2012-07-17 13.02 Evidence Based Practice and Practice Based Evidence -- Is It One or the Other.wmv

Presenters: Lisbeth Schorr, Senior Fellow, Center for the Study of Social Policy, and Lecturer in Social Medicine, Harvard University; Dr. Puneet Sahota, Senior Research Fellow at the National Congress of American Indians Policy Research Center; Dr. Lawrence Palinkas, the Albert G. and Frances Lomas Feldman Professor of Social Policy and Health at the University of Southern California.

Facilitator: [00:00:00] [in progress] ...webinar, Evidence Based Practice and Practice Based Evidence -- Is It One or the Other, is the second of eight topical webinars that will be offered between now and April, 2013. Today's discussion will explore the concept of evidence-based practice and practice-based evidence, and the role that each plays in child welfare.

Before we begin, just a few housekeeping items. First, please note that we have muted all telephone lines to minimize background noise. We will open the lines at the conclusion of the presentation to allow questions and comments from our audience. Also, your feedback on these webinars is very important to us. We will be asking for your comments at the conclusion of today's presentation and ask that you take a few minutes to share them with us.

Finally, the slides and a recording of today's presentation will be available at the Children's Bureau's Centennial Website at https://cb100.acf.hhs.gov/. We will share this information with you again at the conclusion of today's webinar.

Now I would like to introduce today's speakers. First we have Lisbeth Schorr. Ms. Schorr is a Senior Fellow at the Center for the Study of Social Policy, and a lecturer in Social Medicine at Harvard University. Ms. Schorr's work has focused over the last three decades on what works in social policies and programs to improve outcomes for disadvantaged children and families.

Our second speaker today will be Dr. Puneet Sahota. Dr. Sahota is a Senior Research Fellow at the National Congress of American Indians Policy Research Center. She has written about evidence-based practice and the challenge of evaluating tribally-based suicide prevention programs. She is also an expert on tribal research regulation options.

Our final speaker today will be Dr. Lawrence Palinkas. Dr. Palinkas is the Albert G. and Frances Lomas Feldman Professor of Social Policy and Health at the University of South California. Dr. Palinkas is particularly interested in health disparities, implementation science, community-based participatory research, and the sociocultural and environmental determinants of health and health-related behavior.

I'd like to welcome all three of our speakers today, and at this point I would like to turn things over to Ms. Schorr to start our discussion.

Lisbeth Schorr: [00:02:03] Hi, and good morning and good afternoon to everyone here. I'm very eager to participate in this conversation, and to weigh in on that it's not evidence-based practice or practice-based evidence, I believe it's both, and even more. My view, based on more

years of experience than you will believe, is that we need all the evidence that we can get from all the sources from which we can get it.

We need all this evidence in order to continuously make interventions more effective, to guide the selection and design of interventions that we choose to implement or to scale up, and to demonstrate that the work is improving lives.

For those three purposes we need evidence from many difference sources, and I've identified four of those, if we can go to the next slide. We need evidence from experimental evaluations, which is what we often think of as the evidence-based practice; we need evidence from non-experimental evaluations of many kinds; and from many kinds of other research, as well as from practice and experience. And I'm going to go back to each one of those and go into some detail on each of these four categories of evidence.

In order to get evidence from all four of these sources -- and this is really a textural way of repeating what's on the previous slide, that we have four different sources of evidence, all of which we need to be able to use. And now if we go to the next slide, that's the one that I really want to focus on. Because the key here, at least in my view and that of the colleagues that I've been working with, is that the way you get the evidence and the sources of evidence that we need, the methods we use have to be matched to the purpose for which we're getting the evidence.

And in the left hand column, the dark blue column, I tried to distinguish between four different purposes for getting evidence. The first is to inform resource allocations. To decide what we actually should be funding. Whether we are the foundation, or a state, a community, or the federal government, how do we select interventions that we want to invest in, that we want to implement, that we want to scale up? What works and what doesn't, basically, is what we're asking here.

The second purpose is to improve quality and achieve a greater impact. This goes beyond what works and what doesn't, it's how do we actually improve on the performance we're getting from the interventions that we are responsible for?

A third purpose is to inform the intervention design when the interventions that we have known from the past may even have been proven, are not achieving the outcomes we are after. Not achieving the results we're trying to achieve.

And a fourth purpose of gaining evidence is to guide the quality of implementation.

Now, I want to talk about how you achieve each of those purposes, and how our methods for getting evidence should be matched to the purposes and should be determined by what we're trying to learn from. So for example, if we are trying to learn about standardized interventions that have a clear causal relationship to the outcome, then we want to use randomized assignments or other experimental kinds of methods. Now what's an example of that?

Let me go way back in history and talk about the very first randomized trial that really shed light on what works and what doesn't. And that was a trial of the treatment of breast cancer. For eighty years the only treatment for breast cancer had been to remove the offending contaminated breast.

For eighty years that had been done, and had been invented be a doctor named Halstad, and he did it for eighty years and so did all his colleagues, until the idea of randomized trials was first invented. And they subjected this to a randomized trial and compared it to less invasive methods of treating breast cancer, and sure enough, the less invasive ones were as effective or more effective than the more radical surgery.

Well, that's when it began, and we found that we could test drugs that way; we found that we could test all kinds of very clearly defined interventions with randomized trails, and we could obtain proof of impact.

What about interventions that were not that clearly defined? Are there other ways of finding out what works and what doesn't when it comes to complex, evolving, place-based interventions, because these RCTs are really only good for interventions that remain constant and that don't change from one population to another. And yes, we can assess progress against results in order to establish not certainty, but the probability that change resulted from the intervention. And if we can just quickly go to the next slide, and then I want to go back to this one.

I just want to put up some of the kinds of results that are in current use in the child welfare field, so that it is not impossible to find results that we can agree on that actually measure progress, with or without randomized trials. And the ones I've listed here are very child welfare specific, but of course we're going more and more into the area of child wellbeing, so these are not the only kinds of results that are of interest. But I just wanted to put these up here just so that you could see that there are results that people are using in order to measure progress. Now if we could go back to the previous chart, thank you.

So we can establish probability that, for example, in these much more complex interventions, and especially when multiple organizations have to work together to solve a common problem, let me just give you an example.

We know that you can reduce teen pregnancies through a well-evaluated peer counseling program. But we also know, but can't prove with certainty, that you get a much greater reduction of teen pregnancy if you can also get effective teachers in high schools, if you can campaign to change community norms, if you can help teens to use contraception. Well, that's much harder to evaluate with the most traditional ways of evaluation, and that's where we have to use other ways where we don't get certainty but we do get probability.

A third source of evidence is from research. The research on brain development, the research on threats to normal development, on identification of protective factors, for example, and this kind of research can inform theories of change that will illuminate and help you discover the relationship between actions and interventions and outcomes so that you can build an evaluation framework that really articulates the logical links between clear goals and strategies and the measureable results.

When we get to the lass column of practice and experience, that's a very important source of evidence just not for deciding what works and what doesn't, it's for the other purposes. Now let's go to the second purpose. How do we inform efforts to improve quality and achieve greater impact? When it comes to experimental evidence, we can use the findings from experimental

evidence to identify common patterns and cross program factors of effectiveness. Let me just give you a quick example.

In a study of some 500 programs that were aimed at reducing recidivism among delinquent youth, it was found that much of the program's effectiveness could be accounted for by a small number of straightforward factors targeting high-risk cases and taking a therapeutic approach to changing behavior, rather than a control or deterrent philosophy. Well now, we have not just what is an effective program, we have the factors that make the program effective. And we do that even more easily with the methods that allow us to -- I'm going to the second column now -- learn from complex, and evolving, and place-based interventions by using formative evaluations, developmental evaluations that actually describe the content of the intervention, so we'll know how and why the intervention is working. And that, of course, gives you a much more powerful tool for improvement than does simply knowing yes, no, the program worked or it didn't.

The third column -- Research on Development, Protective and Risk Factors -- how does that help you to inform efforts to improve quality? Well, you can draw on research to identify opportunities for improvement in adaptations that we can't get just from program evaluation, for example. We know from research that children in foster care do better when they are in fewer out-of-home placements. We may not have the programmatic information about the nature of interventions that are routinely effective in bringing out fewer placements, but non-programmatic research and experience can still guide action and resource allocations.

A second example. You probably all know that the Nurse-Family Partnership is one of the most elegantly proven interventions that we have in our arsenal. However, we have discovered through research that the two most frequent factors that are behind child abuse and neglect are substance and maternal depression.

Well, Nurse-Family Partnership has not been able to, within its protocols, have the capacity to deal with those families where those two are very important risk factors. We draw on research then to add those to the proven program. We draw on practice and experience -- I'm now in the fourth column -- to identify opportunities for improvement in adaptation.

Going back to the example of the Nurse-Family Partnership, it was practitioners who discovered that one of the big issues that the Nurse-Family Partnership model was not able to deal with was housing problems. Eviction problems. And a number of programs that have adapted Nurse-Family Partnerships have added a housing specialist to their capacity. So here again, you're drawing on practice and experience to identify opportunities for improvement in adaptation.

Now going to the third purpose of gathering evidence is to inform intervention design when known interventions aren't achieving outcomes. So we can again, examine the evidence from randomized trials to find the principles and practices -- not just the models -- that could inform the creation of new interventions; we can -- going to the second column -- learn from the complex, evolving place-based interventions, what are the principles and practices that could inform the creation of new interventions. Because after all, there are areas where our old interventions simply are not working. And we, knowing the effectiveness factors of what has worked, can shape and minimize the risks of designing new and better interventions.

The third column of the research, Sources of Evidence: for example, we know from research that social isolation is a major risk factor. We don't have a lot of interventions that have been successful in reducing social isolation, or not ones at least that have been proven. So we have to keep inventing new responses to what we've not been able to do in the past.

Practice and experience allow us often to act on the greatest unsolved problems with promising solutions. For instance, we were able to draw on exemplary programs and practitioners around the country to learn how to build protective factors on the ground to reduce child abuse and neglect. We're learning from practice and experience to strengthen the capacity of family, friend, and neighborhood caregivers to learn in a structured way from exemplary programs and practitioners how to build those protective factors in new settings.

The guiding the quality of implementation is another purpose for which -- and I want to rush it a little bit here so that I don't use up more than my 20 minutes -- that we need different kinds of evidence to guide implementation, because we have discovered that the quality of implementation is often a greater determinant of outcome than actually the nature of the intervention.

I just want to summarize this idea of using multiple methods to make sure that the methods we use to assess impact and otherwise understand our interventions won't distort or discourage our efforts to maximize our effectiveness.

When the entire emphasis is on the rigor of the evaluation research -- either that's already been obtained, or that can be obtained in the future -- there's a danger of discouraging the development of more complex and less standardized interventions. Interventions whose very complexity prevents them from obtaining evidence from experimental evaluations. And I realize that putting the highest priority on the strictest research evidence is meant to minimize the risk of investing in interventions that fail. But too great an emphasis on narrowly defined forms of evidence and on past programmatic success without enough room for the development of more effective innovative responses to unsolved problems carries its own risk. The risk of shifting resources away from the complex, multi-faceted interventions and strategies that aren't so easy to evaluate by experimental methods because they can't be standardized with all the variable self constants, but that could have a tremendous potential for breakthrough impacts.

So that's my argument for using all the sources for the evidence that we can get, including the ones from very rigorous research, the ones that can capture the probability of success from complex interventions using research and practice and experience, as all the sources of evidence we can draw on to get better impacts. And I will look forward to the other two presentations and to your questions.

Facilitator: [00:24:32] Wonderful. Thank you very much, Ms. Schorr. At this time I'd like to turn it over to Dr. Puneet Sahota.

Dr. Puneet Sahota: [00:24:39] Thank you. I also appreciate the opportunity to be here today, and I'm going to saw a few things that I think you've already heard in the first presentation, but I'll try to give an additional angle from my work in Native American Communities, which is where a lot of my discussion will come from today.

I'm an anthropolotigist by training, and supposed to be in this position, and I've worked recently on issues of suicide prevention in native communities. And so the discussion that I'll present about evidence-based practice and practice-based evidence comes out of that work in youth suicide prevention, and I hope that context is helpful.

I wanted to begin by talking a little bit about Native American communities' perspectives on evidence-based practice. I don't speak through these communities, but have interviewed a number of stakeholders across the country about this, so I hope I can provide a snapshot of some perspectives.

As was mentioned by the previous speaker, randomized controlled trials are one of the challenges that needed community space, many times because the interventions being tested are local, conducted in an individual community where there may not be the sample size or even the desire in a community to have a placebo or control group. And I'll talk a bit more about those cultural values as we move further across one of the challenges.

Practice-based evidence has been offered as an alternative by some native communities, and I'll talk about that more in the context of youth suicide prevention. The project that I worked on in collaboration with Dr. Serrick Hasselic [ph-unclear] was sort of an overall look at the natural landscape of suicide prevention efforts in native communities. It's not a compressive review, but it does include a broad review of existing literature and interviews of key informants across the nation, including suicide prevention programs, the healthcare providers, and survivors of suicide.

We didn't set out on this project to look at the issue of evidence-based practice, but still, many of our informants raised concern about there being some agency requirements for evidence-based practice, so we ended up writing a separate paper just about that, and on some of the alternative strategies being used in native communities for program evaluation.

So because evidence-based practice is tied to program funding for a number of different types of interventions, it has become a really critical issue for tribes. I'll try to talk about some potential alternatives, and then I will also discuss a case example.

I also, like our previous speaker, would like to point out I don’t think evidence-based practice and practice-based evidence are opposed; I don't think we have to choose one or the other. Rather, I think what's emerging now is a spectrum of ways for developing what we call evidence

-- and that term itself is contested -- and what evidence means, I think it is a really important piece of this conversation, particularly when we think about programs for youth and children.

Cultural factors in American Indian, Alaskan Native communities sometimes mean one approach is preferred over the other, and I'll talk a bit more about that.

I wanted to start first with some definitions from the literature to see if we can all be on the same page about what some of these terms mean. So evidence-based practice is defined by the American Psychological Association Presidential Task Force as: evidence derived from clinically relevant research on psychological practices which should be based on systematic reviews, reasonable effect sizes, statistical and clinical significance, and the body of supporting evidence. The validity of conclusion from research on interventions is based on a general progression, from clinical observation, through systematic reviews of randomized controlled trials.

So again, what we hear is that randomized clinical trials are the gold standard. And goals used are quote: the best available evidence in the context of patient characteristics. So randomized clinical trials, as we heard in the previous presentation, have their role. But there are certain contexts where they may not always be the most appropriate method of evaluation. And one of the contexts, also as the previous speaker said, might be locally-based interventions. So in many tribal communities across the U.S. there are now Suicide Prevention Programs that are being developed based on traditional culture.

As the definition presented by SAMHSA as a substance abuse, and Mental Health Service Administration of a culturally needed program is quote: those that are grounded in tradition and supported by anecdotal evidence.

Many of these interventions are based on traditions and spiritual beliefs or ceremonies that are centuries old. And so communities, and community members will say that they know these kinds of interventions work, and that a return to traditional culture can help heal from some of the traumas that Native American communities have faced. However, those kinds of interventions may not always be tested in randomized clinical trials, or may not have evidence that funders are looking for.

So practice-based evidence has been offered and put forward by some native communities as a solution, and by practice-based evidence here, one definition I read that is a use of quote "systems ___ [?-inaudible], which seek to take into account all the complicated variables that affect real-life healthcare practice, as opposed to a randomized clinical trial that might have artificial parameters in terms of selection of participants, and then a control group with no interventions.

So next, and on the slide titled "Challenges," some of the challenges that native communities face in terms of evidence-based practice really do go back to historical trauma. And by historical trauma, what I mean are traumas that a group of people have experience in previous generations that continue to impact communities today. So for native communities and children in particular, this includes recent history up to the 1970s of children being forcibly removed from their homes, placed in boarding school, not being allowed to speak their own native languages, and being sexually and physically abused in those schools, even when they did try to speak languages that were traditional.

So given that that sort of trauma has happened only a generation ago -- and there are grandparents and parents who are now raising children after having experienced those kinds of traumas -- there continues to be reverberating impact. Why is this connected to evidence-based practice? Some of the informants I spoke to raised the issue of the historical trauma and said that they felt externally imposed standards of evidence-based practice were an extension of this kind of trauma. They felt that requirements for randomized clinical trials, or other kinds of federal mandated evaluation were an imposition of values that are not intrinsic to native communities, particularly when funding is tied to requirements for evidence-based practice.

Many native communities don't have resources to do evaluation, many even barely have the resources to implement locally-based programs. And so these additional requirements felt to many like an extension of previous traumas that had occurred. And so this is connected to community values. It's not just a matter of what type of evaluation fits the program, but rather what values we're following when we decide what sort of evidence is acceptable.

In the case of randomized clinical trials, many of the informants that we spoke with talked about how it feels wrong to their communities to have a placebo or control group. That everyone in the community should at least be able to benefit from an intervention, even if the intervention has not yet been tested or proven. The thought was that a placebo group was being withheld or denied an intervention that could potentially help. And so there were very strong feelings about this kind of research design because of cultural and traditional community values.

And then in addition, some of the locally developed approaches that I've been alluding to are very specific to individual tribes. And so there are over 570 federally recognized tribes, each with their own culture, language, and ceremonies. So what we're works for one tribe may not work for another. And in very small communities, generalization becomes a real challenge in evaluation and in justifying evidence for an evaluation to funders.

Finally, there are other tribes that choose to implement existing programs. Programs or interventions that have been designed for the general population. And in that case, if they try to adapt the program to local culture or needs, maintaining the fidelity of that program becomes an

important concern. So if the program's been adapted in ways that are different from originally intended, then the original evaluation tools may also not be completely appropriate.

I'm now on the slide called "Evaluation Strategies." I wanted to briefly talk about some of the strategies that our key informants talked about using when they're called upon to provide evidence for the advocacy of their program. As we heard, some quantitative data can be complicated. In the case of suicide prevention, the most intuitive data that we would collect would be the number of suicide attempts and hospitalization, to see if those theoretically are reduced after implementation of an intervention.

However, even this type of quantitative data can be complex, because intervening with a new program in the community can also lead to increased awareness and reporting of attempts. And so even when we think about quantitative data that would sort of be viewed as objective at face value, there can be complications as to why a rate would be higher than you would think.

There are other kinds of quantitative data that have been accepted by funding agencies including SAMHSA when looking at evidence for program efficacy. These include data like the number of people attending a new program for intervention, as well as surveys on knowledge and attitudes. Pre- and post-tests were the most commonly cited form of evaluation by our informants. And so looking at change over time in people that do participate in new interventions can be one useful alternative to a randomized clinical trial.

Qualitative data also can provide a rich and important source of information, particularly in combination with quantitative data. So in the example I just mentioned about number of suicide attempts or hospitalization, if we were to see a rise, for example, in those numbers after an intervention is implemented in the community, qualitative interviews might help understand why. And so if interviews of program participants, for example, showed increased awareness and reporting of suicide attempts, then that might provide conceptual information and help explain a quantitative data point.

Another challenge, as I mentioned earlier, for communities that implement local or tribally-based programs is generalizability. It's difficult to find the sample sizes in many small native communities where there are just a few hundred numbers to provide statistical power showing efficacy.

So some tribes have started to form regional consortia, where tribes will work together to define data points ahead of time that all the tribes will collect if they implement an intervention or similar interventions together. And by pooling their data, they can argue as a region for funding or support. So that's another strategy we've seen being used.

Finally, we've seen intermediate outcomes being used as a proxy measure for some of the target outcomes of intervention. For example, reduced rates of suicide in native use have also been shown in previous studies and literature to be correlated with positive cultural identity. So in evaluating a suicide prevention program, a youthful intermediate outcome might be to look at youth's sense of cultural identity.

These kinds of intermediate outcomes are helpful because they're short-term and cost effective to measure; longer term outcomes like rape or suicide attempts for completion may require longer-term and more large and extensive studies to find change. So with cases where there are limited resources, as we see frequently in native communities, intermediate outcomes can offer one potential evaluation strategy.

I'm now on the slide called Case Example. So just to extend this impression about intermediate outcomes, I thought I would talk briefly about a great case example of that. There's a study called Practice-Based Evidence: Building Effectiveness from the Ground Up, which is a ten year collaborative effort between the Native American Youth and Family Center, or NAYA, and the National Indian Child Welfare Association, in partnership with the Research and Training Center on Family Support and Children's Mental Health, and this is in Portland, Oregon.

This study team developed strategies for documenting the effectiveness of services provided to youth at NAYA. They used a community-based participatory research approach and informants and numbers of the study helped with checking of study results and interpretation of data. The study team used community feedback to develop their initial list of possible indicators of successful outcomes, or services provided at NAYA. They also conducted an extensive literature review to locate culturally appropriate measures about funds, and developed new outcome measures where none were found to exist. All of the measures were then reviewed by staff and youth served by NAYA as well as the court partners. The outcomes identified by communities were then included in program assessment tools developed by the team.

So here, practice-based evidence is combined with community-based participatory research, where the communities themselves, the urban Indian community in Portland, is helping define what success means, and therefore what evidence is.

I'm now on the slide that shows a diagram, and this diagram just give you a visual depiction of how intermediate outcomes identified by the study team and the community were linked to more long-term target outcomes. And so the outcomes on the left are the intermediate outcomes that were measured by the teams, and those are short-term measures that can be looked at in a study period. And then they link them by a literature review to other outcomes that are more long-term and more traditionally looked at by funders.

For example, you'll see on the right, the fifth one down is Reduced Suicide, and again, it's linked to positive cultural identity. And so this kind of systematic look at intermediate outcomes and connecting them to broader outcomes, is one potential strategy that can be used in a practice-based evidence approach.

So those are my comments. In conclusion, culturally-based interventions, or local interventions like we see in tribal communities, may require new kinds of evaluation; and creative strategies are being developed in Native communities, including looking at proximal outcomes or intermediate outcomes, changes over time, and forming of ____ [?-unclear] for generalizable results.

So I just wanted to thank my colleagues at the National Indian Child Welfare Association who provided the previous slide, Sarah Kastelic

Facilitator: [00:41:29] Thank you, Dr. Sahota. Before we move to Dr. Palinkas, we did have a couple of people requesting the source for your definitions that you used at the beginning of your slides. I don't know if you know that off the top of your head, of if that's something you'd need to look up for us.

Dr. Sahota: [00:41:41] Sure, I do. And I can also email the reference. So the American Psychological Association has a Presidential Task Force on Evidence-Based Practice. And that group, the APA Presidential Task Force on Evidence-Based Practice, published a paper called "Evidence-Based Practice in Psychology." And I don't have the full journal citation here, but it is a paper that they published with that definition, and it was from their statement on evidence-based practice. And so I can email that citation.

And my definition for practice-based evidence as well, came from a separate paper. And then finally, the definition of culturally-based programs came from a new Suicide Prevention Guide for Native Communities called To Live to See the Great Day That Dawns.

Probably the easiest thing is for me to email you the references, which I'll do, and then those can be sent out.

Operator: [00:42:32] Perfect. Thank you, very much. We'll include them with the materials that we post on the centennial website.

At this time I'd like to turn things over to Dr. Palinkas, to go ahead and give us our final presentation for the afternoon.

Dr. Lawrence Palinkas: [00:42:45] Well, thank you very much. By now you've kind of gotten the idea that the theme of this webinar presentation is that it's not one or the other, but rather both

playing a very important role in the delivery of effective services to disadvantaged youth, at-risk, children and adolescents.

The question though is, how exactly do we accomplish the use of both types of approaches in services delivery, and that's going to be the focus of my presentation today. What I'm hoping to do is to draw from three separate studies that I've been involved with, or am currently involved with, that examine the following issues.

One: the approaches that researchers and practitioners take to both evidence and the practice; secondly: the importance that is given by program or systems administrators and line staff to research evidence, how they view it, how they access it and so forth; and the finally: the use of evidence-based practices, and what kinds of youth make sense from a clinical perspective, particularly when delivering dental health services to children and adolescents.'

The next slide, the one that begins with the Mixed Methods Study. So I'd like to begin by talking about a particular study that I was involved with in the state of Oklahoma. About seven years ago, Oklahoma's Office Of Children's Services decided to implement an evidence-based practice known as Safe Care, Project Safe Care throughout the state, but in collaboration with Mark Chaffin at the University of Oklahoma Health Sciences Center, it was decided to do it as a randomized control trial in which half the state implemented Safe Care and the other half had a wait-list feature, or actually was not using that at the time.

In collaboration with Gregory Aarons, who's at the University of California San Diego, we were involved in a study that was designed to look at the factors that impeded or facilitated the implementation of Safe Care throughout Oklahoma, the focus of Safe Care being to reduce child abuse and neglect in child welfare involved families, and therefore to prevent the necessity for out of home placement.

We were also interested in looking at the impact of implementation on the service delivery organizations themselves, and their staff; and then thirdly, to look at the effect of organizational factors on the working alliance between home visitors and their clients, and to look at not only the process of developing and maintaining that alliance, but the client outcomes as well.

My role in the study was to conduct some qualitative evaluations. And in one of those phases of that process I interviewed 15 clinical case managers from the different agencies participating in this study using a semi-structured guide that looked at knowledge, attitudes, and behaviors related to the Safe Care model; the extent to which home visitors maintain fidelity to the Safe Care model or adapted it to meet the needs of specific families; the factors that the facilitator implemented in its use and the likelihood of continuing the use at completion of the study.

Among the number of things that we found, one of the things relevant to today's topic that I'd like to mention had to do with the relationships that were developed in the course of conducting this randomized effectiveness trial between the researchers and developers of the Safe Care intervention, and the home visitors themselves, what I'm referring to as the end-users. And what I saw was that for Safe Care to be implemented effectively, it required a kind of collaboration between the two groups of stakeholders.

On the one hand, the researchers or treatment developers, provided short-term funding for the services in the first NL [ph] in the context of the trial itself. So NIMH money was used to hire new staff, to train them in the Safe Care model, and to provide support services for them while they were participating in the study. The clinicians, for their part, provided access to the researchers for the study participants themselves. So there was a form of exchange or reciprocity that occurred with respect to resources.

Similarly, there was an exchange of knowledge as well, in that the treatment developers, propagators, provided what I call a global-based or global evidence-based approach to services that were found to be effective with other populations in other settings, thereby enhancing its generalized ability.

Now one of the strengths of an evidence-based practice or evidence-based approach is that it enhances generalized ability. One of its drawbacks, however, is the concern about external validity -- part of which is the ability to translate from one setting or population to another; part of it lies in the nature of the design itself in a randomized control trial.

To compensate for those weaknesses, we have the advantage of what I call a local practice-based knowledge that are provided by the clinician. Now of course while that enhances external validity in this specific setting, the issue, as you heard from the previous presentation, is that it limits generalized ability. So essentially what you've got are two different approaches, or two different forms of knowledge, where each helps to address the limitations of the other.

The second study I want to talk to you about is one that actually was funded in part through the Children's Bureau, but my role in it was funded through the William T. Grant Foundation. And this was a study of Innovation and the Use of Research Evidence in Public Youth-Serving Systems. This study was done in collaboration with Patty Chamberlain at the Oregon Social Learning Center, and Hendricks Brown at the University of Miami.

The focus of this particular study was to look at how systems leaders used and applied research evidence. How they acquire it, how they evaluate it, and then how they apply it in their decision making processes when considering adopting new and innovative programs. Now this one's done in the context of an existing randomized control trial -- the use of community development teams to scale up the use of an evidence-based practice known as multi-dimensional treatment in foster

care -- one that's widely used among child welfare agencies and systems across the United States, and a highly regarded evidence-based practice.

My role was to focus specifically on understanding and measuring the use of research evidence by decision makers, and then identifying the factors that predict that use, and then determining whether that use made a difference with respect to the implementation of MTFC or similar evidence-based practices.

And so one of the things that we did is conduct what's called the Mixed-Method Study, which has both qualitative and quantitative components. So to really get a handle on how systems leaders and their staffs acquire, evaluate, and use research evidence, we conducted a focus group with child welfare directors in Southern California; semi-structured interviews with mental health department directors and chief probation officers; and then also did participant observation at these community development team meetings, which are really designed to bring agency directors and their staff together to sort of pool resources and to problem solve issues that prevent the implementation of evidence-based practices.

Using the information that we acquired from that, we then conducted a survey of participants in the larger clinical trial known as the Cal-40 Study at the time -- it was being conducted in 40 California counties -- and then collecting data from 164 systems leaders and their staff, a little more than a third of whom were employees of child welfare systems, and then matching it with data that was currently being collected through the larger clinical trial.

Among the number of things that we found is significant differences in how system leaders or administrators and their staff actually acquire and evaluate research evidence. But as you can see from this, administrators were much more likely to seek out information about the evidence that supported one or another evidence-based practice, usually by Internet searches, going to scientific conferences, talking to treatment developers, talking to their colleagues, than did their staff.

They also spent a fair amount of time evaluating the validity, the reliability, and the relevance or generalized ability, using the same kind of criteria that researchers use to a much larger degree than did line staff as well.

You'll also notice that there really wasn't any significant difference as to the extent to which they either used that evidence or the circumstances in which they might ignore that evidence, either because they didn't believe that it worked even in the face of all the research evidence, or they just felt more likely that it was just too expensive to implement and to provide the time to train the staff in a manner that would allow effective use of these practices.

The third study that I wanted to mention had to do with a program or project that was funded through the MacArthur Foundation. John Weisz at Judge Baker Children's Center was the principal investigator, and this was intended to look at the effectiveness of a couple of different approaches to using evidence-based practices.

The approaches involved both the usual care that children, 8 to 13 year olds, receive in community mental health treatment programs; a standard approach to using evidence-based practices whereby one takes a manualized version of a treatment for depression, anxiety, or conduct disorders, and applies the entire manual over the course of treatment for a particular child.

The third approach was to take what's called the Modular Manualized Approach to treatment, whereby the clinician had more latitude in determining what elements of the evidence-based practice to apply, and what elements to ignore. So that rather than go through all twelve chapters of a manual, for instance, they might go through chapters 4, 7 and 8, because that's what they felt the child was most in need of.

And the reason for the modular approach, at least the rationale, was that single disorder cases like depression or anxiety are very rare, that comorbidity is more common with this population; children and their problems shift over the course of a treatment process; clinicians disliked the rigidity and the single focus of many of these manualized interventions; and then finally, it tended to mirror what clinicians actually do with evidence-based practice, which is to consider it part of their tool kit. Rather than employ the entire practice or program with any one child, they will pick and choose certain elements of that; likewise, they may apply the entire program, but not with all children.

Now in a paper that was published in February of this year, the outcomes of this randomized trial were presented in which we found that the modularized approach produced significantly greater improvement in child's outcomes as measured by three problem check-lists and a number of other measures that were used to evaluate child outcomes. And in fact, the modularized approach, compared to usual care, produced significant reductions in problem behaviors in this study population; whereas the standard manualized approach was not better than usual care in affecting these outcomes.

So the bottom line to this study was that there was that there was something about the modularized approach that seemed to work effectively in these community-based settings.

As part of my role in this study, I evaluated a process of disseminating and implementing each of these approaches in the context of this project by looking at how it was implemented in the two sites in which the study was conducted -- one being in Honolulu, Gui, the other in Boston, Massachusetts -- and I was particularly interested in the characteristics of the clinics themselves

that either facilitated or impeded the dissemination and implementation of these evidence-based practices.

So similar to the previous study, we conducted some qualitative interviews with treatment providers, with clinicians, the clinical directors, the managers, as well as the researchers and clinical supervisors involved in the study. We used ethnographic techniques of participant observation at the training sessions and the clinics themselves; key informant interviews; and also we used focus groups as a member checking device to make sure that our analysis resonated with study participants themselves.

One of the things that we really were interested in is why was the modularized approach so successful. One the one hand, we found that therapists really supported its use. Like "Mikey" with the Chex cereal, after they came to try it, they really got to like it. Whatever initial skepticism about the lack of efficacy or concerns that they might have had about the lack of control over treatment were dispelled using this approach to a much greater degree than was the case with the standard manualized approach.

It also seemed to improve morale, because they were learning something new. For those who were not trained in a CBT techniques in graduate school, they liked the structure that if offered, they found it to be useful, and they came to believe that it worked. So that both their clinical impressions seemed to be matching quite well with the outcomes data that were being collected by the researchers.

It was also more consistent with their own priorities, in that it gave them greater flexibility to pick and choose modules and techniques based on the unique needs of their clients; it didn't interfere with the therapeutic alliance that they had concern that it would; and all therapists, including those in the standard manualized condition, expressed an interest and willingness to use the protocols in the future, but much more selectively than they had during the course of the clinical trial.

One of the most intriguing explanations though for the effectiveness of the modularized approach is that it allowed for more exchanges between the therapists and the researchers. Now if you remember in the Oklahoma study, I pointed to the exchanges of knowledge and of resources that occurred in the context of implementing the Safe Care intervention in child welfare settings.

Well a similar exchange seemed to be going on in these community mental health settings as well, in that there was an association with the investigators that the clinicians really valued and thought very highly of. They loved the training, they loved the supervision; and many thought the supervision actually was the best part of participating in the study, the supervision that they got from the study therapist supervisors.

But it also allowed for more accommodation and negotiation than the standard manualized approach, in that whenever clinicians came to their supervisor and said, "I want to do this kind of modification with this particular client, is it okay to do that." Having the license to do that, to negotiate modifications was felt by both the researchers as well as the clinicians as one of the best features of this particular approach.

Taking these three studies together, one of the things that seems to be going on when we talk about the application of evidence-based practice and practice-based evidence is sort of an exchange or transformation in the way that both clinicians or therapists as well as researchers think about evidence and think about practice. And I call this transformation a kind of cultural exchange.

And you can think of it as both a theory and a method for conducting translational research, as well as facilitating the translation of research in the practice. And it's defined as a transaction or transformation of knowledge, attitudes, and practices of individuals or groups that represent different cultural systems. So think about the global culture of evidence-based practice being transformed along with the local culture of practice-based evidence, and it occurs through a process of debate and compromise.

This slide sort of illustrates that process. So if you can think of three particular stages whereby researchers armed with that evidence-based practice, and practitioners armed with practice-based evidence engage one another, initially through a process of assessing each other's culture, figuring out what they value most highly, where they have points of agreement and where they have points of divergence; and then beginning in the second stage, a process of accommodation. Where you begin to see areas that they're able and willing to work together in a combined effort to adapt EBPs to local circumstances.

The third stage being one of cultural integration, where you have the emergence of essentially a new global and local culture. And these steps are essentially motivated through the activities of communication, collaboration, and compromise.

Just to sum up, in terms of approach, the evidence-based practice offers the global approach to services delivery that is more generalizable and can be transferred from one setting to another. The practice-based evidence, on the other hand, offers the local approach that is specific to a setting and its population, thereby enhancing its external validity.

In terms of the evidence itself, systems leaders acknowledge the importance of evidence obtained through rigorous procedures like the randomized control trials, where a line staff acknowledged the importance of evidence obtained through personal experience, either their own, or experience of people that they know and trust.

And then finally, with respect to the use, evidence-based practices offer structure, professional identity, consistency, and perhaps most importantly, measurable outcomes to services delivery. On the other hand, practice-based evidence offers control, familiarity, and adaptability to services delivery. The modular approach, like the one used in the Clinical Treatment Project, may offer the best of both worlds.

In the end, however, one of the things that we must remember when trying to decide whether it's one or the other, if we take what initiated the whole evidence-based medicine movement, the fact is that it really accommodates both evidence-based practice and practice-based evidence. So if you look at the definition that David Sackett and his colleagues provided, it's 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 -- well, that's the practice-based evidence -- with the best available external clinical evidence -- the evidence-based practice -- from systematic research.

So having both is inevitable, but it also may require the transformation of the organizational cultures of researchers and practitioners.

And I think I will stop there, thank you very much.

Facilitator: [01:07:00] Thank you, Dr. Palinkas. I'm going to go ahead and have our operator open up the lines for questions at this time, and while we're doing that, we do have one question that has come in from online. So I'll go ahead and open that one up as well.

Operator: [01:07:17] If you'd like to ask a question please press Star 1.

Facilitator: [01:07:20] The question that we have from online says: Giving the growing emphasis on evidence-based practice and the increasing funding requirements that require EBPs across human services, how do we help communities and funders understand the nuances of developmental evaluation that helps programs utilize existing evidence, research, and data to demonstrate program effectiveness in a real world context. In short, how can we build implementation capacity within programs, as well as deepen and broaden understanding amongst funders about how to financially support integrating evidence in the work.

Dr. Sahota: [01:07:57] This is Puneet Sahota. I guess one thing I'd like to say in response is that some funders already are opening up their definition of evidence to include some of the strategies we've talked about today, including practice-based evidence and real world strategies. SAMHSA, for example, has in many of their funding announcements that they will accept multiple types of evidence, including anecdotal evidence, surveys that are used in local interventions, some of the kinds of data I talked about, number of participants attending at an intervention.

I think there still is a challenge in that the hierarchy of accepted evidence I think continues to often have randomized clinical trials as the gold standard. But we are seeing some expansion in the definitions of evidence; at least for native communities we're seeing it from the Indian Health Service and SAMHSA -- those funders have started to really expand their view.

I think continued advocacy is important, and I know that's a very general answer to your question, but I do think that is the way forward. I think dialog with program officers is critical for grants; we seen a number of cases where native communities have engaged in direct dialog and even negotiations with federal funders around what kinds of data or evidence will be collected, and some of those cases, there have been successful negotiations where native communities have been able to submit alternative kinds of evidence.

So I think direct contact with grant officers is critical, both at the application stage and after a grant has been awarded. I mean, if there's a funding opportunity, for example, that your organization saw and was interested in but was concerned about the requirements for evidence, I would reach out directly to that funding agency and see what kinds of acceptations or adaptations can be negotiated. Because we are seeing that happen, and in addition, there are funders that are becoming increasingly open to this, because these problems are well known in terms of local interventions not being able to be adequately studied with some of the more traditional evidence-based practice approaches.

Ms. Schorr: [01:10:11] This is Lisbeth Schorr, I'd to piggy-back on that. I think in order to make a sort of a cultural change in terms of more inclusive ways of gathering evidence, we need to affect both parts of the system. We need to affect the funders, and we need to affect the community capacity. And I think very often its intermediaries and technical assistance providers that can have really that two-pronged kind of influence. Because if the funders won't accept the kind of evidence that they produce of the evidence, the producers of the interventions are offering, then it's not going to make enough of a difference.

So I think we both have to increase the capacity of the local people to produce useful evidence, and the willingness of funders and policy makers to accept it. And in that connection, I wanted to ask Dr. Palinkas a couple of questions.

One was whether he ever looked at what kinds of evidence were persuasive to policy makers, not just staff and administrators.

And my other question was whether everything that he said, which was so really rich in giving us new information about how this translation occurs, whether it applies only to programs that are caring for individual patients, and can't really be applied to population-wide place-based community-wide interventions where the target is a whole population or a whole neighborhood.

Dr. Palinkas: [01:12:12] Okay, so in answer to your first question, systems providers in many respects, like I said, while they tend to access their evidence from sources that are different from those of their line staff, ultimately there are points of prominality [ph] between the two. And that is the relevance of the evidence to their particular communities or clinic population. Child welfare systems, county mental health departments, all places are top priority evidence that seems to mirror the nature of the populations that they serve.

The issue from a systems leader perspective that you tend to see more frequently than you do among the line staff of course, is financial in nature. Can they afford it? Do they have sufficient numbers of clients who meet a particular need for a particular practice to make it financially viable? Do they need to partner with other counties or other systems in order to acquire sufficient numbers of clients or sufficient numbers of providers to meet the needs of those clients?

So there are the number of features of evidence -- it's not so much whether one considers a randomized control trial to be of greater value than say a field visit to a neighboring county to actually observe how a program operates, and to talk to both clients and providers to get their perspectives on the use of that program; but it's also the features that are of greatest relevance to their particular role within the organization.

With respect to your second question, whether it's just individual clients, since the Children's Bureau put this little shindig on, I wanted to focus on areas in the child welfare delivery that tended to be most relevant to the question being asked. However, it's also true that a number of evidence-based programs that target population level outcomes and target entire communities rather than individual clients, much of this is equally relevant.

So that for example, SAMHSA funds a program called Communities that Care, run by David Hawkins at the University of Washington, and that's a community-based approach to prevention of many of the same kinds of issues that I've been talking about, but that engages communities in both collecting information on the needs for these programs, helping to select which evidence-based practices are most likely to be successful, both from the accessibility or cultural appropriateness standpoint as well as from the outcomes standpoint; and then working with treatment developers to implement these programs and put them into place.

There are a number of other programs that are like that, that have a very similar approach to using evidence-based practice in that treatment providers work with communities either in a community-based participatory format or something similar to that, that produces equally successful outcomes.

So it's not just individual clients.

Facilitator: [01:16:21] Operator, do we have any questions on the line?

Operator: [01:16:23] No, ma'am, we do not. None did come in on the line, ma'am.

Ms. Schorr: [01:16:36] I have another question. About when we're talking not about administrators or programs but the legislative authority that funds or doesn't fund programs, and "B" is getting much involved in what kind of evidence they think should be available for federal funding and so on -- have either of my co-panelists found ways to persuade legislative bodies, governors offices, supervisors of child welfare at the state and county level, what kinds of evidence is persuasive to them?

Dr. Sahota: [01:17:42] Hi, this is Puneet Sahota. There's a great example of this in the state of Oregon [laughs], I'm returning there for my example; so a coalition of tribal communities there did work successfully with the mental health department at the state level to expand the definition of acceptable evidence. They needed that push, because evidence-based practice was being used as a funding criterion in the state for programs. And native communities, again, had concerns about that, so we were able to work successfully with staff in that department to come up with different criteria for evidence-based.

Like one of the criteria they used was that if a program had been in a community for a long time and accepted by elders, then it had internal acceptance and was being past down with fidelity. So that in criteria we often talk about regarding fidelity as program implementation. They adapted that definition to incorporated traditions that have been passed down culturally. And so if the tradition or particular intervention -- for example, for suicide prevention -- was based on ceremonies that had been used for many generations, then it was viewed as having fidelity, because that intervention had been continued throughout the history of that community.

And you can find more information online, or I can email information of that as well, if folks are interested in that case study. But the state of Oregon actually has adapted guidelines on their website that are specific for native communities that are speaking as ____ [?-unclear] interventions approved as quote "evidence-based practices."

Dr. Palinkas: [01:19:31] I can speak from the experience of California in that when you look at initiatives that have been supported by the state government and its designated agencies, it does tend to favor the more evidence-based practice approach, and the adherence to the standards that you described in your presentation, Lisbeth, about randomized control trials and so forth. Just an example, so the California County Mental Health Directors Association collectively supports with funding provided from the state of California, the California Institute of Mental Health, whose function is to disseminated information throughout the state on evidence-based practices dealing with mental and behavioral health problems.

And the reason why those approaches tend to be favored by state legislators or state agencies is precisely the issue of generalizability. While they acknowledge the issue of limitations to

external validity in the sense a program that might work in one county with one population may not work equally effectively in another county with another population, that one of the problems that the state has faced for a long time in services delivery is the fact that not all services produce the same outcomes. And you have substantial disparities, whether it's with specific populations like Native Americans or Latinos, or specific reasons in the state, that some have fared better off in terms of making the most out of the services that are available.

And the state approach has always been to assume that if you deliver the same services throughout the state, even if the suitability or appropriateness of the service may differ, that at least you're ensuring that the state has satisfied its mandate to ensure an opportunity for equal delivery, even if that opportunity hasn't been realized.

Ms. Schorr: [01:22:06] But isn't that interesting, if you -- I think you're absolutely right in what you just said. But if you look at that in relation to what Dr. Sahota was telling us about the recognition that that generalizability, and that everybody is really the same as long as you implement the model with fidelity, that the Indian tribes, the Native American tribes have managed to convince a lot of policy makers that that doesn't quite encompass them.

And it seems to me, it's only a question of where you are on the spectrum of how different you are from where the original model was proven. And the Indian tribes have managed to persuade the funders that they are really different.

And if you are just in a slightly poorer community, or a slightly more chaotic community than where the original model is tried, it's much harder to persuade the legislators or the policy makers of the difference, and why the generalizability may not pertain.

Dr. Palinkas: [01:23:29] No, I agree entirely.

Facilitator: [01:23:32] Operator, could you remind us again how folks on the line can ask a question?

Operator: [01:23:36] Certainly. If you'd like to ask a question, please press Star 1.

Facilitator: [01:23:39] And we do have one that's come in online: With respect to implementation and sustainability, what advice do you have for counties that are selecting specific evidence-based models and mandating use of the selected models by providers to receive contracts, in some cases pushing agencies to convert existing child welfare programs to evidence-based models to maintain funding.

Dr. Palinkas: [01:24:04] Well, one of the things that I would suggest is right now, it's not just the practice itself, but it's the strategy that's designed to facilitate the implementation of the practice that is being looked at, and probably to a much greater degree than ever before.

People always assume that if you had a program with great outcomes that people would naturally want to adopt it. But since then, we've learned that there are a whole host of factors that are needed to prepare counties or agencies within counties to enable them to not only be enthusiastic about it, but to use these programs effectively.

So in California we've been looking at the use of these community development teams that the California Institute of Mental Health has developed. In other states, learning collaborative based on these two for health care initiatives has been adopted. Charles Glisson at the University of Tennessee has developed a model called ARC, which is designed to prepare organizations by changing essentially their culture, or organizational culture, making them more qualified and more capable of implementing these programs.

So it's not just a matter of educating counties or communities, or even providing them with the funding, but it's also a matter of creating an environment that's conducive to the use of these practices as well. And that may involve interventions that are currently available, it may involve even new strategies that people haven't thought of yet.

Ms. Schorr: [01:25:56] And I would just add to that, that that is aimed at one side of the equation; the other side of the equation is that maybe the people who are resistant to implementing this evidence-based practice know something that the people who are insisting they implement it don't know.

And I would say you'd have to have some conversations to find out whether maybe the program needs to be adapted and not implemented with fidelity to the original model in order to work in this new setting. So there may have to be a little give on both sides, not just on the one side.

Dr. Palinkas: [01:26:41] Well, that's the beauty of negotiation and compromise, that you end up with a best possible solution, even if not everyone gets their way entirely. But I think that conversation needs to be held much earlier in the process, even as interventions are being developed, and not waiting until they've undergone rigorous testing and evaluations. And then as I said, assuming, because they produce positive outcomes, that people are naturally going to want to adopt them.

Facilitator: [01:27:25] I see we're right at 2:29; operator, do we have any other questions on the line?

Operator: [01:27:29] Yes, we do. One moment, please.
Our first question today comes from the Family Center in New York. Your line is open.

Warren: [01:27:40] Hi, Warren from the Family Center in New York, thanks for your presentation. This is probably redundant with what was just asked. It seems to me that scientific evidence and practitioner-based evidence represent two largely different paradigms. And that of

course brings up the issue of what happens when their conclusions conflict with one another. So I'm wondering, has it happened often, and what do you do, when say a randomized or non-randomized trial shows that something is clearly not working from that perspective, but the practitioners, or at least some of them, remain convinced that they are being effective? How would you initiate a negotiation of sorts in such a situation?

Ms. Schorr: [01:28:25] I would say first of all that you need more information that the randomized trial worked or didn't work. You need to know what are the components of the intervention? And once you know something about the components and you know something about what components are in fact effectiveness factors across the board, then you can have a conversation in which you can determine whether some way of modifying what the interventionists did not succeed at, whether there might be some way of modifying what they've been doing in order to get the outcomes that you're after.

And that's why we need a lot more information about what actually is in the black box. And it's not enough to know: no, it failed; yes, it succeeded. So I think this need for a greater richness of evidence in order to make those conversations that we're all agreeing should take place between the implementers and the authorizers, that in order to have those conversations be based on a lot on facts on the ground as well as the global knowledge that Dr. Palinkas was talking about. Then, I think, we can hope to not only know what's working and what isn't, but to improve what's not working well into what will work even better.

Dr. Palinkas: [01:30:14] One of the things that that model of cultural exchange that I described is that first of all, without even assuming the priority of one type of evidence over the other, the fact is that the cultural systems, if you want to call it that, of researchers, the people who've developed evidence-based practice, and the systems of practitioners who developed practice-based evidence, each had their own hierarchy of value. The things that they consider important to how they do what they do and why they do it, and the pragmatic rules for how to get it done.

And I think by looking at the areas of commonality and then using that as the starting point, both sides are in a much better position to influence the stands of the others through an estimation of what their values are, what they know, and why both of those are important.

And as I said, researchers are just as susceptible to holding on to beliefs even in the face of evidence to the contrary, so practitioners certainly are not unique in that respect. But the fact, as Lisbeth says, coming to an understanding about exactly what evidence is and how one makes decisions based on that definition, I think is an absolutely essential starting point.

Facilitator: [01:32:05] Operator, do we have anyone else on the line?

Operator: [01:32:06] Yes, thank you, I have a question from Allen, your line is open.

Allen: [01:32:11] Thank you. Hi, my name is Allen. I actually live in a Native American community and have been involved in this debate over evidence-based practice, practice-based evidence for quite some time now.

But I've noticed that things such as CBP, or cognitive behavioral therapy was a multi-dimensional treatment... actually, a lot of those evidence-based practices fit well into our traditional value systems and our teachings. I think it's just a matter of... it's not always about convincing or trying to negotiate or make adaptations, sometimes it's just a matter of putting it into the language.

I'd be curious to know how an organization would work with somebody like a researcher to just help them understand that they're not asking to adapt, they're just asking to change the language maybe, so that it fits.

Dr. Palinkas: [01:33:08] Well, I think that's an excellent question. If you noticed on my slide about the cultural exchange, the very first step is communication. Can you speak the same language, or develop a common language through which you interact with one another?

Unless you can do that, you really can't work together effectively, or even compromise, advance to that stage.

But I think particularly... it's clear that Native American communities have been able to find researchers like Dr. Sahota who share a common language. And I think there are several more out there, and perhaps more than even realize that they have that capability.

But I think part of the responsibility of researchers is to learn that language. To spend time in communities understanding that language and understanding those value systems before beginning the process of making suggestions or working with communities to implement programs.

Facilitator: [01:34:31] Thank you. And our next question comes from Hope Lasard [ph], your line is open.

Audience Question: [01:34:35] I did have a question about just wanting to hear each of you talk about examples. And you just mentioned you were in work about how to build the evaluative capacity of the organization as a whole. So that folks are engaged obviously in the data gathering process, but it becomes a way of working within the organization. In terms of collecting data, reflecting in practice, and utilizing that information, that practice-based evidence in a way that kind of points people toward greater evaluations or better evidence and the like.

Dr. Palinkas: [01:35:20] I'll start with an answer to that. So communities state participatory research is a tradition that has a very elaborate set of procedures and principles for enabling

communities and researchers to work together to build capacity for communities. Now sometimes they assign roles so that the evaluations are done by the researchers, in other contexts the whole point is to train communities to prepare them to handle that responsibility entirely on their own.

One technique that I've used in the past is something called rapid assessment procedures, or RAP. And this is a tradition that comes out of developmental or cultural anthropology, whereby teams of evaluators are usually brought together to conduct program evaluations in a very short turnaround, usually 6 to 8 weeks. But they're multi-disciplinary, and they involve research outsiders as well as community members.

And that process involves training community members to both collect and analyze data, and to engage the community in attaining evaluation of the evaluations themselves, and to facilitate the dissemination of that information for the benefit of local communities as well as funding agencies in a much shorter period of time than one would normally have, either for a research study or even a developmental program.

So there are techniques out there like that, that I think can be helpful in building that kind of capacity that would enable communities to eventually assume responsibility for program evaluations on their own.

Ms. Schorr: [01:37:22] I'd just like to add one thing to that, and that is that starting with results seems to me to be absolutely fundamental. We've all been reading the obituaries of Steve Covey, and almost all of them quote him as being the originator of "start with the end in mind."

And when people can agree on the results they are aiming for in the smallest or largest and broadest intervention they're involved in, then how you figure out whether you are achieving those results becomes a doable process, especially if you choose only a handful of results and don't try to achieve 25, but try to achieve 5 or 8. Then you can figure out what are the measures you get help in, getting the measures and the indicators that you use, and the interim measures that we talked about, and that simplifies the process and organizes the process so that it becomes doable by almost any sort of community-based effort.

Audience member: [01:38:53] Thank you. Thank you very much.

Facilitator: [01:38:54] I'm sorry to have to cut off the discussion. I'm afraid we've already run about ten minutes overtime, and Dr. Sahota has had to drop off of the call.

I did want to thank everyone for their participation in today's discussion, and a special thanks, too, with Ms. Schorr, Dr. Puneet Sahota, and Dr. Lawrence Palinkas for sharing their time and knowledge with us to advance this discussion. It's a very important topic, clearly, and one that's very engaging.

I'd invite you all to please visit the Children's Bureau Centennial Website at the address shown for more information on past and future webinars, as well as the slides from today's presentation and a recording of today's webinar.

Our next webinar will be on August 16, 2012, at 3:00 pm Eastern Time, and is entitled: The Story of the Children's Bureau, America in War Time: 1938 to 1960.

Finally, I'd like to remind all of you to please complete the webinar evaluation that will appear on your computer at the end of today's discussion as you log off the webinar. These evaluations provide an important source of information for us as we continue to plan events in celebration of CB's centennial year.

Thank you again for your participation in today's conference call.

Operator: [01:40:02] Thank you and good night. That does conclude today's conference call, you may all disconnect at this time.

[End webinar.]