

The Move to Evidence Based Practice: How Well Does it Fit Child Welfare Services?

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Child Welfare Services: What's in a Name?

- GAO continues to call it the “foster care program”, many authors and community people call it “CPS”.
 - 5,000,000 calls to CWS agencies each year
 - 3,000,000 accepted reports of child maltreatment
 - 1,000,000 children judged to be “victims”
 - 250,000 children enter foster care each year
 - 180,000 children return home each year
 - 50,000 children are adopted each year
 - 25,000 children “age out” of foster care each year

Who Does CWS Serve?

About
30%

- Battered and sexually assaulted children
- Children in need of supervision
- Children whose parents fail to provide basic necessities
- Children who are emotionally abused
- Children who are educationally neglected
- Children beyond parental control
- Mentally ill children
- Children exposed to domestic violence

How Are Children and Families Served

- Investigation of child abuse, no further CWS action
 - Voluntary services at home
 - Court ordered services at home
- 88% of cases
- Foster care, kinship foster care, and treatment foster care
 - Group home care
 - Adoption, subsidies, and post-adoption services
 - Guardianship
 - Independent living following end of formal foster care

Total according to the Urban Institute is \$25 billion dollars a year--at minimum a \$400,000,000 a year enterprise in WA (with about half of that coming from the State)

How are CWSs Organized?

FEDERAL AGENCIES PAY A SUBSTANTIAL PART OF THE COSTS AND OVERSEE A SYSTEM OF POLICIES AND OUTCOME INDICATORS



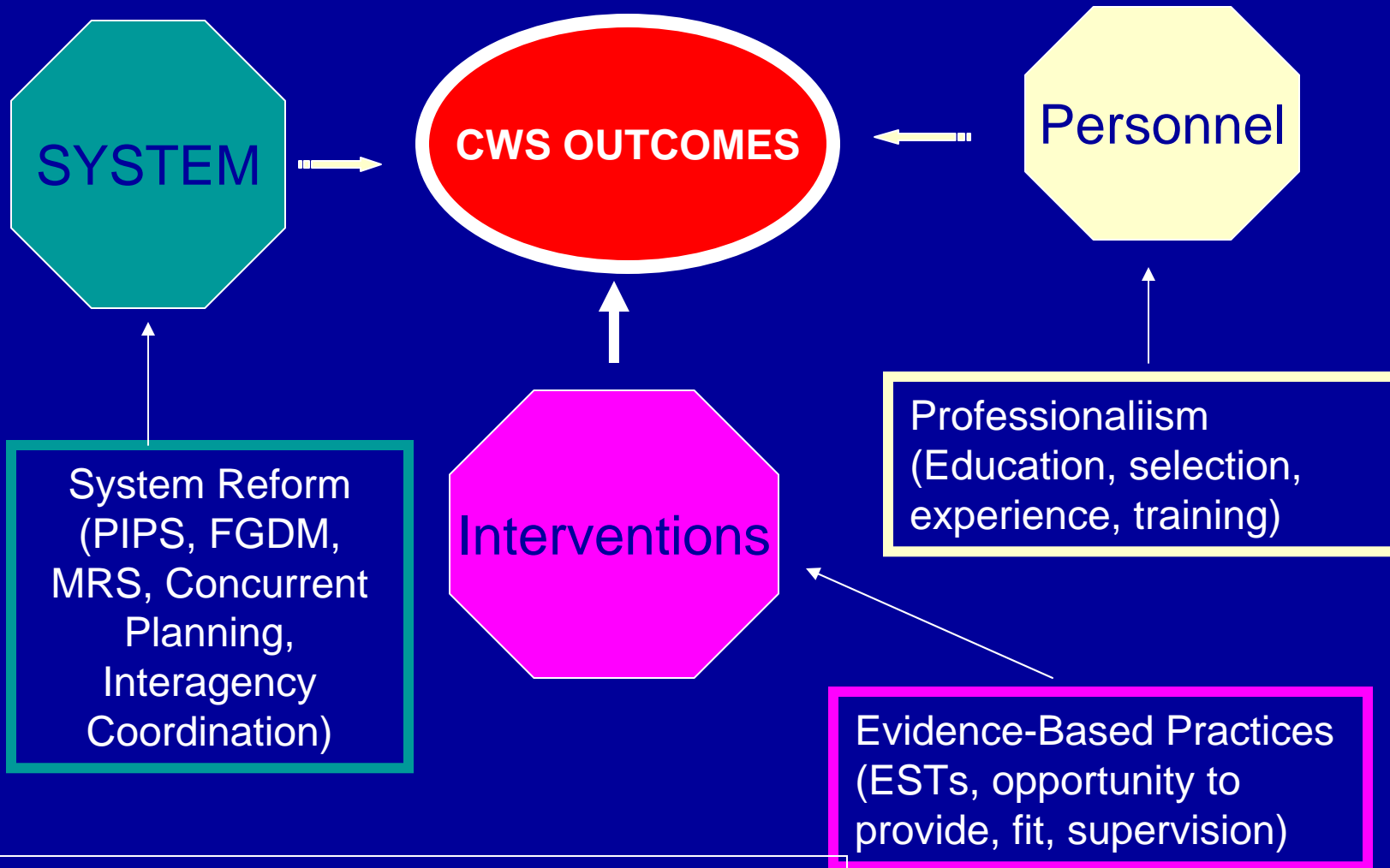
State agencies are responsible for the organization and delivery of **services** to promote **safety** and **permanency**



Private agencies are often involved in the delivery of in-home and placement programs as well as specialty programs (like independent living) with emphasis on **well-being**

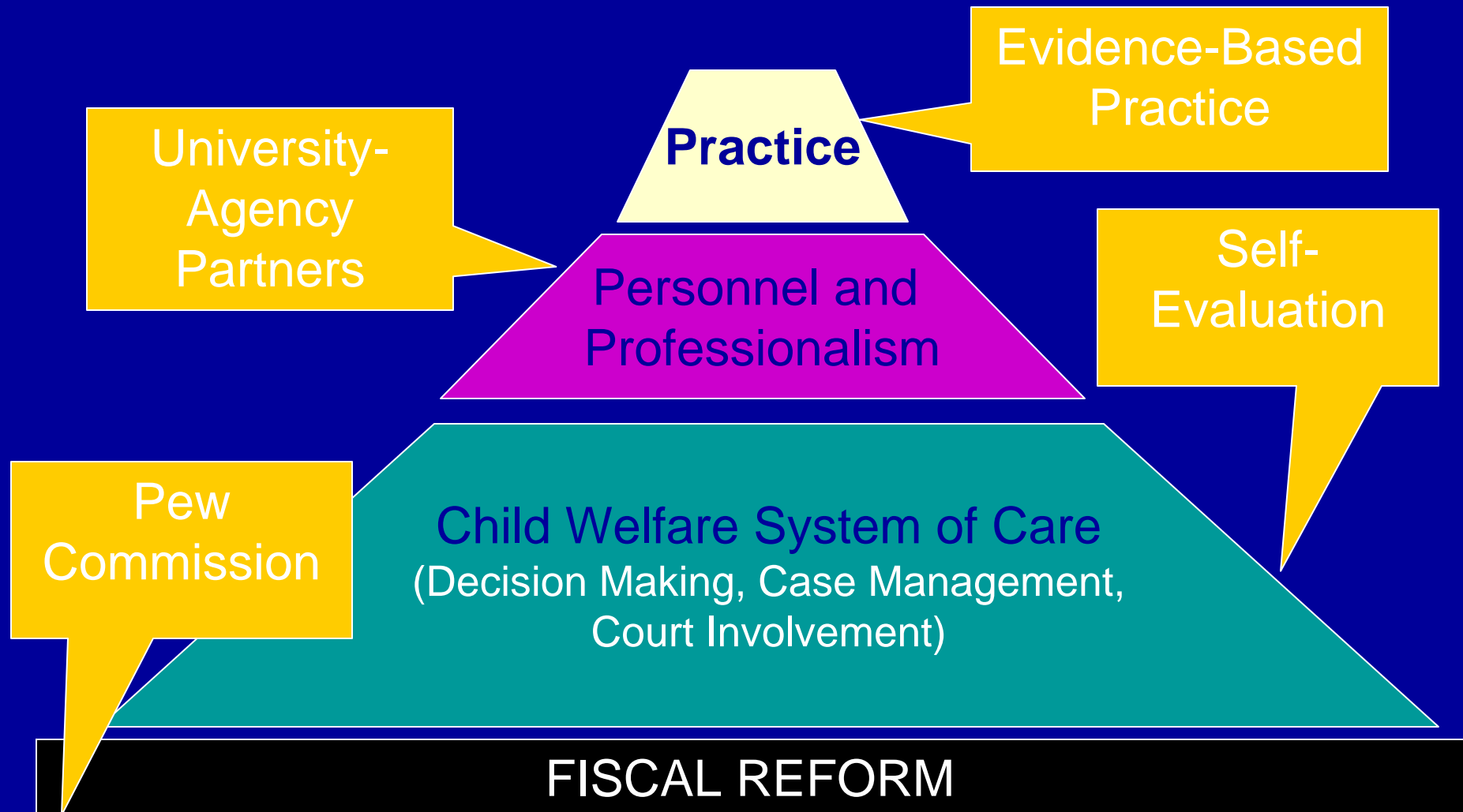
Approaches to CWS Reform

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Heavily adapted from Bickman & Reimer, n.d.

Evidence Practice is a Relatively Small Component of CWS Reform



Top 3 Reasons for Evidence Based CWS

1. If we don't focus on better ways to achieve our outcomes, someone else will do it for us (but not as well)
2. We can continue to find ways to increase the benefits of CWS
3. There's Evidence Based Everything Else—Why Not EB-CWS?

The Alphabet of EBP

What is needed, it seems to me, is some course of study where an intelligent young person can ... be taught the alphabet of charitable science.

Anna Dawes (1883)

From a paper given at the International Congress of Charities and Correction at the Chicago World's Fair.

Source: Lehninger, L. (2000). *Creating a new profession: The beginnings of social work education in the United states*. Washington, DC: Council on Social Work Education.

EBP and ESIs and Practice Guidelines

- **Evidence Based Practice**
 - Procedures and processes that result in the integration of the best research evidence with clinical expertise and client values
- **Evidence Supported Interventions**
 - Interventions that have the support of the “best research evidence” showing their efficacy or effectiveness
- **Practice Guidelines**
 - A set of strategies, techniques, and treatment approaches that support or lead to a specific standard of care that guides systems, care, and professions in their relationships to consumers

A Children's MH ESI Sampler

Priority Set of Evidence-Based Practices for Children and Families:

[Home-Based Crisis Intervention \(HBCI\)](#)

[Intensive Case Management \(ICM and MST\)](#)

[Cognitive Behavioral Therapies for Childhood Trauma](#)

[Functional Family Therapy \(FFT\)](#)

Family Empowerment

[Family Education and Support Services](#)

Promising Practices

[Treatment Recommendations \(Practice Guidelines\) for the Use of Antipsychotics for Aggressive Youth \(TRAAY\)](#)

NYS OMH's Website

Quality Practices Underlying EBPs

- The nature and quality of the therapeutic relationship is critical
- Quality practices are:
 - inclusive and continuous
 - individualized: matching services to the needs strengths, preferences, and values of the recipient
 - promoting of responsible partnerships via informed and shared decision making.
 - inseparable from quality practitioners
 - dynamic, outcome oriented, and continuous
 - culturally competent

<http://www.omh.state.ny.us/omhweb/ebp>

SW Education and ESIs

- SW has generally not adopted the approach of using “practice guidelines” (c.f., GWB website for an extensive list of them)
 - Few programs use therapist protocols, client workbooks, or training videos
- One program (Washington University) is trying to teach ESIs in all practice methods courses

Source: Woody, J. D., D'Souza, H.J., & Dartman, R. (2006). Do masters in social work programs teach empirically supported interventions? A survey of deans and directors. *Research on Social Work Practice*, 16, 469-479.

Limitations of Evidence-Based Treatments

- Long-term effects of the treatments may not be known.
- Assessments of the effectiveness of a treatment may vary across studies, populations, questions, and methods (Rodwin, 2001).
- Clinicians often need to be re-trained and carefully supervised by experienced practitioners
- Many of the studies used in evidence-based medicine and psychosocial treatment have excluded very important variables such as training, staff turnover, minimal family involvement and co-morbidity of conditions (Burns et al., 1999).

YET.....

... Unlike the APA and School Psychology and Medicine:

- CSWE, SSWR, and NASW have not formed any task forces to identify and disseminate information about EBP and
- No school of social work has formally adopted a list of ESIs

What Would EBP-Sensitive SW Education



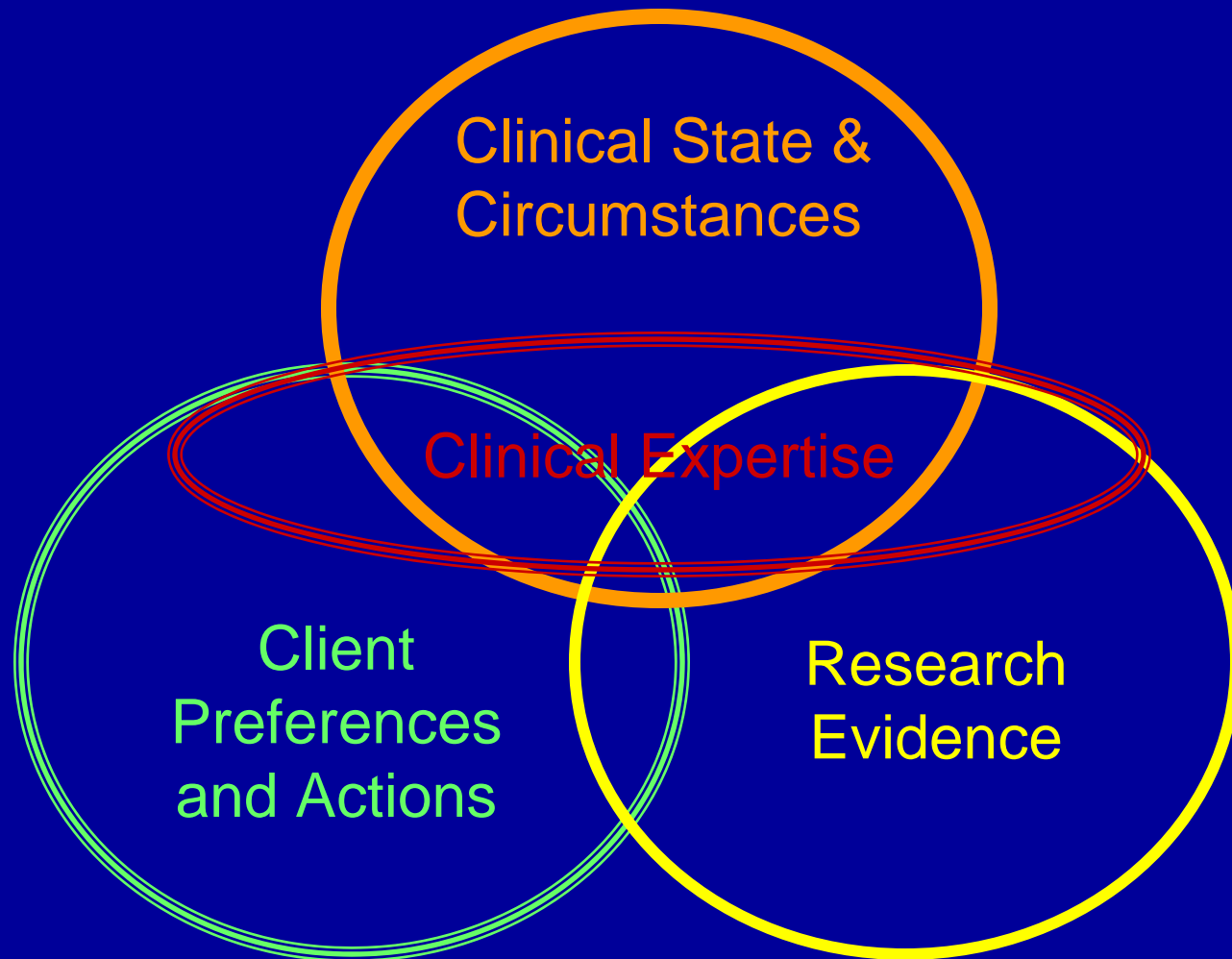
?

STUDENTS WOULD HAVE:

- Understanding of EBP approaches
- **Commitment to ESIs**
- Capacity to seek and find information through the reliable use of scientific databases
- Ability to choose ESIs
- Ability to deliver ESIs
- Capacity to evaluate intervention efforts

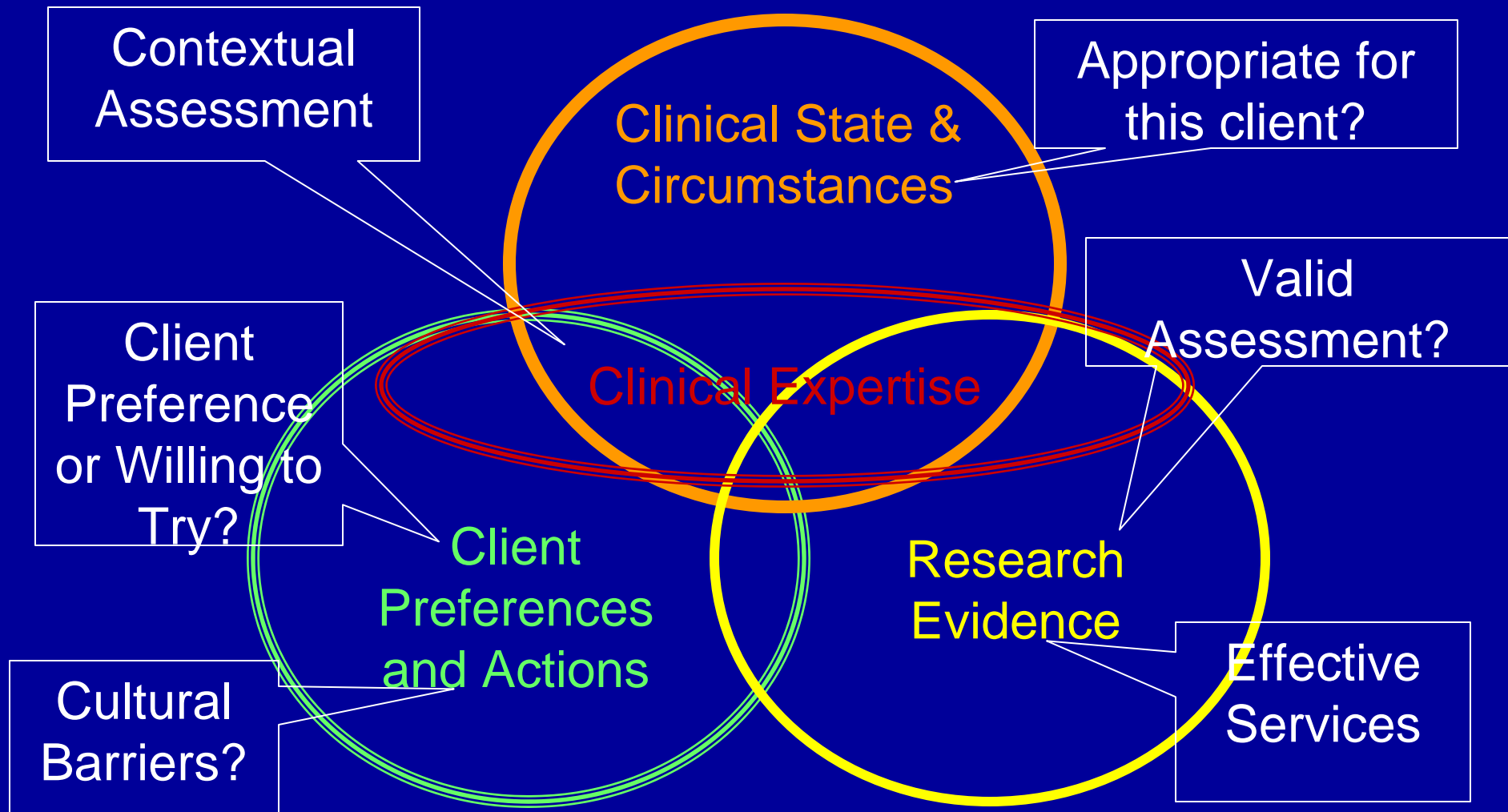
Howard, M.O., McMillen, C.J. & Pollio, D.F. (2003). Teaching evidence-based practice: Toward a new paradigm for social work education. *Research on Social Work Practice*, 13, 234-259.

Teaching Evidence Based Practice



Source: Shlonsky and Wagner, 2005

Teaching Evidence Based Practice



Source: Shlonsky and Wagner, 2005

Where Can CWS Learn About EBP?

- Mental Health?
- Health?
- Education?
- Social Work?

All of the above

Present Status of MH EB Cochrane Collaboration-Second Category

- Eighteen completed reviews focused on various aspects of specialist care provision (majority for people with severe MH) and compared innovative care to standard care
 - In **five** reviews, no conclusion derived because no study met inclusion conditions
 - In **eight** reviews, no difference in outcome between trial and comparison groups
 - In **five** reviews, significant advantages for the trial groups

It's a long road to clarity about effectiveness

Health: Why the Interest in EB Decision Making?

1. Much geographic variation in how medical procedures are being performed, way patients are managed, patient outcomes, and costs of care
2. Strong evidence that large amounts of care provided is inappropriate for patients
3. Services provided are not beneficial
4. Health care costs continuously rising

SOUND FAMILIAR?

Definition of Evidenced-Based Medicine

“Evidenced-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.”

Sackett, D.L., Rosenberg, W.M., Muir Gray, J.A., Haynes, R.B., & Richardson W.S. (1996). Evidenced-based medicine: What it is and what it isn't. *British Medical Journal*, 312, 71-72.

Health: Keys to Rating the Strength of Evidence

- Comprehensive and unbiased approach to literature reviewing is the best way to avoiding bias in evaluating evidence, but ...

... even basic clinical practice guidelines require extensive reliance on a chain of reasoning without many empirical links—opinions fill the gaps

Education's View: What is EBE?

The development of integrating professional wisdom with the best attainable empirical evidence in making decisions about how to provide quality instruction.

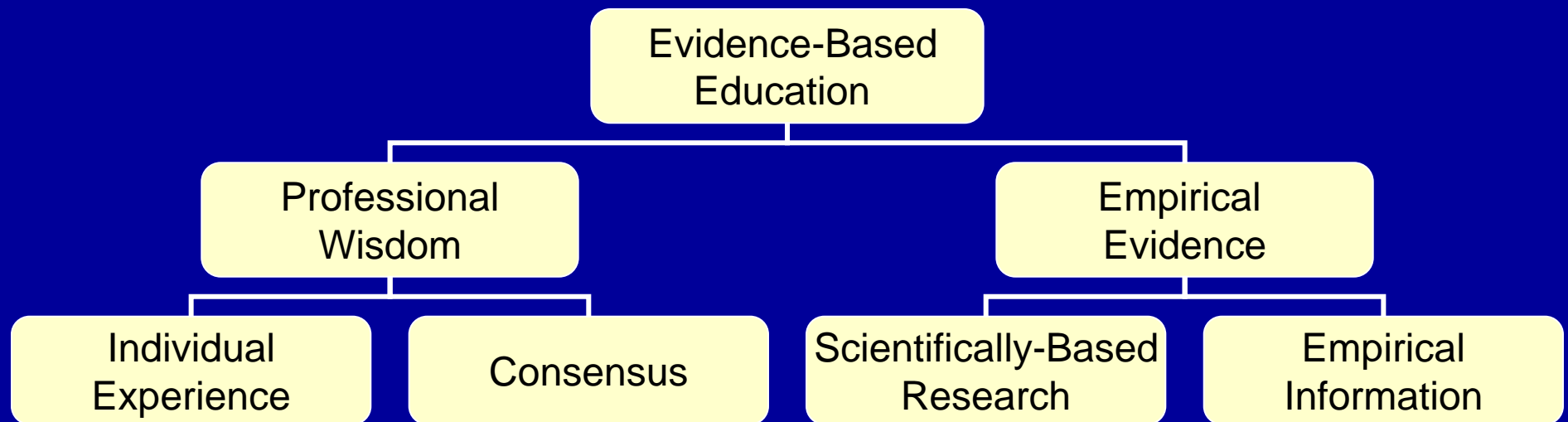
Whitehurst, G.J. (2002). *Evidence-based education (EBE)*. United States Department of Education. Retrieved April 26, 2005 from <http://www.ed.gov/nclb/methods/whatworks/eb/edlite-slide003.html>.

Professional Wisdom is...

- The ability to make decisions is developed through **experience**
- Commonly shared views about effective methods do matter
- EBE is inclusive of effective identification and incorporation of local conditions into instruction

Whitehurst, G.J. (2002). *Evidence-based education (EBE)*. United States Department of Education. Retrieved April 26, 2005 from <http://www.ed.gov/nclb/methods/whatworks/eb/edlite-slide004.html>.

Evidence-Based Education



Whitehurst, G.J. (2002). *Evidence-based education (EBE)*. United States Department of Education. Retrieved April 26, 2005 from <http://www.ed.gov/nclb/methods/whatworks/eb/edlite-slide006.html>.

The Necessity for Evidence & Wisdom

- Professional wisdom is needed for
 - adapting to specific situations
 - operating where research evidence is missing or incomplete
- Empirical evidence is needed for
 - reconciling competing approaches
 - “generating cumulative knowledge”
 - avoiding popular wisdom and individual bias

EBE — The Reality



Whitehurst, G.J. (2002). *Evidence-based education (EBE)*. United States Department of Education. Retrieved April 26, 2005 from <http://www.ed.gov/nclb/methods/whatworks/eb/edlite-slide021.html>.

Child Welfare: What is New about EBP

- The transparent interlinking of evidentiary, ethical, and application concerns in all professional venues
 - practice and policy,
 - research
- Seeking ways to facilitate their integration within a developmental framework attentive to ... ethical and philosophical issues (like)
 - involving clients as informed participants and
 - honesty regarding our state of ignorance about important practice questions

Gambrill, E. D. (2003). Evidence-based Practice: Sea Change or the Emperor's New Clothes? *Journal of Social Work in Education*, 39, 3-23.

EBP is About Choices

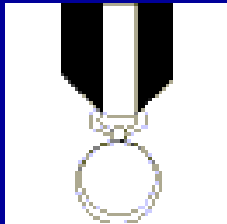
- The choice to be clear about what we are and are not doing well:
- “Given the many burdens that social work clients confront, we could argue that accurate brokering of knowledge and ignorance is especially important in our field (p. 19).

Gambrill, E. D. (2003). Evidence-based Practice: Sea Change or the Emperor's New Clothes? *Journal of Social Work in Education*, 39, 3-23.

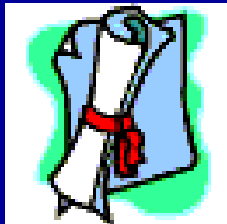
Child Welfare: CWLA R2P Standards



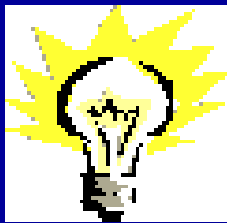
Exemplary Practice



Commendable Practice



Emerging Practice



Innovative Practice

See Next Slide
for Criteria

CWLA R2P Criteria

Exemplary Practice

The research in this category has the following characteristics:

- Randomized study
- Control group (that mitigates selection bias)
- Effects sustained for at least 1 year
- Multiple replications (by 3rd party investigators)

Commendable Practice

The research in this category has a majority of the following characteristics:

- Randomized or quasi-experimental study
- Control or comparison group
- Posttests or pre- and posttests
- Follow up
- Replication

Emerging Practice

The research in this category has a majority of the following characteristics:

- Quasi-experimental study
- Correlational or ex post facto study
- Single group pre- and posttest or post-test only

Innovative Practice

The research in this category has a majority of the following characteristics:

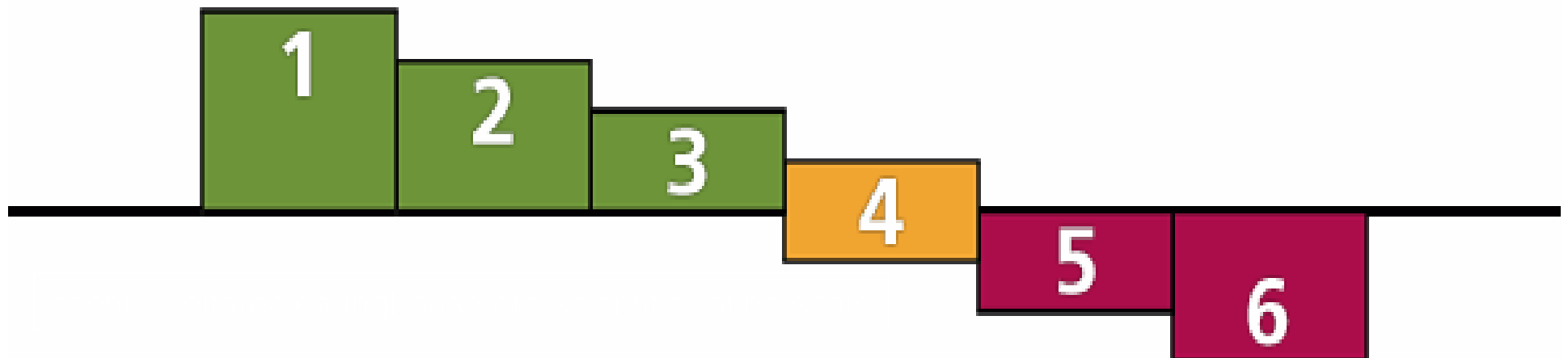
- Case study
- Descriptive statistics, only
- Treatment group, only

California Clearinghouse Scientific Rating Scale

1. Well Supported – Effective Practice
2. Supported – Efficacious Practice
3. Promising Practice
4. Acceptable/Emerging Practice – Effectiveness Unknown
5. Evidence Fails to Demonstrate Effect
6. Concerning Practice

Effective Practice ←

→ Concerning Practice



CEBC Also Has A CWS Relevancy Scale

- Most of ESIs have not been conducted on CWS populations in actual service settings
 - Some have child welfare clients mixed in
 - Some have similar children and families

Only one intervention has the highest rating for scientific merit and relevance (Kolko and Swenson's *abuse-focused cognitive-behavior therapy*).

Practices of Greatest Interest to Child Welfare Directors and Managers (in CA)

Domestic/Partner Violence: Batter Intervention Programs
Domestic/Partner Violence: Services for Women and Children
Motivation and **Engagement**
Parent Training
Placement Stabilization
Reunification
Substance Abuse (Parental)
Trauma Treatment for Children
Youth Transitioning Into Adulthood

Note no mention
of “visitation” or
other classic
CWW functions

Source: California Clearinghouse on Evidence Based Child Welfare Services

Family Engagement in CWS

- Family engagement strategies are much needed in CWS, but rarely discussed or evaluated
- Completion of parent training is as little as 20% in some programs—may be about 55% overall (CDC)
 - Even court ordered parent training is not highly likely to be completed

Family-Centered Practice vs. Family Engagement ESIs

Family-Centered is a Perspective or Practice Framework

Family Engagement is a set of ESIs
(we need a CWS set)

Family Engagement in CWS

Mary McKay has developed an ESI for Family Engagement in Children's Mental Health

- Family is contacted rapidly and repeatedly to help them get and stay connected to the helping process. Family is helped to deal with:
 - Relationship problems with service personnel,
 - Negative attitudes about services,
 - Family stress, and
 - Discouragement from social support networks to seek or use help

Parent Training

- Part of the social contract of child welfare services—the opportunity for parents to improve and be free of CWS involvement
 - Parents report that CWWs are good but services are poor (NSCAW, 2005)
- The most common service—may be provided to as many as 800,000 families each year
- Relatively little attention devoted to parent training services for families in child welfare but a lot has been done in other fields, thus, it is highly improvable

Organization and Delivery of Parent Training

	Primary Provider %
Child welfare staff	30
CWS contracted providers	35
Community based organizations	27
Mental health agencies	6
Other	3



Organization and Delivery

Agency requires that specific program(s) be used ¹	1%
Delivered in conjunction with non-CWS families	84%
At least in part, provided at no cost to child welfare by community-based organizations	61%

Organization and Delivery

- Parent training sessions are typically less than 15 occasions.
- About 72% of parents receive 20 hours or fewer
 - less than 10% receive 30 hours or more

Basic Components of Effective Parent Mediated Interventions

- Social learning framework
- Strengthening parent-child relationship
- Effectively use praise and reward
- Sets clear and effective limits
- Reserves most significant consequences for targeted, limited behaviors
- Strictly limits negative consequences
- Parent Training + may have worse outcomes than parent training alone (CDC)
- Addresses family as well as parent-child issues

Hurlburt, M., Barth, R.P., Leslie, L. & Landsverk, J. (in press). Haskins, R., Wulczyn, F., & Webb, M. (Eds). Research on child protection: Findings from NSCAW. Washington, DC: Brookings.

The Incredible Years (TIY)

- Carolyn Webster Stratton (U.W.) developed; she is a nurse and psychologist who also trained at OSLC and is very interested in developing TIY for child welfare work

- The Incredible Years Home:

<http://www.incredibleyears.com>

- Office of Juvenile Justice and Delinquency Prevention-exemplary best practice program:

http://www.ncjrs.org/html/ojjdp/2000_6_3/contents.html

- Strengthening Families:

http://www.strengtheningfamilies.org/html/programs_1999/03_IY_PTCTS.html



Goals of The Incredible Years

- Reduce conduct problems in 4 - 8 year olds
 - Negative behaviors
 - Classroom disruption
 - Peer aggression
 - Noncompliance
- Promote competence in children
 - Social
 - Academic
 - Emotional
- Promote more positive and supported parenting



Parent Training

- 4 Program blocks, covering ages 2-12.
- Developmentally appropriate training for:
 - Discipline and limit-setting
 - Problem-solving
 - Encouraging positive behaviors
 - Increasing school engagement and achievement
 - Communication
- Materials include videotapes, books, homework, “reminder magnets and notes for fridge, posters.

GOOD **GEAR**

Child Training

- Small groups for aggressive children:
 - Counselor or therapist-administered.
 - 20-22 weeks, groups of about 6 children
- Dina Dinosaur Curriculum:
 - Classroom-based, teacher-administered.
 - Emphasis on academic and social skills (following the rules, problem-solving, understanding feelings).
 - 60 lessons, administered 2-3 times per week.
 - Includes Circle Time and small group activities.



TIY Evaluations: Parent Training

- Multiple randomized trials with large effect sizes
- Parent aggression, corporal punishment decreased
- Parent effective discipline increased
- Oppositional behavior decreased in children with and without diagnosed conduct disorders
- Gains lasted up to 3 years
- Outcomes and are NOT associated with parent gender, ethnicity, class, or education

NOT YET WIDELY REPLICATED BY OTHER INVESTIGATORS

Key Features Of TIY

- Children and Parents are Both Learning the Same Skills in Groups
 - Self control and anger management
 - Giving “time out” (accepting “time out”)
- It’s Enjoyable for All

CWS HAS ALMOST NO PARENT TRAINING RESOURCES THAT OCCUPY PARENTS AND CHILDREN TOGETHER BUT DO NOT REQUIRE THEM TO BE TOGETHER— TIY IS A POTENTIALLY GREAT FIT WITH CWS

PCIT, RCT in OK with PA Parents

- Participating parents had history of engaging in severe physically abusive behavior.
- Physical abuse re-report rates at a median of 850 days of follow-up were 19% for the PCIT group compared to 49% for a standard community parenting group.
- PCIT cost more than standard approach.
- But, the additional benefit of averting a single re-report range from \$371 to \$1,326, so PCIT **quite cost effective**.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Breston, E. V., Balachova, T., et al. (2003). *Physical abuse treatment outcome project: Application of parent child interaction therapy (PCIT) to physically abusive parents*. Washington, D C: U. S. Department of Health and Human Services, The Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect.

Parent Child Interaction Therapy (PCIT)

- PCIT is now in place in several CA sites and other states[^]
- The PCIT program is for children 4 to 12 and consists of:
 - Relationship Enhancement: Parents are taught and 'coached' how to decrease negativity and increase consistently positive communication with their child.
 - Discipline: parents are taught and 'coached' the elements of effective discipline and child management skills.
 - Parents are taught specific skills, given the opportunity to practice these skills during therapy, then continue practicing skills until mastery is acquired and the child's behavior has improved.
 - Therapists provide reports of parental competency at end of PCIT!!!

[^]e.g., Sierra Adoptions, FRC, UC Davis Medical Center, Long Beach, WVA, WA, OK

Parent Management Training

- 30+ years of practice and research at OSLC
 - Teaching parents to manage child behavior.
 - Rewards for positive behaviors, consequence for negative behaviors.
 - Randomized trials from the 1970s to 1990s found that parenting improved, changes persisted, and adolescent delinquency decreased.

Patterson, G. R. (1975). *Families: Applications of social learning to family life*. Champaign, IL: Research Press.

Reid, J.B., Patterson, G. R., Snyder, J., (2002). *Antisocial behavior in children and adolescents: A developmental analysis and model for intervention*. Washington, DC: American Psychological Association.

Parent Management Training

- Four Basic Components to in-home and out-of-home approaches:
 - Close supervision and monitoring of child,
 - Consistent consequences by caregiver,
 - Promote positive relationship with an adult,
 - Maintain low levels of interaction with deviant peers

- Chamberlain, P. (2003). Multidimensional Treatment Foster care program components and principles of practice. In P. Chamberlain (Ed.), *Treating chronic juvenile offenders: Advances made through the Oregon multidimensional treatment foster care model*. Washington, DC: American Psychological Association.

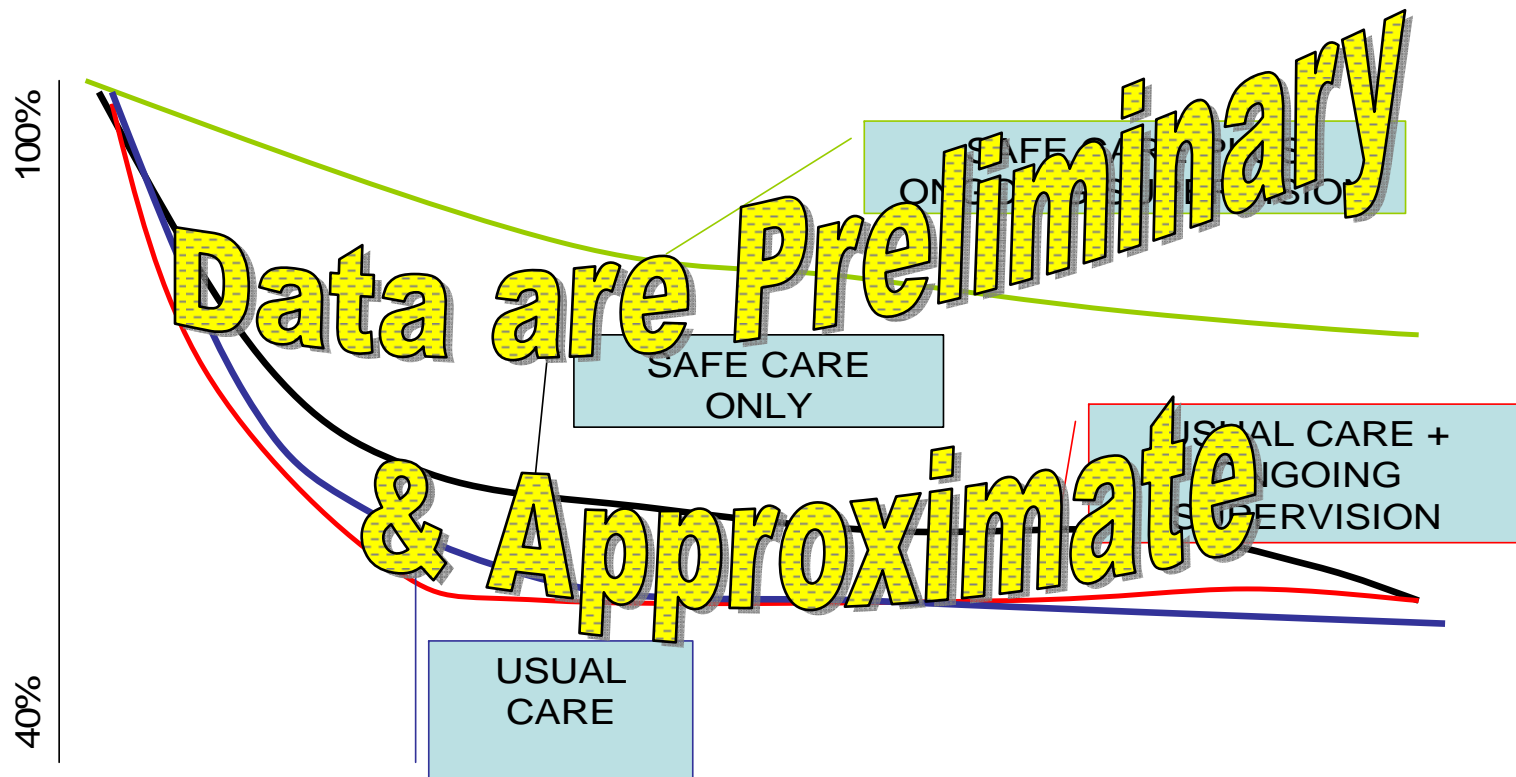
Project SafeCare Modifications

- Based on work of Green and Lutzker in *Project 12 Ways* in Southern Illinois
- Comes from a special education perspective—use of behavior change projects and data
- Appears to work best with “neglecting” clients, requiring that cases be sorted by maltreatment type prior to referral
- Requires that services be in the home
- Extensive supervision is needed following instruction

Lutzker, J. R., & Bigelow, K. M. (2002). *Reducing child maltreatment: A guidebook for parent services*. New York, NY: The Guilford Press.

Project SafeCare in OK

Time to Reabuse by Condition



Multi-Systemic Therapy

- **MST is 2nd Generation “Homebuilders” but it:**
 - lasts longer
 - is more focused around community partnerships
 - has better quality control
 - provides a manualized intervention
 - **MST Home**, <http://www.mstservices.com/>
- **MST has many studies and kudos to support it:**
 - **Center for the Study and Prevention of Violence - Blueprints model program**
<http://www.colorado.edu/cspv/blueprints/model/programs/MST.html>
 - **Clemson University Fact Sheets:**
http://virtual.clemson.edu/groups/ncrj/youth_violence_prevention.htm

Randomized Trials of MST

- Simpsonville, SC
 - 84 Chronic or violent youth offenders
 - One year later, youth receiving MST had less antisocial activity, re-arrests, and time incarcerated
- Columbia, MO
 - 200 juvenile offenders, ages 12 to 17
 - Some received MST, others individual therapy
 - 4 years later, MST youth had lower recidivism rates
- **Doors of Psychiatric Hospital**
 - **Randomly assigned to MST or in-patient hospitalization**
 - **Fewer hospital days by 6-months**
 - **No difference at one-year follow-up**

Henggeler, S. W., Rowland, M., Halliday-Boykins, C., Sheidow, A. J., Ward, D. M., Randall, J., Pickrel, S. G., Cunningham, P., & Edwards, J. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 543-551.

Critique of MST Evaluations

- Systematic review of MST evaluations by Julia Little and colleagues
- So far, results suggest that MST reviewers:
 - Ignored attrition (only analyzed results for subjects who were successful with MST)
 - Did not implement randomization correctly
 - Found better results when the model's creators were evaluating it
 - Did not report on variables for which there was no positive change
 - Used data from the same study repeatedly
 - Did not include important unpublished studies

MST Critique (Continued)

- *Yet, the p-values from Little review are almost all smaller than .20 and generally smaller than .10*
- *MST is probably a “supported and efficacious practice” (2) with a relevance of 2 (the program was designed, or is commonly used, to serve children, youth, young adults, and/or families who are similar to child welfare populations (and likely include current and former child welfare services recipients)*
- While MST may not be *significantly* better than other alternatives, there is no evidence that MST is harmful.

Other Areas of CWS Intervention Needing a Stronger Evidence Base

- **Multiple Response/Dual Track/Alternative Response**
 - Too early to tell impact on re-abuse rates
- **Post-Adoption Services**
 - Intensive Family Preservation NOT
 - Attachment-Focused Treatment & Holding Therapy NOT
 - We don't know what works, yet
- **Intensive Reunification Services**
 - Walton and Fraser's work is promising
 - NY City work is promising but no overall impact
 - Funding is minimal but the promise is great

Walton, E. (1998). In-home family-focused reunification: A six-year follow-up of a successful experiment. *Social Work Research*, 22(4), 205-214.

Evidence Based Implementation Requires Reform of Programs and Processes

- Good new ideas have been developed that could assist CWS
 - Parent training is the most developed and needed
- Their use will require deep involvement of CWS in implementation:
 - We cannot implement them all at once
 - We must allocate adequate resources to adapting them to CWS populations and practice parameters
 - We must also provide extensive supervision during implementation
- Self-evaluation strategies and strategy teams, and personnel policies to increase longevity of service are also needed to strengthen CWS processes.

Expanding Evidence-Based Practices

- Changing funding practices, by:
 - Key funding, and reimbursement for CWS, to objective outcomes rather than outputs (in limited cases)
 - Use differential payment structures favoring best practices delivered with fidelity (generally)
 - Targeted funding of EBP implementation projects (e.g., EBP uptake grants), to provide agencies with the necessary start-up capital to migrate to best practice models.
- Increase advocacy and social demand for best practices by disseminating **cautiously derived** (emphasis is mine) information to:
 - funding organizations,
 - governing boards,
 - third-party payers,
 - parents,
 - and professional organizations

Chaffin, M. & Friedrich, W. (2004). Evidence-based treatments in child abuse and neglect. *Children & Youth Services Review*, 26, 1097-1103.

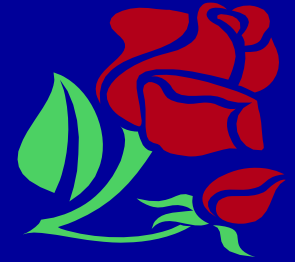
Next Steps for CWS

- Expand research on Family Engagement and Parent Training
- Adapt and test interventions with strong evidentiary support with related populations
- Improve quality of methodical and cost-effectiveness reviews.
- Develop standards for providers and funders of evaluations to follow
- Plan systematic and long-term research programs to fill service gaps

Remember What Progress We Have Made...

- "Anybody who has been seriously engaged in scientific work of any kind realizes that over the entrance to the gates of the temple of science are written the words: Ye must have faith. It is a quality which the scientist cannot dispense with."
~ [Max Planck](#) (1858-1947)

Thank you for this opportunity



Comments?



OR



'S

Partial References

- Aarons, G. A. (2005). Measuring provider attitudes toward evidence-based practice: Consideration of organizational context and individual differences. *Child and Adolescent Psychiatric Clinics of North America*, 14(2), 255-+.
- Aos, S. Lieb, R. Mayfield, R. Miller, M. Pennucci, A. (2004) Benefits and Costs of Prevention and Early Intervention Programs for Youth. Olympia: Washington State Institute for Public Policy, available at <<http://www.wsipp.wa.gov/rptfiles/04-07-3901.pdf>>.
- Barth, R. P., Landsverk, J., Chamberlain, P., Reid, J., Rolls, J., Hurlburt, M., et al. (in press). Parent training in child welfare services: Planning for a more evidence based approach to serving biological parents. *Research on Social Work Practice*.
- Burns, B. J., & Hoagwood, K. (2002). *Community treatment for youth: Evidence-based interventions for severe emotional and behavior disorders*. New York: Oxford University Press.
- Chambers, D. A., Ringeisen, H., & Hickman, E. E. (2005). Federal, state, and foundation initiatives around evidence-based practices for child and adolescent mental health. *Child and Adolescent Psychiatric Clinics of North America*, 14(2), 307-+.
- Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, 52, 685-716.
- Dawson, K., & Berry, M. (2002). Engaging families in child welfare services: An evidence-based approach to best practice. *Child Welfare*, 81, 293-317.
- Flynn, L. M. (2005). Family perspectives on evidence-based practice. *Child and Adolescent Psychiatric Clinics of North America*, 14(2), 217-+.

Partial References II

- Hoagwood, K. E., & Burns, B. J. (2005). Evidence-based practice, part II: Effecting change. *Child and Adolescent Psychiatric Clinics of North America*, 14(2), XV-XVII.
- Kolko, D. J., & Swenson, C. C. (2002). *Assessing and treating physically abused children and their families: a cognitive-behavioral approach*. Thousand Oaks, CA: Sage Publications.
- Littell, J. H. (2005). Lessons from a systematic review of effects of multisystemic therapy. *Children and Youth Services Review*, 27(4), 445-463.
- McKay, M., Hibbert, R, Hoagwood, K, Rodriguez, J, Murray, L, Legerski, J, & Fernandez, D. (2004). Integrating evidence-based engagement interventions into "real world" child mental health settings. *Brief Treatment and Crisis Intervention* 4,2, 177-186.
- Saunders, B. E., Berliner, L., & Hanson, R. F. E. (2003). *Child physical and sexual abuse: Guidelines for treatment (Final report: January 15, 2003)*. Charleston, SC: National Crime Victims Research and Treatment Center.
- Sundell, K., and Vinnerljung, B. (2004). Outcomes of family group conferencing in Sweden: A 3-year follow-up. *Child Abuse & Neglect*, 28, 267-287.
- Thomlison, B. (2003). Characteristics of evidence-based child maltreatment interventions. *Child Welfare*, 82, 541-569.
- Wulczyn, F., Barth, R. P., Yuan, Y. Y., Jones Harden, B., & Landsverk, J. (in press). *Evidence for child welfare policy reform*. New York: Transaction De Gruyter.