Evidence-Based Practice in Child Welfare:

Implication for Research and Education

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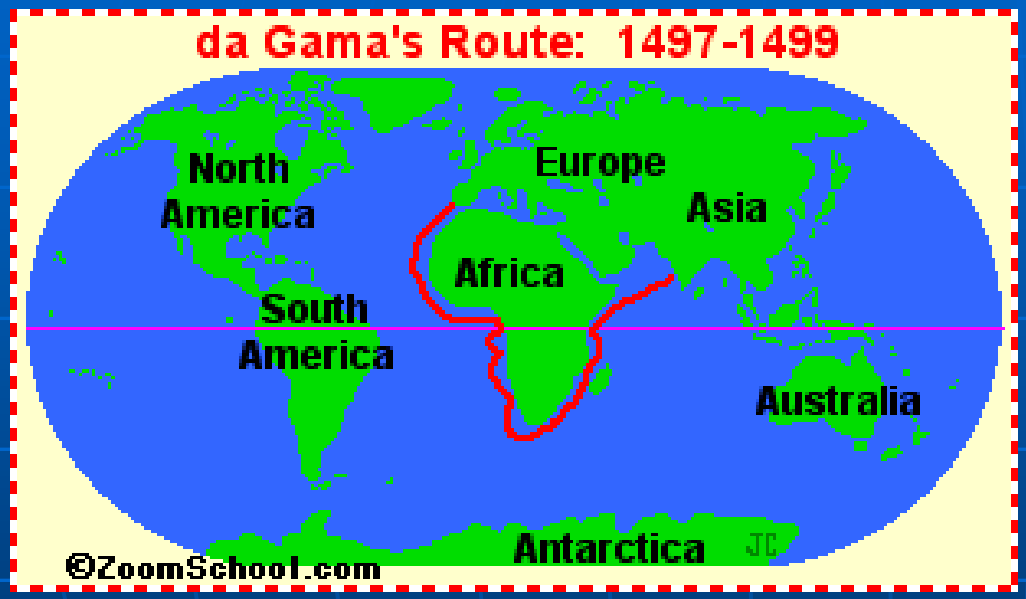
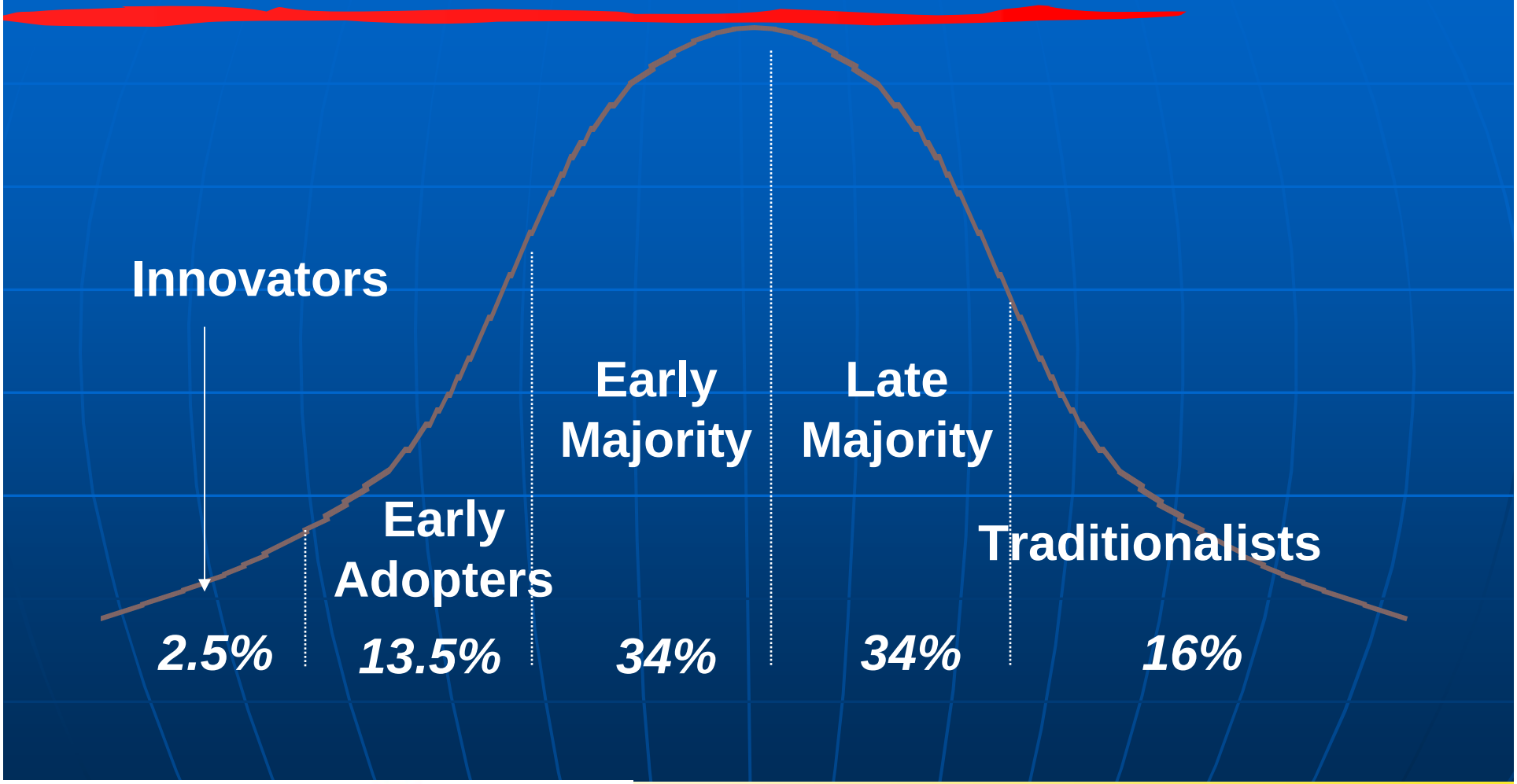


100 of the crew of
160 died of scurvy

Captain James Lancaster

- In 1601 he conducted a RCT of lemon juice for scurvy.
- At the halfway point of the trip 110 (40%) of the 278 sailors on the three “control group ships had died of scurvy vs. none on the lemon juice ship.
- 264 years after the first definitive trial, the British ordered proper diets on merchant marine vessels in 1865.

How can we describe those who adopt technologies?



National Child Traumatic Stress Network - Mission

To raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States.

One of the key functions of the NCTSN is transferring research and learning to practice

The California Evidence Based Clearinghouse

For Child Welfare

Supported by the California Department of Social Services
Office of Child Abuse Prevention

Managed by the Chadwick Center for Children and Families &
Child and Adolescent Services Research Center
Children's Hospital - San Diego

Challenges for Clinical Science

- How do we discover what practices are effective for what problems with what people in what settings?
- What is the best way to disseminate theoretically sound and empirically supported practices?
- How can front-line practitioners best be trained in their use?
- How can front line social workers, supervisors, administrators, and intervention systems be motivated to use theoretically sound and empirically supported practices?
- How can we identify and overcome the barriers that inhibit the use of empirically supported practice?

Challenges to Social Work Education

- How can we contribute to the knowledge base of what really works
- How do we prepare students to search and evaluate practices as to their evidence base and relevance to their practice?
- How do we prepare them to effectively assess and match assessment to evidence based intervention?
- What guidance can we give them in the absence of a clear evidence based practice?
- How best can we teach them to skillfully use existing evidence based practices?
- How do we best help support existing child welfare work force professional education about evidence based practice?

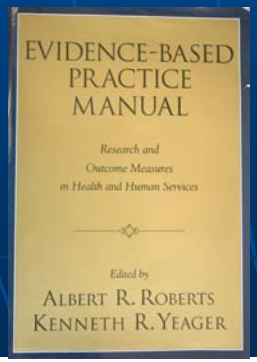
Lots of Terms

- Emerging Practice
- Promising Practice
- Best Practice
- Evidence Informed Practice
- Evidence Supportive Practice
- Empirically Supported Practice
- Empirically Based Practice
- Evidence Based Practice

Evidence Based Social Work

"Professional judgments and behaviors should be guided by two interdependent principals:

1. When ever possible, practice should be grounded on prior findings that demonstrate empirically…that they are likely to produce predictable, beneficial, and effective results.
2. Every clients system, over time should be evaluated"



Evidence Based Practice Manual
Oxford University Press
2004
Albert Roberts, PhD
Kenneth Yeager, PhD, LISW

Definition of an Evidence Based Practice for Child Welfare

Modified from Institute of Medicine

- **Best Research Evidence**
- **Best Clinical Experience**
- **Consistent with Family/ Client Values**

The California Evidence Based Clearinghouse For Child Welfare

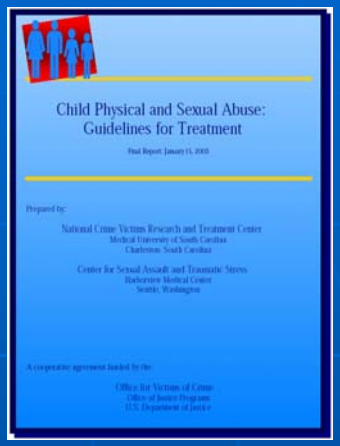
Operationally What is an Empirically or Evidence Based Practice?

- Treatment, intervention protocol, or practice that has at least some scientific, empirical research evidence for its efficacy with its intended target problems and populations.

- Evidence may be based on a variety of research designs
  - Randomized Clinical Trial (RCT's)
  - Controlled studies without randomization
  - Open trials, pre- post-, or uncontrolled studies
  - Multiple baseline, single case designs

- The degree to which we are persuaded that the practice is effective will vary by the quality and relevance of the empirical support.

Questions to ask of any Practice or Treatment

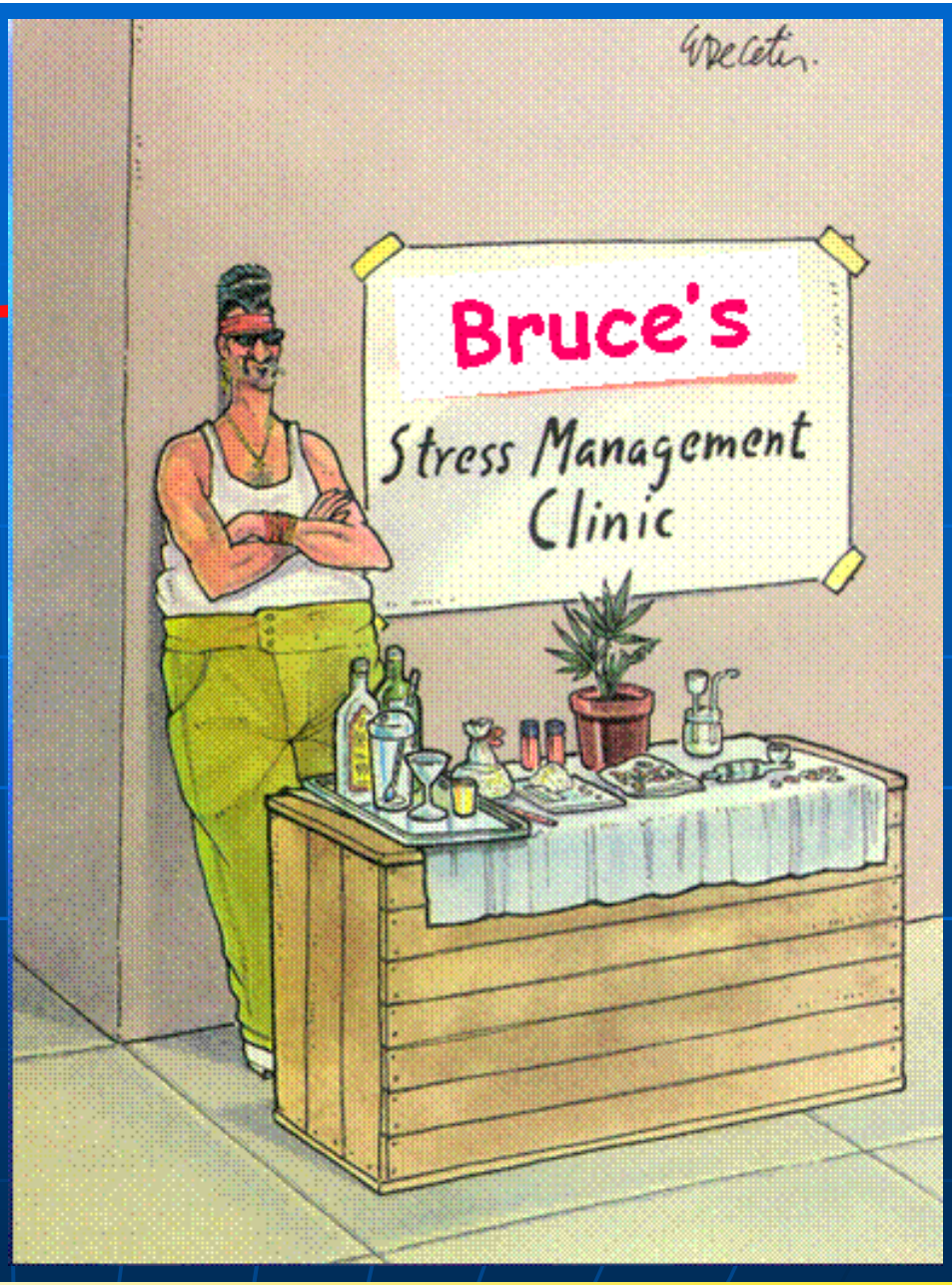


- **Is it based on a solid conceptual and theoretical framework?**
  - Is the theory upon which it is based widely accepted?
  - Is there a logic model that makes sense?
- **How well is it supported by practice experience?**
- **Does is have an acceptable benefit vs. risk for harm ratio?**
- **Can it be used by the average provider?**
  - Are books, practice manuals, and procedure descriptions available?
  - Is training, supervision, and consultation available?
  - Is there any reason the practice cannot be used with the clients you work with?
- **How well is it supported by scientific research?**
  - How many evaluations have been conducted?
  - How rigorous were the research designs? How strong are the results?
  - How relevant are the results to your clients?

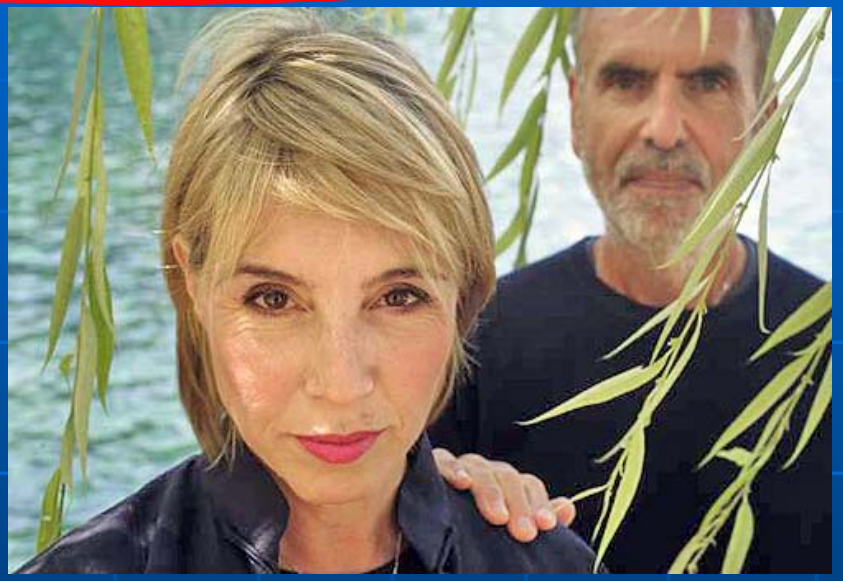
Problems in the Trauma Field

- Empirical evidence of efficacy has not been a common criteria for treatment selection in the trauma field.
- Lack of outcome research for many commonly used interventions.
- Ready willingness among some to use, embrace, promote, and staunchly defend practices that have no evidence for their efficacy and questionable theoretical bases.

All sorts of "treatments" are available out there.



Los Angeles Times October 14, 2005



Gerald Levin former chief executive of AOL Time Warner and Laurie Perlman, “a former agent at Creative Artists Agency” who was interested in testing alternative mental health treatments, have founded Moonview Sanctuary, “a new high-end clinic for the rich and, often, famous. It is a kind of psyche-spa for the burned out, the depressed and the anxious elite who want total anonymity and are willing to pay $175,000 a year for the latest innovations in mental health — no insurance accepted.”

Los Angeles Times October 14, 2005

"Moonview offers a dizzying array of 60 specialists, offering Western and Eastern medicine, traditional psychiatry, psychopharmacology, talk therapy, neuro-feedback, high-tech scans that study brain waves, chiropractic services, acupuncture, reflexology, art therapy, equine therapy and more. The practitioners include UCLA professors and veterans of some of the well-regarded local rehabilitation facilities, as well as shamans and psychics."

"PerIman's specialty is life after life, which can be more prosaically described as talking to the dead"

Why worry about doing Best Practice?

The Post and Courier

Therapist gets jail in 'rebirthing' death

Woman receives minimum 16-year prison sentence

Associated Press

GOLDEN, COLO.—A therapist was sentenced to 16 years in prison Monday in the death of a 10-year-old girl who suffocated while wrapped in blankets during a "rebirthing" session.

Connell Watkins, 54, received the minimum sentence for the death of Candace Newmaker. The therapist could have gotten 48 years behind bars.

"I failed Candace and I failed her mother," Watkins told Judge Jane Tidball. "I failed to keep Candace out of harm's way."

The girl was covered in blankets and pillows meant to simulate the womb and was encouraged to push her way out during the April 2000 session. Therapists hoped she would emerge "reborn" to bond with her adoptive mother.

A jury convicted Watkins of reckless child abuse in April. A second therapist, Julie Ponder, who led the session in Watkins' home, was convicted of the same charge and awaited sentencing later Monday.

Prosecutor Steve Jensen argued for the maximum sentence, saying Watkins had shown little remorse. He called the therapy "torturous cruelty of a sickening and depraved nature."

But the judge noted that Watkins had no criminal record and said there was no indication she had ever meant to hurt Candace.

Tidball said the sentence would send a powerful message to other therapists.

A videotape of the 70-minute therapy session was shown to the jury.

Four adults leaned on Candace with pillows, applying several hundred pounds of pressure.

The girl had been diagnosed with attachment disorder, in which children resist forming loving relationships and are violent and unmanageable.

Colorado has since outlawed the New Age form of therapy.

Candace's adoptive mother, Jeane Newmaker, is scheduled to go on trial in November on charges of criminally negligent child abuse.

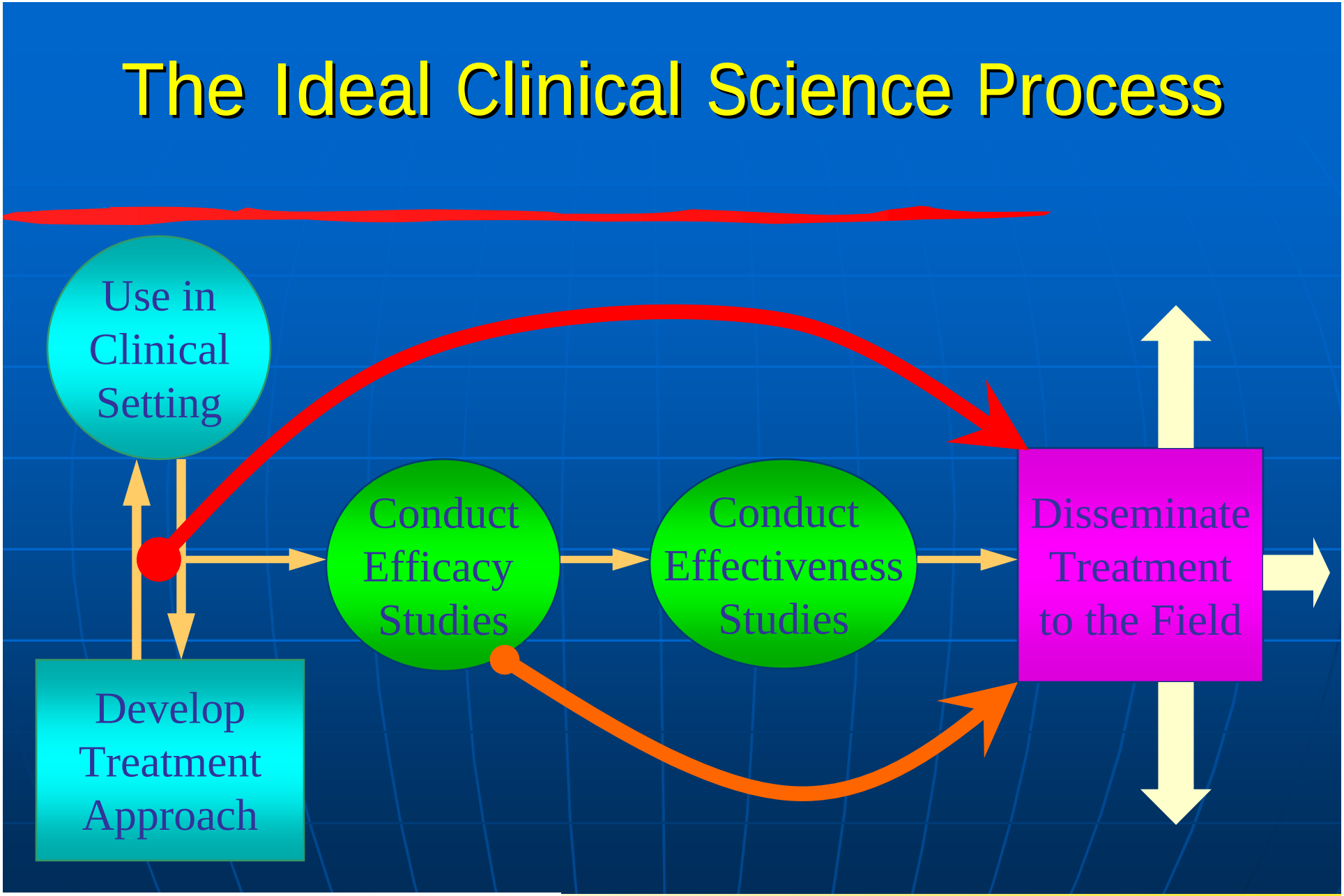
Watkins' office manager and an intern await trial in September.

Problems in the Trauma Field

- Empirical evidence of efficacy has not been a common criteria for treatment selection in the trauma field.
- Lack of outcome research for many commonly used interventions.
- Ready willingness among some to use, embrace, promote, and staunchly defend practices that have no evidence for their efficacy and questionable theoretical bases.
- Poor dissemination of the significant clinical outcome research that has been done.
- Naturally self-limiting dissemination models for empirically supported practices

Evidence Classification Schemes

The Ideal Clinical Science Process



Colorado Blueprints for Violence Prevention

- Model Programs
- Promising Programs
- All the Rest

The High Bar

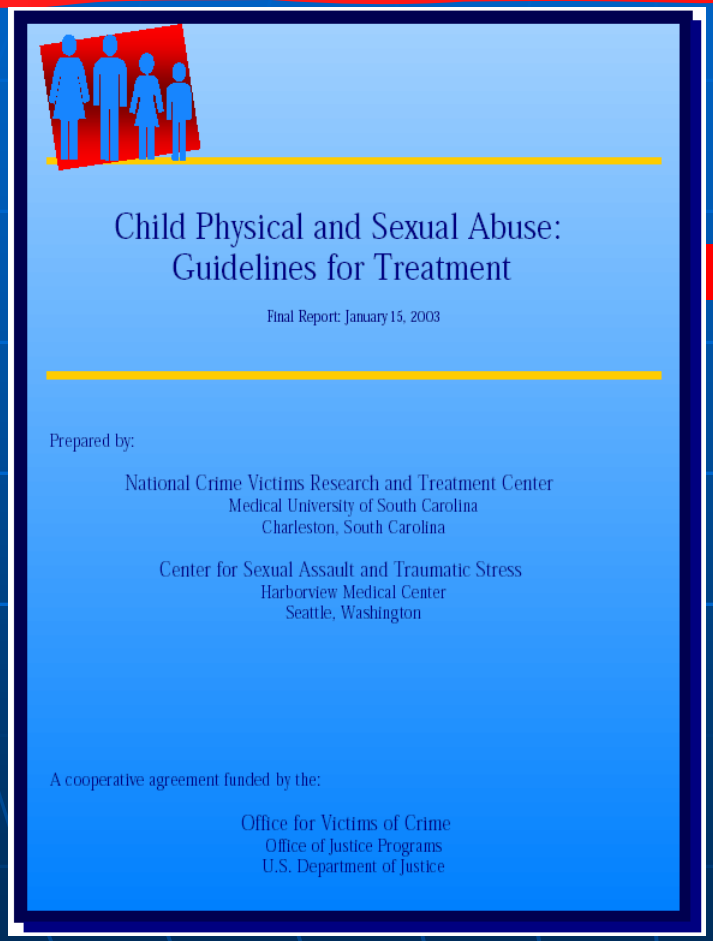
Emerging Practices in the Prevention of Child Abuse and Neglect (OCAN)

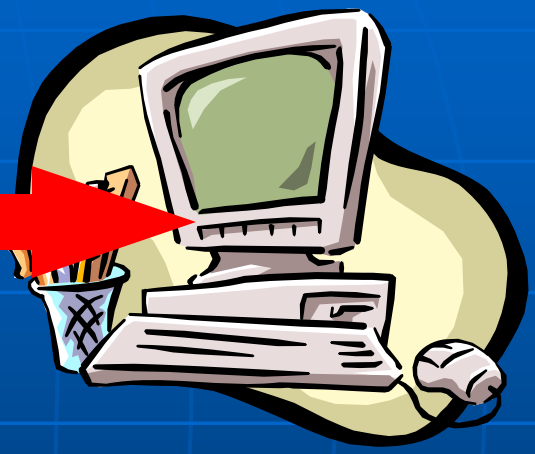
- Demonstrated Effective Programs
- Reported Effective Programs
- Innovative Programs

The Low Bar

Systematic Reviews

OVC Guidelines Project





www.musc.edu/cvc/

Download the full report

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OVC Guidelines Project:
Criteria for Judging a Treatment

- **Theoretical basis**
- (sound, novel, reasonable, unknown)
- **Clinical/anecdotal literature**
  (substantial, some, limited)
- **General acceptance/use in clinical practice**
  (accepted, some, limited)
- **Risk for harm/benefit ratio**
  (little, some, significant)
- **Level of empirical support**
  (randomized controlled trials, nonrandom controlled trials, uncontrolled trials, single case studies, none)

Finding Evidence Based Practices

The web also has a variety of resources that have considered the evidence and classified practices related to child welfare

- http://www.colorado.edu/cspv/blueprints/model/overview.html
- http://modelprograms.samhsa.gov/matrix_all.cfm
- http://www.strengtheningfamilies.org/
- http://www.chadwickcenter.org/
- www.musc.edu/cvc/
- http://www.cochrane.org
- http://www.campbellcollaboration.org/Fralibrary.html
- www.preventionresearch.org
- www.childtrends.org
- www.wsipp.wa.gov

The California Evidence Based Clearinghouse

For Child Welfare

- www.chadwickcenter.org

  In April 2006

- www.cachildwelfareclearinghouse.org

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Search Phase

Candidate Programs and Practices Selected

- Scientific Panel
- EBP web sites
- Advisors
  - i.e. SAMHSA NREP & Blueprints
- Cochrane
- Campbell
- National Clearinghouse
- Meta-Analysis
- Pub Med & other lit searches
- Google

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Two Dimensions of the Clearinghouse Rating

Scientific Rating

Relevance Rating

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California Evidence Based Clearinghouse for Child Welfare - Scientific Rating

1. **Well supported – Effective practice**
2. **Supported - Efficacious practice**
3. **Promising Practice**
4. **Acceptable/Emerging Practice**
5. **Evidence Fails to Demonstrate Effect**
6. **Concerning practice**

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For Child Welfare

1. Well supported – Effective Practice

A. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

B. The practice has a book, manual, or other available writings that specifies the components of the service and describes how to administer it.

C. Multiple Site Replication: At least 2 rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, peer-reviewed literature.

D. The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.

E. If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.

2. Well Supported - Efficacious Practice

A. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

B. The practice has a book, manual, or other available writings that specifies the components of the practice protocol and describes how to administer it.

C. At least 2 rigorous randomized controlled trials (RCTs) in highly controlled settings (e.g. University laboratory) have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, peer-reviewed literature.

D. The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.

E. If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.

3. Promising Practice

A. There is no clinical or empirical evidence or theoretical basis indicating this practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

B. The practice has a book, manual, or other available writings that specifies the components of the practice protocol and describes how to administer it.

C. **At least one study utilizing some form of control (e.g. untreated group, placebo group, matched wait list,) have established the practice's efficacy over the placebo, or found it to be comparable to or better than an appropriate comparison practice. The study has been reported in published, peer-reviewed literature.**

D. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.

E. If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.

4. Acceptable/Emerging Practice-Effectiveness is Unknown

A. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

B. The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it.

C. The practice is generally accepted in clinical practice as appropriate for use with children receiving services from child welfare or related systems and their parents/caregivers.

D. The practice lacks adequate research to empirically determine efficacy.

5. Evidence Fails to Demonstrate Effect

A. Two or more randomized, controlled outcome studies (RCT's) have found the practice to be no better than services as usual.

B. If multiple outcome studies have been conducted, the overall weight of evidence does not support the efficacy of the practice.

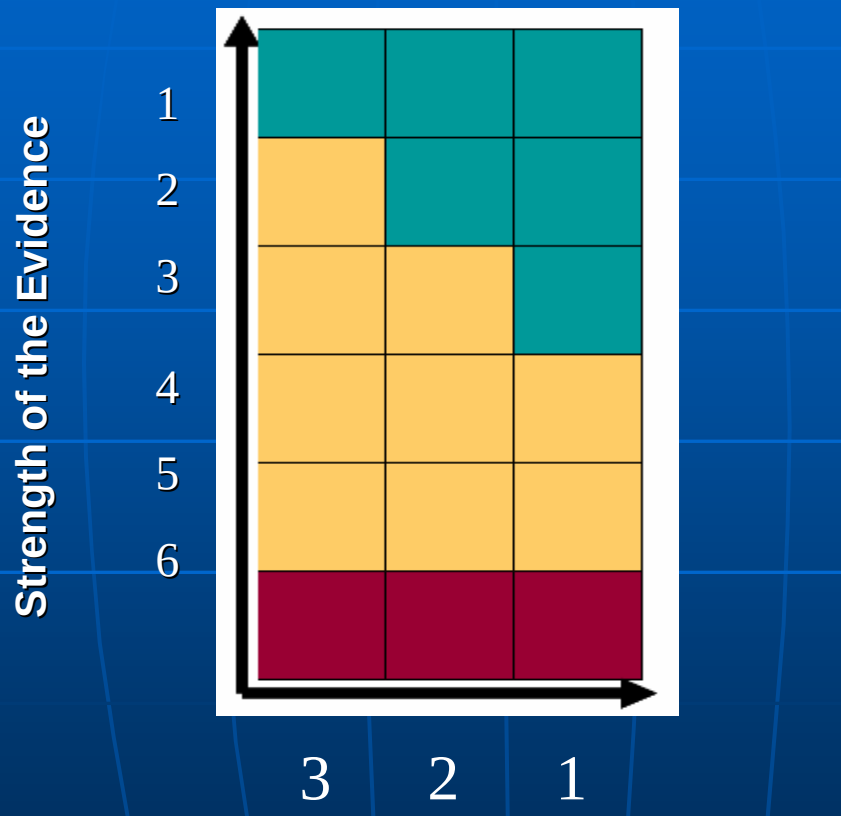
6. Concerning Practice

A. If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served.

and/or

B. There is a reasonable theoretical, clinical, empirical, or legal basis suggesting that compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

Overall Clearinghouse Rating
How closely does the intervention fit with the child welfare outcomes?



Relevance to Child Welfare Populations

1. **High:** The program was designed or is commonly used to meet the needs of children, youth, young adults, and/or families receiving child welfare services

2. **Medium:** The program was designed or is commonly used to serve children, youth, young adults, and/or families who are similar to child welfare populations (i.e. in history, demographics, or presenting problems) and likely included current and former child welfare services recipients.

3. **Low:** The program was designed to serve children, youth, young adults, and/or families with little apparent similarity to the child welfare services population.

A Logical Question...

If they are so great, why have EST's not spread more widely and more quickly in the U.S.?

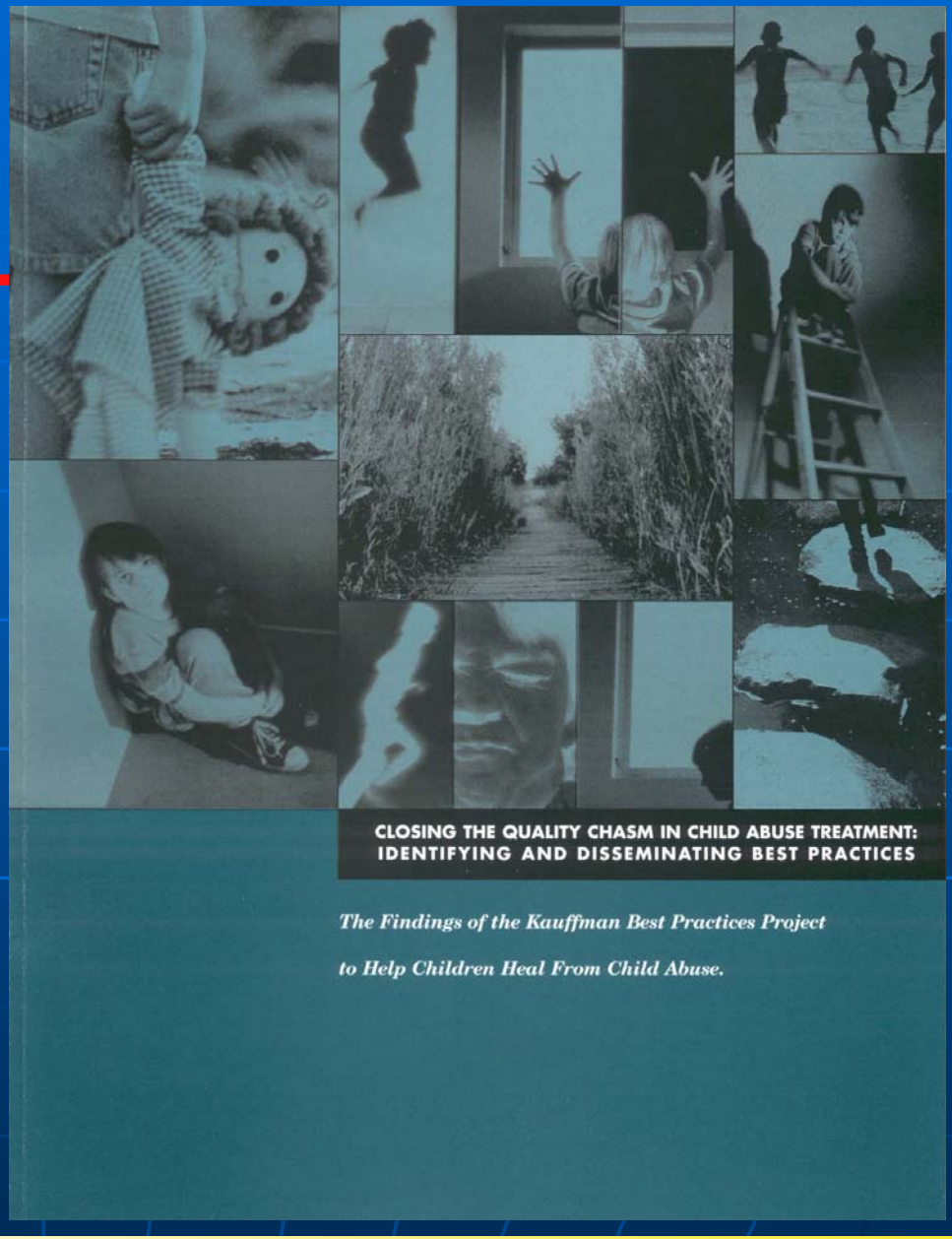
Why Have These EBP's Not Spread Widely in the U.S.?

- **Tradition in the field and acculturation of practitioners**
  - View of clinical social work intervention as primarily an **art** vs. a science.
  - Few practitioners were trained in the use of proven treatments or protocols.
  - Empirical support has not traditionally been a criteria practitioners use in practice selection.
  - Primary reliance on previous training and clinical experience rather than new scientific breakthroughs for treatment selection.
  - Resistance to the notion of structured protocols or standardized procedures.
  - Lack of accountability for outcomes. Payment for time spent rather than outcomes achieved.

Why Have These EBP's Not Spread Widely in the U.S.?

- **Poor connection between research and practice**
  - Segregation of researchers and clinicians and research and practice classes in primary training programs.
  - Some researchers can't seem to say anything works or apply it to the real world.
  - Research findings are always overly qualified to the point of seeming to be useless or not applicable to many clients.
  - Not enough outcome research with commonly used interventions.
  - Little effectiveness research.
  - No or ineffective dissemination efforts by developers of EBP's.
  - Inadequate continuing education system.
- **Lack of demand for EBP's by consumers of services.**

Kauffman Best Practices Project Final Report



Download at
www.chadwickcenter.org

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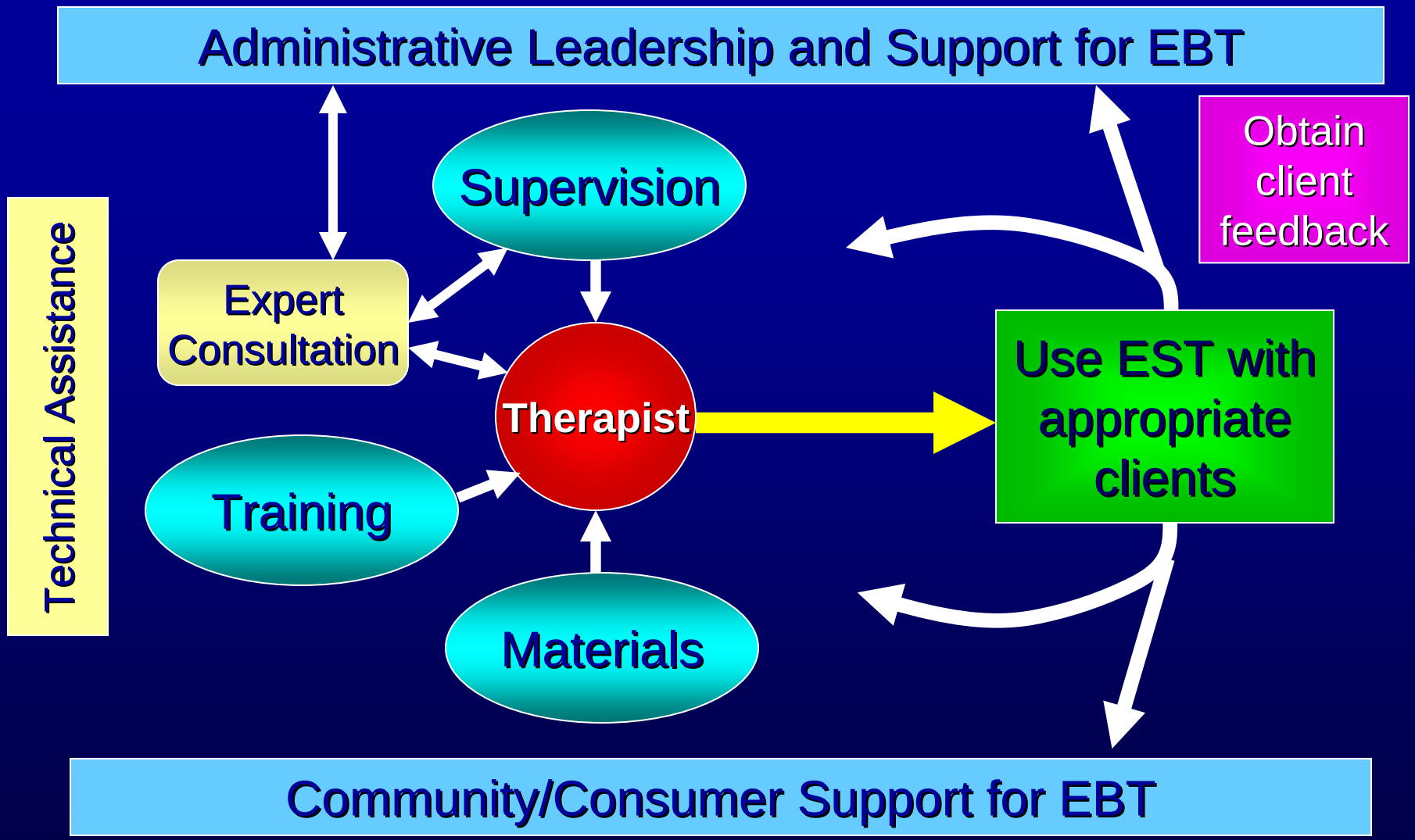
Why Best Practices Have Not Spread Widely

What can we learn from successful dissemination models in our field?

Common Continuing Education Dissemination Model

Supportive Implementation Model



Questions For Social Work Education

- Can we say anything really works?
- Can practices developed in a controlled environment be moved to the real world with confidence?
- Can the essence of an empirically based practice be distilled and replicated or must a program be followed prescriptively?
- How well do practices developed in one setting or with one cultural groups transfer to others?
- In doing so, is it necessary to culturally adapt empirically supported practice-if so how far can we go before losing the empirically base?
- How best can systems be supported in managing the change-
  - **the Art and Science of Diffusion**
- How do funders, administrators, supervisor know if a practice is being delivered with fidelity and effect?
- How can we use EBP to better engage and empower clients?

Huge Policy Implications

- **Should policy makers support adoption of EBP?**
- **If so, how best can they do so?**
- **How can we get expanded investment in RCTs of promising and emerging practices?**
-

What are the pitfalls of a state or national policy level adoption of EBP?
  - Impact on Innovation
  - Watering down of empirically based practice-in name only
  - Ideology vs. Science

NCTSN Products for Child Welfare

- Training Tool Kit-
  - Comprehensive Guide
  - Case Vignettes
  - Trainer Guide
- Child Trauma Profile
  - Screening Tool

WWW. NCTSN.org

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Contact Information

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