An Evidence Base for Child Welfare Policy:

The Need and

A Proposed Framework

A plenary presentation by:

Fred H. Wulczyn, Ph.D.
Research Fellow
Chapin Hall Center for Children
at the University of Chicago

for the Child Welfare League of America
"Using Research and Technology for Excellence
in Policy and Practice"
National Conference on Research in Child Welfare
Denver, Colorado

June 2001

Good morning and welcome to the General Session.

My remarks this morning concern the evidence base for child welfare. I would like to focus on three broad areas:

- the need for and advantages of building an evidence base in child welfare
- the critical methodological challenges of building such an evidence base
- and a framework that has been adapted, a least on an interim basis, for discussing the reauthorization of the Safe and Stable Families Program.

The Need for an Evidence Base

It is hard to imagine the need to argue for building an evidence base in child welfare when the room is filled with researchers. Nevertheless, I do want to spend some time laying out the reasons why this is important, at least from my perspective, so that the assumptions are out in the open.

First, the primary driving force is the rapidly expanding interest in measurable outcomes. Over the next few years, as the methodological issues embedded in the current structure are finally dealt with, states will gain a clearer comparative understanding of their performance vis a vis these outcomes. With this knowledge, the states will become increasingly interested in reducing the gap between their performance and the normative standards that will eventually emerge. The same will be true for those states whose performance exceeds the standards – their motivation will be a bit different insofar as they will want to maintain their edge. In either case, states will grow less interested in consensus-based practice models rooted in ideological positions, and more interested in evidence-based models that are linked to outcomes. This dynamic is already underway on a somewhat smaller scale in New York City. Our work there unveiling differences in the performance of contract agencies has those same agencies searching for ways to improve their performance relative to the baselines that have been established.

Second, all one need do is look around and an emerging preference for evidence-based practice is everywhere – health care and mental health in particular. There is no reason to believe that child welfare services are any different, that our field will some how escape the imperative. In these allied disciplines, the interest in the evidence base is in some respects an outgrowth of the issue I raised above. Comparative performance data leads inevitably to the question of cost effectiveness. Outcomes will be compared with budgets and the pattern of variation will stimulate the demand for evidence.

Third, the timing is right. In the past 10 years, the amount of information that has become available in child welfare is quite frankly extraordinary. Consider for example the state of knowledge in 1993 when the family support and family preservation funds were first authorized. At that time, NCANDS data was brand new. Up until that time, national child abuse and neglect data was largely aggregate when it was available at all. Today, NCANDS contains individual-level report data from 27 states for 826,000

substantiated allegations for 1999 alone. In 1993, the AFCARS did not exist; today, AFCARS uses individual-level data from 49 states. In 1993, the Multistate Foster Care Data Archive did not exist; at present, the Archive contains continuous placement histories for more than 1.3 million children from 12 states, dating as far back in some instances as 1983. In 1993, there were no state waiver demonstration programs; now there are more than 21 states conducting experiments of one sort or another. Finally, the National Study of Child and Adolescent Well-Being is in the field, with initial data now available to the research team.

With all of this data, the timing is right to begin building an evidence base. The importance of building such a base, as a conscious effort on the part of the scientific community, rests in the possibility that all of this data will remain in a largely unstructured format. In other words, there is a very real possibility that the knowledge base will remain a fragmented collection of factoids that have little impact on the direction of the field. As researchers trying to have an impact on the field, I would think we would want to prevent this from happening.

What is an evidence base?

At first glance, the idea of an evidence base has a natural appeal. Most everyone agrees that child welfare services have been dominated by ideological commitments as the basis on which reform has advanced. Unfortunately, these ideological commitments are of little value when confronting the thornier problems in the field. These thornier problems include such general matters as how to minimize the trauma of abuse, resolve issues of parent/child separation, and build stronger bonds between a child and his or her adoptive parents. In these contexts, the fundamental question is not a matter of family preservation or the best interests of the child. Rather, the question is "What works?" How can the circumstances of the instant case be resolved for the betterment of the individuals and families involved?

In these situations, it is helpful to have tried and true "techniques" that bring about desired results with a minimum of trial and error. Evidence in this context means effectiveness – "the probability of benefit to defined individuals of a defined treatment." In other words, a given set of inputs will achieve a given set of outcomes, with more or less one-to-one correspondence. Evidence or evidence building suggests a deliberate process of testing and re-testing, rooted in devising a theory of intervention that is applied systematically. The process is scientific in that replicability and randomized clinical trials are highly prized.

I suspect that such a narrow construction of the meaning of evidence leaves some of you with a bit of a chill. It is a feeling I share with you, if only a little bit. My primary concerns are as follows. First, I would like to focus more on the knowledge base in child welfare, as opposed to the evidence base. At the end of the day, we may not arrive at a different place, but by focusing on knowledge, I believe we open ourselves to a much richer discussion. This richer discussion is possible because we are more likely to stress the diversity of knowledge and a diversity of methods for "knowing."

Two examples may help make my point. First, evidence and effectiveness seem inextricably linked at this moment in time. If so, then evidence will eventually become a clinical term. This is a fair conclusion, but limited to the extent that many of our most fundamental concerns in child welfare have to do with system effects. That is, how does the organization of services influence not the effectiveness of treatments, but the ability to make effective treatments available to those who need them? Questions of this sort rely less on clinical studies of treatment efficacy and depend much more heavily on a basic understanding of the spatial, temporal, and population-based differences in the utilization of services. The methods for understanding these issues are much less dependent on randomized clinical trials, yet the knowledge obtained from these studies is in some respects more important to the goal of building a better child welfare system. That is because studies of this sort are much more likely to reveal the system structures that are responsible for what happens within the system.

Second, a focus on knowledge building may help us emphasize theory building within the field. Specifically, my concern with the use of the term "evidence" in the context of clinical effectiveness is that the preference for randomized clinical trials will lead the field to become method driven as opposed to theory driven. At present, I see this as more of a risk than a certainty. Nevertheless, to the extent that there are other ways of knowing – ethnography, history – the collective impact of this knowledge is diminished if it develops outside the context of theories that are in the process of being tested.

Now, I do want to be clear about my own preferences. I hold quite closely to the fundamental value of randomized trials, especially in the case of efficacy and effectiveness in clinical research. I especially see value in randomized trials for testing the central tenets of theoretical models that describe system effects. For example, the HomeRebuilder program, which we tested in New York City in the mid-1990s, used a randomized experiment to test for the presence of fiscal incentives. The presence of incentives or the potential for such incentives was part of a theory we developed having to do with how the system operated. An incentive is, however, hard to measure. We had evidence that suggested they were present; the experiment was a test of the theoretical proposition; the presence of those incentives had to be inferred from the behavior observed.

Given the limited opportunity to conduct research involving randomized trials, it seems to me that theory building that spawns strategically opportune experiments designed to test critical propositions is indeed the way to go, especially if our theories are constructed using the many ways of knowing we have at our disposal.

A Framework for Building Knowledge and Evidence

Based on the assumption that the Safe and Stable Families Act will be reauthorized, bolstered by an additional $200 million proposed by President Bush, a number of

researchers from a number of institutions[*] have joined me and collaborated on a project to identify the evidence base to support child welfare policy. To support our work, we developed a framework with three layers. The first layer focuses on two basic questions:

1. Who are the children who may need child welfare services? What is their contact with these services?

2. What works for children who need and/or use child welfare services? Are there successful services and programs?

To answer these questions, we applied thresholds. For the first question, we were interested primarily--though not exclusively--in trends and patterns in the risk of maltreatment and placement that show persistence over place and time. In other words, we asked whether the risk of placement for one group of children is consistently above or below the comparable rate for some other group of children

The second question – What works? – is a more difficult question. The threshold in this case is randomized clinical trials (with a well-defined theory of change). Thus we were interested in studies such as the National Evaluation of Family Preservation Programs, as well as any others that in the first instance met this test. We also looked at what Barbara Burns called "promising approaches."

The second layer we used to organize our information concerns the notion of trajectories. We see three trajectories that are a part of a child's engagement with the child welfare system.

1. **Developmental trajectories**. These are trajectories that relate to normative developmental cycles over the life course of childhood. Children have developmental trajectories whether they are in the child welfare system or not.

2. **Clinical trajectories**. These trajectories are closely related to developmental trajectories in that the clinical manifestation of maltreatment is often heightened or attenuated by developmental stage of the persons involved. Nevertheless, the complex of behaviors that make up maltreatment represents a process in its own right. We refer to those as clinical trajectories. These can be a response to the behavior of adults, if you are a child. There are corresponding themes on the side of the perpetrator.

3. **Administrative trajectories**. These trajectories refer to the movements of children through the child welfare system as defined by actions of child welfare professionals. The are typified by administrative milestones. They are also driven by treatment regimens. Developmental and clinical trajectories are embedded in the administrative trajectories in that a child faces higher risks of placement or reporting, etc. at different ages or stages of development. But these trajectories are also very likely to be a function of institutional structures.

---

[*] Richard Barth, Brenda Harden, John Landsverk, and Ying-Ying Yuan

We use the term trajectories because of their value in organizing complex subject matter into a research framework. In particular, the obvious interdependencies force the researcher to consider how movement through the child welfare system is interdependent with child development trajectories. Moreover, the notion of trajectories is itself inherently developmental. It requires the researcher to think in terms of patterns in the timing, duration, spacing and order of events; the timing of an event may be as consequential for life experience as whether the event occurs and the degree or type of change. Age differentiation is manifested in expectations and options that impinge on decision processes and the course of events that give shape to life stages, transitions, and turning points (Elder, Glen. 1978. "Family History and the Life Course." In Tamara Hareven, ed., *Transitions: The Family and the Life Course in Historical Perspective.* Pp. 17-64. New York: Academic Press). Finally, trajectories are important for understanding the basic goal of intervention, which is to alter the trajectory. For example, the services the Safe and Stable Families Program is supposed to fund–family support and preservation, reunification, and post-adoption services--are intended to alter the trajectories of children. They are intended to lower the probability of abuse and neglect, to reduce the likelihood of placement, to shorten duration in substitute care, and to reduce the likely of reentry or adoption disruption. In short, it is designed to alter the sequence, timing, and duration of key transitions.

The final layer concerns age. In effect, we adopted this perspective because of what we knew about what the data have to say in the first place. However, in the context of trajectories, the notion of age-differentiated trajectories is particularly important because of what it says about the structure and organization of services. Although we might be interested in preserving families, or reducing length of stay in foster care, the manner in which we pursue those goals is quite different if we are dealing with a population of infants as opposed to adolescents. Moreover, the analysis of age-differentiated trajectories is oriented to the process of change and ultimately to the tasks of explaining such change, and the expectation that we can learn how to "manipulate" the trajectory in favorable ways.

What have we learned applying this framework to the evidence in child welfare? First, the epidemiological data is far more developed than data about program outcomes. For example, we can say with a high degree of certainty that we have in this nation a substantial problem with the maltreatment and placement of infants. The specific problem, in the context of the family, is neglect--although other types of maltreatment are important. Placement rates for this population are considerably higher for this population in almost all of the 12 Archive states. There are inconsistencies, but as regards the persistence over time and place, infants are the single most important population of children facing the child welfare system. The second population of concern is teens.

As to the question of what works – we know very little, although there are some promising programs, especially pertaining to the high-risk populations I described above. The have to do with home visitation programs (for very young children) and multisystemic therapy for older children. The specific value of these programs is that they have been tested rigorously with difficult populations, and shown to have positive impacts on the children involved. Perhaps more important, as models for testing

programs – building evidence--these examples point to the need for programs that are well targeted with regard to the population they are designed to reach, the need to have a well-defined theory that frames the intervention in the context of outcomes, the need to have a well-developed intervention, and the need to follow a path that starts small and slowly and builds on the cumulative evidence of the preceding steps.

This is perhaps the most important note, and I will close with this. Evidence accumulates. It is the result of a deliberative process wherein scientists challenge assumptions and test ideas carefully. We are quickly reaching in child welfare the point when the data we have at our disposal can be used in ways that are in some sense unfamiliar to us. Remember, 10 years ago we did not have individual-level maltreatment and placement data to use as the basis for building knowledge. The times have changed. We have a lot of work to do.