Our purpose today is to talk about what works for children in families of diverse populations in child welfare services. So, for our work today we need to establish what we know now and what we need to know for the future, and where we are now and where we are going in terms of our practice.

We are going to look at research, practice and policy. This is our conceptual approach to the day so it follows the timeline of the day. The foundation is this morning with the introduction which I will do and Dr. Bell’s conceptual framework. Then the folks on the panel will talk about implementation and an informational discussion. And then from lunch on is all about building for the future – it’s your group discussions. Your group discussions will first be by role, for example we have administrators meeting, researchers meeting, and so on; then the next groups will be by region. We have different groups represented here from different regions so they will meet together, and the folks who are here – kind of at-large guests – will be sprinkled among the regions.

A note on things familiar and unfamiliar. Because you are experts in your fields, many of you could stand here and do this as well as I could, but in addition, I think, there will be things that are new to you. Some folks who have worried more about law and legislation may not have been thinking about how many angels can dance on the head of a pin which is what we do in research. So, some topics may be new, and we understand that it will make for a very interesting and fruitful discussion.

One resource for you is your meeting book. Your meeting book has your standard items – for example, agenda, bios, roster, maps of buildings and area. [Thanks, Scotty. I want to thank Scotty. Scotty, as you know because you’ve all heard from her, has been really amazing.] There’s structured guidelines for group discussion, some legislative information, preliminary bibliography, copies of PowerPoints and also in the back in the envelope there are examples of some folks’ ongoing projects.

To get to the point then, a preliminary review has found that most of the literature in child welfare is on evidence-based practice or is on cultural competence. It’s not very often that you see both. So some research on evidence-based practice includes race or ethnicity as a factor in the clients’ experience and effectiveness, but the ones that attend to cultural competence and evidence-based practice together can be in health and in mental health. They are a few years ahead of us. They had a meeting similar to this which our speaker, Dr. Bell, attended in 2003. They did it a little bit differently than we’re doing it, and they have those findings which I think I sent to you in one of my e-mails. They also have some publications.

Let’s talk about definitions. I’m going to do the “Vince Lombardi” thing. My dad was very fond of football, so we’re going to talk about the basics. In practice we use the most recent and viable information that results for change for children and families - that’s evidence-based practice, basically. If you are going to talk about evidence-based practice, you are going to have to say, “How
do you know?”, “How do you know what you’re observing is true – is real?”, “How do you know that X caused Y?”, “That my treatment made that change.” Well, you have to have association between cause and effect. That means that things have to vary together. If one goes up, the other goes up and if one goes down, the other goes down. You have to have time order, the cause has to come before the effect. And you have to eliminate alternative explanations and that’s where it gets really tricky because there are all kinds of alternative explanations that everybody can think of. That’s why all the research articles end with “and so we should all do more research on it.”

Let’s do a little graphic that I would do for my class. You have grass, you have rain, you have grass growing. You have association and you have time order, okay? Now you say to yourself, “Yeah, but I’ve grown grass and what about all that fertilizer you need and what about temperature and the sun?” All right, let’s look at that. Now we’ve got a few more things going on, and, lo and behold, the grass is growing. But what we have to do if we want to see what the effect of that rain is, is to control for all the other things – for the sun, for the temperature, the fertilizer, and so on. The ideal way to do that is to take two plots of grass that are just alike. How do you make sure they’re just alike? Well, you randomly sample them. You apply water to one of them. And you hold everything else you can think of the same. They get the same fertilizer, they get the same sun – okay? You measure them in the beginning and then you measure them at the end. And then you can say, “The water caused the grass to grow.” Well, almost, but you’ll say, “What about those darn bugs?” and that’s what happens in research. That’s why it’s difficult to do. That’s why there needs to be so much replication and so much work to try to isolate these things. Also, you can see it’s a heck of a lot easier to do with grass than it is with people! Just think of all those blades of grass as people, and it’s a little bit like herding cats.

Once we figured out that we know how we can establish evidence-based practice we want to talk about what are the levels of evidence because there are various levels that we can trust. We might have clinical experience, and good clinical experience is very important in case studies. That might be all we have, so that’s what we use. But if we have more evidence than that, we couple that clinical experience with the additional evidence. You might have observed associations. You might be able to say, “Well I know these things happened together. I don’t know what the cause is because there were 16 other things going on, but I have some association so that’s helpful” but you don’t have the comparison group for example.

Then you get to the randomized control group designs which are peer reviewed and publicly reported. That’s what they call the “gold standard” as you know. That’s what everybody talks about and that’s what everybody says is impossible to do. It is not exactly impossible, but when you get to reality, there have to be a lot of adjustments. You also need, as we said, replication. You have to measure the same intervention and outcomes with different groups in different places over time. And then once you get a bunch of replications, people will do what you call a meta-analysis. The meta-analysis will bring all those studies together and say, “Now looking at all these studies together, what is the effect? Is it a large effect, is it a small effect, is it inconsequential?” And that’s how that goes.

Then, of course, the next questions are can it be applied in realistic settings? What is the applicability of outcome findings? And you’ll hear the terms efficacy and effectiveness. Just to give you some background . . . Efficacy is about what happens in a more controlled setting. Effectiveness is what happens in practice and are the outcomes sustained over time. You remember
the discussions on Head Start and the early studies and then the follow-ups and the worry about whether the changes were sustained over time.

The best interventions are culturally competent, are well-researched, are standardized; they are appropriate to the population, to agency mission and services, assessment results, and the purpose of the intervention. They are used by a well-trained clinician who can conduct an expert assessment, who can discern the appropriate interventions and the variations of need (so we’re not talking about a cookbook) and provide intervention in an expert manner. It doesn’t help you, all the manuals in the world aren’t going to help you, if you look like an automaton.

When well used, evidence-based practice is responsible to a family’s race, ethnicity, culture and language; a family’s specific needs and circumstances; and the recognition of diversity within cultures. We talked about there being very few controlled studies in child welfare on evidence-based practice, and they rarely attend to race. I want to tell you a little bit, very quickly, about some of the studies that have been done. We’re going to talk about therapeutic interventions, parent training, and policy. Therapeutic interventions, abuse-focused cognitive behavioral therapy – I’m not going to talk about all of these – but just to give you an idea, these are interventions that have focused on parents who are abusive, or may tend to be abusive, or at risk of, or the children have behavioral problems. There has been a lot of work to help intervene with these parents and change the interaction between the parents and children. Some of these, like the parent-child interaction therapy, have been done with diverse populations but that’s how it’s reported. It’s not . . . people don’t set out when they start to do the study to say, “Okay, I’m going to do this work with the intent to serve diverse populations” necessarily. I just also want to give you an idea of cost because you’ll hear later today also something, I think, about cost. Some of these are so expensive that no public agency can afford them. Others really appear to be expensive, but when you weigh the cost of the kid not going to jail or of not going into a foster home, you can really show some huge cost effectiveness of prevention work. And that’s the kind of work that needs to be done.

The Incredible Years has been done with diverse populations, and they’re beginning to do some more work in that area. The one study that I think is important to talk about is Family Connections, out of the University of Maryland at Baltimore by Diane DePanfilis and her associates. This project was undertaken with a very, very poor population – it was 86% African American, mostly mothers, and they were referred to the project when the people who were doing the referral were afraid that this family was going to become neglectful. They weren’t involved with CPS at the time, but 58% of them had been involved with CPS at a prior time. There was a quasi-experimental design in that they didn’t have a control group that didn’t get any intervention. They had two groups; well, actually they started with four but ended up with two; one that had 3 months treatment and one that had 9 months treatment. And the 3 months did as well as the 9 interestingly enough because that isn’t what I would’ve bet. But it’s a child welfare target population and it is currently being replicated – the Children’s Bureau is paying for replication in, I think, 5 sites – so, that’s something to watch.

In policy, I am just calling your attention to three. There are a number of controlled studies. The Illinois’ Subsidized Guardianship Project I thought was really good in that it had a community base, it had a community board, they hired people from community in doing the project, and it was control-designed. It grew out of the need of African American families taking care of their children and looking at how we could make that more permanent for those children, more stable for those families and caretakers. Also, Minnesota’s Alternative Response had recruited parents to help them...
with their design and that was very helpful. That has shown tremendous cost-effectiveness to divert people from the child welfare system.

So, the barriers are obvious. Funding – that initial front-end funding, the funding for the research. The lack of advocacy or consumer demand. We have someone today who is going to talk about consumer issues. Lack of incentive linking reward to client outcomes. The gulf between the research and the practice communities, which is why we’re all here together today. The constant search for the “magic bullet” – you remember family preservation and the attitudes about EBP or practice generally. I remember back in the ‘70s when deprofessionalization of social services started, and I don’t think we’ve gotten over it yet – we’re trying.

So the suggestions are to change funding to support and reward outcomes-based practice, to fund implementation grants, increase EBP emphasis in graduate schools, and so on. I’m not going to go on because all these things people are going to talk about after me. This is an important thing you might want to think about and that Dr. Bell is going to address further – Evidence-Based Practice and Cultural Competence and developing a conceptual framework. So with that I’ll end.