True Evidence-Based Practices Deserve Wide Acceptance

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Child welfare professionals strive every day to keep children safe, to keep families healthy and together, and to break multigenerational cycles of maltreatment. More than three million new cases of child abuse and neglect are reported every year in the United States and approximately 400,000 children are in foster care at any given time (U.S. Department of Health and Human Services [USDHHS], 2016). The financial cost to our society is enormous (Gelles & Perlman, 2012).

Caseworkers do their best, sometimes against overwhelming odds and with few effective engagement or intervention strategies. The community characteristics and population demographics may vary, but the common goals are always the safety and well-being of children and the preservation of families. We now have a moral imperative to recognize decades of hard data from multiple studies covering hundreds of thousands of clients and showing compelling evidence that a different approach can improve outcomes dramatically. Evidence-based practices (EBPs) indicate that child welfare interventions are now a science with protocols that have been proven effective through decades of clinical trials. Providers can now save more lives than ever before with the rigorous and diligent application of these strategies.

A century ago, doctors gave patients medications they developed themselves—sometimes with a good rationale based on their own personal knowledge and experience. Some were effective, some were not, and some had very bad outcomes. Today, physicians do not prescribe, and the public would never accept, medications whose effectiveness had not been proven through multiple clinical trials.

But change, even when it represents proven improvements, is often met with resistance. When Joseph Lister began promoting the idea of sterile surgery and the use of antiseptics 150 years ago, many in the medical profession stubbornly refused to acknowledge the effectiveness of this new concept. They acted offended at the suggestion that the surgical techniques and approach to patient care they had used throughout their careers could be improved upon.

Today, the resistance to EBPs feels much the same as that faced by Dr. Lister. Some in our profession continue to express skepticism that EBPs can achieve improved results in their unique communities or question the cost or effort to implement a system that requires high levels of oversight, reporting, and accountability. Despite the voluminous data on outcomes for large numbers of families, demonstrating the efficacy of evidenced-based programs, they continue to resist.

EBPs have been in use since 1973 (Alexander, 1973). They require extensive training and adherence to well-defined and proven clinical protocols. They also require recording and measurement of clinician development and tracking of family progress on a granular level. Fidelity to the protocols, transparency, and peer reviews is key, so that others can monitor, guide, learn from,

improve on, and replicate success.

Well-established EBP clearinghouses have developed a clear definition for what constitutes *evidence-based*. Among the required characteristics of these programs is that they must be validated through multiple well-designed, rigorous scientific evaluations and produce data that show systematic and sustained improvement. It is important that the results, procedures, and protocols are transparent and that the program and its outcomes have been proven to be replicable.

So why the hesitation? Some believe that these practices will not translate to their unique populations or that social work practices cannot be broken down into metrics, measured, and replicated with rigid adherence. It is exhausting to hear a continual refrain from objectors: "My kids are different," "my community is different," "my situation is different," "families are not all the same," and "we are not robots." This often comes without ever seeing data explaining why EBPs would be any less applicable to their families than they have been with over 300,000 others (Family Functional Therapy LLC, n.d.).

Some fear that the use of EBPs will interfere with the clinical relationship and render treatment ineffective. In fact, the opposite is true. EBPs actually facilitate the clinical relationship and enhance the role of the caseworker, whose client relationships must be at the center of any practice. No intervention can be effective without caring, creative, and dedicated caseworkers establishing and developing relationships with their clients.

Still others, regrettably, are bound by inertia. They have always done things a certain way. They have anecdotes describing the many lives saved and families strengthened over their careers. Some hear recommendations for change as negative criticism of their past practices. The idea that they could achieve better outcomes if they worked differently is uncomfortable. But no one who works in this profession expects a comfortable career. Caseworkers deal with the most challenging situations imaginable and, at the end of day, the outcomes for the children and families in our care fall under their responsibility. Improving our treatment of children and families in every way possible to achieve better outcomes should be our paramount concern, and agencies have an obligation to provide caseworkers with the most effective tools for achieving that goal.

It is heartening to see the federal government, in the recently enacted Families First legislation, underscore the importance of EBPs by requiring their use. But the effectiveness of that legislation will ultimately depend on how the government defines *EBPs*—whether they require programs to be truly *evidence-based*, as defined by one of the established clearinghouses, or allow looser definitions that encompass a wide array of lesser-studied other programs.

The troubling debate over what constitutes evidence-based has picked up steam in recent years. Some organizations prefer to make changes to existing evidence-based programs and still call them evidence-based. Using small sample sizes, for example, may produce some evidence, but it does not make for the type of meaningful evidence-based program we need to go to scale with confidence. Likewise, client satisfaction surveys and staff surveys are not a substitute for rigorous testing with controlled clinical trials.

Some agencies argue that they should be able to treat EBPs simply as a guide and adapt them to account for community, cultural, or other population differences. In fact, innovation is needed, but only if it includes a rigorous clinical evaluation process, time frames, and complete and transparent reporting of results—so they can be reviewed by government agencies and peer organizations. Those are the kinds of requirements we should all adhere to and that the federal government has agreed to adopt in the rollout of The Family First Act (FFA).

FFA states that, for the first time ever, Title 4E funds will be used to keep children at home who would otherwise be placed in foster care (USDHHS, 2018). The federal government will financially encourage states to use Title 4E dollars toward the implementation of proven practices—those practices that have strong evidence of their positive impact—to prevent maltreatment. Along the same lines, the EBP constituency is hopeful that the NYC Administration for Children's Services, in its 2020 rebidding of all contracts, will extend its investment in

certified EBPs by requiring their use in all preventive and foster care services.

Without requiring proof of effectiveness, the successful widespread implementation of EBPs will be undermined by programs that are EBPs in name only. Condoning the use of "EBP interventions" without rigorous proof of effectiveness would be like supporting a physician's use of a home-grown drug therapy crafted in his own clinic and claiming it is a certified FDA-approved drug therapy. It does not bear consideration.

Anyone in our profession who honestly considers, with an open mind, the vast amount of data that now exists on EBPs cannot help but acknowledge them as proven strategies they should use within the clinical relationship to increase the probability of sustained positive outcomes for the children and families in their care.

Years of studies clearly show that EBPs are more efficient in engaging youth and families, from the beginning of treatment, though a range of complex and multifaceted situations, to achievement of goals (MST Services, n.d.). EBPs address the entire range of issues our families deal with, from abuse and neglect to domestic violence to mental health to substance abuse. They demonstrate conclusively the efficacy of these programs across different settings, with different races, genders, and socioeconomic status (MST Services, n.d.).

And there is an additional positive aspect of EBPs. Public funders and foundations alike increasingly want to see evidence of successful outcomes in programs they support. Although this is not the central reason to adopt EBPs—our mission is the central reason—for those of us who are always cognizant of the gap between funding and the services we provide, it is a tangential but important added benefit of these programs.

The compelling data are readily accessible, as are support and resources for implementations (MST Services, n.d.). EBPs are one of the most important developments in the practice of child welfare in decades. EBPs will help all of us more predictably achieve our primary objective: the safety and well-being of children and the preservation of their families.

About the Authors

Bill Baccaglini, *President and CEO of The New York Foundling, leads one of the oldest and largest child welfare organizations in the country. The Foundling has had a long history of advancing the science and practice of child welfare and, under Bill's leadership, it has been a prominent advocate for innovative initiatives that have transformative impacts on the lives of children. Bill was one of the early proponents of the use of evidence-based practices (EBPs) and The Foundling today is not only utilizing EBPs to achieve better outcomes for its own families but has also become a global leader in this field. Through its participation in publicly available trials and studies and through the creation of the Implementation Support Center (ISC), The Foundling provides data and practical training to service providers and governmental entities in the United States and overseas. Bill has been a driving force in making education a centerpiece of The Foundling's focus—based on the belief that, after ensuring health and safety, education can have the greatest impact on a child's future. In addition, Bill has overseen the expansion of The Foundling's Developmental Disabilities programming, which, through the addition of The Thrive Network, recently increased the number of individuals it serves to nearly 1000.*

Sylvia Rowlands, PhD, *Senior Vice President of Evidence-Based Community Programs at The New York Foundling, has led the organization's use of evidence-based practices, and her pioneering work has made The Foundling a global leader in the field. She manages the world's largest evidence-based practice portfolio with over 400 licensed professional staff and 200 paraprofessionals under her direction. Under Dr. Rowlands' leadership, The Foundling created its Implementation Support Center (ISC) and has worked with numerous service providers and governmental entities in the U.S. and abroad to implement effective, evidence-based initiatives, including in Australia, England, Scotland, Canada, New Zealand, Russia, China, and Japan. She has a twenty-five-year background of social service and health care industry leadership, large system transformation expertise and executive management experience.*

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Additional Resources

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