

ACKNOWLEDGMENTS

The University of Pittsburgh, Pennsylvania Child Welfare Training Program thanks the following organizations for permitting the inclusion of this document in our training materials.

- Chadwick Center for authorship
 - Charles Wilson, Executive Director
 - Laine Alexandra, Project Manager
- National Association of Public Child Welfare Administrators (NAPCWA) for publication and sponsorship
- American Public Human Services Association (APHSA) for permission to post and use document

Guide for Child Welfare Administrators on Evidence Based Practice

***Published by the National Association of Public Child Welfare Administrators
an affiliate of the American Public Human Services Association***

American Public Human Services Association, 810 First Street, NE, Suite 500, Washington, DC 20002
(202) 682-0100; Fax: (202) 289-6555; <http://www.aphsa.org>

CONTACT INFORMATION

Pat Shapiro, Senior Research Analyst
National Association of Public Child Welfare Administrators
American Public Human Services Association
810 First Street, NE, Suite 500
Washington, DC 20002
(202) 682-0100
pshapiro@aphsa.org

Charles Wilson, MSSW
Executive Director
Chadwick Center for Children and Families
Children's Hospital – San Diego
3020 Children's Way, MC 5016
San Diego, CA 92123
cwilson@chsd.org

Laine Alexandra, LCSW
Project Manager
California Clearinghouse for Evidence Based Practice in Child Welfare
Chadwick Center for Children and Families
Children's Hospital – San Diego
3020 Children's Way, MC 5017
San Diego, CA 92123
(858) 966-7431
lalexandra@chsd.org

ACKNOWLEDGMENTS

This document was written as a collaborative effort between The Chadwick Center, which manages the California Child Welfare Clearinghouse for Evidence Based Practice, funded by the California Department of Social Services, Office of Child Abuse Prevention, and the National Association of Public Child Welfare Administrators (NAPCWA). The purpose is to provide guidelines for a common language and framework with which to understand the conditions, challenges, and opportunities of evidence based practice in child welfare. This document pertains to prevention and intervention services, but the overarching principles can be applied to all practices in child welfare. It is intended to provide a foundation of information for child welfare administrators. We invite you to contact us with any questions or comments.

Authors

Charles Wilson, Executive Director

Chadwick Center for Children and Families, San Diego, California

California Child Welfare Clearinghouse for Evidence Based Practice

Chadwick Treatment and Services Adaptation Center of the National Child Traumatic Stress Network

Sam and Rose Stein Endowed Chair on Child Protection

Laine Alexandra, Project Manager

Chadwick Center for Children and Families, San Diego, California

Editors

Laura LaRue Gertz, NAPCWA

Patricia Shapiro, NAPCWA

NAPCWA Evidence Based Practice Workgroup

Uma Ahluwalia, Chair

Assistant Secretary, Children's Administration

Washington Department of Social and Health Services

Ken Deibert, Administrator

Division of Family and Community Services

Idaho Department of Health and Welfare

Raymond S. Kirk, PhD, Research Professor

Jordan Institute for Families

University of North Carolina-Chapel Hill School of Social Work

Paul Ronningen, Director

Children and Family Services Division

North Dakota Department of Human Services

Joan Van Hull, Assistant Deputy Director

Office for Children and Families

Ohio Department of Job and Family Services

Brief Overview and History of Evidence Based Practice

A number of social science fields are currently focusing increased attention on the identification and delivery of practices that are supported by strong scientific research and the active integration of research evidence into day-to-day service provision. While some fields have embraced this movement to “evidence based practice” for decades, there is reason to believe that it still takes years to spread scientifically proven practices into everyday practice across the country (IOM 2001). It is only logical that the expectation to base our practice on scientifically supported knowledge would increasingly be focused on child welfare, where the lives and well-being of millions of children are affected and where billions of public and private dollars are being invested.

Several factors influence a current emphasis toward evidence based practice in child welfare today. The practice of child welfare has long been based on a strong professional literature and on thoughtful analytical discussions of what constitutes best practice. Considerable effort has gone into building a strong base of research studies that have tested a wide range of innovations and service models. Within recent years, the field has begun to amass an evidence base of comparative empirical studies that test relevant innovations against standard current practice or other models. We are reaching a point where we can begin to draw lessons and apply them widely across the country. The evidence based movement in child welfare is being hastened by the demands of a variety of funding sources from governors, state legislatures, local government leaders, and private foundations to invest their resources in practices that have a proven high likelihood of success. This movement is also likely to further strengthen as states find that implementing evidence based practices can play a positive role in a state’s response to class action litigation and can enhance agency performance as measured in Child and Family Services Reviews.

Challenges

While the logic of evidence based practices has strong appeal to funding sources and many child welfare professionals, there are many challenges to implementing the concept in reality:

The Research Base in Child Welfare.

Adopting evidence based practices requires a volume of scientifically sound research that has been tested in ways that allows for it to be applied reliably in new communities. In fact, the base of solid empirical research evidence on child welfare practice is still in an early developmental state. The level of federal and state resources focused on important child welfare research questions and available for sophisticated research studies has long suffered from the relatively low priority legislative bodies have placed upon research on these issues. As a result, child welfare has lacked an institutional sponsor of well-funded rigorous research such as that provided by the National Institute of Mental Health (NIMH) and other National Institutes of Health (NIH) divisions in related fields. Nonetheless, there are some areas where we know a fair amount about very specific questions and still other important areas in child welfare where quality practice research has simply not been conducted at this point. That does not mean there are no effective interventions and practices in these areas, only that we do not have research evidence that measures which practices are most effective. There are also some related areas of social science (i.e., juvenile justice, mental health, and violence prevention) for which strong research evidence is available for some related questions that may well serve to inform child welfare professionals about effective interventions. As is true in other areas of social science, child welfare practices cannot be simply divided into “evidence based” and “non-evidenced based.” We must assess them along a continuum from highly research supported practices on one end to very questionable and concerning practices that lack even a sound theoretical or common sense bias, or that may even be harmful, on the other end.

Replication.

Given the highly individualized nature of families and communities with whom child welfare professionals interact, there is considerable skepticism in some circles that practices can, or even should, be delivered with consistency across the country. Others argue with conviction that services proven effective in rigorous studies should be replicated with fidelity in order to reap the benefits of the services as demonstrated by research. Proponents for this perspective fear that if the practices proven effective in research studies are modified significantly as they are adopted and adapted in new communities, the power of the research and the outcomes one can

expect will be diluted. At some point, adaptation can render a program so fundamentally different from what the designers intended and what was studied that it can no longer be considered evidence based.

Expectations Management.

Funding sources, especially public officials, may embrace “evidence based practice” in hopes of dramatic and rapid improvements in the state child welfare system. If administrators adopt practices that are incorrectly categorized as “evidence based” and the practice fails to show the desired results, or a legitimately labeled evidence based practice is adapted in ways that significantly dilute its effect, the funding sources may feel that “evidence based practice” is just another false promise for dramatic gain in the quality of public child welfare services. The needs of children and families in the child welfare system are highly complex, and many variables affect outcomes; some evidence based practices have been developed and tested with clients who exhibit much less complex needs and are in more controlled settings. Even when properly selected and replicated with fidelity, selected evidence based practices may, in fact, provide superior but still modest gains in outcomes. If stakeholders expect a “magic bullet” that dramatically changes the system overnight they will be disappointed. For these reasons both administrators and advocates should be precise in how they define their terms, carefully determining which practices they embrace as evidence based and how they implement the selected practices. In addition, the adoption and implementation of evidence based practice is generally not cost neutral. As noted in the “Adopting Evidence Based Practices” section of this guide, resources are required to develop training and quality assurance mechanisms needed in order to ensure model fidelity. There must also be an investment in the organizational change management strategies essential for successful adoption of a new practice.

Pace of Science.

Child welfare administrators are faced with a wide array of demands and issues and families and children face a multitude of needs. Once a decision is made to adopt an evidence based approach, it is important to know what models work best, with which families, and under what circumstances. There are currently not enough answers to these important questions. We have pressing needs to act now to improve services for families yet there are many areas of child welfare that lack the type of research needed

to define any one practice as more effective. Child welfare workers are providing standard, accepted services now, adapted to the traditions and cultures of different communities and affected by state, local, and federal policies; at issue is determining which are the *most* effective services in the field, giving the best outcomes for children and families. Informed child welfare leadership is then faced with a difficult decision: Do you invest in a promising practice built upon solid theory that is still being tested in a research environment, or wait for the results, knowing that proper research may take several years to complete when families and communities need services now?

Definitions.

There are a lot of terms being used around the nation to describe services delivered in a child welfare setting from “emerging practice” to “promising practice,” “good practice,” “best practice,” “evidence informed practice,” “science based practice,” and “evidence based practice.” A number of these terms have very specific meaning to some professionals but others may use the same term in dramatically different ways. Some may use words that imply a rigorous scientific base to describe a practice that lacks even the most basic evaluation. Some have addressed this issue by establishing a numeric classification system such as that described in Appendix A.

To provide guidance and support to state and local child welfare administrators on these complex issues, NAPCWA is offering this guide for use in exploring evidence based child welfare practice. In reality, there are a variety of schemas that could be proposed to organize these issues. While there is really not one right way to do this, there is some advantage to using consistent language and terminology among child welfare professionals across the nation.

Definition of Evidence Based Practice

The Institute of Medicine (IOM) defines “evidence based practice” as a combination of the following three factors: (1) best research evidence; (2) best clinical experience; and (3) consistent with patient values (IOM, 2001). These three factors are also relevant in child welfare. This definition builds on a foundation of scientific research while honoring the clinical experience of child welfare practitioners, and being fully cognizant of the values of the families we serve.

We propose adopting the Institute of Medicine's definition for evidence based child welfare practice with a slight variation that incorporates child welfare language:

- Best Research Evidence
- Best Clinical Experience
- Consistent with Family/Client Values

Other key terms related to evidence based practice are defined in Appendix B.

Finding Evidence Based Practices

There is now an enormous literature base in child welfare and literally thousands of ways of performing child welfare services in public and private environments. The National Clearinghouse on Child Abuse and Neglect Information has over 35,000 published articles and electronic documents available. The web site has a searchable database capacity (<http://nccanch.acf.hhs.gov>). There have been thousands of research and demonstration projects funded by federal and state governments and private foundations. In most communities there are a variety of providers who passionately believe their services are effective and worthy of replication. Many have some data they believe supports their belief in what they do. The challenge to the child welfare administrator is to find clear and objective evaluations of services based on sound research methodology, and based on that evidence, to find the gems of effective practice in the sea of advocacy and opinion.

Implementing Evidence Based Practice

There is a basic pathway to implementing evidence based practice in the child welfare environment worth considering:

Define the Issue.

The world of child welfare is too broad and complex to look for evidence based practices indiscriminately. Administrators and agencies are well advised to focus their questions in very clear and discrete terms so similar practices that may qualify as evidence based can be located and evaluated. For example, seeking evidence based practices among child welfare services that broadly target behavior changes in parents would be a very unfocused and enormous task. However, a search for evidence based group parenting education programs, or mental health interventions to help traumatized children recover

from abuse are much more focused and would result in specific practices that could be evaluated.

Conduct the Search and Analysis.

Agency staff that understand research methodology and the array of resources available in social work and related libraries and over the Internet can locate programs and practices appropriate for consideration. The same can be done through collaboration with affiliated university or private agency resources. California has moved to establish a formal state clearinghouse on evidence based practices for child welfare. An advisory committee with state and national representatives will guide the selection of topical areas and dissemination. A national scientific panel will conduct the research and analysis of the selected topical areas. Other states may follow the lead of the California clearinghouse creating the potential for a collaborative national effort.

Web Based Resources.

There are numerous resources in child welfare and related areas (mental health, violence prevention, prevention, etc.) available on the Internet. Many of these resources have already assessed a range of practices and selected specific programs as models to replicate. Great caution should be exercised in reviewing this type of resource. Some, such as the Blue Prints Project at the University of Colorado–Boulder, have support to rigorously evaluate programs before listing them as evidence based (for prevention of violence, in this case) on their web site. Many other web resources use a far less rigorous and objective basis to label a program as a “model program.” These sites may, or may not, reflect a careful assessment of the research upon which the model is based or the risk it may represent in child welfare. Unfortunately, some web sites are merely marketing forums masquerading as objective assessment for persons or organizations with a proprietary interest in advancing adoption of specific interventions or models. Web sites that might be useful in locating model programs are listed in Appendix C.

Assessing Practices as Potentially Evidence Based

Once practices are identified for potential adoption, child welfare administrators should consider:

Is the practice under consideration based on a solid conceptual/theoretical framework?

- Is the theory upon which it is based widely accepted?
- Is there a logic model that makes sense in child welfare?

Can the practice, in fact, be replicated?

- Are there practice manuals, protocols, and related written materials?
- Is training/consultation available?
- Does the practice lend itself to application in other communities or with other populations?

How well is it supported by research?

- How rigorous is the design?
- How closely did the research subjects relate to a child welfare population?
- How many evaluations have been conducted?
- How strong are the results?
- Are the results superior to other “usual services”?
- Have there been systematic reviews/meta analyses?

Does the practice pose an acceptable risk ?

- What is the benefit to risk of harm ratio?
- Does this practice place children at undue risk?
- Is this practice potentially more toxic than the circumstances it tries to prevent or ameliorate?

Rating a Practice

Rather than merely classifying practices as “evidence based” or not, there are a number of criteria available from organizations and researchers who have sought to assess practices along a continuum of evidence based. Using a rating system is wise since there are varying levels of evidence available, especially in child welfare where some areas have a strong research base and others are at a much more rudimentary level of evidence.

One such scheme that was used in a well-developed analysis of treatment models for abused children supported by the Department of Justice, Office of Victims of Crime (OVC) (Saunders, et al. 2004) offers a model worth considering, with some modifications, to incorporate in child welfare.

- What is the theoretical basis? (sound, reasonable, novel, unknown)
- How strong is the clinical/anecdotal literature? (substantial, some, limited)
- How well accepted is it in actual child welfare clinical practice? (accepted, some, limited)
- What is the risk for harm/benefit ratio? (little, some, significant risk of harm, unknown)
- What is the level of empirical support? (have there been systematic review/meta analyses, randomized controlled trials, non-random controlled trials, uncontrolled trials, single case studies, others, none)

The practices and programs being reviewed can then be assigned to one of six levels of evidence base (based on a modified version of the OVC guidelines):

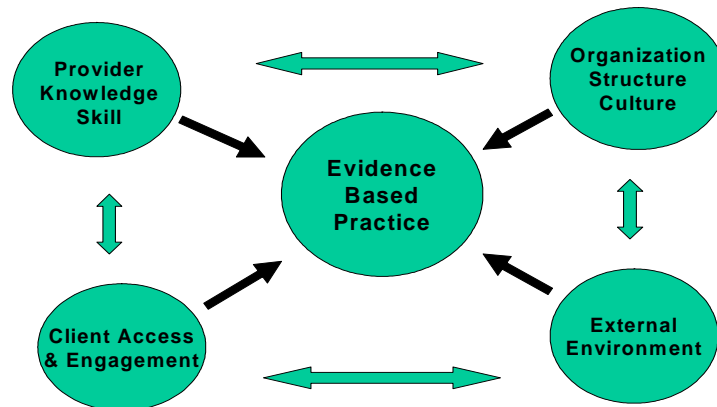
1. Well-supported, proven efficacious practice
2. Supported and probably efficacious practice
3. Supported and acceptable practice
4. Promising and acceptable practice
5. Innovative or novel practice
6. Experimental or concerning practice

Specific criteria for each classification system category are presented in Appendix A.

In some areas of child welfare, administrators will find one or more practices, models, and protocols, or interventions that can be rated as 1, well-supported and proven efficacious practices. Even in such well-studied areas there maybe other practices that are as effective or hold even greater promise that may be worth considering, but have yet to be subjected to the same level of rigorous evaluation. In other areas of child welfare services, there will be no practice that can be rated as 1 or even 2. In such areas, the best available practice may be level 3, supported and acceptable practice, or in some cases even level 4, promising and acceptable practice, where no one has yet rigorously investigated the efficacy of the service models or the models that have been investigated have proved ineffective.

Even administrators committed to moving to an evidence based practice must accept that the best they will be able to do at times is make an “evidence informed” judgment about which practice to endorse and/or attempt to adopt

Multiple Factors of Implementation



using the best available studies and analyses. McNeece and Thyer (2004) note that in practice areas where there is a lack of systematic review, meta-analyses and randomized clinical trials, “EBP says that one should rely on the best AVAILABLE evidence...” (Evidence-Based Practice and Social Work. *Journal of Evidence-Based Social Work*. Vol. 1(1), p. 12).

Adopting Evidence Based Practices

Identifying and selecting evidence based practices is a complex and challenging task but it represents just the beginning. There are innumerable obstacles to adopting an evidence based practice in child welfare that must be strategically overcome. A recent national analysis of barriers to implementing three selected evidence based practices in the related area of treatment of abused children (Chadwick Center 2004) identified literally hundreds of barriers that must be systematically addressed ranging from the cost of implementation (training and material costs, lost productivity due to training and start up, etc.), to entrenched status quo (providers who do not perceive a need to alter their practice or resist implementing a manualized intervention that they perceive reduces their clinical flexibility) to arguments that “our families are

different or unique” and the “research does not apply to us.” Other studies have sought to explore the conceptual complexities of diffusion and dissemination in service organizations in ways that may help guide state or local strategic efforts to manage the process of spreading evidence based practices within their jurisdiction (Greenhalgh, et al. 2004).

In many areas of child welfare, adopting evidence based practices will also require the involvement of community service providers and contractual relationships between the child welfare agency and private providers. Some providers will be in tune with the concepts of research evidence and welcome the move. Others are far more grounded in community service provision and may lack a tradition of reliance on research or the resources to engage in research and to train staff in new practices. Such organizations may not welcome the introduction of a practice developed elsewhere and supported by, what they perceive as “Ivory Tower” academic research which they fear may supplant their existing services or funding. To implement new practices based on the best available evidence within public agencies, strategies must be developed to identify and address barriers at a variety of levels (Chadwick Center, 2004); not only at the practice level (i.e., child welfare workers and families) but at the

unit level (child welfare supervisors and peers), the organizational level (county directors, program management, etc.), at the community level (allied local service providers, community stakeholders such as judges, guardians ad litem, court appointed special advocates, local elected officials) and at the state level (policy makers, elected officials, regulatory bodies, etc.). The complexity of this implementation challenge is exacerbated when the public agency must rely on contractual partners to deliver the desired services. One model states might consider is California; they have identified selected evidence based practices in child welfare and sought, with considerable success, to spread their adoption among key community based organizations by offering resources to offset the cost of training and retooling, as seen in the case of their strategic support of adoption of Parent Child Interaction Therapy. Other states are struggling with alternative methods to use the power and influence of the contractual dollar to help shift their state service delivery system to an evidence based approach. In fact, child welfare is in an influential position to use their contractual resources and the influence of their referral pathways in ways that encourage or drive the move toward more evidence based approaches.

In the final analysis, child welfare administrators must cautiously and thoughtfully select practices that they believe, after objective review, have an adequate evidence base. They must then develop plans to ready the organization(s) to adopt the change, while educating and coordinating with the external environment, developing strategies to engage families in the new practices, and providing the service delivery staff with the knowledge and skills (and time) necessary to deliver the evidence based service. Then, and only then, can one expect to successfully implement evidence based child welfare practice.

References

- Chadwick Center (2004). *Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices. The Findings of the Kauffman Best Practices Project to Help Children Heal From Child Abuse*. San Diego, CA: Children's Hospital-San Diego, Chadwick Center for Children and Families.
- Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). *Diffusion of Innovations in Service Organizations: Systemic Review and Recommendations*. University College London: University of Surrey.
- Institute of Medicine (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, DC: National Academy Press.
- McNeece, C.A. & Thyer, B.A. (2004). Evidence-Based Practice and Social Work. *Journal of Evidence-Based Social Work*, Vol. 1 (1), 7-25.
- California Department of Social Services (2003). *Parent Child Interaction Therapy, Promising Practices Approaches to Improve Outcomes for Children and Families*.
- Saunders, B. E., Berliner, L., & Hanson, R.F. (Eds.), (2004). *Child Physical and Sexual Abuse: Guidelines for Treatment* (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research and Treatment Center.

APPENDIX A

Child Welfare Practice Classification System

The proposed classification system uses criteria regarding a practice's theoretical soundness, clinical support, acceptance within the field, and potential for harm, documentation, and empirical support to assign a summary classification score. A lower score indicates a greater level of support for the practice protocol. The summary categories are:

1. Well-supported, efficacious practice
2. Supported and probably efficacious practice
3. Supported and acceptable practice
4. Promising and acceptable practice
5. Innovative or novel practice
6. Concerning practice

Specific criteria for each classification system category are presented below:

Well-Supported, Efficacious Practice

- The practice has sound theoretical basis in generally accepted child welfare or related professional principles.
- A substantial clinical-anecdotal literature exists indicating the practice has value with children receiving services from the child welfare or related system and their parents/caregivers.
- The practice is generally accepted in clinical practice as appropriate for use with children receiving services from the child welfare or related system and their parents/caregivers.
- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, or other available writings that specifies the components of the service and describes how to administer it.
- At least two randomized, controlled outcome studies (RCT) have found the practice to be superior to an

appropriate comparison practice, or different or better than an already established practice when used with children receiving services from the child welfare or related system and their parents/caregivers.

- If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.

Supported and Probably Efficacious Practice

- The practice has a sound theoretical basis in generally accepted child welfare or related professional principles.
- A substantial clinical-anecdotal literature exists indicating the practice's value with children receiving services from the child welfare or related system and their parents/caregivers.
- The practice is generally accepted in clinical practice as appropriate for use with children receiving services from the child welfare or related system and their parents/caregivers.
- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, or other available writings that specifies the components of the practice protocol and describes how to administer it.
- At least two studies utilizing some form of control without randomization (e.g., matched wait list, untreated group, placebo group) have established the practice's efficacy over the passage of time, efficacy over placebo or found it to be comparable to or better than an already established practice.

Supported and Acceptable Practice

- The practice has a sound theoretical basis in generally accepted child welfare or related professional principles.
- A substantial clinical-anecdotal literature exists indicating the practice's value with children receiving

services from the child welfare or related system and their parents/caregivers.

- The practice is generally accepted in clinical practices as appropriate for use with children receiving services from the child welfare or related system and their parents/caregivers.
- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, or other available writings that specifies the components of the practice protocol and describes how to administer it.
- At least one group study (controlled or uncontrolled), or a series of single-subject studies suggest the efficacy of the practice with children receiving services from the child welfare or related system and their parents/caregivers

or

A practice has demonstrated efficacy with other populations, has a sound theoretical basis for its use with children receiving services from the child welfare or related system and their parents/caregivers, but has not been tested or used extensively within the child welfare population.

- If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.

Promising and Acceptable Practice

- The practice has a sound theoretical basis in generally accepted child welfare or related professional principles.
- A substantial clinical-anecdotal literature exists indicating the practice's value with children receiving services from the child welfare or related system and their parents/caregivers.
- The practice is generally accepted in clinical practice as appropriate for use with children receiving services from the child welfare or related system and their parents/caregivers.
- There is no clinical or empirical evidence nor theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

- The practice has a book, manual, or other available writings that specifies the components of the practice protocol and describes how to administer it.

Innovative or Novel Practice

- The practice may have a theoretical basis that is innovative or novel, but is a reasonable application of generally accepted child welfare or related professional principles.
- A relatively small clinical literature exists to suggest the value of the practice.
- The practice is not widely used or generally accepted by practitioners working with children receiving services from the child welfare or related system and their parents/caregivers.
- There is no clinical or empirical evidence nor theoretical basis suggesting that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, or other available writings that specifies the components of the practice protocol and describes how to administer it.

Concerning Practice

- The theoretical basis for the practice is unknown, a misapplication of child welfare principles, or a novel, unique, and concerning application of child welfare or related professional principles.
- Only a small and limited clinical literature exists suggesting the value of the practice.
- There is a reasonable theoretical, clinical, or empirical basis suggesting that compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.
- The practice has a manual or other writings that specifies the components and administration characteristics of the practice that allows for implementation.

APPENDIX B

Definitions

Meta-analysis

“a statistical methodology...which enables one to compare finding across different studies which used different outcome measures in evaluating a specific problem.”

Randomized controlled trials (RCTs)

“involve the random assignment of clients to different conditions, such as to an experimental treatment group, a standard treatment, to a placebo...or to a no-treatment group. The publication describing the RCT should provide sufficient information for the reader to make a determination if the assignment to such groups was legitimately random, or possessed the potential for bias (which can cloud results).”

Systematic review

“A systematic review is a genuinely comprehensive interdisciplinary worldwide compilation of published and unpublished (where accessible) research which addresses a particular answerable question which is carefully critiqued and conclusions derived.”

Reference

McNeece, C.A. & Thyer, B.A. (2004). Evidence-Based Practice and Social Work. *Journal of Evidence-Based Social Work*, Vol. 1 (1), 7–25.

APPENDIX C

Links to Other Relevant Web Sites

The Internet has a variety of resources that have considered the evidence and classified practices related to child welfare.

- National Clearinghouse on Child Abuse and Neglect
<http://nccanch.acf.hhs.gov/>
- SAMHSA Model Programs
<http://www.modelprograms.samhsa.gov>
- Center for Study and Prevention of Violence-Blue Prints Project
<http://www.colorado.edu/cspv/>
- The Findings of the Kauffman Best Practices Project
<http://www.chadwickcenter.org>
- Child Physical & Sexual Abuse: Guidelines for Treatment
<http://www.musc.edu/cvc/guide1.htm>
- Office for Victims of Crime
<http://www.ojp.usdoj.gov/ovc>
- Cochrane Collaborative
<http://www.cochrane.org>
- Campbell Collaborative
<http://www.campbellcollaboration.org>
- Strengthening America's Families
<http://www.strengtheningfamilies.org>