Partnering to Promote Evidence-Based Practice Innovation in Child Welfare: Challenges and Ingredients for Success

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Conflict of Interest Disclosure

• Cindy M. Schaeffer and Cynthia Cupit Swenson are consultants in the development of Multisystemic Therapy for Child Abuse and Neglect and related programs through MST Services Inc., which has the exclusive licensing agreement through the Medical University of South Carolina for the dissemination of Multisystemic Therapy Technologies.

• The Medical University of South Carolina owns intellectual property rights to the MST treatment model. As such, the university receives royalties related to the treatment implementation.
Connecticut DCF landscape

• Strong system-wide investment in Evidence-Based Practice
  • excellent track record for adherent implementation of many different models
  • infrastructure investment to preserve model fidelity
  • strong collaboration with model developers to support innovation

• Multisystemic Therapy (MST)- specific partnership since 1999:
  - Standard MST and MST adaptations
  - effective implementation
  - research collaboration

• Change in child welfare practice to Strengthening Families framework
  • 7 Cross-cutting themes
  • differential response
  • family preservation
  • family driven treatment planning

• Regional structure of child welfare system promoting local partnerships with providers
Regional Partnership

DCF selection of provider (Wheeler Clinic):

- Long history of responsiveness and collaboration
  - Partnership in promoting effective service system
  - “go to” for case specific creative problems solving
  - “personal cell phone” level connection and commitment between leadership of DCF and Wheeler

- Well respected for expertise in child, family and adult treatment

- Rigor in adherent implementation of EBPs

- Proven track record of successful implementation of model adaptations
Family Interventions to Address Safety and Promote Healing

• Sequentially building upon the whole family approach of evidence-based Multisystemic Therapy (MST) to address:
  • Child abuse and neglect
  • Parental substance misuse
  • Intimate Partner Violence

• Research-demonstrated clinical interventions to address core treatment needs (for all family members):
  • Trauma, Psychiatric and dual diagnosis
  • Addiction and recovery
  • Intimate partner violence

• With broad systemic attention to:
  • Child safety
  • Ecological supports
  • Healing
  • Sustainability
Elements for success:
Model developer/researcher perspective:

• Build upon existing Evidence-Based Treatments
  • Grounding the adaptation in available science
  • For child welfare population this entails complexity of needs that require attention in the development of the model

• Early and ongoing discourse with key stakeholders
  • protective services
  • provider partners- when feasible, targeted client population –
  • what needs do they see as central?
  • broader context – e.g., police, addiction recovery support
  • advocates

• Designated team partners from protective services who are trained in the model

• Regular “stakeholder” conference calls
Elements for success:
Sponsor (research funder) perspective:

• Projects that focus on:
  • Areas of significant gaps in scientific knowledge base
  • Issues that every state is struggling with
  • high potential for dissemination / generalizability

• Evidence of high public system commitment to the project and willingness to serve as an example to other states

• Research team committed to seeking continued research funding
Elements for success:
Child welfare perspective:

• Using data
  • to identify needs of specific child welfare subpopulations (e.g., substance abuse, intimate partner violence) and gaps in service array
  • to monitor impact
  • to secure and retain funding
• If a model doesn’t yet exist, let’s build it
Elements for success: Child welfare perspective (continued):

• Identifying child welfare offices/staff that embrace:
  • innovation
  • strengths-based approaches
  • shared risk management

• Choosing partners:
  • Researchers/model developers with well-defined interventions, openness to model input, and track record of protocols for quality assurance / implementation fidelity
  • Providers with proven track record for partnering with protective services and with adherent model implementation
Elements for success:
Provider perspective:

• With high risk populations, choose model adaptations that are well articulated and grounded in research
• Strong level of ongoing consultation and collaborative problem-solving with model developers
• Super strong partnership with local child protective service team (ideally with an internal champion)
• Designated protective service staff to be assigned to the clients served by the pilot
• Training clinical and protective service staff together
• Including leadership of both provider and protective service agencies in the training
...and don’t forget

• This is NOT “business as usual”

• Take time to collectively review and reflect on successes