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Evidence-based treatments in child abuse and neglect

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Abstract

This article summarizes the background and basic concepts of evidence-based practice (EBP), contrasts EBP with traditional approaches, and examines how EBP fits within child welfare and child maltreatment related service systems. The emerging recommendations of best practice workgroups are reviewed, along with evidence across a range of child welfare target areas, including prevention, treatment and foster care settings. The article concludes with a review of challenges and possible solutions for implementing EBP's in child welfare and child maltreatment related service systems. © 2004 Elsevier Ltd. All rights reserved.

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1. Introduction

Those who are enamored of practice without science are like a pilot who goes into a ship without rudder or compass and never has any certainty where he is going. Leonardo da Vinci

Evidence-based practice (EBP) is a relatively new perspective in health care and social services. EBP was born out of the recognition that many common health care and social services practices are based more on clinical lore and traditions than on scientific outcome research. Practice traditions sometimes even run counter to outcome research evidence. EBP strives to bring services more into line with the best-available clinical science and promote practices which have been demonstrated to be safe and effective. This paper will

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briefly review some of the basic tenets of EBP, the arguments of its proponents and critics, and describe the strengths and limitations of differing types of evidence for evaluating a given practice. Next, the paper will examine the context of child maltreatment services and the relevance of EBP to this specific practice field. This section will include a very short review of some better-supported practices. Finally, the paper will examine some of the facilitators and barriers to uptake of EBP within child maltreatment and child welfare practice settings, and suggest strategies and policies for promoting their dissemination and implementation.

1.1. Evidence-based practice

We would suggest defining EBP in child abuse services as the competent and high-fidelity implementation of practices that have been demonstrated safe and effective, usually in randomized controlled trials (RCTs). There is general agreement in the clinical research community over what is meant by “demonstrated safe and effective.” There is comparatively less consensus over questions of fidelity, competency, and implementation issues. Much of the controversy surrounding EBP involves the parameters of what is meant by “competent and high-fidelity implementation.” Fidelity to an intervention protocol raises questions of how strictly protocols or manuals must be followed and the extent to which practitioner creativity, idiosyncratic practice styles, and individualized treatment approaches can be retained in EBP.

Funding sources and government agencies are increasingly emphasizing EBP. As the EBP movement spreads across health care and social services systems, there is the risk that it will become merely a shibboleth or a slogan—ill defined, often invoked, but rarely actually understood or practiced. Indeed, if one were to ask practitioners, “is your practice based on scientific knowledge about what works,” most probably would respond with an enthusiastic, “yes.” Yet, expert reviews of child abuse and neglect field services appear to have come to the opposite conclusion (Kauffman Best Practices Project, 2004; Saunders, Berliner, & Hanson, 2004), and suggest that most field services provided to abused children and their families are not based on any clear evidence that the services actually work. It is common for models to be widespread despite fairly strong evidence that they do not work well, at least as currently implemented (for example, see studies of popular family preservation and home-visiting prevention programs such as those by Duggan et al., 2004; Littell, 1997; Littell, Scheurmann, & Rzepnicki, 1994). Similarly, many field practitioners appear to have never heard of, let alone use, better-supported intervention models. In order to understand this gulf between what is known from outcome research and what is practiced, it is important to understand something about social services and mental health service traditions, and how the EBP perspective is a radical departure from the cultural fabric of traditional practice.

As with any movement challenging established practice traditions, the move toward EBP has been met with some degree of reticence or resistance. A few clinical traditionalists appear averse to science in general or intervention outcome research in particular, arguing that practice is inherently subjective and too complex to be evaluated with the blunt instrument of clinical science (for example, see Clemens, 2002). For them, science is of almost no value when it comes to psychosocial interventions, a field they

perceive as one of the humanities rather than one of the sciences. Other practitioners, perhaps the majority, take more of a middle ground and would consider themselves judicious consumers of science as well as practitioners of the art of therapy or human services interventions. For many traditional practitioners, scholarly or scientific information is consumed, weighted, combined with clinical experience, and used ideographically and creatively to articulate a case-by-case intervention plan. The resulting practice behaviors reflect both unique aspects of the case and the unique personal characteristics of the practitioner. The practitioner is an expert whose own personality, own unique assessment of the individual case, and own unique read of the scientific evidence are what drives practice. This approach to using scientific information might be termed “evidence-informed practice.”¹ However, the evidence-informed or evidence-suggested approach is quite distinct from true EBP. The evidence-informed or -suggested process is far more subjective and more driven by personal values, ever-changing practice fashions, popular theories, charismatic opinion leaders, and political or social contexts. Traditionally, these factors, rather than outcome evidence, have driven intervention approaches in child maltreatment and related fields.

Part of the difficulty with evidence-suggested or evidence-informed perspectives is that it is difficult to know what they do not describe, given that some sort of indirect evidence can be cited to support virtually any intervention. Indirect evidence may obscure the fact that the intervention is based more on political, cultural or entrepreneurial agendas than on efficacy. For example, in the 1980s, there was widespread public fear of juvenile delinquency and political advocacy to the effect that the “soft” juvenile justice system was unable or unwilling to take control of young criminals. This gave rise to using boot camps or fear-based programs, such as “Scared Straight,” which proliferated around the country, and are still practiced in some states. These sorts of intervention models were able to articulate a coherent and plausible theory. They were able to marshal indirect scientific evidence to support core theory propositions. They seemed intuitively correct to many front-line practitioners and policy makers eager to bring a “tougher” approach to delinquency. They had articulate expert proponents. They might easily have been described as evidence-informed or evidenced-suggested, at least by their proponents. As it turned out in later controlled outcome research, boot camps did not produce better outcomes, and Scared Straight was shown to be deleterious and worse than doing nothing at all (Petrosino, Turpin-Petrosino, & Finckenauer, 2000).

The child welfare field also has seen its share of advocacy-driven, fashionable and “evidence-informed” policies, from family preservation, to home-visiting prevention, to adoption promotion, to juvenile sex-offender treatment, each informed by some sort of evidence and some plausible theory, but often with very little well-controlled evaluation of the actual bottom-line outcomes produced. For most of these evidence-informed interventions, we simply do not know whether they deliver the desired outcomes or not.

The central difficulty with “evidence-informed” practices or policies is that the bar is set too low; so low in fact that inert or harmful practices can qualify, especially given reasonably articulate proponents and a rationale that resonates with current social values. This is not to

¹ These terms have various meanings. In other contexts, they may refer to practice based on lower levels of evidence, such as quasi-experimental studies or case studies, rather than randomized trials.

suggest that no evidence-informed practices work. Some evidence-informed practices probably do work, while others do not. Unfortunately, there is no basis within the evidence-informed perspective to confidently separate the two. A second overarching problem caused by the low bar of the evidence-informed approach is that it yokes intervention development and evolution to the vicissitudes of random fashion rather than to a program of clear step-by-step cumulative progress towards the ultimate goal of improved outcomes. A generation ago, one of the fathers of empirical psychology, Paul Mehl, noted, “it is simply a sad fact that in soft psychology, theories rise and decline, come and go, more as a function of baffled boredom than anything else, and the entire enterprise is characterized by a disturbing lack of cumulative character. . .” (Mehl, 1978). Thus, in the traditional evidence-informed practice culture, we can expect only that tomorrow’s interventions will look different from today’s—we cannot confidently expect that they will work any better.

From the EBP perspective, social consensus and changing values do have a place. However, their place lies more in setting ultimate goals for programs (e.g., preventing harsh parenting) rather than selecting the programmatic means to reach those goals (e.g., home-visiting). Systematic science is required in order to define the methods that are effective at achieving whatever ultimate goals we, as a society, set. The promise of EBP is that it puts the selection of programmatic means on a road where cumulative progress can be made towards meeting ultimate goals, and the reliable expectation that we will obtain better outcomes tomorrow than we obtain today. Indeed, reliable cumulative progress has been the hallmark of the experimental scientific fields.

A summary emphasizing some contrasts between EBP and traditional clinical practice are shown in [Table 1](#).

Having punctuated and emphasized some of the differences between EBP and traditional clinical practice, it also is important to note their commonalities. Both EBP and traditional practice are governed by common codes of good practice and professional ethics. Both recognize the importance of core nonspecific intervention practices, such as the importance of establishing a working client–practitioner relationship, having good interpersonal skills, and respect for client dignity. Both recognize that personal characteristics of the therapist or interventionist are important. Indeed, it is not protocols or models alone that yield efficacy. Some individual providers are more successful than others are, and there is significant variation in client outcomes from one provider to the next, both within traditional models and within EBP models. A significant amount of provider-to-provider variation in EBP results appears to be related to how faithfully a provider adheres to the specified EBP protocol (Schoenwald, Shiedow, & Letourneau, 2004; Washington State Institute for Public Policy, 2004). We would suggest that multiple service dimensions are probably important for achieving results: personal provider characteristics, nonspecific provider skills, the quality of the model itself, and the fidelity and quality with which the model is implemented. Although outcomes may be multiply determined, and factors aside from the intervention model may contribute, this should not obscure the fact that model selection and model fidelity matter.

Finally, it is important to note that EBP has been questioned on ethical grounds. Most criticism centers on two main points. The first is that EBP may be viewed as cookbook, lockstep and inflexible. This view sees EBP as requiring slavish adherence to manuals which ultimately results in poor services if client needs are not strictly in line with the

Table 1
 Contrasting evidence-based practice with traditional practice

	Traditional clinical practice	Evidence-based practice
Source of knowledge	Accumulated subjective experience with individual cases. Opinion about practice outcomes emphasized. "In my experience. . ."	Well-designed, randomized trials and other controlled clinical research. Facts about practice outcomes emphasized. "The data show that. . ."
Knowledge location and access	Hierarchical. Knowledge is possessed by opinion leaders and gurus. Charismatic expert driven	Democratic. Knowledge is available to anyone willing to read the published scientific research or research reviews. Information technology driven
Method of achieving progress	Haphazard, fortuitous, based on changing values, fads, fashions, and leaders	Systematic, predictable, based on incremental and cumulative programs of outcome research
Practitioner expertise	Quasi-mystical personal qualities and intuition	Specific, teachable, learnable skills, and behaviors
View of practice	Art. Creative artistic process with fluid boundaries	Craftsmanship. Creativity within the boundaries of the supported models and protocols
Research→Practice Link	Indirect. Inferential	Direct. Integral and fundamental to practice
How is research summarized and applied to practice	Individual subjective practitioner synthesis of whatever literature is consumed	Best practices workgroup or collaborative summary based on exhaustive reviews of the outcome research and meta-analysis
Program evaluation	Inputs (credentials of practitioners) and Outputs (number of clients served, number of service units delivered)	Outcomes (measurable "bottom-line" client benefits)
Location of research	Mostly in laboratory settings and divorced from actual practice	Field clients routinely enrolled in trials in order to test benefits and refine services
Quality control	Focuses on how well service rationales are conceptualized and the credentials of who provides them	Focuses on how well services are behaviorally delivered vis a vis a prescriptive protocol
Practice visibility	Actual practice is seldom observed by anyone other than the practitioner and the client	Direct peer or consultant observation of actual practice, and specific feedback is common
Assumptions about outcomes	Faith. Service programs in general are seen as good and are assumed to be beneficial	Skepticism. Knowledge that interventions may be inert or even harmful. Benefit must be empirically demonstrated, not assumed

manual. This criticism is because EBP is an attempt to bring some of the consistency found in laboratory outcome trials into field practice. Some have suggested that failure of EBP to completely customize the intervention for the individual client is ethically questionable. Many of these critics advocate for more free-form services, basically, a defense of what we have described as the "evidence-informed" position.

To a certain extent, this criticism is something of a straw man, in that it presents an inaccurate caricature of controlled trial research. Part of the difficulty may be that

traditional practitioners and clinical scientists may move in different worlds. Many traditionalists have limited direct experience with clinical trials. Practitioners who have delivered services within the confines of a controlled clinical trial, particularly in child abuse and neglect, would find these critiques rather amusing, and certainly would not consider themselves automatons slavishly bound to a manual, or required to sacrifice ethics and humanity in order to achieve fidelity. The reality is that no manual or protocol runs nearly as smoothly or lockstep as it might appear on the surface or in a scientific article. At ground level, clinical trials are very human activities, and few cases are without complications, surprises, or complexities. Considerable fluency with the intervention protocol, the underlying theory model, and good general clinical practices are necessary to execute EBP competently and adapt to case-by-case variations. This is true even within the confines of a clinical trial where fidelity is emphasized.

Secondly, the argument that EBP produces inferior results compared to individualized services runs counter to considerable research. Many studies compare relatively more structured EBPs to relatively less-structured, and presumably highly individualized “services-as-usual.”² Across multiple studies, results commonly run in favor of the more structured, behaviorally focused, manualized EBP laboratory service models, contrasted with standard field practices (Weiss & Weisz, 1995; Weisz et al., 1995).

1.2. What kinds of evidence counts?

When talking about EBP, it is critical to understand what is meant by “evidence.” Not all evidence is created equal, at least when it comes to determining intervention effectiveness. Certain types of evidence, although important for some aspects of practice, may be inadequate for establishing effectiveness. For example, client testimonials or client satisfaction ratings may be poor indicators of effectiveness, although they may be very relevant for understanding how clients make service related decisions, and provide valuable information for how services should be delivered. However, even demonstrable quackery or proven deleterious interventions can proffer testimonials and yield high client satisfaction ratings, and consequently, these types of data provide little information for discriminating the effective from the ineffective.

EBP assigns little evidentiary value to clinical experience, such as the experience of seeing clients get better over the course of a certain type of intervention. The limitations single-case or single-group pre–post change evidence has been well known for decades, and were perhaps best articulated in the classic text by Campbell and Stanley (1966). Both clinical experience and pre–post data suffer from a lack of equivalent comparisons. Absent key comparison conditions, spontaneous improvement may be confused with intervention benefits, and prevented deterioration may be confused with intervention failure. In short, without comparisons, whether clients appear to get better or not during treatment is

² “Services-as-usual” may be difficult to define and can mean different things in different studies. In some studies, it may mean “no services” for the majority of cases. However, in studies where diverse and varying services are received in the services-as-usual condition, we would argue that the fluidity and idiosyncrasies of services-as-usual in these studies are essentially what advocates of individually customized evidence-informed services are promoting.

irrelevant to the question of treatment effectiveness. One cannot know how clients might have fared with an alternative, competing intervention or with no intervention, hence, relative effectiveness cannot be determined. Finally, clinical experience and similar sorts of data are vulnerable to a variety of biases, including expectancy effects or demand effects, and may involve highly subjective judgments.

Evaluations that involve nonrandomized comparisons also have potential comparison group problems. Although nonrandomized comparisons using statistical adjustment procedures may sometimes replicate the findings of true randomized trials, they often do not, and it can be difficult to know when nonrandomized and statistically adjusted comparisons are equivalent in their findings to randomized trials and when they are not (Glazerman, Levy, & Myers, 2002; Ioannidis et al., 2001). Ultimately, obtaining confident evidence of intervention benefit involves well-designed and -controlled true randomized trials. Typically, early tests are conducted in controlled settings or under fairly ideal circumstances, sometimes, but perhaps misleadingly called “laboratory” trials. These tests demonstrate “efficacy,” or the ability for the intervention to yield effects under ideal circumstances. Because child abuse and neglect intervention is not a scientifically mature field, there is currently a small, but not insignificant number of models that have proven efficacious in these types of trials. A different type of trial is known as an “effectiveness” study. Effectiveness trials typically take place in actual field settings and under somewhat looser controls, and answer the question of whether the model will work when it is put into larger-scale field practice. Ideally, effectiveness trials follow efficacy trials and are an intermediate step between initial efficacy testing and widespread dissemination. In practice, this important step is often skipped. We would argue that the child maltreatment field, although generating limited controlled research, has done a good job of conducting “ecologically valid” field-based effectiveness studies. Many EBP models currently being tested in child abuse and neglect (including Parent–Child Interaction Therapy (PCIT), MultiSystemic Therapy, Family Connections, and SafeCare) have been or are currently being tested in field settings.

Acceptable evidence of benefit also depends on what outcomes are measured. Benefits should include tangible “bottom-line” outcomes that directly reflect ultimate program goals. For example, a treatment designed to help children with traumatic stress should actively reduce traumatic stress symptoms. A program designed to prevent child physical abuse should measure parent behavioral outcomes such as future abuse reports, harsh parenting, or parent-to-child aggression. Outcome evidence based on “soft” outcomes, such as psychological tests tapping presumed mediators of ultimate benefits, is less persuasive. For example, a program designed to reduce child neglect might measure changes in the presumed mediating variable of parenting distress. Although reducing parenting distress is probably a good outcome, one could not confidently infer that the program was effective for achieving the ultimate outcome of reducing child neglect. There are a range of complex outcome research issues, such as differences in subgroup response, the impact of differing intervention dose, impact of attrition patterns on outcomes, and how the receipt of multiple concurrent services effects outcomes; but these are complex methodological and analytic issues that are beyond our scope here.

It is important to note that EBP does not necessarily mean that only practices meeting the highest possible criteria for scientific support should be used. Nor does it imply that a

complete body of rigorous research must exist for all potential outcomes or with all potential population subgroups before EBP can be realized. In child maltreatment, very few intervention models meet the high standards required to designate a model as “well-supported.”³ EBP simply means favoring the best-supported available practices. Where well-supported or empirically validated treatments are available, they may be synonymous with EBP. Where there are no fully supported interventions, one must pick from among competing models with varying levels of support. For example, there might be one model tested in a single well-conducted randomized laboratory trial, along with a few quasi-experimental field studies or single-case multiple baseline studies, and with a robust clinical literature. This model might be compared to competing models having no randomized trials and only anecdotal support. In this example, the first model might not meet full criteria as empirically validated, but compared to competing models, would clearly be the best supported and could be consistent with EBP.

1.3. EBP in child maltreatment service settings

We would argue that EBP is a particularly good match for service systems such as child welfare and juvenile justice. First, critiques concerning the narrow focus of EBP are not salient for child welfare service systems. For example, some psychotherapists have criticized EBP for under-emphasizing therapy as an exercise in personal self-exploration, introspection and meaning making, and over-emphasizing symptomatic, behavioral, and concrete changes. However, overt behavioral and concrete changes (e.g., cessation of physical abuse, improved home environment, reduced child symptoms) are precisely the goals on which child welfare systems are and should primarily be focused. As a service purchaser, child welfare systems are interested in services that achieve child welfare outcomes. These include outcomes such as reduced rates of future abuse reports, improved child safety, placement stability, and family preservation. Moreover, because child welfare systems serve the public interest and expend public monies, they are accountable to state and federal governing bodies for the services they provide or purchase. Providing services that are demonstrably effective in yielding objective measurable outcomes is consistent both with child welfare’s mission and with public accountability requirements.

Modern State child welfare systems are expanding beyond investigating allegations, substantiating or unsubstantiating maltreatment, and placing children in out-of-home care. They are increasingly becoming service providers or purchasers. These services may range from in-home family preservation or family reunification programs, to services for children in foster care, to parenting or comprehensive wrap-around programs for families. Federal initiatives, including the Preserving Safe and Stable Families projects funded under CAPTA, and requirements in the Adoption and Safe Families Act, have supported this shift. Moreover, child welfare systems are increasingly recognizing not only the limitations of foster care as their main service option but also

³ Designation as “well-supported” may require multiple randomized trials done by independent groups. For a discussion of the types and quantity of evidence required for various levels of empirical support, see [Chambless and Ollendick \(2001\)](#).

the necessity of having options available to respond to the large majority of their cases that fall well short of requiring child removal and placement. These types of cases may be more appropriate for service need assessment and quasi-voluntary prevention services.

Finally, the nature of child welfare related service systems is particularly conducive to EBP. Child welfare related service systems are often large-scale programmatic initiatives, rather than being networks of independent case-by-case providers. Disseminating and implementing EBP across networks of independent providers (e.g., private individual practitioners, or “private practice in a agency setting”) is a daunting prospect. In individual provider service systems, each individual provider is a service model decision maker, clients may be quite heterogeneous, and dissemination may be a slow one-at-a-time prospect.

In contrast, programmatic services are more defined, specified, and homogeneous. They often involve organized teams of providers, working with defined client populations, and following an established program-wide model. For example, an agency may provide a parenting program for teen mothers, a family preservation program for drug-addicted parents, a treatment program for juvenile sex offenders, a program for treating child traumatic stress problems, and so forth. Several characteristics of programmatic services favor EBP. First, the decision to adopt an EBP is often an agency-wide or program-wide decision, rather than an individual therapist or interventionist decision, making large-scale uptake more feasible. Second, because EBP involves consistent use of manuals and greater structure, EBP models are well suited to programs delivering a defined and consistent service that ideally does not vary across individual practitioners. Finally, EBP models are targeted at a well-defined problem or population and are conducive to programs serving a well-defined and relatively homogeneous client population.

2. Projects to identify evidence-based practices for maltreated children and families

In EBP, levels of evidence supporting various interventions in an area may be evaluated by a review group or task force. The process typically involves panels of experts who examine the available outcome research evidence and evaluate each intervention model against preestablished criteria for levels of support. Two projects in the area of child abuse and neglect have been completed. The largest project, funded by the U.S. Office for Victims of Crime (OVC, 2001), examined mental health interventions for children who were victims of intrafamilial physical or sexual abuse, and their families. The OVC guidelines reviewed 24 treatment protocols. Treatments were selected for problem areas known to be related to physical or sexual abuse, and that also had manuals or clinical literature specific enough that the treatment could be replicated in field settings. Criteria were developed to rate the strength of empirical support, the soundness of the theory base, the extent of general clinical acceptance, the size of the clinical literature, and the treatment’s potential for benefits and harm. Overall ratings range from “well-supported and efficacious” (the top rating) to “concerning” (the lowest rating). Only a single treatment, trauma-focused cognitive-behavioral therapy (TF-CBT; Cohen & Mannarino, 1997; Deblinger, Lippmann, & Steer, 1996) merited a

rating of well-supported and efficacious. One treatment, attachment therapy (the Evergreen Model), was rated as concerning with a significant potential for harm. Other rating categories, which characterized the remaining 22 treatments, include, “supported and probably efficacious,” “supported and acceptable,” “promising,” and “novel and experimental.” In addition to ratings, the guidelines provide a short description of each treatment, references for published outcome studies, and information for obtaining the treatment manuals.

Although the OVC guidelines represent the opinions of the developers and the project panel, and not the opinion of the OVC or any federal agency, the fact that the guidelines were developed and disseminated through a federal agency may be auspicious. The guidelines are clearly intended to point practice toward a foundation in demonstrated effectiveness. This parallels some initial steps taken by other federal agencies, such as OJJDP’s Blueprints project in the area of juvenile justice.

A second effort, funded by the Kauffman Foundation of St. Louis, followed up on the work of the OVC guidelines project to systematically identify a small number of under-disseminated EBPs for abused children and their families, and to suggest strategies for expediting their uptake in front-line practice settings. The project was a collaboration between the Kauffman Foundation of St. Louis, the Chadwick Center for Children and Families in San Diego, and the National Call to Action, and was done in cooperation with SAMHSA’s National Children’s Traumatic Stress Network (NCTSN; www.nctsn.com). Three treatment models were identified for dissemination: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen & Mannarino, 1997; Deblinger et al., 1996), Abuse-Focused Cognitive–Behavioral Therapy (AF-CBT; Kolko, 1996), and Parent–Child Interaction Therapy (PCIT; Chaffin et al., 2004; Hembree-Kigin & McNeil, 1995; Urquiza & McNeil, 1996). Ongoing efforts through the NCTSN also are also focused on disseminating TF-CBT, PCIT, and other EBPs.

3. Summary of EBP models in child abuse and neglect

Both the OVC and Kauffman EBP projects focused on mental health interventions. However, EBP is also relevant to other classes of services, such as family preservation or reunification models, broad ecologically based intervention models, and prevention models. In this section, we will briefly identify and discuss selected models which show promise within child abuse and neglect, including but extending beyond mental health interventions. These will be outlined under classes of services.

3.1. EBP for preventing physical abuse and neglect

Although perinatal home-visiting has been widely lauded as effective for preventing future physical abuse and neglect among new parents, the randomized trial evidence is largely disappointing. For example, although relatively weaker program evaluation studies have suggested promise for the popular Healthy Start and Healthy Families programs, the more rigorous randomized trial studies have been largely disappointing in finding any

actual abuse or neglect reductions (Duggan et al., 2004; Landsverk et al., 2002). The Nurse Family Partnership model (Olds et al., 1998) has amassed considerable randomized trial evidence for a range of benefits, and is probably the best-supported model currently being practiced. However, evidence of reduced child maltreatment outcomes has been only indirectly measured in some trials, appeared only as a long-delayed effect where it was directly measured, and appeared weak for cases where there was substance abuse or domestic violence (Eckenrode et al., 2000). However, cases with factors like substance abuse or domestic violence may be the most concerning and important cases for prevention efforts.

3.2. EBP for preventing sexual abuse

Sexual abuse prevention programs have mostly been comprised of “victimization prevention” efforts which aim to educate young children (potential victims) about avoiding sexual abuse or disclosing if abuse occurs. To date, none of these victimization programs have been evaluated in randomized trials for actual abuse prevention outcomes. Quasi-experimental studies have yielded mixed findings of some possible benefit, but also the concerning finding that children receiving these programs may be more likely to be injured if they are abused (Finkelhor, Asdigian, & Dziuba-Leatherman, 1995). An alternative to victimization prevention is “perpetration prevention,” which is targeted at actual or potential sexual abusers. The “Stop It Now!” program (Henry, 2002) is perhaps the best known example of this type of program. Outcome evaluation data for the program’s effectiveness in preventing future sexual abuse is unavailable, although the model is beginning to generate some evaluation data. At this point, there is simply insufficient evidence making a clear case for the effectiveness of either victimization or perpetration prevention models.

3.3. EBP for child neglect

Although neglect comprises the majority of child welfare system cases, there is limited study of intervention models. Of these, Project 12-Ways/SafeCare model is among the more widely studied and the best supported. The model uses behavioral methods, and focuses on various targets in the ecology of multiproblem families entering the system for child neglect. The pattern of evidence supporting the model is complex, and involves over 60 published studies, although few randomized controlled trials. A number of studies have been multiple baseline designs supporting the concordance of targeted behavior changes with the intervention. These specific behavior changes have been linked in randomized trials to the model, and both liberally and conservatively biased quasi-experimental studies have suggested benefits in terms of reduced maltreatment reports (Gershater-Molko, Lutzker, & Wesch, 2002; Lutzker & Rice, 1987; Lutzker, Tymchuk, & Bigelow, 2001). The model is currently being tested in a large-scale field trial.

The Family Connections model (see Thomas, Leicht, Hughes, Madigan, & Dowell, 2003 for a description) is another ecologically focused in-home model, similar in some ways to 12-Ways/SafeCare. An ongoing randomized trial is comparing short vs. longer-term doses of the model, and ultimate benefits are yet to be fully determined, although the

model may be promising. Intensive Family Preservation Services are extensively used with families in the child welfare system. However, randomized trial evaluations of these models, and the Homebuilders model on which they were originally based, have been disappointing (Littell, 1997; Littell, Scheurman, & Rzepnicki, 1994).

3.4. EBP for physically abusive parents and physically abused children

Two models in particular show promise for physically abusive parents. Parent–Child Interaction Therapy (PCIT) is a live-coached behavioral parent training intervention which has already met criteria as a well-supported, empirically validated treatment for early childhood behavior problems (Chambless & Ollendick, 2001). Recent randomized efficacy trial evidence also suggests that PCIT can significantly reduce rates of future physically abusive behavior among abusive parents (Chaffin et al., 2004), and a follow-up field trial is currently underway. Kolko (1996) conducted a randomized trial, and found benefits for physically abusive parents and abused children using a structured cognitive–behavioral treatment. Multisystemic Therapy (MST) has produced favorable results in one trial (Brunk, Henggeler, & Whelan, 1987) and a larger randomized trial is currently nearing completion (Swenson, personal communication).

3.5. EBP for sexually abused children, sexual abusers, and children with sexual behavior problems

Although sexual abuse is not invariably traumatic, it is commonly associated with the development of trauma symptoms (Dykman et al., 1997). Trauma-focused cognitive–behavioral therapy, using the principles of gradual exposure and cognitive restructuring has been evaluated in a series of randomized trials (Cohen & Mannarino, 1997; Deblinger, Lippmann, & Steer, 1996) and has consistently been found superior to competing approaches. Because TF-CBT meets criteria as a well-supported treatment for sexually abused children with traumatic stress symptoms, it is a clear choice for EBP with this population.

Treatment for adult sexual abusers has a mixed record of success, possibly related to the fact that sexual abusive behavior reflects a range of heterogeneous motivations and behavioral trajectories. There have been a significant number of quasi-experimental outcome studies evaluating adult sex-offender treatment. Meta-analysis of these studies suggests that current cognitive–behavioral interventions have a moderately beneficial effect (Hanson et al., 2002). However, there has been only a single true randomized trial of contemporary, adult sex-offender treatment. The trial, although sizeable, found no actual reductions in future sex offenses between treated and untreated groups (see Berliner, 2002 for a discussion), and a large study of Canadian programs has similarly suggested that they do not reduce recidivism (Hanson, Bloom, & Stephenson, 2004). Given these disparate findings, it may not be possible to confidently draw conclusions about the effectiveness of adult sex offender treatment, or to clearly define which treatments are effective for which populations subgroups.

Juvenile sex-offender treatment, as it is usually practiced, is virtually untested in any type of trial. Although some states have promulgated standards for treatment, these cannot

be described as evidenced-based, and appear to rely more on unverified clinical lore than on outcome evidence. The exception to this pattern is Multisystemic Therapy (MST), which has been evaluated in two randomized trials treating highly delinquent juvenile sex offenders, and appears beneficial for this particular subgroup (Borduin & Schaeffer, 2001). A third randomized trial comparing MST with typical juvenile sex offender treatment is currently underway (Letourneau, personal communication).

Treatment for young children with sexual behavior problems has been evaluated in two randomized trials (Bonner, Walker, & Berliner, 1993; Pithers, Gray, Busconi, & Houchens, 1998). Both compared some version of focused, cognitive-behavior treatment with an unstructured treatment control. Few treatment condition differences were found, with children in both treatments demonstrating reductions in inappropriate sexual behaviors. Thus, no conclusions about best practice can be inferred from this research, although it does appear that the overall prognosis for children with sexual behavior problems is good.

3.6. EBP for children in foster care

Recent studies have begun to examine the benefits of migrating well-supported EBP parent training models into foster care settings. Child behavior problems are a common cause of foster care disruption. Parent Management Training (PMT; Kazdin, 1997; Patterson, Reid, & Eddy, 2002) is a well-supported behavioral model for child behavior problems in general. Early results from an ongoing PMT study appear encouraging (Landsverk & Chamberlain, personal communication).

Other parenting programs, each with considerable empirical support, appear promising for child welfare service settings. These include The Incredible Years series (Webster-Stratton & Reid, 2003) and the Triple-P model (Sanders, Cann, & Markie-Dadds, 2003).

4. Issues in disseminating and implementing EBP

There is substantial agreement that disseminating and implementing EBP models in field settings is challenging for both individual practitioner and systemic reasons. Indeed, disseminating and implementing EBPs may be more challenging than developing them. Dissemination is not merely a matter of publishing results or a manual, and implementation is not merely a matter of buying a manual and attending a workshop. First, simply because something works better does not mean that the practitioner marketplace will take it up. Second, implementing new models may require a period of skill development and consultation, not simply buying a manual or attending a workshop. Finally, there may be systemic barriers that must be overcome.

The Kauffman Best Practices project focused specifically on barriers to EBP uptake in child maltreatment service settings. One key element noted in the final report is that there appears to be very limited awareness of available EBP models. Not only are few front-line child welfare treatment agencies offering EBP services, many have never heard of them. Diffusion of new technologies may be a slow process. For example, the Institute of Medicine (2001) estimates that it may require around 17 years for a new technology to make it way into widespread clinical use in medicine. The Kauffman project examined

barriers to EBP uptake in child abuse service settings at various levels including policy, community, organization, and individual factors. Barriers identified for child abuse field agencies included:

- (1) Structural problems with funding and payment plans. For example, funding of child abuse service programs often does not allow for the costs involved in adapting new technologies, such as equipment, training, initial supervision, and quality monitoring. In addition, because most EBP protocols are shorter-term than customary therapies, there may be financial disincentives involved in their uptake.
- (2) Lack of advocacy. There is limited consumer or purchaser demand for new technologies in the child abuse field. Similarly, there may be limited organizational leadership pushing for practice change. However, we would argue that demand for EBP within child welfare systems can hinge on a small number of decision makers, and may be easily malleable.
- (3) Lack of incentives that link rewards to client outcomes. Agency funding is often linked to programmatic outputs (e.g., number of clients served) rather than client outcomes.
- (4) No tradition of agencies as “learning organizations,” which value rigorous outcome evaluation, feedback of outcomes into service design, and scanning the emerging research for best practices.
- (5) The gulf between research and practice communities. For example, many best practice models are disseminated in the peer-reviewed scientific literature, which few front-line practitioners read. Much of the training in evidence-based best practices occurs within academic settings, and is not accessible to front-line counselors or agency staff.
- (6) Many unsupported or even questionable models have marketed themselves very effectively, and child abuse treatment agencies may already be financially and professionally invested in these models. Evidence-based best practices, on the other hand, often have not been effectively marketed. For example, there are not the same sorts of well-designed, well-marketed “tool kits” or turnkey training packages available for many evidence-based best practices.
- (7) Some therapists are resistant to research-based interventions. The decades-long “art vs. science” division in Psychology continues to characterize the dialogue on this issue. Many practitioners fear that they will be deprived of creativity, satisfying personal relationships with their patients or may perceive evidence-based practices as “cookbook” or inflexible. Moreover, many evidence-based practices require a more active, planned and goal-directed approach from the therapist, which may be unfamiliar or stressful to some practitioners.

The report offers several suggestions for overcoming these barriers and accelerating the pace of diffusion and uptake in child abuse service settings. These recommendations include:

- (1) Changing funding practices, keying funding, and reimbursement for child abuse services to objective outcomes rather than outputs, and using differential payment

structures favoring best practices delivered with demonstrable fidelity and competency.

- (2) Targeted funding of EBP implementation projects (e.g., EBP uptake grants), which would provide agencies with the necessary start-up capital to migrate to best practice models.
- (3) Increased emphasis on EBP in graduate training programs.
- (4) Improved marketing of EBP approaches and development of model implementation tool kits such as those currently under development within the National Child Traumatic Stress Network.
- (5) Encourage child abuse service agencies to adopt a “learning organization” orientation. Agencies with strong leadership and positive organizational climates are good candidates for early adaptation of new best-practice technologies and can set an example that other organizations can emulate.
- (6) Counter misperceptions that EBP models are sterile, inflexible, impersonal, or professionally unsatisfying for those who implement them.
- (7) Increase advocacy and social demand for best practices by disseminating information to funding organizations, governing boards, third-party payers, parents, and professional organizations.

Ultimately, moving the child welfare and child abuse service systems toward EBP will require a combination of organization leadership, policy changes, and marketing. More fundamentally, however, it will require a fundamental change in the estranged relationship between clinical science and front-line practice. EBP does not merely involve practitioners taking up models handed down from clinical scientists. It also means that practice must become more like research and research must become more like practice. The path toward cumulative progress and refined interventions lies in partnerships, and in synergistic efforts of clinical scientists and front-line practitioners to innovate and refine models, systematically test the results, then feed this information back into the service system. This iterative approach has proven fruitful in other fields. For example, the treatment of childhood leukemia has been one of the success stories of medicine, moving in a few decades from no long-term survival to long-term survival by a large majority of children. Success did not come from a single major scientific breakthrough made in a laboratory. Rather, it came by treatment centers and researchers organizing into research–practice collaboratives, and conducting large-scale randomized field trials of progressively more refined and effective treatment protocols. Thus, progress was evolutionary, rather than revolutionary. To the extent that we can form similar partnerships in child abuse, we can see our own evolutionary development.

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