

Session 4.16 – What Is the Shelf-Life of an Evidence-Based Practice? Thinking About Relevance, Effectiveness, and Changing Social Context: Implications for Child Welfare

Panelists:

Peter Watson
John Landsverk
Lisbeth B. (Lee) Schorr
Jeffrey C. Valentine
Daniel J. Whitaker

Please note: The following is a direct transcription and has not been edited.

Peter Watson: Welcome to the opening session and really welcome since everyone had such battles to get here I think. I just wanted to I guess thank the organizer of the summit for gutting it out. I'm sure that was just a wrenching decision to make to cancel Monday session. So, thank you for everybody for coming to this and still showing up are really looking forward to this conversation today. My name is Peter Watson and I'm the Director of the National Child Welfare Resource Center for Organizational Improvement. It's one of the Children's Bureau 10 National Resource Centers that they fund. And I have been asked to moderate this panel session. I'm really, really looking forward to it.

I want to give you a quick overview about what we're going to try to discuss today, introduce our panelists and then really let you know that what we're going for here is a conversation you'll see. We don't have PowerPoints turned on here. We're not doing long formal presentations. We're going to try to move through this hopefully a really kind of interesting discussion and we'd really be interested in having people get involved in this.

So, a quick reminder that we are recording this session, so, when and if you engage in the conversation, if you could use a microphone and I think I'll probably try and flow it around since there is a lot of view and hand the microphone around. I'll be to fill Donahue and these will be our panel members up here. But let me give you a quick overview of what we're trying to accomplish here. There is an article in the New Yorker what was the date last December 13, 2010, it was called The Truth Wears Off and it just raised a number of really I found fascinating issues around what one researcher referred to is the decline effect. And I'm not even going to be able to do justice to this, but it raised a bunch of issues around research you know double-blind research in the biomedical and other fields that people had a very difficult time replicating.

So, an example would be second generation of different drugs that over a number of years when people tried to replicate the results that were supposed to be spectacularly better than the first generation slowly found the more they're replicated the more the results started to decline and in the end people started saying you know the first generation was as good or better. Raised a whole bunch of issues about what is evidence-based anything mean. There are a number of issues in that session. I'm not being sarcastic sorry. I don't want the panel to get mad at me.

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No, but really it's fascinating there are issues in there around publication bias, meaning, what journals decide to publish. There are issues around selective reporting that researchers engage and not in a dishonest way, but just human nature. We're looking for positive results and we're not going to engage in those specific issues in this session the publication bias or the selection bias. We're more engaged in trying to think about some of the other pieces around what does it mean to replicate evidence-based practices, how might evidence-based practices change or decline over time, what might explain some of that decline and really what does that mean for choosing what to do is administrators of programs and as evaluators and researchers around these types of issues, how do you think about how to evaluate these, what are some of the issues that are raised.

That's' and as you can imagine we can probably sit here not that anyone would necessarily want to, but all day trying to sort a lot of these out. So, the way that we decided to go at this as a panel was to lay out some broad questions and talk about them and really hopefully engage people here in the audience. We want you to jump in; we want you to raise questions; we want you to make some points and I'll try and move us through these, but the types of questions we're going to try to get to in this session are, what do we mean by evidence-based practice and how might different definitions of that affect our confidence and their potential effectiveness over time.

Another one would be what are some of the issues involved in determining the potential shelf-life of evidence-based practice, right, that's in the title of our session. Couple of issues there. There is research issues involved about the precision of the initial evaluation you know how much things were laid out, how easy or difficult it would be then to replicate those, how, you know if they're very specific to certain populations and your populations are different, what are some of the things you have to think about, but then there are context issues that I'm getting at here as well, if your population is different, if time has passed and then conditions have changed.

The other piece of that is then what is the theory beneath some of these evidence-based practices and I think sometimes people not really look at the theory underneath and think about do I agree with the theory, do I understand the theory, does that theory fit where we want to go as a program or as an agency.

And then the last one although it's not really a separate question as much as something flowing throughout, this is what I said before given whatever we talk about, what advice do our panelists and all of us have for people who are trying to make these difficult decisions in a time of diminished resources about where to put our dollars, where to put our effort, how to think about what we want to implement to bring about positive change for children and families.

That's my broad take on this. One of the things we wanted to do is just get a sense of who you are. There is too many of you to do introductions, but trying to I don't have all the categories memorized that Brian just talked about in the opening. But how many people here, how many of you would categorize yourselves as researchers or evaluators? And then how about program administrators, program directors, how about CIP leads

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frank, I knew we had one. Oh all right, we have a few. Are there any Children's Bureau staff? That's great. And T/TA network and our C folks, good.

So, we've got a mix of people here. And I know people can categorize themselves as more than one. So, all right. So, I think that's what we wanted to know. Let me just give you a quick sense of who we have here on the panel to my right, Lee Schorr. Many of you probably know Lee. She is at Harvard University and the Center for the Study of Social Policy, Lecturer and Senior Fellow there and has done writing on a variety of pieces of work that are both related to this, related to social policy. I told our panel that I would just introduce them very broadly and then they could throw in the things that they think would be particularly important for all of you to know.

John Landsverk is the Senior Research Scientist at the Rady Children's Hospital in San Diego and he directs the Child and Adolescent Services Research Center there and in particular of interest for this panel he is the Scientific Director of the California evidence-based clearing house for child welfare. And Dan Whitaker is the Director of the National SafeCare Training and Research Center at Georgia State University.

So, we're going to start in the opposite order of what I just said. Each of our panelists here is going to give about five minutes just of an overview, their take broadly on these issues and then we'll try to jump into some of these questions. Makes sense everybody? All right. Dan?

Daniel Whitaker: Come up there?

Peter Watson: Whatever you're comfortable with, you all can sit and use microphones or you can stand whatever you.

Daniel Whitaker: What do you guys want me to do?

John Landsverk: I'm out, but...

Daniel Whitaker: All right. We're sitting. See why my wife loves me.

Peter Watson: Now let's make sure it is on.

Daniel Whitaker: Yes, can everyone hear me? All right. Well, first of all I want to thank our sponsors for inviting me to be on this panel and be at this conference. I'm very honored to be here with John and Lee to talk about these issues. So, just a little bit about sort of my background so you can understand where I'm coming from. I spent the first I guess 10 or 11 years of my career at the CDC. I was a scientist within the division of HIV prevention and then violence prevention. And one of the nice things I'm not sure of it's like this at ACF or NIH, but one of the nice things about being in that role is you can think about all the big questions that need to be addressed and for the most part you don't really have to do the knitty gritty work of actually doing the studies and you know the very hard things are tracking subjects and so forth.

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From there I moved to in 2008 I moved to Georgia State University to direct something called the National SafeCare Training and Research Center and I'm also a Professor in Public Health that's where my center is housed. SafeCare is a behavioral parent training program with the fair evidence-base. It's housed within the -- or it's usually implemented within child welfare systems. So, I went from sort of this nice place where I can think about all the tough research questions that other people needed to address to really jumping into true implementation and dissemination and we do a lot of training of child welfare providers. We interact a lot with child welfare systems around changing the models that they use from sort of unstructured, what we would call unstructured case management to something that's much more focused and skill based and so I've seen a lot of the challenges that can arise when child welfare systems try to do that.

We've done quite a bit of work in California incidentally with some folks I'm sure John knows Charles Wilson and Greg Aarons. So, I guess when I was invited to be on this panel and the question is -- the question was raised you know what is the shelf life of evidence-based practice and I think about this in terms of child welfare. My first question is well, let's get something on the shelf first and then let's worry about when it's going to expire. You know for me, you know if we look at what actually works in child welfare and again you know you can get everything you want to get on this at the Evidence-Based Clearinghouse that John Center runs.

For me when we think about what works in child welfare, if you actually look at the number of programs that have affected probably the results we care about most which is child welfare recidivism, things like out of home placements, there ain't a whole lot you know we've seen some results from PCIT, we've seen some results from PPP, there are some data on SafeCare coming out of a statewide trial in Oklahoma. But there is not a whole lot out there and so you know I guess the first question is you know I would say we need to back that question up a little bit and say you know if we think about this as a trajectory of let's develop programs and test them, then disseminate them and once we have a series of nice programs, disseminated, let's worry about, let's think about how we have to change or adapt them over time or whether they're going to you know sort of wear out or wear off.

I think we're still much more at a nascent stage of development. The other thing I would add is that and I'm sure John is going to hit on this too is that there are some real challenges in terms of getting what we might call an evidence-based program into practice and I would say these challenges are not in training people to do the model. We've trained, I mean we've only been in I guess business for a few years, but we've trained over 500 people. We can get people to do SafeCare that's not a problem. The problem is systems level issues, organizational level issues, funding issues and other kinds of issues that come up that I assume you all have lots of questions about that and I'd go into it little more if we had the time.

And so, that's sort of my take on the issue and I think I'll probably stop there and pass it on to John.

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John Landsverk: A little bit about my background. I'm trained as a sociologist. I was never any good at trying to help people. And I really wasn't, but I've spent my career mostly working with people that are very good clinicians and many of whom are in the business of developing interventions that are run through randomized controlled trials. I'm a services researcher and all of my work has been primarily focused on the services being delivered particularly related to well being, delivered to kids in child welfare, largely because I was recruited to children's hospital by David Chadwick to develop a program of research in an area I had no experience in whatsoever.

But the first four candidates were selected and dropped out because there was no tenure slot there and I was really interested in the issue of the kinds of kids that had gotten such a tough start in life. So, it really appealed to me. My current work is focused primarily on the problem that Dan alluded to which is that we have two different kinds of interventions it seems to me broadly speaking. We have interventions that have been developed from within child welfare. Family teen decision making is a really good example. And in general, those family to family -- there is a whole range of them, family preservation, almost none of them have been subjected to any kind of rigorous evaluation before they are implemented.

So, they are examples of interventions that actually have been implemented and brought to scale at a quite astonishing amount. They're very successful at being implemented, but we don't know whether they work. On the other hand, we have a whole class of interventions that were not developed by child welfare people. They were not developed in general for child welfare populations. There is a class of them called parent training interventions that has a robust 20-year history and we have many models with multiple randomized trials that say we really do know how to change the behavior of parents. None of them have been implemented or brought to scale in the child welfare system.

And in fact in the randomized controlled trials what researchers call efficacy trials. They are the most carefully controlled. It's a kind of thing Lee talks about where you try to control, you'll clearly randomize and you try to control all the variables and the ones that you don't know about you'll get taken care of by randomization. The problem with efficacy based evidence is they weren't designed to have in mind the service delivery platform that they would have to be moved on to whether it's children's mental health, whether it's schools, whether it's child welfare with Juvenile Justice, they were not designed specifically to be mounted well or implemented well. But they were designed to demonstrate a beneficial effect. And we have lots of those that are very good, that are good candidates. So, that's the dilemma.

The problem is we don't know how to bring them to scale even the smaller ones within a system as complex and multilevel as child welfare. So, currently the major work that I do is to run an NIMH funded center that is focusing on methodological issues of implementation research. How do you develop methodology to study dissemination and implementation processes and therefore, hopefully increase the potential of bringing to

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scale interventions that look on the face of it like they might be quite a good fit for a service system like child welfare in the children's mental health services.

One last thing I'll say is that reading this, by the way, I love the New Yorker and when I saw this in December I thought boy, you know most of the time I look at the funny stuff first as most of us do. What I said I have not seen an article like that in the New York. I got to read that. So, I was so when Brian called me to say would you part it, I said of course that's a most fascinating article. It is still journalism and there is a broad stroke there. The thing that they start out with I know something about the KD trial which was a comparative effectiveness of the old psychotropics with the new psychotropics.

Now, what's not clear in here is that the new antipsychotics we developed not necessarily to get a better effect, but to tamp down the really tough side effects that came with the first generation. And they've done a very good job of that. What was surprising in the KDA study and it was absolutely a mind-boggling finding for NIMH was that the old antipsychotics for that are used typically for schizophrenia worked actually a little bit better than the new ones, but that is not. So, the story here is a very broad brush and it's sort of like opening up, boy, let me tell you about all the secrets of modern science.

Well, I still remember 1968 when Watson published the double helix and all of the dirt came out about Rosalind Franklin and the X-rays and the enormous drive to get first you know and it was a wonderful eye-opener to a young graduate student about aah, so that's how science is done even in the hard core physical sciences, they're human beings just like the rest of us. And in fact much of science of course is a career trajectory it's a job as opposed to also being just science. Anyway it's a really interesting article. I think it opens up, but I don't think it has the best feel necessarily for the technical issues in there.

So, I just wanted to, but I do remember, I love the double helix, because it beat all hollow all of the research methodology textbooks that I've been forced to weigh through, which really weren't in a sense it was an idealized form of how studies are done, all studies are complex and all studies have within them many unanticipated things that one has to take into account, because human behavior even in RCTs and certainly in bringing to scale things, that's complex business, there. Thank you.

Lisbeth B. (Lee) Schorr: I'm worried about myself. I -- am I okay? Because I don't have an advanced degree and people and because I work across many different domains of early childhood and healthcare and child welfare and Juvenile Justice, people ask me what is my specialty and I finally after many, many years have learned to say my specialty is in what works. And I wrote a couple of books about what works. In the last three years, my colleagues at the Center for the Study of Social Policy and I have been working on the -- on several new administration initiatives, federal initiatives, which have in common that three of the four that we work with have innovation in their title and all of them require the bulk of the money go to proven programs.

And that's a very interesting attention which we've tried to explore and which is how I've gotten to thinking about this problem of what is, how do we define evidence-based

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practice so that it won't be a damper on what we're able to do. Now, I believe that the shelf life of evidence-based practices not only is but ought to be very, very short. Not because of the possibility of diminishing returns as the New Yorker article talks about, but because our strategies have to aim for more than the results we've been getting in the past. It's more than we can get with proven practices even when they're scaled up.

The results we're achieving with the practices that are established as evidence-based are falling short of the outcomes that were after. We haven't solved the problem that John was just talking about, about how do we take the stuff that's been rigorously tested with RCTs and implemented in the real world. In child welfare particularly, evidence-based practices can't be the destination. They, we can take the nuggets from the evidence-based practices and build on them and make them launching pads. We're in a field that's trying to improve results because the results we're getting with our interventions are good enough and the object of research ought to be to constantly improve results.

And as both John and Dan have implied, so much of what we need to do in child welfare goes far beyond individual programs and practices, the creation of partnerships between informal and formal supports, changing how the system relates to the community, both the powerful figures in the community and the powerless families that we're working with. None of that kind of change can be found in the evidence-based practice lists in that connection the most relevant part of the New Yorker article maybe in the last paragraph, "just because an idea is true doesn't mean it can be proved." And that sure is true of a lot of stuff we work with in child welfare.

Diminishing statistical evidence over time isn't our problem. Our problem I think is that we define evidence-based too narrowly. We get stuck on what's worked in the past and are afraid to adapt and build on it to be more successful in the future, but we focus on proving rather than improving. I want to take one example to make this point, you know one of the nurse family partnership which is one of the really well established well functioning programs that has been replicated that has been tested in three randomized trials with different demographics.

The first randomized trial began three decades ago in Elmira; the second one was Memphis, 23 years ago and the last one in Denver beginning 17 years ago and in all three trials nurse home visited women had a longer spacing between their first and their subsequent pregnancy. In two of the three trials there they found reductions in child abuse neglect and among a subset of children that were called low -- subset of families with low resource mothers, there were improvements in language development and academic test scores among their children. But there was no reduction in behavior problems or foster care parent placements among the children, among the mothers, there was no reduction in substance abuse, psychological distress or a risk.

But because the results were achieved, were documented out of randomized trials, the NFP was the only early childhood program that qualified for a top tier rating by the coalition for evidence-based policy which I'm sure you work with John. The pressure on proven programs to stay constant regardless of changing circumstances and the

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knowledge I think is what has gotten us stuck and has made it hard for us to build on what works. We know so much today that we didn't know when NFP was originally developed and tested. We know that a large proportion of high risk babies are born to mothers who don't get any prenatal care and yet NFP excludes mothers who don't get prenatal care.

So, we would change that. We would partner with programs that have been successful with substance abusing mothers who are depressed. The two most common precipitants of the toxic stress that we know is so damaging to young children are parental substance abuse and postpartum depression which NFP has not been able to affect. They might add the capacity to work with family violence and with housing problems. Now, there are programs that have added exactly those components to NFP. Their problem is they're no longer proven programs. And one of the -- one person who has told me about this is exactly what they did says they're now very worried that they won't be eligible for the federal home visiting fronts because they're no longer a proven program, because they've improved it.

Now, that doesn't make any sense. So, I think we have to move, we have to use what we've learned about proven programs which is very, very helpful. I mean if a judge is going to mandate parent education you want to mandate something that we know works. So, I'm not dismissing the idea of proven programs and proven practices. I'm saying we just can't stop there. We have to move beyond what's been proven to work in the past in order to get to significantly better outcomes in the future.

That's my story and I'm sticking to it.

Peter Watson: I guess so all of you in beginning here raised issues that in my mind make the first question. We're going to talk about much more complex than when we think upon reading it, but let's talk a little bit more about that issue of you know what do we actually mean by evidence-based practice and how could different definitions of that affect both how we interpret the impact we'd expect to get and affect how we make decisions about how to use those programs going forward. I'm just going to throw it open at this point and we'll try to move around and then let's I just want to let's have our panel expand on that a little bit and then we'll see if people in the audience want to jump in on that as well.

John Landsverk: Well, I'd be happy to start. By the way I'm not representing the Clearinghouse. I assure you. We do the scientific work for it. The -- if you look at the registries which is really what you're talking about and I clearly what Lee is talking about with regard to the overlapping politics and science occurred with regard to the home visitation, I'm not going to enter that. That's a tough one. I mean it's -- it was far more politics and it wasn't any, we've just a lot of stuff going on in there. Clearly, the Cochrane Collaborative talks about systematic reviews and that's the gold standard at the present time for whether a class of interventions that are related to the same outcomes, what overall do we know about can you change something the phenomenon. And they remained really the goal standard. They're highly medically oriented. There is some

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mental health in there. In the areas of things that are critical at the safety and permanence not much there, but that's why the Campbell Collaborative was begun was to really move into areas of Juvenile Justice education and again child welfare in there, but it's not nearly as a robust as set of systematic reviews.

The Clearinghouse in California was developed on the basis of we do not do systematic reviews. The Office of Prevention at the State Department didn't give us enough money to do that and it would have taken forever. It just was not so what we've done is it has to be in a peer-reviewed journal. So, the issues of what we're not going to talk about which is peer-reviewed selection and all of that we won't go into. It's a downside of that. But clearly, we're looking at issues about on two counts, one is what's the evidence-based on fairly strict rigorous criteria, were there two or more RCTs, you'll be surprised that how few have had replications that's why the article I think by Jeffrey Valentine that at least we appear had a pleasure to be able to read was really how do you stitch together even just two studies and come up with well, does it work or doesn't, because that's the fundamental question.

The clearinghouses range enormously. There are clearinghouses that would call something promising that the Cochrane Collaborative wouldn't even look at. I mean it -- so there is the use of and often there are clearinghouses that where there is not as much science based research. They will bring in stuff that will help at least was there some kind of research that was done. So, we followed that some of that sort of thing, but anyway, I -- evidence-based is generally based on RCT kind of thing.

I think what Lee is talking about with regard to that's where it can't stop is absolutely correct, because what we're almost always talking about our efficacy trials and again, let me be clear. The findings from an efficacy trial were done to try to get rid of the noise so you could find some signal in there and it's tough to find signal in human behavior kinds of research and so you try to make it as clear and easy to interpret as possible, but that means that the whole issue of what researchers call external validity which is, is this ready for real service systems delivered is about as far from treatment developers minds as can be, because that's not their primary concern so also by the way what most folks in universities that's not where they get tenure on.

They get tenure on is developing a brand name treatment that makes it into the highest level of peer-reviewed. So, the whole issue of relevance to the child welfare service system, the whole issue of -- by the way, there is always with the client, been documenting I mean when you move from efficacy, you got to say bye-bye to part of that effect size. You're not going to see it when you try to bring it to scale in effectiveness trials and on into implementation studies. They're just -- it will diminish.

Lisbeth B. (Lee) Schorr: One way to solve that it seems to me is by defining evidence differently.

John Landsverk: Okay.

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Lisbeth B. (Lee) Schorr: If we say that evidence is reason to believe something is true and comes not just from program evaluations, but it comes from other kinds of research; it comes from theory; it comes from practice, well then you know we have the theory that Jack Shonkoff at the Harvard Center on the Developing Child has developed that I briefly alluded to about that the toxic stress from substance abuse and maternal depression in the mother of very young child is the most little thing there is, okay, that's a theory, which some very reputable scientists have sort of signed on to.

That doesn't mean that we know how to deal with substance abuse and maternal depression within the child welfare system. It does say boy, we better learn; we better figure that out and you can take some practice experience as for example, the strengthening families intervention does and put that together so that you have converging evidence where you're not just dependent on what programs you've been able to evaluate by these rigorous methods, because as you point out, it gets the -- RCT gets rid of the noise. It lets us see this little nugget inside there, but you can't stop there and the real world is very noisy.

And so if we incorporate what we've learned from the noisy messy real world with what we can learn from these very fancy evaluations, I think we've got a better array of evidence and better knowledge base to build on.

Peter Watson: Dan?

Daniel Whitaker: Yeah, I guess I would add a couple of things. I mean one of the issues in that I struggle with in terms of -- thanks. One of the issues I struggle with in terms of thinking about this is thinking about evidence-based programs versus techniques that we know work and I think sometimes there is too much of a focus on the program, the brand name, you know the NFP, the healthy families, the parents-teachers, the SafeCare, which is again that's the program I've handled rather than techniques that we now work with families and so in some ways these program names become hollow shelves for things that we don't really know what's inside of them and if we were to focus on sort of what's in the innards and maybe this is some of what Lee was -- not exactly what Lee was saying, but rather than you know is this brand, you know is this brand name effective.

Let's look at what they're actually doing and say are they using techniques that are effective. Now, I certainly understand the -- in the recent federal review of then home programs why there had to be a focus on brands because they needed brands that could be replicated across sites or across states. So, you know I'm sympathetic to you know to the job that the reviewers had to do and sort of selecting that, but I think that's actually that is a problem in thinking about well was a program effective yes or no, I mean let's some of these, these programs are two, three, four years long, what about it is, you know what's in them, what's -- what about them is effective and if we can start to understand that I think that will help us -- that will go a long way in helping us figure out you know how can we replicate that more efficiently or in other systems and so forth.

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The other thing I would want to say is that you know replicating an effective program and this wasn't the question that was addressed but what the heck I got the mic. You know in thinking about what is an evidence-based program, it sort of -- I think this is what John was saying initially, it's sort of an irrelevant question if you don't know how to replicate it or it's an irrelevant question for now because if you don't know how to replicate, if you don't know how to do it within a child welfare system, you almost need to figure -- I won't say you need to figure that out first, but you need to figure that out at the same time and maybe that's kind of one effort where you're figuring out both how do we replicate this and is it going to work within the system.

So, you know I would say that implementation standards are as important as knowing that something works. You know we probably know that that you know we could do a lot of good for families and child welfare if we gave them you know \$1 million a year, but we know that that's not really replicable. So, that's not really an intervention that anyone would buy and it's the same concept applies. If you got an intervention, but you really don't know how to replicate it, then you're sort of back to square one.

Peter Watson: I guess one thing I wonder about what that is I knew this was going to happen, this is a discussion where we would go anywhere about a thousand different directions right now, but is there something in that piece stand that we need to hold researchers and evaluators to a higher standard of when they're looking at these programs to put in some pieces about what it means to replicate them as opposed to are they effective and how are they effective? Now, I don't pretend to understand that well, but is that a piece of this and so, I'm not sure if this is related or not but I had a question for John, John you implied that if you had a lot more money from California, you could do more than just look at journals, and I don't think I understood what you meant. So, I want to just quickly...

John Landsverk: Sure.

Peter Watson: What would you do if you had more funding, more ability and is it related to what I just said or not I'm just wondering if that's -- if those two come together or not.

John Landsverk: Well, considering about whether you have more money inside California is just a non-starter, so I don't go there. The -- you know let me take a tougher stance I think in response. There is a term in that economists use called opportunity costs. You are all shaking your heads, yes. So, you know that term. Actually it's a pretty interesting term which is if you're putting a lot of money into programs, and clearly child welfare is a big business billions and billions of dollars are going into the delivery of services under IV-E and the various statutory ones.

If you are spending the money on programs that don't have evidence that they work, by the way, it's also as they've never been tested, we don't have evidence that they don't work, but if you are spending the money that way, you lose the opportunity of using that money for alternative ways to deliver services. If you are ignoring a body of evidence generated programs and interventions, because you think that you're going to have to add

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more money to bring them in instead of thinking can you substitute that, then it seems to me you're kind of stuck in a rut where the money and the programs that remain which I think is a part of the problem that you're really focusing on is no improvement occurs, we also end -- it is true that it is far more complex to implement in real service systems, but I also want to hold out that it's very critical that there is some possibility that you actually have a mechanism that can produce signal.

It is not easy to find an effect particularly with very complex comorbid kinds of conditions and the sorts of broad outcomes of permanency, safety and well being that we see in child welfare. For some reason, now the Cochrane Collaborative came out of medical science and there even Don Berwick will say that RCT has been fabulous for determining when you go to see a doctor are you going to get a medicine or a therapeutic that has some real possibility? Now, clearly around we have sometimes the evidence is not clear. Hormone replacement therapy is a wonderful or a lousy example of where we - - the evidence is not clear and it goes back and forth, but most of it the signal is quite clear.

For some reason, when we move from medicine to child welfare which I would maintain is just as critical in terms of the outcomes for the public health, we have virtually no tradition of randomized trials at any level and actually most of the programming is done based on values rather than evidence, and that does not give as much opportunity for considering other ways. One last thing I want to say. The business of much of child welfare is what gets called case management.

I can think of hardly any studies, randomized studies that have ever compared different ways of doing case management in child welfare. That's the bread and butter business. Why are we not generating better ways to investigate and assess and to coordinate services? By the way, children's mental health has several studies that looked at and adult mental health has several studies that looked at different models of case management where it's actually not the general modality, but why, so anyway, so I would maintain that bringing more evidence in and a basis of looking at evidence would be quite critical here for the services.

Peter Watson: Yeah, Lee you want to, and then we'll...

Lisbeth B. (Lee) Schorr: Can I just comment on...

Peter Watson: Check in with the audience here.

Lisbeth B. (Lee) Schorr: John's point about for some reason in child welfare we don't use the medical model of testing between the placebo and the pill.

John Landsverk: Actually it's the science model that has been used...

Lisbeth B. (Lee) Schorr: Science right.

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John Landsverk: By medicine.

Lisbeth B. (Lee) Schorr: This is very good reason for that. And that is when you're testing one pill against a placebo, the pill remains constant. There are very, very few things that we do in child welfare where the intervention is totally standardized so that you know that everybody in the control group and everybody in the experimental group gets the same intervention. That's why we don't have an RCT of case management, because you cannot standardize the intervention enough to be able to measure it with an RCT.

And Don Berwick you mentioned who has written a lot about this is now the Head of the Centers for Medicare and Medicaid says that the RCT is one of the most powerful instruments that science has ever developed and we have been over-using it in places where it simply doesn't apply. And I think in child welfare with the exception of circumscribed programs and practices that's what's true. And we're making a terrible mistake if we try to put these interventions into a box that lends itself to RCTs. We have to figure out other ways of measuring the results of different practices. And we're trying to do that.

For example, in the field of community building, where you have 115 things going on at once and you can't even get a comparison community. Well, we are learning how to evaluate what's effective there. We're trying to figure out if the promised neighborhoods actually get implemented. How are we going to figure out whether they work. Well, we're not going to do it with random assignment trials. What we're going to do is we're going to document what the intervention is and we're going to document what the results are. We will have from that something that is rich in information and knowledge without being certain. We won't have proven it, but will know a lot more at the end of that process than we did at the beginning.

Peter Watson: Let me, I want to check in and see if people have some comments. I see right here, sure.

Dennis Embry: Hi, my name is Dennis Embry and I am from Tucson and I've been listening to this with some interest. I have some recommendations on how we can get ourselves out of this problem. Number one principle to remember is Wayne Gretzky's comment. Skate to where the puck is going to be rather than where the puck was. We are constantly in the process of implementing many programs of implementing by skating toward the puck was. And I want to comment on effect sizes of where many things are.

If you carefully look through the list of the things which have high levels of replication and effectiveness in large scale applications, I'm quite familiar with the SafeCare because I'm a University of Kansas graduate and actually did a bunch of behavior analysis studies with John Lutzker. The ones that have the best effect sizes are those studies that began measuring the everyday source of variability, a randomized trial in an effectiveness -- in an efficacy trial tries to suppress all forms of variability in order to find a signal point. In applied behavior analysis, you are attempting to find out where the sources of variability

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are and then develop maneuvers Wayne Gretzky sort of think, okay, if you move this way, what do you do in that circumstance. So that you are now tracking real time play data.

The difference between child welfare and a medical thing is that the behaviors in question can be measured in 10-second intervals. I've done studies measuring everyday behavior of families who abuse their children and the rates of abuse vary moment by moment, day by day, by social context last week will predict what happens next week. So, these are the kinds of things that we need to learn to see and measure and there are four basic categories of things that will phenomenally affect the variability.

One are the rates of reinforcements in the system for differential behaviors, so for example, we have this craziness now where people are being reinforced for not making logical adaptations like including NIDA's prize bowl thing for the treatment of substance abuse among pregnant women or the NIH work on Omega-3 fatty acid to reduce postpartum depression, you know we're ignoring all of those things even though they have very good evidence. So, we have to measure physiology and to see the things that are -- might affect physiology.

For example, in the I just read the article in the New Yorker, one of the reasons we're seeing a decline in the efficacy of certain psychiatric medications is that the background noise from other factors in the environment are upping the anti in the biology causing a need for higher doses. This has to do with fatty acid ratio. So, we have to measure those context and then I think it's really important when we're designing and testing interventions not to go into a randomized trial too early, because then you miss the noise, you're misunderstanding what are the contextual variables that are driving it and then you have an effect size that is actually small.

We've actually been getting as we have been depending more and more and more and more on early randomized trials, the effect size is that we are seeing in the published literature like in prevention science are staying very small, they're not getting bigger and so that is I think a very significant problem. The methodology, the scientific methodology can lead us to where we need to go if we stay informed by the data in front of us looking at where the puck is going and what the plays are.

Peter Watson: Any comments, reactions, bring up any in that. Other people want to ask question or you go.

Mark Testa: Well, I'm Mark Testa and I wanted to play off this distinction that John introduced between internal validity and external validity. And I think you know as evaluators we have been pretty good around thinking about how RCTs help with internal validity, but we've really fallen down after job with external validity. And much of what I read that Lisbeth Lee puts out is really chiding us for becoming better in translating our average causal effects that we find, because remember when we are talking about proven programs, we're talking about programs that are proven for population on average and that to translate the average causal effect into an individual recommended treatment is

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what evidence-based practice is all about that's why when you look at these diagrams, evidence is one component, then you've got clinical expertise and patient or client values is the third component and you indeed really to combine all of those in order to translate an overall effect into an individual level effect.

Even my own experience with blood, I should say blood pressure medication, the very first proven medication I took sent my blood pressure through the rough, so obviously I must have been part of that distribution in which it wasn't very effective. So, I think what we need to really think about now is one, Daniel how do we load up to shelf because that's the big problem right now. We don't have enough proven programs on the shelf and partly that's a resource problem, but once done on the shelf, how do we make sure that we have truth in advertising as Lee would suggest so that it just doesn't sit there without having to be translated into individual practice.

And one of the ways that we when I was in Illinois, we're able to load up the shelf was because we had old program that was the best support for randomized controlled trials that child welfare ever had and that was the waiver program, the IV-E waiver program. Hopefully, it's going to come back, but I get worried when I hear in The Senate that they're going to want to impose restrictions on the types of evaluations that can't be done to exclude randomized controlled trials.

So, somehow we better get on the same page, because if we're going to be fighting over, oh no, there is too much going to RCTs, oh no, there is too little, we're going to defeat ourselves once again lose a valuable program and so I think that we ought to get together and say how do we load up the shelf, how we make sure we have truth in advertising and third, how do we build in to the translation of evidence supported interventions that's not com based so that they work better for individuals and that's where I think we can and we should be going as a group in a profession.

Daniel Whitaker: I want to put in a plug by the way for Mark's reference to the -- it's essentially a randomized waiver programs. That was a terrific mechanism. It should be there all the time. It should be allowed for, because I do think that those are -- those have been attempts to really build some evidence-base within ongoing processes, but do it in a rigorous way. So, I think and it clearly broke away from the one size fits all under Title IV-E and that sort of thing or even a counsel on accreditation.

Now, let me just say that I think the shelf is full of interventions that have very good evidence from efficacy trials. Again, the business of child welfare is dealing with parents whose behaviors are putting kids at risk and that therefore, the State has to move in and make some sort of intervention and has one of the most powerful interventions that any service system has, the removal of the child, I can't think of a more powerful intervention from a disruptive point of view, but we have a lots of programs that have very good promise on an evidence-base. What we -- but they don't generally come from the child welfare or the social work professions, they come from other places and therefore, they weren't designed, but why wouldn't one start there and try to see if you could, you know I think the kind of work that Lee is talking about and the innovation coming from within

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systems, that's crucial. Let it flower like crazy, but let the other work also flower which is can we implement some interventions?

We had, I worked with Patti Chamberlain in the group from Oregon. We've had very good success at using parent management training to train foster parents, 600 of them, randomized and we had very good effects with regard to decrease in behavior problems and also for those kids that were bouncing in terms of disruptive placements, they settle down. And the third one which was unanticipated hasn't been replicated is the kids were more likely to be reunified.

Now, those are great outcomes and it was done with a randomized trial in a service system in San Diego that has we're into our fifth or sixth randomized trial and that program is now been adopted into the service system. I think it's a powerful way to provide foster parents who are in unheralded and ill-paid labor force for dealing with really challenging kids and over that sort of thing, so anyway I just think let both of them come. Let the practice bubble up; let there be waiver exemptions in all of that, I think that's terrific, but also let's see if we can bring some of the interventions that are on shelves in other – coming from other disciplines could do that.

Dan: Yes, I just want to echo what John says and just add. I think what he is saying is we need to move from efficacy to randomize field effectiveness trials that where we're working with in the service systems and not within university office spaces to examine these effects.

The other thing I would add is that I've been struck at how I guess complex it is and how many layers of buying and support are needed to do one of these kinds of studies. You need funding usually from the federal government; you need state buy-in, county buy-in and then local provider buy-in. So, it's certainly not easy. Again, when I move to a – an environment where I was pursuing grants, I've quickly realized that actually writing the grant was the easy part. It's all the other stuff that you have to get in place in order to actually house the grant. The state wide trial of Safe Care was done in Oklahoma and really in large part the funding for that child came from the state who wanted to implement Safe Care as an alternative to what they are already doing, and they agree to allow the state regions to be randomized in – to produce a randomized trial. Now, there was additional funds attained by the researchers at the Oklahoma to beef up that study and add another component, but really that was the state lead effort.

Peter Watson: We'll take another question at the back here. I saw Nicole first, then I'll get to you. I do want to shift things, I want to make sure that we don't – I want to shift to people who are sitting here saying okay, but what do I do right now. There are people who are running programs, making decisions, policy makers' administrators and I want to try to – and it could be what do I do in terms of choosing.

Dan: Really a tough question.

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Peter Watson: Yes and it could be what do I – some of the things Mark was saying, what do I to – do to try and build this evidence as someone who’s sitting over some of these, but let me start with you Nicole.

Nicole: The one question that I had and John, your very last comment really took me back to something Lee that you said about expanding our definition of evidence to include kind of information from multiple streams. So the evidence, the research the practice, but you said, “hey we’re on fifth or sixth randomized controlled trial here,” and as a TA person sitting here, I would love to see us expand our notion of what this evaluation should look like so that it’s not just the study on the intervention we’ve got to. It seems to me be able to contextualize it to kind of raise the evaluative capacity of the entire context in which the intervention will be delivered. And that gets back to your implementation issue, the scalability issue and how are we also tracking not just that strict intervention, what’s happening, is it working or is not working. But what’s happening and Dan you talked about this obviously. What’s happening in the context in terms of how things are actually getting done so that when we get to the issue of replication we know what to do and what to say for those of us that are kind of around that context supporting this systemic change? We know what to be doing and frankly what not to be doing, what creates barriers and other additional clogs in the system. So, I don’t know if you’ll have any additional comments to that but hopefully Peter that creates a bridge into the question that you just put out in terms of what to do right now.

Peter Watson: *Ellie [phonetic] [01:03.53].*

Ellie: In order – I think you are 100% right. In order to contextualize our learning, we cannot remove the noise. The context is the noise. So, we have to find other ways and broader and more inclusive ways of learning, because otherwise our learning stays on the shelf. If – because the minute you try to implement a program in the real world you have to deal with people who say I don’t want to change the way I do this work. You have to deal with supervisors who are very skeptical of something that’s imposed from outside. You have to deal with politicians who say this wasn’t invented here I’m not interested. And unless, we can deal with that context, the learning we do just on the inside of the program isn’t going to be of as much value as we need it to be. So, that’s why I think we have to think about evidence coming from many different places and not just from program evaluations.

Peter Watson: And that we I think would also be people who are running programs, right I mean that we have to think of those things as we’re implementing...

Ellie: Absolutely.

Peter Watson: I think there is seduction that if you have an evidenced based program then there is some sort of formula to implement it. And we just follow that formula and we’re set, it brings up all those implementation issues *Mary [phonetic] [01:05:45]* and then Nicole.

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Mary: Yes. This is really an interesting conversation and I guess I spend a lot of time in the field with the workers and all I'm thinking is if a kid dies on my watch while I'm trying to implement this program who's had *[indiscernible]* [01:06:02]. So, where does the courage come from to take the time it requires to do the work in this way and the risk aversions, it's a political issue and it started in a political way. And so how do we create that political will to give people the freedom to move from this crisis intervention framework of the thinking to a more deliberative purposeful practice that you are all talking about without workers getting fired and supervisors losing their jobs and state commissioners being terminated.

Peter Watson: Dan, you can say something.

Dan: Yes. I guess one thing I would say is in our experience in working with child welfare workers it takes some time for them to learn to do the model we pedal and I'm sure it would take similar amount of time to learn any other of the well known parenting programs. But it's really not taking any more of their time once they learn it. And so, maybe I'm not understanding exactly what you're saying but what I thought I heard you saying is that there is a crisis – kind of a crisis mentality where we're dealing with issues sort of as they come up. But I don't think there is a mismatch between the time being spent with families and sort of what workers would do under a new program, that is if they were to implement something more structured and skill based.

So, maybe I'm not quite understanding what you are saying, but I think it's – I mean, clearly there is fear and worry, and I think if you can get over that, the issue that that John raised of opportunity costs, yes, I mean I guess it's the devil you don't know versus the devil you do. But you're really I think missing out on a chance to use that time more effectively with families at least again as from what we know from the data.

Ellie: I think if you're going to be able to deal with the issue of the child dying and who gets blamed, that's a matter not of parent education programs that's a matter of public education. I don't know how many of you know that work of Olivia Golden, Olivia was the Assistant Secretary for Administration of Children and Families and then subsequently became head of the Child Welfare Agency here in the district, is now with the Urban Institute.

Olivia wrote a book about successful reforms of child welfare and then for those of us who didn't – who didn't get into the total innards of her book she wrote an op-ed piece about what she really meant. And it was that unless we change how the editorial writers, the columnists, the legislature sees the death of a child we're not – we're stuck in the blame game. Unless they can see that it was – it wasn't the last worker who got failed to visit that family. It was a system that had too many cases on that workers role that had that lacked the supervision that lacked the funds to be able to do what they know how to do. And until you can get a translation of what the system failures have contributed to that child's death from blaming one worker for that child's death and that is an enormous job of public education that I think all of us have to engage in.

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Dan: I – you know, when you are talking about the death of child, by the way we've been very fortunate to work with a child welfare system for 25 years, I can't remember one child welfare director that was fired because a child died. And they've been very stable.

Ellie: Just the worker was.

Dan: No. They have just – there has been more stability, so it has made work with them more, but the problem with child death issues it is an extraordinarily rare event. And science has really a lot of problems with extremely rare events. And now what Lee is saying and what you are reflecting, which is the public media, of course, loves very dramatic rare events. And it is a matter of – it's a tough one. And the problem is the population that you are dealing with has risk for that's why we say that safety is one of – is probably the most important in cardinal elements of child welfare practice. But it is – it's a tough one. I mean, I the evidence base does not have much to contribute your job is take a step here.

[Overlapping conversation] [01:11:37]

Ellie: But John, that's a very, very narrow definition of science when you have death review boards.

John: Sure.

Ellie: They can learn from the twelve deaths that occurred.

John: I agree.

Ellie: You can't randomize them.

John: I agree.

Ellie: But you can learn from them.

John: I agree.

Ellie: And, I don't what you call that science, I call it

[Overlapping conversation] [1:11:54]

John: Its investigation and its research into...

Ellie: And you can...

John: ...what went wrong?

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Ellie: And people have learned a lot from those.

John: Absolutely. Absolutely, I agree with you.

Peter Watson: I mean I'm not a researcher but I've also heard a lot of people talk about the data and that always troubles me, the data from the 12 worries me that you make those decisions. So, I mean it's all of that is yes, I mean I agree with the learning but I get worried about the...

Ellie: Let me give you...

Peter Watson: Iron clad decisions based on the learning.

Ellie: Let me give you an example and this is also from Olivia Golden. She talked about the review of 12 deaths and found that one of the commonalities was that the workers given the opportunity to only say yes or no on the first day of the investigation about whether this family was involved with drugs or alcohol. Said, "no", because they didn't know, they didn't have time to review.

Peter Watson: Yes.

Ellie: And when they change – and that review resulted and that system changing when that question had to be answered. Okay, it wasn't on the basis of a lot of data, but there was enough data there to say here is the problem and it's a problem we can fix.

Male Speaker One: Great.

Peter Watson: And someone has been waiting here very patiently, so let me...

Female Speaker One: Hi. I'm from California where we have propped 10 dollars to do flexile services around prevention and earlier intervention for early childhood. And we started with the home visiting programs looking at what were the – trying to keep kids out of the child welfare system. So, we targeted pregnant and parenting teens, we targeted kids who are coming out of the neonatal intensive care unit and we targeted of families where there was a call to the child abuse hotline, but they didn't meet the criteria, sort of an alternative response program.

Then we looked at the nurse home visiting model and said "well, there are some good things so it's evidence space," but we had to add a specially provider team with mental health people, child development specialists, substance abuse counselors and lactation specialist to make this work. Then, we added reflective supervision then we brought in strengthening families tenants. And so by the time we are finished it really didn't quite look like the nurse home visiting model, but there were nurses who were out doing most of the home visiting.

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And so I feel very vindicated by this conversation and, then lots of informal supports too, because strengthening families as parents are isolated, right. So, we started doing groups and bringing families together and help in doing parent cape phase which are a component of strengthening families. And all of a sudden, things are looking really good. And we did – the only – we monitor data. We report a lot we look at our outcomes; it's not a randomized control trial. But, we did do, since part of propped 10 funding is really around school readiness, that's sort of the ultimate goal of everything we're doing.

We do, do kindergarten observation forms on all kids – not on all kids, but on kids entering kindergarten. When we look back and compared it to all the services and supports that they got, guess what stood out as one of the strongest factors with intensive home visiting not the short term but the longer term home visiting programs. Those kids did better at school with our school readiness run, impulse control around a lot of the issues. It wasn't really a randomized control sample, but it did control the kid like did compared kids who got these services versus kids who didn't.

Now, with – and we're a project launch site. We sham the project launch around on which is really more of the front end and early intervention piece of it. We did get special researcher study and money to look at – and we're targeting on east open neighborhood in Oakland that has a building healthy – it has we're calling dormant money for community based approach. So we wanted to link services to a community building effort. We did get special study dollars to look at all kids in this East Oakland community that we're targeting who are entering kindergarten to do this kindergarten observation form, and look back in a neighborhood that's been sort of saturated with services to be able to see what the outcomes are. So our initial study did show that there was an impact of the home visiting programs on the kid's school readiness.

So, I don't know what we do with that but – and then guess what the counting when it came down to the home visiting – the federal home visiting money applied for home nurse home visiting, because they wanted the money and that was all that would be accepted. So, it's like oh! My god, what – how do we deal with this, right, so...

John: And the problem...

Female Speaker One: And also nurses don't speak two languages in our community. They don't understand the cultural context. They're not trained in substance abuse or lactation even though if we've tried to training them, they're just – it's not what they do.

Dan: There was a...

Female Speaker One: So, how do we begin to deal with this?

Dan: Well, there was a pretty interesting study that was done by Mark Chaffin in Oklahoma where he took an off the shelf intervention, parent child interaction therapy and used it with physically abusive parents that were referred from the child welfare system. But, he decided to put as a comparison group; PCIT without adjunctive services

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PCIT was everything but this kitchen sink. I mean all the kind of thing you're talking about, which is these are complex families we need to put this program that program we need add on it services and services as usual.

The finding that came out was that PCIT by itself was substantially better than PCIT with all of the adjunct services. And it was done experimentally Mark had not thought it would come out that he had said because PCIT does is a pretty targeted on how parents deal with challenging externalizing behaviors. But when he came out where they said "when he thought that when you provide parents with so many tasks that are involved in so many services you don't get the focus." But it is an interesting example of experimental work that I know of that really called in to question how do you deal with very complex multi-problem families. And it was sort of a now, child welfare is a long tradition of providing comprehensive services and there is they make sense because there are so many problems. But it does raise this question about focus and can you get benefit in the same sort.

[Overlapping conversation] [01:18:48]

Female Speaker One: And, comprehensive is not always coherent.

Dan: That is correct, that is correct.

Male Speaker Two: More effective.

Dan: Right. So, what I worry about is when I hear an evidenced based practice like nurse and family partnership, which has a very good evidence space but then but it doesn't have – and it clearly – David, it's very clear. They have not had they've not done well in domestic violence, they've not done well under pressure and so he is adding modules on to it. But, I think we, in a way that would be congruent with your sense of coherence as opposed to this. And I do think that's one of the problems you have is how do you integrate all those services.

So, just a piece from kind of the research, it was a just a really interesting find. By the way I think Mark Chaffin is doing some of the most interesting work and what's interesting about Mark in particular is he has not stake, he never developed the treatment. He will also tell you there isn't a treatment that he doesn't fiddle with, because, they are hard to fit. PCIT has turned out he said, "I say the best results with PCIT," and he's had the hardest time fiddling with it to make it fit with the population and the delivery system.

Peter Watson: I want to take one more question Dan, do you something you want to say well, I go back here, no.

Dan: Go ahead.

Peter Watson: And then I want to just give our panelists a chance to wrap up comments.

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Female Speaker Two: I just wanted to go back to the child death panels. I'm from the state of Delaware where we have fewer than a million people, so the number of child deaths we experience are really very rare and if to even get 12 over a period of time practice would have changed. Before I joined the family court, I spent almost 10 years in the department in the policy section and was almost hanged by the workers because I suggested we look at mere deaths to find as serious injury. And much more of those, much more learning, much more recognizing during the course of the reviews that things that we had put in place aren't working. And so you really get to see what's having an impact or whether we need to train more that sort of thing.

But, I want to go back to what was said over here about the political will, because when you have a change of administration, I won't say all politicians are like this, but they really want to have said they brought something in and then fixed it. And, so if you can sneak in what has been working right under a different label that they get to lay claim for its great. But, I think that's even more so than the challenge of what you are talking about is the reaction to the death is just what you do about that pure change in administration so that more we can get the data that shows what we are doing as working the less likely because they don't want that death on their watch, they are to pay attention.

Peter Watson: Thank you. Since we have about five minutes left I just wanted to the folks on our panel a chance to wrap up if you have any wrap up comments. Again, going back to that advice for people on either where to take their research or how to figure out what to implement and how to implement to give some people some takeaways, that would be great no pressure, no pressure, no pressure, but let's see what you think.

Ellie: I want to just make a comment on this last comment. I think any agency or a system that is doing something that you feel that they feel is really working has to build in the outside support in order to protect itself against the change of administrations. In my first book I wrote about the Beacon Schools in New York and what was so remarkable about them was that they were started in the Dinkins Administration and survived the change to, I believe it was the Giuliani Administration and why did they – why was that possible? They built from a very powerful community group that was outside their intervention. They built support and it was partly a foundation, it was partly a city agency, but if you can do that while you are still – while you are succeeding and have some outside support for whatever it is then the chances are you will be able to survive the next administration.

My general comment is only that I think a lot of what we are saying not all of us are saying, but a lot of what we are saying is be open to opportunities to learn from what you are doing in order to improve what you are doing. Do not think that you have to be stuck with very narrow approaches to program evaluation as your only source of knowledge. Be prepared to learn from other kinds of research from research outside the child welfare system from theory and especially from practice. Be prepared to learn in order to be able to build on what we know for sure. Because what we know for sure isn't all that we know.

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Peter Watson: Dan.

Dan: Yes, just to piggy back on that, so, sorry.

Peter Watson: That's alright.

Dan: I always thought I was a loud talker. Just to piggy back on that, so one of the things, a lot of experiences we work with child welfare systems is often people don't and I'm and I'm people I mean supervisors directors they don't really know what their staff do with families. So I'd say if you could do any one thing when you leave here go try to figure out what your staff do.

And I think that's the first step in understanding whether it works or whether you need to do something different. And the second thing I think is what really what Lee was saying is collect some data we work with lots of child welfare systems that don't really have ways to collect data in a manner that would allow them even to look at pre-post outcomes. And let's face it if you are running a child welfare program you're not going to do a randomized trial I mean probably the best you are going to hope for is some sort of quasi experimental evaluation.

But even in the absence of that you can understand what you do and you can if you have a data system you can sort of look at your own outcomes I think from there again I mean you have ideas from that about is what we are doing working it all and working again not in an RCT science kind of way but from this feeling that you're getting from what you are able to clean. Those data are certainly valuable and that's my two cents worth of advice.

Peter Watson: John, last thoughts?

John: I want to say something that's kind of I think very hopeful, two things one is Greg Aarons, our colleague has done work with Mark Chaffin in Oklahoma. And he was testing whether workers that were using an evidence space namely Safe Care and we'd seen some anecdotal evidence that workers were opting out of doing that. They didn't want to do it they resisted it, so we had expected a higher dropout rate. What Greg found and has published an article is he actually had a lower dropout rate among those that were trained and were delivering.

And it was a very hopeful thing. It looked actually like having the evidence space and having a structured way to deal with the families lifted moral and actually kept them excited in their work and their feeling that they were improving. So I thought that was a really nice glimmer. It's also where research actually can surprise you.

The second things is we're really working hard on how to use randomization in a way that's not the standard where you deny sort of as to one group and you give to the other and you see the difference and Hendricks Brown is working with a group he's most this

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creative design guy and he is using the notion of don't randomize by person randomize in terms of groups of persons or that sort of thing but randomize by time. And I think child welfare systems are all split out into regions or offices they're and it's a wonderful place where instead of denial of service you use randomization to determine who goes first who goes second who goes third.

It also so nobody get denied what could be a beneficial system and you can learn from this. That's I think we need creative thinking like that so we get out of a kind of rigid notion of how science is done and come with methodology that is rigorous allows us interpret the data with a little bit more a certainty, but also reflects the values of the field and the values of the practice. That work is ongoing and we're going to come up with some solutions how to do that sort of thing.

Peter Watson: Thanks for the hopeful ending, John, that's great. I want to thank all of you for listening and participating and let's, please join me in thanking our panel here for...