Towards Evidence-Based Policy and Practice in Child Abuse Prevention

developed for the network of Parent Aide programs
with the National Exchange Club Foundation
by Jill Bomberger, MSW student and Jeanette Harder, PhD
February 26, 2008

This article describes evidence-based practice as it relates to the roles administrators play in child abuse prevention as well as what is needed in order to establish the Parent Aide model as "evidence-based." Different issues surrounding evidence-based practice in community settings are explored. The strength of evidence supporting child abuse prevention interventions is discussed. Increasing efforts at program evaluation can both expand the base of empirical evidence supporting interventions and improve program service delivery.

Is EBP for Policymakers, Administrators, or Practitioners?

The *de facto* mandate to work towards evidence-based practice (EBP) is felt by professionals involved in child welfare at all levels. Yet, the demands presented by the need to engage in evidence-based practice vary greatly between those who work directly with clients and those who administrate programs designed to promote child welfare. Program administrators are continually faced with the challenge of providing the best services to the most families in need while demonstrating to funding sources that program services are effective. The majority of resources about evidence-based practice in child welfare focuses on clinical practice with clients and states little regarding evidence-based policy and management. Mullen and Streiner (2006) emphasized the importance of recognizing that "EBP encompasses policy, management, and direct or clinical practice" (p. 22). Understanding what evidence-based practice is and is not is a necessary step for program administrators as they continue to strive towards providing the best, most effective services.

Evidence-Based Practice in Child Welfare

According to Proctor and Rosen (2006), evidence-based practice is "the use of treatments for which there is sufficiently persuasive evidence to support their effectiveness in attaining the desired outcomes" (p. 93). Thus, without "sufficiently persuasive evidence" a treatment cannot be evidence-based. Community organizations typically engage in evidence-based practice by providing treatments as part of intervention models which have been shown to be effective in randomized controlled trials.

The implications of conducting evidence-based practice in the field of child welfare are distinct because the amount of empirical research in child welfare is minute compared to that available in other fields such as medicine. The shortage of empirical research is confounded by ethical concerns associated with research methods involving random assignment to control groups of participants who are in need of services that are designed to prevent the removal of children from the home and protect children from harm. Yet, the need for evidence-based practice and policy is high precisely because child abuse prevention involves working with children and families at high risk of experiencing trauma.

> ***… the amount of empirical research in child welfare is minute compared to that available in other fields…***

Whether or not a treatment meets a standard of "sufficiently persuasive evidence" is based upon both the results of studies of it and the level of scientific rigor at which studies were conducted. A rating system is used to rank programs and interventions based on the level of scientific evidence that supports them as effective. According to the California Evidence-Based Clearinghouse for Child Welfare (n.d.), interventions may fit one of six levels on their scientific rating scale, ranging from "Well Supported- Effective Practice" to "Concerning Practice." As shown in Table 1, in order for an intervention to receive the highest scientific rating, at least two published randomized control studies must demonstrate sustained effects at least one year after treatment.

Every professional who works in child welfare or provides services to at-risk families is familiar with the practical difficulties of retaining participants and contacting participants for post-treatment follow up. Professionals are also aware of the ethical concerns and difficulty of creating a control group, effectively denying or postponing services to families in need. These same professionals recognize that the services they provide make a difference in the lives of

Table 1 Scientific Ratings
adapted from California Evidence-Based Clearinghouse for Child Welfare

Scientific Rating	Risk	Book or Manual	Research design	Follow-up evidence	Outcome Measures
Well Supported-Effective Practice	No evidence of risk of harm	Service components specified. Instructions for administration	At least two randomized control studies conducted at different sites show practice is superior to comparison practice published in peer-reviewed journals	Studies show sustained effects 1 year after treatment	Reliable, valid, consistently and accurately administered
Supported-Efficacious Practice	No evidence of risk of harm	Service components specified. Instructions for administration	At least two randomized control studies show practice is superior to comparison published in peer-reviewed journals	Studies show sustained effects 1 year after treatment	Reliable, valid, consistently and accurately administered
Promising Practice	No evidence of risk of harm	Service components specified. Instructions for administration	At least one study with some type of control shows efficacy over comparison published in peer-reviewed journal		
Acceptable/ Emerging Practice	No evidence of risk of harm	Service components specified. Instructions for administration	Lacks research to determine efficacy.		
Evidence Fails to Demonstrate Effect			At least two randomized control studies show no advantage over comparison		
Concerning Practice	Likely or possible				

clients. Nevertheless, lay observations of success do not constitute sufficient evidence of effectiveness in the eyes of funding sources and researchers.

Many programs rely on comparing the services they provide to those featured in published studies. Yet, the services provided, populations served, and intended outcomes may vary significantly. At the same time, the field of research within child abuse prevention has many gaps and inconsistencies. For example, home visitation programs for the prevention of child abuse are widespread, and while various studies have indicated they are likely effective (Bugental et al., 2002; DePanfilis & Dubowitz, 2005; Harder, 2005; Olds et al., 1997), others have shown little or no effectiveness (Macmillan et al., 2005; Duggan et al.,

… lay observations of success do not constitute sufficient evidence of effectiveness in the eyes of funding sources and researchers

2004). Various home visitation programs differ in intended populations, staff characteristics, durations, family risk-level, and focus. Individual programs can make concerted efforts to help increase the availability of more conclusive evidence regarding home visitation, while advancing their program evaluation practices.

While programs may not have the resources to engage in studies that meet the standards required for the highest level of methodological design, they can take steps that more closely align them with the design needed to show efficacy.

Individual programs can make concerted efforts to help increase the availability of more conclusive evidence regarding home visitation.

Evidence-Based Practice and the Parent Aide Model

According to the California Evidence-Based Clearinghouse for Child Welfare, "promising practices" show efficacy over some type of comparison group, such as a control group or a quasi-experimental group. For a practice to be considered promising, there must be no evidence of risk of harm, the program must have a manual specifying components, and at least one study must be published in a peer-reviewed journal.

The Parent Aide program may be considered "promising" under this definition. Harder's (2005) quasi-experimental study comparing recidivism among participants who completed the program to those who dropped out or initially refused services from Dallas's Parent Aide program showed that those who completed had fewer subsequent substantiated reports of child abuse or neglect. Currently, Guterman is serving as principal investigator for an experimental study involving five Parent Aide programs in North Carolina. According to the Exchange Center of North Carolina (n.d.), random assignment is used to assign clients to either a treatment condition of Parent Aide services in addition to case management or a control group, which is placed on a waiting list and provided with case management alone. This study has the potential to expand and strengthen the evidence-base supporting Parent Aide. Positive results would show that the Parent Aide model is superior to case management alone as measured by CPS reports and several standardized measurement tools related to child abuse prevention. Positive results from this study and others, which include analysis of post-treatment follow-up data, would be needed in order for the Parent Aide model to move to a higher level of scientific rating as described by the California Evidence-Based Clearinghouse for Child Welfare.

While the results of Harder's study are encouraging, they are not sufficient to indicate that Parent Aide is unequivocally preventing child abuse. Furthermore, because the study was conducted on the Dallas program and the unique population they serve, the findings cannot be said to imply that the same results would occur at other Parent Aide locations. The same is true of the study based in North Carolina. By conducting further studies at other locations the Parent Aide program as a whole can strengthen the body of evidence that supports it as an effective, worthy intervention. Such endeavors require both dedication from individual Child Abuse Prevention centers as well as coordination, incentive, and resources from the National Exchange Club Foundation. Improving and standardizing the collection of data regarding clients, services, and outcomes not only increases the programs' professionalism, but also facilitates the use of data for research and program evaluation. Administering standardized instruments and systematically designating the level of success or completion for each client are also ways individual centers can prepare for more advanced evaluations of services. Collecting and analyzing follow up data on participants, including information on reports to Child Protective Services, is a key component of measuring the preventative nature of services and ultimately gaining more scientific support for the Parent Aide intervention.

Collaboration between practitioners, administrators, network leaders, and researchers will facilitate the establishment of the Parent Aide model as "evidence-based."

The results of one study cannot designate the Parent Aide program "evidenced-based." Rather multiple studies, at multiple locations add to the body of evidence available to support the efficacy of Parent Aide. Despite the fact that child abuse prevention programs do not have unequivocal, overwhelming evidence supporting their home visitation models, evidence-based practice is important for ethical and practical reasons. This does not signify that the interventions are not effective, just that there is not yet enough empirically evidence to conclude that they are effective. Collaboration between practitioners, administrators, network leaders, and researchers will facilitate the establishment of the Parent Aide model as "evidence-based."

References

Bugental, D.B., Ellerson, P.C., Rainey, B., Lin, E.K., Kokotovic, A., & O'Hara, N. (2002). A cognitive approach to child abuse prevention. *Journal of Family Psychology, 16* (3), 243-258. Retrieved September 5, 2007, from EBSCO database.

California Evidence-Based Clearinghouse for Child Welfare. (n.d.) *Scientific rating scale.* Retrieved February 17, 2008, from http://www.cachildwelfare clearinghouse.org/scientific-rating/scale

DePanfilis, D., & Dubowitz, H. (2005, May). Family Connections: A Program for Preventing Child Neglect. *Child Maltreatment*, *10*(2), 108-123. Retrieved February 17, 2008, from EBSCO database.

Duggan, A., Fuddy, L., Burrell, L., Higman, S.M., McFarlance, E., Windham, A., et al. (2004). Randomized trial of a state wide home visiting program to prevent child abuse: impact in reducing parental risk factors. *Child Abuse & Neglect, 28*(6), 623-643.

Harder, J. (2005). Prevention of child abuse and neglect: An evaluation of a home visitation Parent Aide program using recidivism data. *Research on Social Work Practice, 15*(4), 246-256. Retrieved May 12, 2007, from http://myweb.unomaha.edu/~jharder/CANResearch/Recidivism.pdf

MacMillan, H.L., Thomas, H.B., Jamieson, E., Walsh, C.A., Boyle, M.H., Shannon, H.S., et al. (2005). Effectiveness of home visitation by public-health nurses in prevention of the recurrence of child physical abuse and neglect: A randomised controlled trial [Electronic version]. *The Lancet, 365,* 1786-1793.

Mullen, E. J., & Streiner, D. L. (2006). The evidence for and against evidence-based practice. In A. R. Roberts, & K. R. Yeager (Eds.), *Foundations of evidence-based social work practice* (pp. 21-34). New York: Oxford University Press.

Exchange Center of North Carolina. (n.d.).*Evaluating the work of parent aides.* Retrieved February 26, 2008, from http://www.exchangescan.org/parentaide.html

Olds, D.L., Eckenrode, J., Henderson, C.R., Kitzman, H., Powers, J., Cole, R., et al. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: fifteen-year follow-up of a randomized trial [Electronic version]. *The Journal of the American Medical Association, 278*(8), 637-643.

Proctor, E. K., & Rosen, A. (2006). Concise standards for developing evidence-based practice guidelines. In A. R. Roberts, & K. R. Yeager (Eds.), *Foundations of evidence-based social work practice* (pp. 93-102). New York: Oxford University Press.