



**INDICATORS OF CHILD
WELL-BEING INDICATORS
IN THE
CHILD WELFARE SYSTEM**

KRISTIN A. MOORE, PH.D.

**Presentation to a meeting on “Strengthening
Abuse and Neglect Courts in America”**

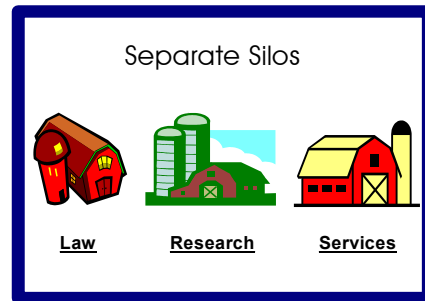
**Miami, FL
June 24, 2004**

INDICATORS OF CHILD WELL-BEING INDICATORS IN THE CHILD WELFARE SYSTEM

KRISTIN A. MOORE, PH.D.

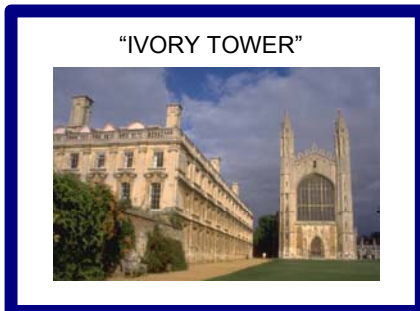
JUNE 24, 2004

When Child Trends began to do work on child abuse, neglect and foster care, I was quite surprised to see how thin the research base is on this topic. It was clear that people were working in silos that is, they are quite isolated and unconnected from one another.



The services community and the law enforcement community including the courts may not always work hand-in-glove; but the research community seemed particularly uninvolved. There are important exceptions; but I was surprised by the degree to which practice on child abuse and neglect has not been linked with research.

Not that this is unusual. A lot of research is very “ivory tower.”

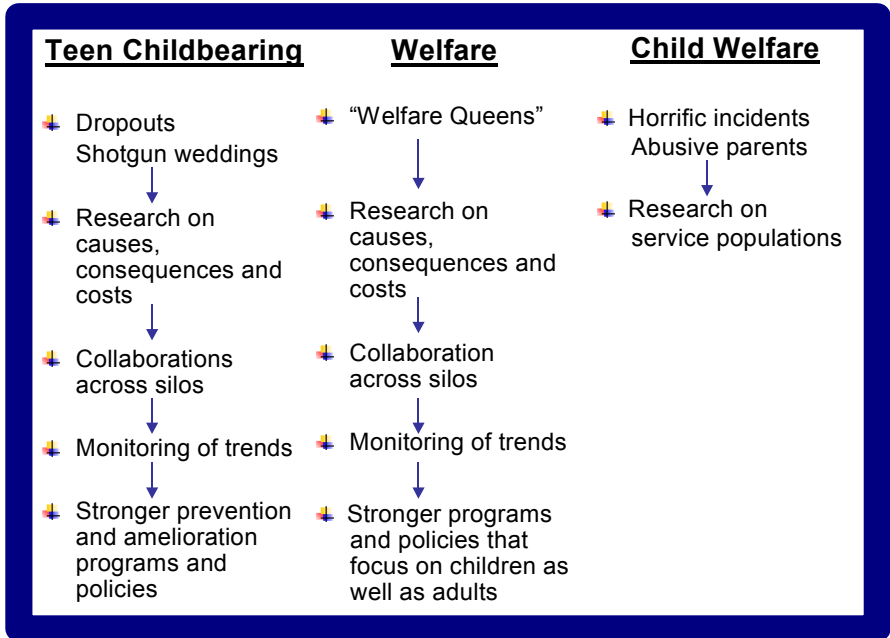


However, over the course of my research career, I have seen several issues with important practical, on-the-ground implications for children go through a series of stages.

For example, I have done a lot of work on adolescent pregnancy. This is a very important issue for this nation; but when I started in the 1970s, the focus was quite simplistic in its focus on high school dropout and shotgun marriages. Research tended to focus on girls in programs for young mothers and girls in low-income communities.

Teen childbearing was often viewed as a problem of private morality; but our research made it clear that teen childbearing imposes substantial public costs and has important implications for children. The development and well-being of the children born to the adolescents came into focus, along with the adolescent parents.

As shown in this chart, over the years, collaborations developed among policy makers, program providers and researchers, who attended conferences together and informed one another. However, program staff did



not want to be held responsible for behaviors that were out of their control. For example, a teacher stressing abstinence and a clinic worker providing contraception both know that they cannot alone prevent teen pregnancy; and they don't want

to be held solely accountable. Understandably so!

Gradually, a rich research literature developed, which has informed discussions about the causes and consequences of adolescent pregnancy, and made it clear how complex the issue is. This work made it clear that accountability is diffuse. It also made it clear how important it is to have clear goals.

Over the years, a number of demonstration and experimental evaluation studies have been implemented. Trends have been monitored at the national level and at the state level. For example, we have done a report, "Facts at a Glance," for two decades, reporting on the trends in teen childbearing in the nation, states and large cities.

And, slowly, we have seen a dramatic decline in the teen birth rate in every single state. Not just because of research, but because, I think, research linked with programs, policies, evaluation studies and monitoring of trends has gradually developed better prevention approaches, despite countervailing forces in society and the economy.

Similarly, in the early 1980s, there was very little research on welfare. As depicted in the center column of the chart, images of “welfare queens” predominated and, oddly, the well-being of the children was again not very much a part of the picture. This was surprising, for a program called “Aid to Families with Dependent Children,” almost nothing was known about the children in welfare families. What research was done tended to focus on families in the system, with little attention to similar families not in the system or the families that moved in and out of the system.

Again, gradually, partnerships evolved between lawmakers and policy makers at the Federal and state level, program managers on the ground, and researchers, and a knowledge base began to develop that acknowledged the complexity of the issue. People have really worked to move out of their isolated silos and collaborate.

Research and evaluation studies were commissioned, and the development and well-being of children in families that received welfare payments started to be included in the focus of research and policy making.

An indicators report on welfare dependency was developed by the federal government, and trends in dependency were monitored.

As you probably know, the last decade has been a time of substantial policy innovation in the welfare field. Researchers have worked hard to monitor and assess the well-being of children during a time of dramatic change. One measure of success in this is that the well-being of the children in welfare families was defined as the “over-arching goal” of welfare reform in the Administration’s most recent welfare legislation.

Again, however, welfare workers and policy makers have resisted being held solely accountable for the well-being of the children in their program. Also, understandable.

Again, though, research has shown the complexity of the issue, clearly showing that, because of this complexity, no one person or agency can be held accountable for the children in the program.

Yet, again, it has proven to be important to have goals for states and programs and to pay attention to the outcomes for the vulnerable children in

families that receive welfare. Welfare rolls have declined, and a lot of state and local services have been focused on the needs of welfare families.

I'm not claiming that either teen childbearing or welfare reform are solved and over and done with. We continue to face substantial challenges to our understanding and our effort to develop stronger programs and policies; but we have made real progress.

What, then, about the child welfare field? I'd have to say that I see a similar pattern:

- A simplistic focus in the media and public on horrific individual incidents and abusive parents, with little understanding of the complex factors that underlie the causes and consequences.
- Research on service populations. That is research on kids in the system, not research on all children that examines the factors that result in some children being abused or neglected.
- Little attention to the development and well-being of the children themselves.
- Little collaboration across silos.
- Minimal monitoring of trends.
- Concern among staffers about being held accountable for outcomes which one cannot produce.

Fortunately, with the support of the Doris Duke Foundation, Child Trends was able to take a small, initial collaborative step, working with an consortium of experts who see the need to move forward in the child welfare field on a variety of fronts, one of which is developing indicators of child well-being that can be used in the child welfare system.

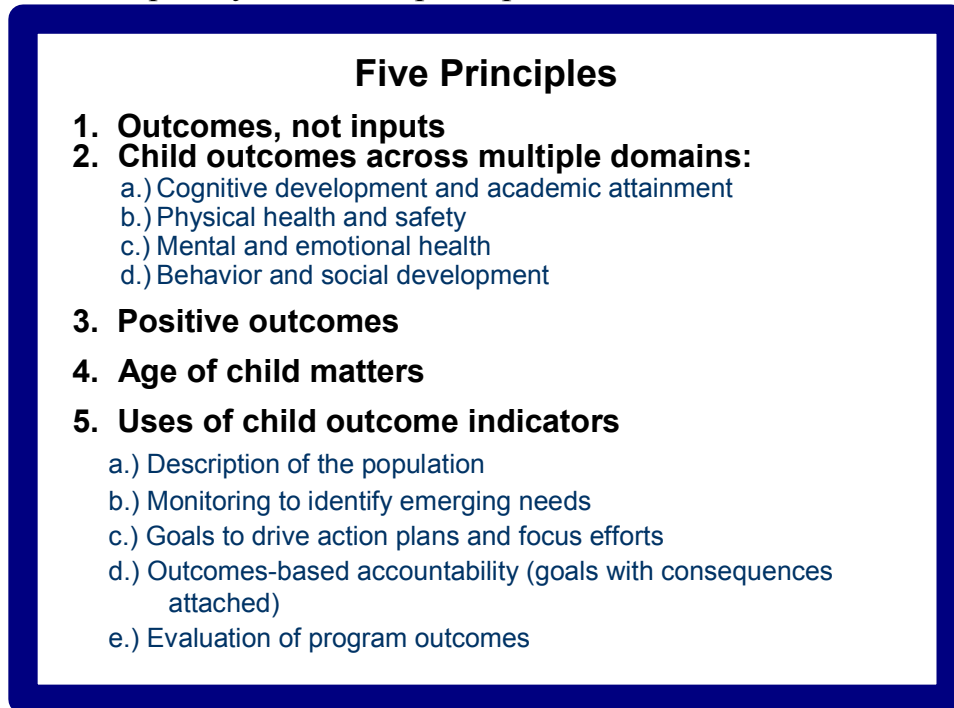
This consortium project focused on the "Development and Use of Child Well-Being Indicators in the Prevention of Child Abuse and Neglect." A series of meetings brought together a consortium of members, including Florida Judge Cindy Lederman, to work toward developing a set of measures of child well-being for use in the child welfare system. This group succeeded in selecting a set of constructs for this purpose, and I want to share them with you, after a brief set of background points.

As I noted, there is a lot of experience with developing indicators of child well-being in other fields and in general; and there is a vast literature on the

development of children. This knowledge base can inform a set of principals to guide work in a new topic area.

In other words, drawing on this knowledge base can enable the child welfare field to leapfrog ahead, especially if some one or some place is willing to take the lead in making it happen.

I would like to quickly share five principles.



Five Principles

- 1. Outcomes, not inputs**
- 2. Child outcomes across multiple domains:**
 - a.) Cognitive development and academic attainment
 - b.) Physical health and safety
 - c.) Mental and emotional health
 - d.) Behavior and social development
- 3. Positive outcomes**
- 4. Age of child matters**
- 5. Uses of child outcome indicators**
 - a.) Description of the population
 - b.) Monitoring to identify emerging needs
 - c.) Goals to drive action plans and focus efforts
 - d.) Outcomes-based accountability (goals with consequences attached)
 - e.) Evaluation of program outcomes

First, it is important to assess child outcomes, not just inputs. In other words, we are not just assessing the services that are delivered that are “inputs” to children’s development, but the child outcomes themselves.

This principle accords with a strong trend among policy makers and funders, who are increasingly demanding a focus on outcomes – not just on providing inputs but on changing outcomes. And, ultimately, for child welfare, those outcomes are child outcomes.

Second, child outcomes need to be assessed across multiple outcome domains. The child development field varies in just how they group child outcomes, but they generally incorporate these groupings:

- cognitive development and academic attainment

- physical health and safety
- mental and emotional health
- behavior and social development

Third, development is not just about the prevention of problems, but also about the promotion of positive outcomes. Thus, it is not sufficient that children avoid violence, death, injury and disease; but we should also help children to develop positive capacities, such as school engagement and healthy relationships.

Fourth, the age of the child matters. Outcome measures need to be sensitive to age differences. Toddlers are very different than adolescents.

Fifth, child outcome indicators can be used in a number of ways; and it is critical to be careful about how they are used. Brett Brown (of Child Trends) and Tom Corbett (of the University of Wisconsin) have identified this hierarchy of uses:

- 1.) description of the population, in this case the child welfare population;
- 2.) monitoring to identify emerging needs;
- 3.) goals to drive action plans and focus efforts;
- 4.) outcomes-based accountability (goals with consequences attached);
and
- 5.) evaluation of program outcomes.

I have found, in the fields of teen pregnancy and welfare reform, as well as child welfare, that the resistance to using outcome indicators comes from the concern that they will be used to evaluate program outcomes or as tools of accountability (the fourth and fifth uses listed here). As I noted, program providers know full well that they cannot single-handedly change child outcomes in measurable ways. This needs to be recognized. Program providers, social workers, judges and others rarely have the time or resources to single-handedly change outcomes for children. And it warrants mentioning that researchers are in agreement: indicators are not appropriate for evaluation of impacts, because you cannot determine causality from indicators. However, indicators have other very valuable uses, and we don't want to throw out the baby with the bath water!

Just describing the child welfare population can greatly enrich our understanding. What proportion of children has had a developmental

screening? What proportion has had a dental exam? What proportion of pre-schoolers has been enrolled in an early care and education program? What proportion of adolescents abuse substances?

Participants in our project strongly endorsed the idea of having richer descriptive information like this about the children in the child welfare population.

There were fewer topics, however, on which participants felt that monitoring would be appropriate, and even fewer where goal-setting was endorsed.

However, there were exceptions. Participants felt that it would be appropriate to set goals and monitor whether children have received their recommended vaccinations, whether children were absent from school three or more days a month, and whether youth aged 15 or older had acquired basic life skills.

In a few cases, participants felt that it would be useful to monitor an indicator, but not to set goals. For example, the proportion of children receiving a developmental screening was seen as useful for description and monitoring but not for goal-setting.

No indicators were chosen for purposes four and five, accountability and evaluation.

The grid that was developed by participants in the consortium is provided below. (It is Table 2 from Child Trends' project report to the Doris Duke Foundation.)

Please note that the five uses of indicators are highlighted in the upper right portion of the grid. This table goes on for several pages, because it defines multiple child outcome domains and it identifies the potential uses of each indicator. The "Xs" represent the votes of consortium members on what they see as the appropriate uses for each indicator *within the child welfare system*.

Many of these indicators are already being tracked for children in the general population or in other sub-populations; but, as I described, there is a process that needs to evolve, and we don't want to rush it. On the other

hand, we do want to move forward; and it is clear to me that today represents an important opportunity to take an singular step forward.

Thank you.

Table 2. Recommended Child Well-Being Indicators for Child Welfare Populations^{i,ii}

DESCRIPTION ⁱⁱⁱ	MONITORING ^{iv}	GOALS ^v	OUTCOMES-BASED ACCOUNTABILITY ^{vi}	EVALUATION ^{vii}
----------------------------	--------------------------	--------------------	---	---------------------------

OVERALL: A. Child Health and Health Services (*High Priority “Short List”*)

• Age of mother at time of first birth (17 and younger)	X				
• # and % of children aged 19-35 months who receive recommended vaccines	X	X	X		
• Overall child health rating by caregiver as very good or excellent	X				
• # and % of youth with substance abuse issues (smoke cigarettes regularly, problem drinking, use of illicit drugs)	X				
• # and % of children who have some professional diagnosis for psychiatric illness	X				
• # and % of children with emergency room visits with injuries	X				

A1: Measures of Healthy Beginnings

• Age of mother at time of first birth (17 and younger)	X				
• # and % of mothers who self-report prenatal use of drugs or alcohol in excess of clinical guidelines	X				
• Birthweight and prematurity	X				

A2: Measures of Preventive and Routine Health Care

• # and % of children aged 19 to 35 months who receive recommended vaccines	X				
• Persons with a usual care provider (person or place)	X				

A3: Measures of Physical Health and Nutrition

• Overall child health rating by caregiver as very good or excellent	X				
• Height and weight	X				

• # and % of adolescents with substance abuse issues (smoke cigarettes regularly, problem drinking, use of illicit drugs) and sexual risk-taking behaviors	X	X			
A4: Measures of Oral Health					
• # and % of children 3 and older who receive annual dental exams	X				
• # and % of children with no dental caries at age 5	X				
• # and % of children at age 6 with untreated dental problems	X				
A5: Measures of Mental Health					
• # and % of children who have some professional diagnosis for psychiatric illness	X				
• # and % of children who take medication for mental health disorders	X				
• Capacity to cope with stress, and to engage in personally meaningful activities and relationships (ages 12-18)	X				
A6: Measures of Healthy and Safe Environments					
• # and % of children with injuries requiring medical assistance	X				
• # and % of children with substantiated or confirmed (open) cases of abuse and neglect following placement	X				
• # and % of children with recurrence of child maltreatment within 12-month period	X				
• # and % of children who have witnessed domestic violence	X				
<i>OVERALL: B. Education and Cognitive Skills (High Priority “Short List”)</i>					
• # and % of children who have ever attended an accredited nursery school, pre-K, or Head Start program by the time of kindergarten entry (ages 0-5)	X				
• # and % of children who are on grade-level by age	X				
• # and % of children demonstrating proficient, advanced, basic, or below basic scores on reading and math achievement tests for 4 th , 8 th , and 12 th graders	X				
• # and % of children who graduate high school	X				
• # and % of children absent 3+ days in previous month	X	X	X		
• # and % of children who change schools/continuity of schools/2 or more moves not for grade promotion	X				
B1: Measures of Participation in Early Childhood Education Programs					

• # and % of children who have ever attended an accredited nursery school, pre-K, or Head Start program by the time of kindergarten entry (ages 0-5)	X	X			
• # and % of children with developmental delays and learning disabilities who participate in preschool programs	X				
• # and % of children ages 3+ who ever had learning disabilities	X				
B2: Measures of School Enrollment, Engagement, and Grade-Level Performance					
• # and % of children who are on grade-level by age	X				
• # and % of children demonstrating proficient, advanced, basic, or below basic scores on reading and math achievement tests for 4 th , 8 th , and 12 th graders	X				
• # and % of children who graduate from high school	X				
• # and % of children absent 3+ days in previous month	X				
B3: Measures of Participation in Extracurricular Programs					
• # and % of children who attend extracurricular program 1time per week	X				
<i>OVERALL: C. Social and Emotional Development^{viii} (High Priority “Short List”)</i>					
• Relationships (e.g., with a caring adult)					
• Status (e.g., developmental status)					
• Services (e.g., getting needed services)					
• Community (e.g., being engaged with a community)					
• Future (e.g., basic life skills)					
C1: Measures of Quality Care During Formative Years					
• # and % of 3- to 5-year olds enrolled in a quality early care and/or education program (e.g., Head Start, pre-k, nursery)	X				
C2: Measures of Home Environment and Child Development					
• # and % of children whose families read to them or tell them stories regularly (ages 0-8)	X				
• Proportion of children less than 13 years old in latchkey situations	X				
• Child attends religious/cultural/community events with friends/family/mentor/caring adult	X				
• Child feels cared about by adults, teachers around them	X				

• Child has an adult they can go to for help	X				
• Child feels safe	X				
C3: Measures of Developmental Screening and Intervention Services					
• # and % of children who receive developmental screenings	X	X			
• # and % of children identified as having special needs by kindergarten entry	X				
• # and % of eligible children in early intervention programs	X				
• # and % of children identified with disabilities who are referred to developmental services by kindergarten entry	X				
• # and % of children with learning disabilities and/or developmental delays	X				
C4: Measures of Developmentally Appropriate Behaviors and Attitudes					
• # and % 0-3 year olds with trusting relationship with primary caregiver	X				
• # and % of children with good conflict resolution and interpersonal problem-solving skills (ages 6-11)	X				
• # and % of children with strong, positive self-image (competent, efficacious) (ages 6-11)	X				
• # and % of youth who have goals and believe they can attain them (hope)	X				
• # and % of children with one or more close friends (can be a sibling)	X				
• # and % of youth arrested for violent crimes in the past year (ages 10-17)	X				
C5: Measures of Youth Development					
• # and % of high school seniors actively engaged in activities or hobbies such as: see friends, read, do sports, work around the house, play music, do art, or write on a daily basis	X				
• # and % of youth involved in postsecondary education	X				
• # and % of youth aged 15 and older with basic life skills	X	X	X		

¹ Indicators in this table were derived from multiple sources, including: Brown, B.V. (1997). Indicators of children's well-being: A review of current indicators based on data from the federal statistical system. In R.M. Hauser, B.V. Brown, & W.R. Prosser (Eds.), *Indicators of children's well-being* (pp. 3-35). New York, NY: Russell Sage; First 5 Statewide Evaluation Team. (2002). *Child, family, & community indicators book*. Sacramento, CA: The California Children and Families Commission; Hair, E.C., Moore, K.A., Hunter, D., Kaye, J.W. (Eds.). (2002). Clark youth development outcomes compendium. Edna McConnell Clark Foundation & Child Trends; Healthy People 2010. Centers for Disease Control and Prevention, National Center for Health Statistics. Available at www.cdc.gov/nchs/hphome.

ⁱⁱ The table is organized by three major domains: health, education, and social and emotional development. The indicators listed under the “overall” category for each domain are the recommended indicators for that whole domain. Then each domain is broken down into multiple subcategories, and recommended indicators are listed for each of those. The overall indicators are comprised of indicators from the subcategories, thus, there is duplication.

ⁱⁱⁱ Description: Indicators in this category describe the condition of children and families. See p. 29 of Brown, B.V., & Corbett, T. (2003). Social indicators as tools of public policy. In R.P. Weissberg, H.J. Walberg, M.U. O’Brien, & C.B. Kuster (Eds.), *Long-term trends in the well-being of children and youth* (pp. 27-49). Washington, DC: Child Welfare League of America.

^{iv} Monitoring: Indicators in this category “provide a means for identifying emerging, waning, and continuing needs of children and their families, needs that may be amenable to change through intentional intervention.” See p. 30 of Brown & Corbett (2003).

^v Goals: Indicators in this category “serve as focal points around which to organize social action in an effective and coordinated manner. Unlike simple monitoring, goals are associated with an active plan to improve social well-being along one or more specified dimensions.” See p. 31 of Brown & Corbett (2003).

^{vi} Outcomes-Based Accountability: Indicators in this category are basically “goals with attached consequences.” See p. 33 of Brown & Corbett (2003).

^{vii} Evaluation: Indicators are rarely used in causal evaluations of programs and policies, but new methods of evaluation are being developed in which aggregate indicators “represent the intermediate and long-term goals of each initiative and are the ultimate measuring sticks for the initiative’s success or failure.” See p. 37 of Brown & Corbett (2003).

^{viii} Instead of choosing overall indicators for this area, these 5 constructs were recommended by the social and emotional development small group. See the subcategories under this area for specific indicator recommendations.