussing their work and presenting a case vignette. As part of the quality assurance assessment of the faculty's grasp of the particular model, guest speakers rate the instructor on the accuracy of the information presented. At the end of the semester, feedback is also collected about student satisfaction with the course overall.

Based on faculty and student feedback, the second edition of the Instructors' Toolkit for the curriculum provides additional classroom discussion guides to help faculty move away from reliance on the PowerPoint presentations. Greater structure is provided through these instructional guides to help the faculty efficiently cover the core content, thus assuring time to introduce the skill-building activities, which students find engaging. The sequence of class sessions

was also adjusted to improve the "flow" of the content. The faculty cohort trained with the second edition of the toolkit indicated fewer difficulties with course implementation, and faculty from the previously trained cohort found the new tools to be helpful.

Dissemination and Adoption

Earlier efforts to enlist graduate training programs in modifying course content to include exposure to the evidence-based in-home models had met with either disinterest or had been impractical due to the lack of a curriculum and teaching tools ready for application within the classroom. However, with the availability of the Current Trends curriculum, Instructors' Toolkit, and faculty fellowship, graduate training programs were quite willing to "try out" the course.

Several targeted strategies and a changed climate also appeared to enhance interest in participation. One factor that appeared to contribute to the greater responsiveness from graduate program directors and deans was an increased pressure on training programs by accrediting bodies such as the Council on Social Work Accreditation and the American Association of Marriage and Family Therapy to incorporate curriculum content on evidence-based treatments. The receipt of data on employment opportunities connected to the in-home treatment programs served as an additional incentive for universities to incorporate the course. It was noted that Connecticut provider organizations were likely to give priority to graduates who had completed the course. Facilitated access to guest speakers from the provider community was also perceived as an advantage for students, exposing them to "real-world" professionals and providing opportunities for networking with potential future employers.

The use of grant funding to provide a stipend to faculty fellows was set up as an incentive to enhance the interest of university faculty and establish prestige to being selected for the program. The stipend was also intended to help reinforce expectations that fellows be active learners, reading in preparation for fellowship seminars, attending all of the required training meetings, and participating in curriculum feedback and evaluation activities.

Given the course content and relevance to accreditation requirements, several programs were able to incorporate the Current Trends curriculum content into existing class offerings without the need for additional funding from the grant. In a few cases where a lack of funding and/or institutional bureaucracy

were identified as barriers within a given university, grant funding was made available to pay for the course to be piloted without additional expense to the department or sacrifice of another course offering. These funds allowed departments to either "buy back" faculty time from other duties or to pay a full-time or adjunct faculty member to add the course to existing duties. Of note is that in the second round of faculty training, several universities asked if grant funds could be used to send a second faculty fellow rather than pay for the course to be offered. One program asked if they might pay to send a second faculty member. The deans of these programs indicated that training multiple faculty members would facilitate increased opportunities for information on evidence-based practice to be incorporated into other courses across their programs' curricula.

Several other strategies were used to promote successful adoption and implementation of the curriculum. In the first year of piloting the course for each program, the curriculum developer offered to assist in the recruitment of students to register for the course by offering special sessions (with food) for students to learn about career opportunities and the relevance of the course to preparing for the workplace. Several graduate programs asked the curriculum developer to attend departmental faculty meetings to discuss the widespread implementation of the empirically supported in-home family treatment models. The intention of this strategy was to have the curriculum developer help respond to anticipated challenges from program faculty who were skeptical about evidence-based treatments or concerned about the course's relevance to the broader curriculum within their programs.

Implementation Progress

To date, 17 faculty members from 11 graduate schools representing social work, marriage and family therapy, counseling, and psychology have been trained to offer the course. The first cohort of six faculty fellows from six graduate programs was trained in the fall of 2008 and taught the course the following spring. In the fall of 2009, an additional nine faculty fellows representing five new programs were trained (four of the trainees were from previously engaged programs seeking to have more than one faculty member trained in the Current Trends curriculum). In the third year, two additional faculty members were trained at the request of two programs. In both of these cases, the faculty member originally

trained was not available (one due to a sabbatical and one due to shifting administrative responsibilities within her program).

Over a period of three years, the full-semester three-credit course has been offered 20 times, with more than 270 students having obtained a certificate of course completion. Current Trends has been incorporated as required course content in two programs and adopted as a regularly scheduled elective in eight programs. In programs that have offered the course as an elective more than once, enrollment has typically increased the second time the course has been offered, suggesting a positive response among students and faculty. The faculty members who offered the course more than once have indicated that they felt “more natural” in presenting the course a second time. They also reported being better able to adapt materials to their own presentation style and experiencing increased confidence with the course content.

Course evaluations completed by students, faculty, providers, and parent participants have consistently been very positive. A compilation of course evaluations obtained to date from 144 students across nine of the graduate programs, and including ratings of 10 different faculty members teaching the course, indicates that 96% of students found the course interesting, 92% felt that the course had enhanced their clinical skills, and 90% would recommend the course to other students. Universally, students indicated that guest presentations, and particularly the family panel, were a favorite part of the course. One indicator of the success of the curriculum in generating interest in the in-home programs was the high percentage of students who responded either “strongly agree” (33%) or “somewhat agree” (26%) to the statement: “I am likely to pursue an internship/practicum or job in one of the evidence-based or promising practice in-home models.” Evidence of the effectiveness of the course in generating an awareness of fundamental clinical skills promoted by all of the in-home models was derived from responses to the question: “What stands out for you as the most important/helpful lesson(s) learned about working effectively with families?” Many students across programs and faculty indicated “family engagement,” an intended primary theme by the curriculum developer.

Lessons Learned

Many of the lessons learned from this successful initiative can be used to inform

curriculum reform partnerships in other regions or for other course content. The level of engagement and support has been substantial across all stakeholder groups, which is seen as a key to the program’s success and critical to its sustainability. In attempting to replicate this kind of collaboration for system improvement, it appears strategic to consider the question: “What’s in it for me?” from each desired partner’s perspective, along with what each might perceive as potential barriers. For this project, two primary selling points for universities appeared to be the opportunity to address accreditation requirements and to provide students with a hiring advantage as they enter the workforce. A critical design feature that facilitated implementation across programs was the development and provision of a detailed curriculum and resources, which made it easy for faculty to learn to teach the course yet have enough flexibility to allow for adaptation of the course to individual teaching styles and integration into the unique curriculum structure of each graduate program. Availability of funding to pay for the first-time offering of the course helped to minimize an array of potential barriers for universities, and faculty fellowship stipends helped to support faculty commitment to rigorous implementation.

Although an honorarium has been provided to clinicians who serve as guest presenters in the classroom, this is not seen as a critical incentive to promote provider/university collaboration. The opportunity to have enthusiastic clinicians present their work in graduate programs is an excellent recruitment strategy to optimize an agency’s visibility to potential job applicants who will enter the workforce with an informed interest and educational foundation more precisely matched to evidence-based in-home work. Provider agencies’ selection of therapists to make classroom presentations offers an opportunity to recognize skilled clinicians and reinforce staff awareness that the work that they are doing is “cutting edge.” Clinicians participating in the initiative consistently report feeling energized by the experience and interested in doing it again.

Perhaps one of the most meaningful lessons learned is the powerful impact of enlisting families to help educate clinicians in training. Families who participate in the course are consistently positive about the experience. Although many are nervous at first, they express appreciation and a feeling of being honored to be invited to serve

as educators. Parents have typically been very diligent in preparing their comments. Most who have participated have agreed to present at more than one university, and the sense of empowerment and energy that they derive from their experience in the classroom has been readily apparent. Many have expressed a desire to “give back” because of the help that their families received through the in-home treatment program. Availability of financial compensation for families is seen as critical, however, both to reinforce the view of parents as educators and to facilitate parents’ ability to offer the time, arrange child care, and cover travel expenses. Compensation has been provided in the form of gift cards to a store of the family’s choice and gas vouchers to cover travel expenses.

As with all other stakeholders in the course, parents were asked to give feedback about their experience in the classroom. They consistently reported that students appeared interested and asked meaningful questions. Although each panel presentation was unique and guided by the particular questions that were generated by students, parents typically provided both specific pointers about how to approach going into families’ homes to be most effective, as well as a sense of the family experience and understanding of model-specific tools.

Additional stakeholder perspectives that are worth noting include the advantage of the course to funders of the various evidence-based treatment programs and to the model developers. For the funding entities, a selling point of this initiative is the opportunity to promote a better educated workforce and to expand the number of candidates in the workforce pool. By reducing staff vacancies, providers are better able to maintain caseload capacity, thus maximizing the number of families that can be served and improving program cost/benefit. The advantage to model developers follows from the premise that services are affected by the skill of the clinicians implementing them. The Current Trends curriculum offers a chance to recruit more clinicians to the field of evidence-based in-home work who will have a foundational knowledge base and the motivation to pursue comprehensive training in a specific model. The model developers who were contacted about this initiative were very supportive of the project, readily reviewing PowerPoint presentations for accuracy vis-à-vis their specific models, providing reading suggestions and articles, and granting

permission to reproduce copyrighted training tools and other materials for use in the course. The developers for several of the models noted that Connecticut's challenges in recruiting a sufficient number of suitably prepared clinicians for effective implementation were the same as those encountered by providers across the United States and internationally.

Sustainability and Future Directions

At the conclusion of the third year of implementation, the Current Trends curriculum was well established and solidly rooted in a number of universities. The course continues to be embraced by providers and by the state agencies that fund the array of in-home programs as a positive resource for workforce development. Providers appear committed to sending clinicians into the classroom as guest speakers and to valuing the training in their recruitment of new clinicians. State funders have demonstrated a commitment to the continuation of the initiative and of seeking funding to sustain the infrastructure necessary to support the ongoing success of the Current Trends initiative. Going forward, there are a couple of needs that have been identified as central to sustaining the program.

Most important for ongoing success is the need for a centralized and coordinated oversight of the curriculum to ensure the continued accuracy and relevance of the course to the state's evolving service continuum and to monitor and promote the partnerships between universities and local providers. It can be anticipated that there will be changes to models due to new research findings and/or the development of new tools, possible changes to the provider agencies or funding of models that are currently included in the curriculum, and the addition of new models to the Connecticut service system. There will thus be a need to keep the course content up-to-date and to periodically disseminate revisions to faculty using the curriculum. It is also anticipated that universities will need support to sustain the Current Trends curriculum in the form of fellowship training for new faculty, both to extend the course to other graduate programs and to replace trained faculty from current programs who may move on, retire, or take a sabbatical. Lessons learned from research about the effectiveness of training (see, e.g., Davis et al., 2003) would also suggest that episodic "refresher" trainings for former faculty fellows will be critical to maintaining the

accuracy of the way in which course content is communicated to students.

From a practical implementation perspective, there will continue to be a need to coordinate and facilitate guest speakers in the classroom, including panels of family presenters to talk to students about their experiences as recipients of the services. It is anticipated that staff turnover in agencies may be reduced as increasing numbers of clinicians entering the field have enhanced knowledge about the nature of evidence-based in-home services and have the relevant educational foundations upon which to apply the advanced training and field experience provided by the clinical models. Nonetheless, there will continue to be a natural attrition within the in-home clinical workforce, with supervisors periodically shifting roles and clinicians moving through agencies. A centralized coordination of the matching of clinicians as guest speakers in the various graduate programs offering the course each semester will therefore facilitate the continuation of this highly valued component of the course.

Similarly, as families move farther away from their in-home treatment episode, the interest and/or readiness to talk about their experience may be less prominent. Although several families have participated in classrooms across all three years of the program to date, others who have reported a very positive experience have nevertheless declined the opportunity to return to the classroom as their recollection of the particular intervention model has become less vivid. Still others have moved or changed telephone numbers, becoming difficult to reach. There will thus continue to be a need to recruit, prepare, and support families as educators. The availability of remuneration for families will also continue to be critical.

Finally, in line with the fundamental premise of evidence-based practice, it will be important for the curriculum developer and all stakeholders to hold themselves accountable as to whether the initiative is having the intended impact on expanding and improving the Connecticut workforce for empirically supported in-home family treatments. Anecdotal feedback from students, providers, and from some of the specific model trainers for new clinicians suggests that the course has helped both to expand the pool of candidates for open positions and to provide a better foundation for manualized in-home clinical practice. More objective data collection and analyses

would be helpful in order to track the actual percentage of students taking the course who are subsequently employed in one of the in-home treatment programs, and whether taking the course has had a positive impact on their job readiness and/or on staff retention.

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