Evidence-Based Practice and Cultural Competence in Child Welfare
Invitational Forum – June 11, 2007

Transcript of the Presentation on
Evidence-based Practice and Cultural Sensitivity
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Here are your objectives. We are going to talk about why these conversations are so difficult. We are going to get this notion of ethnocentric monoculturalism, this issue of competence versus sensitivity as it related to culture, this whole issue of universal versus cultural specific, why we need evidence-based practices (Some people don’t believe we need them.), this whole ecological-based model that I’ve been working on for about 15 years or so. Another very important piece is this adverse childhood experiences. This notion that risk factors are not predictive factors due to protective factors, I think, is critical to the work that we do because we tend to approach things from a deficit perspective instead of a strengths perspective. Some of these field principles I’ve been using in public health and then how do you actually move this stuff – science into service in less than 22 years.

When we started having conversations with people about any sort of issue with race, ethnicity or culture, people get very interesting. They get real tight and real funny. Most black people feel O. J. Simpson was innocent; most white people think he was guilty. How could that be? Everybody got the same evidence. Well, what I finally figured out after years and years and years is that when you go to your average white person and you say there is racism, the average white person says, “Well, no – people should be judged by the content of their character and not the color of their skin.” Which, of course, is absolutely correct. The problem is if you’re African American you frequently, if you go into a store, you get followed by the security guard because there is the assumption that you are going to steal. And that does subtle little things to you.

So as a result of these two different levels of conversation, we don’t feel comfortable having these conversations. It gets very tense. This notion of “melting pot” and being “color blind” has caused us to ignore these dynamics of culture, race, and ethnicity. It makes for very interesting conversation so I hope everybody will just relax. Nobody is accusing anybody of anything, but this whole issue of race and color and cultural sensitivity is a very tense kind of a thing. Interestingly enough, we got this policy passed through the American Psychiatric Association just by having that conversation, because it put people at ease and it sort of cleared the room in terms of people understanding what it took to have this dialogue.

You know the history, the context of racism. It’s been like real serious. I was curious to note that the Jane Addam’s Hull House, which I had this fantasy was this place where everybody could go, was not for black people, they weren’t supposed to go there. They were like excluded from going there, which I didn’t know. That kind of hurt my feelings actually, because I had this thing about Jane Addams and social work. We have this denial about the Native American holocaust in this country that is just remarkable to me. Talk about selective inattention. We really don’t understand about a lot of the issues around Latinos. It’s just an interesting sort of a place to live.

This is some of Derald Sue and Stanley Sue’s work. Talks about this notion of ethnocentric monoculturalism. Heaven help you if you’re doing psychotherapy, and the patient gives you a gift; that’s going to be hours of interpretation about why did you give me this gift. But for most non-
white people, the healing relationship is not transactional, it’s transformational, it’s something spiritual. If somebody saves your life, you paying them does not make you even. And so some people feel like they ought to give you something because it’s personal. It is personal, very personal, but a lot of times because this whole thing that we call psychiatry is very Western, any other cultural aspect of healing sort of doesn’t have any value. It’s fascinating to me. This aspect of ethnocentric monoculturalism makes it very difficult for us to see other cultures and what they do to heal, very difficult. And we apply everything we do to other cultures.

This is some information on vitamin D. When I was in medical school, I studied nutrition; and the research that I did was very strange because all of the measures I used were never standardized on Black children. I was talking to David Williams about self esteem and he said . . . was it the Rosenberg or what is that self-esteem scale? Rosen something. . . it shows that African Americans have higher self esteem than white Americans. And I said to him, “Was it standardized, normed on Black populations?” He said, “Well, no, I don’t think so.” “Well, how do you know that it’s valid?” Because if you look at Vitamin D levels in African Americans, we have low Vitamin D levels because our skin filters out the UV light so we don’t convert as quickly. We need to be in the sun longer to get Vitamin D stuff. There are some people at Harvard who think this why African Americans have the highest rates of TB because Vitamin D stops, it kills the TB germ. How is it possible that this is 2007 and we’re just finding that out? Considering the rates of tuberculosis that have been in existence in African Americans since the 35-40 years I got out of medical school, why is it we just figured that out? Because there is an ethnocentric monoculturalism that we do, and you don’t get any attention.

This was the old food pyramid. Milk was at the top. Milk, as you can see, gives people of color diarrhea and gas and messes up their stomach and they have to take lactate. But it’s this monocultural ethnocentrism that has kept us from understanding things and it’s harming everybody because if we could look at different groups we could be even clearer about what European Americans need, but we don’t.

This is the blood levels among Asians for various psychiatric medications.

This is Dr. Satcher’s Surgeon General’s report on culture, race and ethnicity [slide #14]. Please look at it, it’s got a lot of stuff in there. He points out if you look at all the evidence-based research when the report was done in 2001, you find very little about cultural, racial, ethnic groups that were in the evidence-based trials.

This is around medication, which is kind of like grass. It’s kind of easy to figure that stuff out. And Satcher made these recommendations [slide #16] which we’re still working on and it’s better but it’s still very far from being right.

This is this whole notion of cultural sensitivity. How do you shape your perception, your behavior to meet the needs of other ethnic groups that are different from you? This notion of competence – how do you get that level where you’re able to provide effective clinical care for different ethnic groups? I’m of the opinion that if you’re not from that culture, it’s hard to be competent in that culture. And, of course, you’ve got the other side of that which is if you’re from that culture, you are going to be blind to things in that culture. So, you’re damned if you do and you’re damned if you don’t – what are you going to do? But I think it is possible to be sensitive and that’s what we strive for.
This is the model [slide #19] that we use to develop cultural sensitivity at my agency. We do a lot of service under that. We do research education, and under all of that is this whole issue of leadership and management which, I think, those of us in the social service field have lost because we don’t really understand that. Social service people kind of get the notion that if there is a problem, you get together, you hold hands, you sing *Kum ba yah*, and it’s supposed to get fixed. We’re that kind of people, we’re the warm, fuzzy kind that wants to help and heal people not the shark, barracuda business people and those are the people that get stuff done. The problem is they tend to do the wrong stuff – not all of them but a lot of them.

Why do we need science? Operation Dare and Scared Straight don’t work. In fact, the research we did with Satcher’s Report showed that Scared Straight, which is this program where you take kids to correction and say if you don’t . . . if you’re not good, you’re going to come to prison, and I’m going to rape you. That’s what these guys say to the little boys that come to these things. And you think that ought to scare them straight – nope. Five studies done and three show that Scared Straight sends kids into corrections quicker. So you’ve got to have evidence-based otherwise you’re going to hurt people – you are going to hurt them.

Then there’s this issue of universals versus cultural specifics which, whenever I have these evidence-based cultural sensitive conversations, this always gets messy. Everybody’s got to eat. That’s universal. So there are certain universals regardless of your culture, race or ethnicity. Now don’t bring me sauerkraut – I don’t do sauerkraut. I’ll do Greek food, Chinese food, Japanese food . . . I just haven’t hooked up with sauerkraut for whatever reason. If I’m starving to death, I’ll eat some sauerkraut.

But if I’m from New Orleans and I come up to Chicago and you give me some mostaccioli (or what is that Italian dish?) and I don’t know what that is, I’m not going to eat it and, in fact, I’m going to think you don’t like me. So we’ve got to understand this issue of cultural sensitivity. You’ve got to be able to tease out these universal principles versus this cultural specific stuff if you are going to do good work.

This is the Adverse Childhood Experiences Study. This is Vince Felitti. He now has done 440,000 people in this prospective and retrospective study. These are the adverse childhood experiences [slide #22]. Most people have at least one. Trauma is fairly ubiquitous but if you have 4 or more, these are the greater likelihoods of alcoholism, drug abuse, depression or suicide attempts. So this is critically important. When we did the Institute of Medicine’s suicide report, this is one of the foundational studies that we found that was critical to understand suicidal behavior, absolutely critical. In terms of health disparities, this is critical because you see the rates of smoking, you see the rates of increased 50+ sexual partners, you’ve got an HIV problem, you see the rates of sexually transmitted diseases. But you also see the heart disease, the cancer, the lung disease. Felitti is an internist, and he started his work on obesity: Three-hundred 500 lb. people, within a year they lost 300 lbs., but a year later they were back up to 500 lbs. This was non-surgical intervention for obesity. He said to these people, “What happened?” They said, “You never asked us what was driving our behavior?” And it was adverse childhood experiences. So, Freud was right, it was just that his twilight zone, psycho-physiological mechanism was off the wall.

This talks a little bit about – because if you’re talking about people of color and from different cultural groups – if you’ve got this monocultural ethnocentrism, there’s this very subtle
unwelcoming that occurs. And Chester Pierce talks about these issues of micro-insults and micro-aggressions, which women, by the way, too, are constantly subjected to. These are non-verbal mechanisms. Too frequently they are very subtle and they control space, time, energy and mobility while producing feelings of degradation. So, you’ve got to create things that are welcoming to people of color from different cultural, ethnic groups. It’s difficult because we’ve got this notion. We also find people of color – women as well – are confused. Are you being tolerated or accepted? Are you being supported or is a really destructive action going on by the collective? When, where and how do you fight it? When, where and how do you let it slide? And then this locus of control is another big question. How do you know you’re in control? How do women know they’re in control? Or that there’s some sort of male glass ceiling – you know, male privilege, white privilege.

These first three cause a lot of confusion; they can disrupt rapport between the patient and the provider. They can cause people not to trust child protective services. And this issue of locus of control which gives you a sense of self-efficacy, if you’re lucky, is very important because it is self-efficacy which protects you from getting traumatic stress related disorders. It’s critically important. It’s not the trauma, it’s the helplessness from the trauma. And so we find that people of color, got this . . . we don’t trust because we know better. So you’ve got to look at these things. You’ve got to look at risk factors, you’ve got to look at protective factors and, I think, we’ve got to figure out how to start surrounding people with protective factors. This is sort of the notion of protective factors which I’m going to go into a little deeper.

These are the theories of influence [slide #38]. These are the 20-year theories that everybody is familiar with . . . self efficacy, all those. This is Flay’s Triadic Theory of Influence [slide #39]. And this is a more simple model of it [slide #40]. It’s basically an iteration of a bio-psychosocial model. And because things like that give me headaches, I sort of broke it down to these few principles: rebuild the village, access to health, connectedness, social skills, self esteem, adult protective shield and minimizing trauma. These seven tie back to all those theories.

When we worked with Satcher, this was our rebuilding the village model when he was at the Center for Disease Control. The first player brings the other players to the table, and you create this vision of a common good community. This is what you tend to see most places [slide #43] - everybody working real hard, just fighting with each other, different models, different activity, just a mess, chaos - instead of creating this [slide #44]. This is a leadership, government policy issue – be very clear – this is a leadership, government policy issue. Wouldn’t it be nice if we all had one record in child protection, juvenile justice, school, health care? Wouldn’t stuff just work better? It’s not rocket science. I wish it was.

This is our intervention [slide #45]. We’ve actually used this. We work with this. I wanted to make sure I wasn’t doing something harmful. This is the HIV intervention that we’re doing in Durban, South Africa. It’s manualized. And we try to . . . This is all the science stuff. This is the places we were. We had experimental control, randomized control These were the kids. So that’s all those folk [slides #45 – 48]. And our intention was again to rebuild this village, to create social fabric. Because Shaw & McKay talked about formal and informal control in 1942 and in those communities you have that, you find less violence, you find less drugs, you find less everything. And so we wanted to try to build social fabric and in fact we did. We decreased neighborhood disorganization. We increased primary social networks, secondary social networks - the person that you go to when you’re in trouble.
We applied this in Chicago. The Chicago public schools, for example, took this model. I understand models are like toothbrushes and everybody's got one and wants to use their own, but we took this model and we applied it to Chicago public schools, and we did this interfaith partnership. We had schools do a windshield survey within a half mile to identify large churches that could help them build social fabric. There was a mentoring program. They had 500 kids, they found three mentors for 500 kids. We did the windshield survey, we had the CEO go to the churches and say, “Could you help the school? They’re half a mile away.” Within a month they had two and three mentors for each of the 500 kids. That’s social fabric - youth outreach workers, access to modern technology.

I find it absolutely fascinating that we know the children in corrections have these psychiatric disorders, but they’re not getting treatment. A lot of them don’t even have suicide precautions. We know that multi-systemic therapy reduces delinquency from 70% down to 40 to 20%. We know that these kids have PTSD. And yet they don’t have functional family therapy. They don’t have multi-systemic therapy. They don’t have access to evidence-based interventions. You guys know this, you know that family processes strengthen families, they keep risky behaviors down.

This was Cradle to Classroom, another intervention based on bonding and attachment that we did in Chicago public schools. We went out and the CEO of the Chicago public schools heard this talk about bonding and attachment, which is critical . . . David Olds’ work . . . it’s critical for the development of children. So we provided these pregnant teens with services. And we decreased the pregnant teen dropout rate, because 50% of them drop out. That stopped. They went on to college. This works. But you’ve got to connect stuff.

Resnick’s work shows that when children are connected to schools, parents are connected to teachers, and everybody is connected, you see less suicide, less dropouts, better grades, less fighting, etc., etc. We know this! We know this. So we did a lot of work in Chicago public schools trying to get kids bonded and attached. School uniforms cause kids to be attached. Summer school – why do we have summer? Get rid of summer; I know the kids hate that.

Where parents are connected to kids, there is less abuse, that’s been shown as well. And in our research study, we see an increase in child caregiver environment. Social skills is the other field principle. If you’ve got social skills - communication is a social skill, parenting is a social skill, problem solving is a social skill, discipline is a social skill. These are learned skills. Monitoring children is critically important, we found, in protecting kids from early childhood sexual début, drug use, violence, and the like.

This was the first study we did. This is Aban Aya. This was the $10 million thing that we did in Chicago public schools. We used these principles except at that time we used the triadic theory of influence we had sort of made it simpler so that the ordinary people could understand it instead of geniuses like Brian Flay. And we did the Stop, Think and Act using Roger Weisberg’s work. And of course we saw the violence decrease in the 6th wave [slide #68].

In AmaQhawe, the CHAMP program, we give parents social skills to monitor and supervise their children, know their whereabouts. All of this is published. We’re in a poor community in KwaZulu, Natal and the people there, the adults, have difficulty reading. So it’s all in Zulu. The Zulu people actually helped us develop this 80-page illustrated manual. And in this one, Zodwa appears, and Zodwa has been told if you start your period, you must be having sex with a boy. So she doesn’t
want to talk to her mother. Our studies on HIV have shown where there’s a gap in communication between daughter and mother there’s an increased risk for HIV. And so Zodwa talks to her mother, and they work it out. We do this in multiple family groups which is another technology which is very useful for teaching families because each “one teaches one,” and you’re talking about the family in the manual not your own family so it’s a little easier to do that. And we find that the hard-to-talk-about stuff comfort - we also did a reanalysis of our data - and we also found frequency are both statistically significant; it’s there for both the child and the parent.

Self esteem - this is Bean’s work. A sense of power, a sense of uniqueness, a sense of models, and again the connectedness stuff. This is how we operationalize self esteem. This is what I was talking to David Williams about, about self esteem and self efficacy and minimization of trauma. We find increases in general health, indicator of global well being. Sense of models is another one. How do you communicate, how do you solve problems, how do you lead. What we find is that knowledge by itself is not enough, but you’ve got to have models. So our transmission of knowledge about HIV has decreased stigma, which I didn’t know we could do anything about stigma, but we decreased stigma toward HIV [slides #81 – 84]. This is about 500: 250 controls, 250 experimental kids.

The adult protective shield. Again, parents are useful, they protect children. They provide adult protective shield, they monitor children and we know that if you’re not monitoring you don’t where your kids are or what the hell they’re doing. And we find it increases family rules, increases monitoring, decreases punitive parenting, increases neighborhood social control, as I mentioned earlier. So the neighbors are looking out for one another.

This issue of minimizing trauma is a big one. Behind anger is hurt. Hurt people hurt people. And so a lot of what we do is we try to minimize trauma. Turns out if you catastrophize, that puts you more at risk for developing PTSD. If you say, “Oh my God, this is horrible! I’ll never survive!” If you don’t have a sense of self efficacy, if you don’t have a way to turn that helplessness into helpfulness, you are at risk for PTSD. This is well thought out. This guy Richard Bryant, who is the guy who developed the acute stress disorder, has done prospective research on this and finds this to be the case. It’s fascinating if you look at the Oklahoma City Fire Department and the New York City Fire Department. Most of those fire people have symptoms of trauma, but they don’t have clinical threshold for PTSD because the fire people worked with them. If you look at what they did, they did these field principles. They created social fabric, they did social skills, and they did connectedness. If you look at the police in New York and the police in Oklahoma City, they are all messed up. They have PTSD up the wazoo because they did not prospectively put these protective factors into place.

Again, Satcher’s maxim “risk factors are not predictive factors because of protective factors.” We have not figured that out. We are demonizing and deficit modeling our kids. This is some work we did in McLean County in Illinois. They found out the children, the black children especially, were being snatched out of their homes at high rates. These are the hotline calls we see that in 2000 – 2002 the hotline calls remained the same. We took the model, these field principles, I turned it over to my business people and they did a business plan, went down to McLean County, where we were not welcome, and in 2 years we saw a decrease from 35,000 children being taken out of their homes down to 13.5. We did such good work, they put my salary in the newspaper to discredit me because there were 3 foster care agencies and we decreased their income by 62% and they were like oh, hell, no, we got to get rid of this guy. We checked to make sure that the kids left in their homes were not
being re-abused. What we did was when we found a family in trouble, and it sounded like what was happening in Michigan when you would start to see trouble, you don't run from the family you run to the family with social fabric, social skills, adult protective shield, you monitor, you minimize the trauma in the mother, you give evidence based technology. If you’ve got a substance abuse problem, treat the mother’s substance abuse problem. And we did all of that and this is what the result was.

In terms of this whole randomized control trial, I would suggest a different type of evidence which we are looking at [slide #94] where you do clinical work in large numbers. Robert Gibbons developed a statistical methodology to look at this which is another statistical paper we published. But you do clinical work in very, very large numbers so that you have Ns of 5,000 and you do continuous quality improvement as you do the clinical work. And then you do a meta analysis on the outcome. It may that that type of science which is on the ground reality-based has just as much validity as a randomized control trial. I’ve asked the editor of the Journal of American Medical Association this question and a few other people, a guy at Sloan-Kettering, uh, Bruce, Bruce, Bruce, can’t think of his last name, and this appears to be a good way of being able to do some of this stuff.

It takes 20 to 15 years, something, 17 years to get science into service. We moved our intervention in Durban, South Africa, from science to service the day the research project ended. Because you do what Covey says, begin with the end in mind. So you start planning, if your intervention has good theoretical underpinnings, we’ve done this HIV prevention in Chicago, New York, west side of Chicago, south side of Chicago, so we kind of figured it would work. We weren’t sure if it would work in Durban, South Africa, because we’re with Zulu people. We went through three iterations of the manual; we had people with us adapting the manual making sure it was culturally sensitive, little things. A woman didn’t have her hair wrapped during a funeral in some of our art work, even though we had Zulu artists writing all the cartoons. And the community said, “Oh no, that’s disrespectful, get rid of that. You’ll very subtly insult the people reading it.” So we didn’t translate the intervention, we adapted the intervention so that the universals, rebuilding the village, etc., etc., and cultural sensitivity was all in place. But what you do is you take these models and you do business plans. You’ve got to execute. You find MBAs. When you start out, it’s amazing the research people can design and plan to get an RO1, but they can’t use those same skills to move science to service, and I think we can.

This is Machiavelli. It talks about the prince and how if you’re starting something new, everybody is going to beat you up, so you might as well get used to it [slide #97].

This is Julius Richmond’s work, the guy who helped start Head Start, and he talks about the knowledge, the implementation and the public will [slide #98].

And lastly, again, we’ve got to shift this paradigm from risk factors because, you know, people get traumatized. Trauma is ubiquitous. It’s not automatically a bad outcome, and that’s because of protective factors.

Thank you.