

Applying Evidence-Based Practice in Communities of Color

Prevention Webinar Presented by the Federal Interagency
Work Group on Child Abuse and Neglect

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Melissa Lim Brodowski: [00:17] My name is Melissa Lim Brodowski, and I'm the prevention specialist at the Office on Child Abuse and Neglect at the Children's Bureau. And I think folks know we're in the Administration for Children and Families at the U.S. Department of Health and Human Services. Today's webinar—we're so excited that you're joining us—it's the second of this month with the theme of evidence-based practices in communities of color. So we're very excited that Vickie Ybarra is here. She's with the Yakima Valley Farm Workers Clinic and [is] the director of planning and development. That program has two goals at the Children's Bureau right now: They currently have the migrant program out of the set-aside for the Community-Based Child Abuse Prevention [CBCAP] program—there's a 1 percent set-aside for Tribal and migrant programs—and then they also received last year one of the grants for nurse home visitation programs to prevent child maltreatment.

So it's exciting that she's here to share the work that they've been doing. I just wanted to share a little bit of background that some of you folks might have heard me say before if you've joined us at the different webinars that we've hosted. This is actually the ninth informational call/webinar that we've been hosting at the Children's Bureau via the Prevention Subcommittee with the Federal Interagency Work Group on Child Abuse and Neglect. So some of you may know that the Office on Child Abuse and Neglect actually has the lead on Federal interagency collaborative efforts related to child abuse and neglect. So we've had this interagency workgroup since the 1980s and there are actually over 40 different Federal agencies represented. And then last year, just because of a lot of interest, we started a Prevention Subcommittee to bring together the Federal staff that really are managing a lot of projects related to preventing maltreatment, family support, etc. at the different agencies. So we have lots of great staff who work at the Department of Agriculture; CDC; Maternal Child Health; Office of Planning, Research and Evaluation; Head Start; Child Care; other folks involved with that group so it's been a great group.

It's a fairly informal subcommittee, but we agreed that one of the things is there's so much great work happening at the various agencies and that we really wanted to get that information out to the field, out to our grantees, etc., and our various partners so people know more about the work. So we agreed as part of the work we're doing to host these series of informational calls and webinars. So we have both internal conference calls, and we have these webinars we've been

hosting. And really trying to promote a way to learn more about each other's work and greater connections across our systems and programs at the national, State, and local level.

So again, as I said, very excited at the topic for today's webinar. We've had a nice response from a variety of different folks. Great to see other Federal agencies and Regional Offices joining our call and really prior calls we've had researchers, practitioners, policy folks involved. So they've been well received, and I think we're excited to have a diverse group of people so that we can have some great discussions.

Just a couple of logistical notes: This call is being recorded. We've agreed to record all these calls so that we can post them with the slides after this webinar. Then, since we really wanted to have some dialog and conversation, this call is actually not operator assisted so all your lines are actually open, and we just ask you to put yourself on mute if you're not speaking. And if you don't have a mute button, you can press *6 to mute your line and then *6 to unmute to ask a question. We've had some moments where we've heard some background noise, and I'll apologize if you hear some background noise from me, but we're just trying to keep the distractions to a minimum. So thank you for your help with that.

This topic of evidence-based practices in communities of color is really quite timely. We've been working on this issue of promoting evidence-based and evidence-informed practices with our CBCAP programs for a couple of years now, and it's just very exciting to hear the other issues, the really important issues around trying to do more culturally relevant, and as I've heard Vickie say the term culturally grounded evidence-based practices. So I'm very pleased that Vickie is here to share her expertise and the information about how they've been doing that with their programs. So with that I'm going to hand it over to Vickie.

Vickie Ybarra: [05:50] Great. Thank you Melissa.

Thank you. I think the technology is wonderful. Thanks Melissa for inviting me. I'm very pleased to be here today and share a presentation that we did at a Children's Bureau conference for grantees this spring. So it's been presented before, but we're really happy to get the information out. This is our experience in applying evidence-based practices in communities of color. Most of what we work with here in central Washington and our patient population are Hispanic immigrant population and that's where you'll see that most of our experience is from. As Melissa said, my position here at the clinic is as director of planning and development. I've been here for 19 years, and my clinical background is as a public health nurse. So I started here developing maternal child home visiting programs and doing home visits myself as a public health nurse for the first 10 years. I've worked in and around evidence-based and evidence-informed practices for some time and now have the privilege of evaluating programs and helping to implement them across the organization.

So it looks to me from the invitation list and from who confirmed that's on the call most everyone is certainly familiar with evidence-based practices so this is no new information here at the beginning. But just by way of review, we know that the way that evidence-based practices are generally developed is they're usually developed and researched at a university that has adequate resources to do that kind of development and research and then put through an

extensive process—in most cases a randomized control trial is the gold standard of experimental research—to demonstrate their effectiveness. Then what follows is a publication and dissemination of the results, and often in the case of many EBPs that we've worked with, there's a development of a replication infrastructure by the researchers ... So we call those, after that infrastructure is set up, we call those the developers, the developers that help replicate that EBP around the country and in communities. We would consider that generally a top-down approach. Not that it's a bad approach. It certainly ends up with efficacious interventions, but it is top-down in terms of who developed it and how it was determined to be evidence based.

So the challenges we see for our communities and other communities of color is that there are, first of all, too few researchers of color researching family support and other family prevention intervention practices. Not only too few researchers of color but too few researchers of any type that are concentrating on interventions involving communities of color. So the pool of expertise at the university level is just really limited. We think that culturally grounded interventions, those interventions that are developed from the community up in communities of color are less likely to have gone through this process. It doesn't mean they're not out there—there are many culturally grounded interventions out there—but they've not had the opportunity to go through the process that a university with research resources can put them through. So as a result, most evidence-based practices on the various Federal lists that have any applicability to communities of color were not designed specifically for those communities. And we don't discount those that have been tested in communities of color because many do work and are very important. I think that it's important that when we talk about intervention in communities of color we think about the context of where the intervention came from.

This is just a quote from Gino Aisenberg, who is a Latino professor at the University of Washington School of Social Work that we've worked with. He's been there for about 4 or 5 years and has worked with us in our communities on a couple of interventions, and this is from one of his publications. He says that; “Mere adaptation of programs and strategies developed for middle- to high-income European Americans for use with ethnic minority groups is inadequate.” He says that; “It is imperative that programs also be developed from the ‘ground up’ [where we get culturally grounded] and with consumer/patient input to be culturally responsive and relevant.”

Then another researcher, Donna Hurdle, has said similarly that; “Culturally grounded interventions based on traditional healing practices may have the most chance for success in working with ethnic groups because they reflect the culture and traditions of a particular group.”

So from our point of view, if we're in a position to want to implement a family support or a treatment intervention that's evidence-based or a promising practice or, as Melissa said, evidence-informed it seems to us as though, in our community working primarily with Hispanic and Spanish-speaking populations, that we have three options. We can first of all choose from among the very limited EBPs or promising practices that are culturally grounded. Or we can choose an EBP that's not culturally grounded and adapt it or choose not to adapt it but monitor it for applicability to our population. Or we can choose a culturally grounded practice that's not an EBP and document and research our experiences. And we have experience doing all three of these. I wouldn't say that going into it one of these choices is necessarily better than another, but

I do think it's important as we plan programming and plan to meet the needs of our communities that we consider intentionally that there are these three routes we can go to.

This is just a little bit of information about our organization so you can get an idea of context. We're a large community migrant health center system; we're in fact the largest migrant health center system in the country, and I think right now the third largest community health center system. We have clinics in Washington and Oregon. Last year we served over, this says 125,000 but I think we were up over 130,000 last year; 64 percent Hispanic, 39 percent migrant seasonal farm workers and their family members. And the farm workers are concentrated in particular geographic areas in the Yakima Valley and central Washington and then in the Willamette Valley in western Oregon.

For those of you who might be familiar with Washington State or might not be, Yakima County is in the center of the State and there is a large range of mountains between us and Seattle. So although it looks close, you have to go up over the mountains to get there. And all of central Washington is a big agricultural region. We grow the majority of the nation's hops and apples and some other fruits as well, so big agriculture that requires a large farm worker population to harvest the crops.

So at this point I'd like to turn to the three experiences that I'm going to use as examples of those three choices. Remember that was to choose from among the limited EBPs, something that's on the list that are actually culturally grounded. Choose something that's not culturally grounded and then either adapt or monitor for impact or applicability. Or pick something that's not. And this is an example of the second.

So we had an experience implementing multisystemic therapy (MST) with a SAMHSA grant for a particular high-need population. We looked at it, we worked with a local committee, went through a year of planning, and MST was chosen as the intervention that was felt to be most effective at reaching the very high-risk group we were trying to target. I'm sure many of you know, MST is a mental health treatment intervention. In our view, it's not culturally grounded, and at the time we picked it, it had not been adequately tested with Hispanic or Spanish-speaking populations. So although it had been demonstrated at that time to be a pretty powerful intervention for the risk level of the use we were wanting to work with, it hadn't been tested with Hispanic or Spanish-speaking populations.

Our target in our local project were Hispanic, adjudicated, very high-risk youth with co-occurring disorders. So we were targeting with our community partners this very high-risk group of Hispanic youth who had been through the court systems and had co-occurring substance abuse and mental health disorders. We had some Federal funding, we had SAMHSA, but we also had some support from local, State rather, juvenile justice and child welfare systems.

So when we went into this, we spent a long time with our community partners looking at the potential for adaptations and working with the developers as well. So when we went into it, ahead of time, we knew that we had to make one adaptation that had to do with staff qualifications. And we talked through with the developers quite a bit. The intervention calls for master's level staff. Because of the population we were implementing with, they had co-

occurring disorders, we felt as though we needed people with a mental health background who were also certified chemical dependency counselors. And we needed people who were bilingual. So finding an MSW who also had a CDC and was bilingual was next to impossible. I think there were two in the State and we had both of them. So we made an arrangement with the developers that we were going to use bachelor's level staff as long as they met particular qualifications and experience and as long as they were pursuing a graduate degree. And that was a difficult negotiation, but we were able to do that in advance of implementing.

And then we made a second adaptation during the process and that had to do with the length of the intervention. The intervention has a defined length of time and is prescriptive about if people drop out how soon we have to close them. And I'm sorry I don't remember exactly what that period of days or months is. And we made that adaptation during the process that because this was a particularly high group who did tend to come in and out of treatment that we would allow that overall process to be longer than what it was defined as by the developers.

The second experience that I'll share with you ... Oh and I probably should have added as well, we were able to find sufficient numbers of staff who met these qualifications. The supervisor did have a master's degree and was a CDC, was an MSW, and was bilingual, and then we used I believe two or three staff at the bachelor's level. And we were able to implement that fairly successfully.

Another EBP that we have extensive experience with is the Nurse-Family Partnership. So you know this is a prevention program, a home visiting program that uses nurses as home visitors. It's not culturally grounded; it didn't grow up from the community, at least not in our view, but there is some of the randomized control trial evidence that it is effective with the Hispanic population. So the developer and researcher who developed it has done that work, has done that research work with those populations. It targets first-time, low-income moms who are enrolled during pregnancy and followed until the child is 2 years old. When we first implemented it we had a small team that was funded by SAMHSA. We currently have ACF funding, as Melissa mentioned, through the nurse home visitation, and we've been able to enlarge our team with that. We do have some State child abuse and neglect prevention funding, and we are anticipating that they'll be some State early learning funding that will enable us to enlarge our team. We're currently at five nurses, I believe, and making plans to move up to eight.

We implemented it without adaptation, but we did hire bilingual staff. Again that was a challenge, but we were able to do it and have continued to maintain a team that is half bilingual. And so the bilingual staff get all of the monolingual Spanish-speaking clients. We implemented it without any adaptation, but we did make sure in our evaluation we monitored the process and the outcomes with an eye to meeting the needs of Hispanic and Spanish-speaking clients. So what this meant for us is that we looked at things like were all the Spanish-speaking clients assigned to bilingual staff so that they could receive the intervention without having to go through an interpreter? We stratified the client satisfaction surveys by language and race/ethnicity to see if there were any particular differences there. We looked at dropout rates to the extent we could by race/ethnicity to see if there were any differences there. And we looked at outcomes, we stratified some of the short-term outcomes that we were monitoring like birth outcomes and low-birth weight, infant mortality. We looked at some of the other short-term

outcomes by race/ethnicity. And then we also, in our process and formative evaluations, we were talking with staff and gathering qualitative data on how it's being implemented. We also asked questions related to that.

At one point we even had an opportunity to do a focus group with all of the nurses in the State who are doing NFP (Nurse-Family Partnership) who work with Hispanic and Spanish-speaking clients to get insight into how others are doing it in other parts of the State. We made sure—although we implemented it without adaptation—we made sure that in our evaluation we're monitoring it for applicability to make sure it was meeting the needs of those clients. And we have found that it has. Although we've had to keep an eye on things like making sure we have enough bilingual staff, and those are negotiations we go through inside the project.

And then lastly is the type of intervention that is culturally grounded, but is not yet an evidence-based practice so we implement with the migrant funds that Melissa spoke about. We implement a parenting education program, *Los Niños Bien Educados*, that was developed in California specifically for a Spanish-speaking immigrant population. But really was developed from the ground up. With the prevention program—it's parenting education—it is on some lists of promising practices or innovative practices, but it's not to my knowledge yet on any list of evidence-based practices and to my knowledge there's not been a randomized control trial yet with it. We've been using it for over 10 years. As I said, it targets Hispanic and Spanish-speaking and migrant seasonal farm worker families. We had funding at first through State child welfare; currently we have the ACYF Discretionary Grant. In the past, we've also had State child abuse and neglect prevention funding, and we've supported it as an agency between grants when we didn't have funding.

We also have worked with the developer because this is not an EBP, but we wanted to do some of the fidelity monitoring that we normally do with an EBP. We worked with the developer to identify core program components and we do monitor fidelity. We've just begun that in earnest in the last 1 ½ - 2 years and are still learning how to do it. It's not like working with an EBP developer where you have regular meetings and somebody is sending you reports and you're able to work through that with a developer. We're doing all that internally and so it's meant new systems for us. So we're still working through that, but we believe we've got what those core program components are and that monitoring fidelity has helped us improve the quality of that program.

With the current grant, our priority remains on direct service provision because that's a priority of the funding. We have created a retrospective, multiyear database so part of what we've been able to do with the evaluations funding we have is to look at those tenures of service delivery and create a larger database that puts everything together. So that by the end of the funding cycle we will have a descriptive in the aggregate of clients and services provided, of program performance with the short-term outcomes that we have been able to measure and with client self-reports. And we believe that that large retrospective database will be a platform for us for future research.

We've worked with a researcher at Washington State University who's interested in helping us do some retrospective as well as some prospective research. We don't believe we're in a position by ourselves to conduct a randomized control trial of this intervention, but we do think that with

this more rigorous evaluation, both retrospective and prospective, that we'll be able to get some things in the literature and get some greater recognition for this intervention that we believe, based on what we've seen, is very powerful with families.

So I tell you about that just as an example of that third type of intervention as I mentioned as I went through those choices, the type that's culturally grounded, but that as we work with it we work to bring the level of evidence up so that we can disseminate that and it can be used. This slide is a little [inaudible] and I'll take just a few minutes to go through it. There was a tool that was presented at the Children's Bureau Conference that we were at in March. The TA provider, FRIENDS, presented that around how we make decisions at the community level or how prevention funders at the State level can work with the community as they pick EBPs to implement in their community.

So it's called a Tool for Critical Discussions and as we looked at that tool, I really liked it. I thought it was a very useful. And one of the things we did at the conference with our local team that was there is we walked through the tool ourselves after we've been introduced to it to try to see, well, do these three programs we're talking about fit and if so where do they fit? It was kind of a check for us on is the way we've been thinking about these interventions and the way we think about adaptation and choosing interventions is this consistent with how this other group is thinking about it? And it was a way for us to kind of check our own thinking. We did find that there was nice alignment between this paradigm that we had set up for ourselves and the way that the FRIENDS tool had programs think about how they chose evidence-based practices.

So with the first practice, the multisystemic therapy that I talked about, if we used the FRIENDS tool it would come out as an evidence-based or well-supported because it had been tested with randomized control trial. It would come out as Part B of the flowsheet, which I'm sorry without the flowsheet that probably doesn't make any sense, but it meant we chose to implement without adaptation. That's what Part B means...I'm sorry, implementation with adaptation. And Part B of the flowsheet also defines a practice as limited applicability with diversity and randomized control trial, which just means that it hasn't been tested even though it has randomized control trial evidence, it hasn't been tested adequately with communities of color.

And then when we looked at Nurse-Family Partnership and put it through. That came through on a different flowchart so that was implemented with fidelity with monitoring the processes and outcomes for applicability and evidence-based practices. It's not culturally grounded, but did have diversity and the randomized control trial. It was tested with other populations. And then we put our Los Niños project through the flowsheet. It came out on Part D, which was innovative programs, and Part D goes through steps that can be taken to strengthening existing programs. Much like we had done in determining that we could monitor fidelity and determine our own fidelity measures to monitor. And again they pointed out this was, we would say, this was a culturally grounded intervention.

And that is all I have by way of presentation. I'd be happy to entertain questions or engage in discussion if there's interest.

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Audience Member 1: [27:39]: Vickie, where can we access that tool?

Ms. Ybarra: [27:41] The FRIENDS tool? I believe it's on the FRIENDS website, isn't it Melissa?

Ms. Brodowski: [27:46] Yes, it is. And in fact let me send the link to Jean and maybe we can post it.

Ms. Ybarra: [27:58] It's an excellent tool, I think, for having these discussions.

Lauren Supplee: [28:06] Vickie, this is Lauren Supplee in ACF. I'm curious if you can talk a little bit more about how you work with the program developers, particularly on MST and Nurse-Family Partnership, on the concerns or the focus you have on making sure it was culturally relevant when you were implementing it. And talk also about where you've thought about where that line is about whether if there are adaptations that need to be made, at what point, you know, is there a concern it's no longer faithful to the model?

Ms. Ybarra: [28:40] Yeah, and it's that very question. Is it still MST? Is it still NFP? Now to be clear, NFP, we didn't make any adaptations we just made sure to implement with bilingual staff. With MST, it was quite a process of negotiation and it has to be if ... our funding dictated that it had to be an evidence-based practice so we were highly invested in being able to still call this intervention MST. And we knew that meant that we needed the approval of the developer for any adaptation we were making. As with most relationships between the community that implements and the developer, our supervisory staff and our directors staff in the clinical area had regular contact with the developer. I think they had weekly supervisory calls. And it was in the context of that relationship that supervisory or developer-implementer relationship that we made those requests, that we pushed, that we had staff there to say, "I'm working with clients and this is what I'm seeing."

And as I said, the one adaptation of the level of staff, that was made ahead of time and did take quite a bit of time and quite a bit of talking back and forth before they would approve. I don't know if that's the correct word but before they would approve us to do that. And we had to demonstrate to them that we had experience working with bachelor's level staff under similar circumstances. We run a large mental health agency in town. We try to get bilingual staff at the master's level and have trouble. So we have kind of a system where we've brought in bachelor's level staff with certain kinds of experience and certain kinds of supervision as long as they're pursuing a master's degree, and we allow them to work in those position. It took a long time and there was quite a period of negotiation, and I know for our staff it was frustrating at times. But they bought in to the need to implement an evidence-based practice, and so they stuck with it. I do have to say with that caveat that I'm not sure they ever got permission to do the second adaptation. So there was clandestine work, and I imagine that happens with a lot of these kinds of practices.

Ms. Supplee: [30:58] As a follow-on to that, do you know if MST is recording these sorts of negotiations or adaptations so that the materials in their program can be ... they can say OK it was done well and shows evidence of effectiveness when we made the following adaptations?

Ms. Ybarra: [31:23] Yeah. I have no idea whether they are keeping track of that. I do know that we included it in our evaluation reports to our funders. So the data's there and is available, but whether it's gone through this specific process that that developer is going to use in the future to demonstrate continued effectiveness for their program I have no idea.

Ms. Supplee: [31:46] Thanks.

Audience Member 2: [31:51] Vickie, you mentioned pulling together a community group to join in the discussion. Was it around selecting an EBP?

Ms. Ybarra: [32:01] It was and that was the SAMHSA grant we had that called for a year of planning in advance. I generally think that in implementing interventions for challenging populations that a number of agencies in our community are trying to deal with, we do better when we collaborate with our other agencies. And all of the programs I've mentioned have been collaborative to one degree or another. Nurse-Family Partnership is probably the greatest collaboration. And we find that that expertise in implementing programs ... in the case of MST it was the county funder, all three mental health agencies in town, the local child welfare representative, and some people from the community who had worked on prevention programs, not so much on treatment programs but who knew the community well and were well acquainted with this particular group of high-risk youth. And we find that that works better. We think better when all of us are in the room; we're able to make better choices about what we want to implement. And then when we do implement, we have more support and more buy-in from these other stakeholders.

In doing that—we kind of have a tradition of doing that in our community—in doing that with evidence-based practices what we've found is that there is an increased, I don't know if I want to say baseline, but there's kind of an ... it's increased all of our understanding of evidence-based practices so that we now have discussions across agencies in planning evidence-based practices routinely for grants, not just for grants but to respond to State funding streams, to respond to changing needs of our community. And we've been active in the last couple of years trying to get training to come into the community to help our family of organizations better understand how we implement a variety of EBPs at the same time across the community to address some of the particularly challenging issues in our community. That's been a difficult process, but I think we've come a long way and that we'll be well positioned in the future to make an even greater impact in our community.

Audience Member 2: [34:21] Thank you.

Ms. Brodowski: [34:30] Anybody else with any questions for Vickie?

Ms. Supplee: [34:40] Vickie, this is Lauren Supplee again. I work in research with Head Start, and we have migrant seasonal Head Start. And I know we have conversations here that collecting

data on families who are in that program is challenging for a number of reasons, but one of the things I was thinking about with these programs is dosage ... and I know that the families are sometimes are nonpredictable migrant patterns, and I don't know if again when you were working with the other two evidence-based programs if that issue came up at all?

Ms. Ybarra: [35:21] You know I think that for our State and our area at least and the clients that we're serving, the old picture of migrant workers who came and went frequently is gone. We still serve large numbers of migrant families and they meet our Federal definition of migrant. And our area Head Start serves large numbers of migrant families that meet your definition of migrant. But they are much more likely to be settled out people who are here for the majority of the year. They may not be here all year, but they're here for the majority of the year and their families have a base here. Part of that change over the last 15 years has happened because of immigration reform in 1986; part of it has happened because of the egg industry and the way it's changed so that the season is longer and there is work longer. Part of it is because families have been reunited and are together so a worker is not coming without their family and having to return to their family. I know that still happens in some parts of the country and probably still happens in part of our service area. But it is much less.

While we do have some families who will drop out because of that reason, we still maintain high dosage levels. With *Los Niños Bien Educados*, which is targeting a migrant population, we're getting over 70 percent graduation rates. So that means people are ... over 70 percent of the people who attend even one class are attending at a high level and that's really extraordinary. I do think ... that's not to say that we don't have to make service provision adaptations or have to change our program to meet the needs of our clients. For instance, our migrant seasonal farm worker clients are working during the summer. That's their heaviest time for income. And we don't offer classes during the three summer months because if we did we wouldn't get any attendance. We do offer them in the winter. And we do offer them in all the other seasons of the year, and we have good attendance.

The other adaptation we've had to make for that particular intervention is it was designed initially to be taught over 12 weeks, 3 hours a session. It was designed initially for 3 hours once a week over 12 weeks. And what we've done is shorten the weeks so the families still get the same dosage of hours but they meet twice a week instead of once a week. And that gives us 6 weeks that we have to deal with instead of 12. And we find that helps for people who move.

Ms. Supplee: [37:57] Great. Thanks.

Audience Member 2: [38:03] Vickie, I hate to ask another question ... So figuring out how to adapt or schedule the services was I guess lessons you've learned during this community group or did you use other methods to get that input from community members themselves?

Ms. Ybarra: [38:27] We didn't have a community group early on. That's a really good question. We didn't have a community group early on for that particular intervention, and some of it was trial and error. We just had trouble. Our attendance wasn't what we wanted it to be so we changed and did something else. The other thing we did, that program has a wonderful woman who is our coordinator. We find for class-based interventions that require instructors who are

trained and certified in a particular curriculum, whether it's parenting or diabetes, we find that those classes, the attendance goes best if we have a coordinator whose job it is to provide support, registration, support for the families, support for the instructors, but who is not the same person as the instructor.

So we hire qualified instructors to teach and to do their job, but we don't want to burn them out by having to set up the space and the food and the transportation and follow up on families who miss. So we have a coordinator who does that. Her job is to establish relationships with people who are referred to the class, to address barriers, and to follow up if they miss. And we learned a lot from her. She was from a farm worker family, is a wonderful individual, and has really helped us make this program what it is. So I would say it's trial and error. In summary, trial and error, hiring someone from the community, and then the coordinator position itself has really helped a lot.

Audience Member 2: [40:01] Thank you.

Ms. Brodowski: [40:10] Anybody else with other questions for Vickie on the programs or even just this general topic of evidence-based practices in communities of color?

Vickie, I was actually curious from sort of the family's perspective, do you have a sense ... how cognizant are they that they're participating in this evidence-based ... and some of them might not care in particular or others ... It was interesting, I was in another meeting with a parent leader who's been really familiar with all this work lately, and I thought it was great he actually said he wanted, as a consumer of programs, he wanted to know what kind of evidence there was to support the programs that were available to him. So I'm just curious from that perspective if that's even anything on the radar for families that you're working with?

Ms. Ybarra: [41:10] You know, I don't think the families that are receiving the services know whether ... know about evidence-based practices for the most part. I mean there may be an exceptional consumer, but I don't think that's the case. I do think they know that they're being enrolled in a program that is special in some way because of all the paperwork that goes with an evidence-based practice and the commitment upfront to say this is an intensive intervention and upfront we need to know that you're committing to this kind of period of time. I think they know they're in something that's pretty different and special.

Ms. Brodowski: [41:54] And then the other thing I wanted to mention. I know folks were interested in the FRIENDS tool and actually I realized it's not posted yet and it will be. I was talking with the folks at FRIENDS, and she was still writing up the materials to go along with the discussion tools. So as soon as that's available and Jean was also reminding me that we do have a list of everyone who's registered so we can make sure to forward that information to everyone on this call as well.

Anything else from folks?

I really appreciate everyone joining the call today and also definitely thank you Vickie for doing a command performance of the presentation. I know at the grantees meeting we were all just

very excited about the work that was happening and having you be able to share with the wider group was important to us.

There was one thing I remembered that you were talking about related to the tool, I think after the conversation, and I wasn't sure if you all are thinking about doing some sort of community-wide planning in Washington State. I know I've been reading a little bit about sort of the balanced portfolio approach of evidence-based practice that the Washington State Institute for Public Policy has been ... Are you familiar with that Vickie?

Ms. Ybarra: [43:26] Yeah, I am, and the Washington State Institute's done a lot of work with the legislature.

Ms. Brodowski: [43:30] Right, right. So I'm just curious if you have any kind of comments on that or are they addressing issues of cultural relevance in the programs that they might be ... ?

Ms. Ybarra: [43:43] I would say that they're trying. They are cognizant of the need for cultural applicability, but the way it plays out is different in every funding stream. So for instance, mental health has a mental health transformation grant at the State level and they have a cultural competence workgroup that's looking at that very issue so they would ... We are doing more work at the local level because of the kind of the knowledge base rising of all our community-based agencies and also because of the opportunity that our new early learning initiative presents. We're a community that's one of two in the State chosen by the Gates Foundation for a huge investment in early learning. That provides us an opportunity as well to do some community-based planning around that.

Audience Member 3: [44:33] I did want to respond to the comment around how well families are informed around evidence-based practice. I highly agree because not all programs go to the extent of planning and engaging community that Vickie described, and sometimes evidence-based practices are taken off the shelf and implemented without that level of work. And so it's important that families ask the questions that I think Vickie was asking as part of their process, and families need to ask well, how effective has it been and I guess sort of show me how this will benefit my family and my child.

Ms. Brodowski: [45:30] Right, absolutely. I was talking to someone else about this too and she was saying it's basically like being a well-informed consumer.

Audience Member 3: [45:38] Absolutely.

Ms. Supplee: [45:43] The PROSPER Project—which is funded right now by NIDA, and they're doing an extension that works in Iowa and Pennsylvania—are publishing really interesting work on looking at a tool they're working with on how to get schools to determine which is the best evidence-based program for them. And then they continue to follow the implementation of that, and they study the sustainability of it after. It will be something to sort of watch to see if this tool works because I think it's a really nice decision-making guidance that they're developing.

Ms. Brodowski: [46:20] Yeah, that's great and that's sort of a similar, I mean we're not getting funded by NIDA for the FRIENDS tool that they're developing, but it remains to be seen how well also an application that tool is.

Audience Member 4: [46:40] That would be a consumer-oriented tool?

Ms. Supplee: [46:43] Right now they're orienting it towards school, elementary schools that are picking particularly drug prevention programs. But if they find that it's effective it's definitely something that could potentially be utilized in a larger scale.

Ms. Brodowski: [47:04] Great. Thanks Lauren. Questions or comments?

Thanks again. Thanks Vickie for doing this and thanks everyone for joining us and asking really great questions. I think it's a really important topic and there is so much to be learned still. So hopefully we'll continue to do that. Next month the prevention webinar is actually going to feature programs from the Department of Defense. So we'll be sending out some information about that probably in the next week or so. But keep an eye out, and we'll be posting it on our various listservs. Thanks everyone.